



CLINICAL GUIDELINES

Spine Surgery

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eviCore healthcare Clinical Decision Support Tool Diagnostic Strategies: This tool addresses common symptoms and symptom complexes. Imaging requests for individuals with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist and/or individual's Primary Care Physician (PCP) may provide additional insight.

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Graft (or Implants)

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- 20937 Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)**
- 20938 Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) (List separately in addition to code for primary procedure)**

I. Recombinant human bone morphogenetic protein rhBMP-2 (InFuse®) may be medically necessary for the following indications: (ALL of the following)

- A. Approved lumbar spine fusion;*and*
- B. High risk of fusion failure;** and*
- C. When autologous bone and bone marrow harvest are not feasible or are not expected to promote fusion;*and*
- D. In combination with FDA-approved fusion device for a single-level anterior interbody lumbar or lumbo-sacral fusion (e.g., ALIF) surgery for:
 - 1. Degenerative disc disease at one level from L2-S1
 - 2. No more than Grade III spondylolisthesis at the involved level

II. rhBMP-2 (InFuse®) is unproven for the following:

- A. Skeletally immature patient
- B. Planned use of grafting in the vicinity of a resected or extant tumor
- C. Known contraindications (e.g., pregnancy, hypersensitivity/allergy, infection)
- D. Treatment of the cervical or thoracic spine
- E. Lumbar spine surgery via posterior approach

***High risk for fusion failure can be defined by the presence of one or more of the following criteria:**

- One or more previous failed spinal fusion(s);
- Grade III or worse spondylolisthesis;
- Fusion to be performed at more than one level;
- Current tobacco use;
- Diabetes
- Renal disease;
- Alcoholism
- Osteoporosis
- Steroid use

III. Medical policy does not cover ANY of the following bone graft substitutes for the enhancement of bone healing because each is considered experimental, investigational, or unproven:

- A. rhBMP-7(i.e.,OP-1™)
- B. INFUSE/MASTERGRAFT™ Posterolateral Revision Device
- C. Humanamnioticmembrane bonegraftsubstitute
- D. Cell-basedsubstitutes(e.g.,mesenchymalstem celltherapy)whenusedto enhancebonehealing
- E. Humangrowthfactors(e.g.,fibroblastgrowthfactor,insulin-likegrowthfactor)whenusedtoenhancebonehealing

- F. Platelet-rich plasma (e.g., autologous platelet-derived growth factor) when used to enhance bone healing
- G. Allograft bone graft substitutes used exclusively as stand-alone stabilization devices for fusion (e.g., TruFuse[®] for isolated facet fusion, NuFix[™] for isolated facet fusion, BacFast[®] HD for isolated facet fusion)
- H. Bone graft substitutes used to reduce donor site morbidity (e.g., iliac crest donor site reconstruction)
- I. Ceramic-based products (e.g., b-TCP)
- J. OptiMesh[®] deployable grafting system

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Cervical Fusion with and without Discectomy

- 22548 Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process**
- 22551 Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2**
- 22552 Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)**
- 22554 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2**
- 22585 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)**
- 22590 Arthrodesis, posterior technique, craniocervical (occiput-C2)**
- 22595 Arthrodesis, posterior technique, atlas-axis (C1-C2)**
- 22600 Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment**
- 22845 Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)**

- 22846 Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)**
- 63075 Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, single interspace**
- 63076 Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, each additional interspace (List separately in addition to code for primary procedure)**
- 63081 Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve roots(s); cervical, single segment**
- 63082 Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve roots(s); cervical, single segment; cervical, each additional segment (List separately in addition to code for primary procedure)**

Prior Authorization Requirements:

1. Prior-authorization requests should be submitted at least two weeks prior to the anticipated date of an elective spinal surgery.
2. Minimum documentation requirements needed to complete a spinal surgery prior authorization request:
 - a. CPT codes, disc levels indicated and ICD-10 codes
 - b. Detailed documentation of type of provider-directed conservative treatment (e.g., interventional pain management procedures/injections, medication, physical therapy, chiropractic, or other provider-directed active exercise program) that includes response to conservative treatment
 - c. Most recent imaging reports performed, read and interpreted by an independent radiologist whose report shall supersede any discrepancies (when present) in interpretation
 - d. Flexion-extension films for spinal fusion surgery requests based upon indications of instability
 - e. Documentation of nicotine-free status (see Tobacco Cessation criteria below)

URGENT/EMERGENT CONDITIONS

All patients being evaluated for spine surgery should be screened for indications of a medical condition that requires urgent/emergent treatment. The presence of such indications/conditions warrants definitive surgical treatment in lieu of conservative pain management treatment. If any of the following are part of the clinical presentation with a request for precertification of the CPT code, the request will go to medical review.

Severe neck pain associated with any of the following will still need confirmatory imaging, such as a CT or MRI scan:

1. Acute/Unstable Traumatic Spinal Fractures or Dislocations with or without neural compression
2. Infection (e.g. discitis, epidural abscess, osteomyelitis)
3. Epidural hematoma
4. Neoplasms of the spine
5. Primary or metastatic tumor causing pathologic fracture, cord compression or instability
6. Severe or rapidly progressive symptoms of motor loss, bowel or bladder dysfunction
7. Documented progressive neurological deficit on two separate physical exams
8. Occipitocervical and/or Atlantoaxial (C1-C2) instability (non-traumatic) due to:
 - a. Rheumatoid arthritis, or
 - b. Congenital abnormality of occipitocervical/C1-C2 vertebrae, or
 - c. Os odontoideum

9. Hospitalization* secondary to severe debilitating pain and/or dysfunction to the point of being incapacitated

*Must meet all criteria listed below EXCEPT conservative treatment

I. Initial Primary Cervical Discectomy and Fusion (ALL of the following)

Radiculopathy, Myelopathy or Myeloradiculopathy (A and/or B required)

A. Radiculopathy(ALL of the following):

1. Subjective symptoms consistent with recent (within 6 months) CT/MRI findings
 - a. Unremitting radiating pain to shoulder girdle and/or upper extremity with objective physical examination findings resulting in disability; or
 - b. Unremitting radicular arm pain/radiculitis without objective physical examination findings resulting in disability.
2. Objective physical examination findings: (Any one of the following)
 - a. Neurologic deficit consistent with recent (within 6 months) CT/MRI findings: (Any one of the following):
 - i. Dermatomal sensory deficit;
 - ii. Motor deficit (e.g., biceps, triceps weakness);
 - iii. Reflex changes;
 - iv. Shoulder Abduction Relief Sign;
 - v. Nerve root tension sign (e.g. Spurlings maneuver);
 - vi. Radicular arm pain/Radiculitis without objective physical examination findings.
3. Failure of conservative treatment: (Any two of the following)
 - a. Less than clinically meaningful improvement* from prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks;
 - b. Less than clinically meaningful improvement from a provider-directed program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks;
 - c. Less than clinically meaningful improvement from epidural steroid injections/selective nerve root block
4. Confirmatory Imaging
 - a. Recent (within 6 months) CT/MRI identifies nerve root impingement caused by herniated disc(s) or osteophytes that correlates with the patient's symptoms or physical findings

B. Myelopathy(ALL of the following):

1. Subjective Symptoms consistent with (Any one of the following):
 - a. Upper/lower extremity weakness, numbness, or pain;
 - b. Fine motor dysfunction (buttoning; handwriting; clumsiness of hands);
 - c. Urinary urgency;
 - d. New-onset bowel or bladder incontinence;
 - e. Frequent falls.
2. Objective physical examination findings (Any two of the following):
 - a. Grip and release;
 - b. Ataxic gait;
 - c. Hyperreflexia;
 - d. Hoffmann sign;
 - e. Pathologic Babinski sign;
 - f. Balance insufficiency (tandem gait);
 - g. Inverted brachial radial reflex;
 - h. Increased tone or spasticity;
 - i. Clonus
 - j. Myelopathic hand
3. Confirmatory Imaging
 - a. Recent (within 6 months) CT/MRI findings that correlates with the patient's symptoms or physical findings(Any one of the following):
 - i. CT/MRI demonstrates spinal cord compression; or
 - ii. CT/MRI identifies stenosis with or without myelomalacia.
- C. Recent (within 6 months) radiographs of the cervical spine including flexion/extension lateral views
- D. No previous surgeries on the disc(s) involved with the exception of posterior laminoforaminotomies in a patient with myelopathy from ventral neurocompression
- E. All major psychosocial and substance abuse issues have been addressed
- F. Patient is a nonsmoker or has refrained from smoking for at least 6 weeks prior to planned surgery* (Exception for patients with myelopathy)

*Note: Documentation of nicotine-free status (via lab results) prior to surgery is required (see Tobacco Cessation criteria below).

II. Repeat Anterior Cervical Fusion at the same level

Criteria to be met: (ONE of the following)

- A. Painful pseudoarthrosis unresponsive to 6 months of non-surgical care and confirmatory imaging; or
- B. Malposition or failure of the implant/structural bone graft;
- C. Recent (within 3 months) radiographs of the cervical spine including flexion/extension lateral views with evidence of implant/structural bone graft malposition or implant/structural bone graft failure;

Or ALL of the following:

Radiculopathy, Myelopathy or Myeloradiculopathy (A and/or B required)

- A. **Radiculopathy** secondary to herniated disc or osteophyte(ALL of the following):
 - 1. Greater than 6 weeks since the initial anterior cervical fusion surgery
 - 2. Subjective symptoms consistent with recent (within 3 months) CT/MRI findings:
 - a. Unremitting radiating pain to shoulder girdle and/or upper extremity with objective physical examination findings resulting in disability; or
 - b. Unremitting radicular arm pain/radiculitis without objective physical examination findings resulting in disability
 - 3. Objective physical examination findings: (Any one of the following)
 - a. Neurologic deficit consistent with recent (within 3 months) CT/MRI findings: [Any one of the following]:
 - i. Dermatomal sensory deficit
 - ii. Motor deficit (e.g., biceps, triceps weakness)
 - iii. Reflex changes
 - iv. Radicular arm pain/radiculitis without objective physical examination findings
 - b. Shoulder Abduction Relief Sign
 - c. Nerve root tension sign (e.g. Spurlings maneuver)
 - 4. Failure of conservative treatment: (Any two of the following)
 - a. Less than clinically meaningful improvement from prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
 - b. Less than clinically meaningful improvement from a provider-directed program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
 - c. Less than clinically meaningful improvement from epidural steroid injections/selective nerve root block
 - 5. Confirmatory Imaging (Any one of the following):
 - a. Confirms evidence of neural structure compression (e.g. either retained disc material or a recurrent disc herniation)

- b. Recent (within 3 months) MRI with gadolinium/CT myelogram confirms evidence of neural structure compression (e.g., either retained disc material or a recurrent disc herniation)
- c. Recent (within 3 months) CT scan documenting pseudoarthrosis, no less than 6 months after initial fusion

B. Myelopathy(ALL of the following):

1. Subjective Symptoms consistent with (Any one of the following)
 - a. Upper/lower extremity weakness, numbness, or pain;
 - b. Fine motor dysfunction (buttoning; handwriting; clumsiness of hands);
 - c. Urinary urgency;
 - d. Newonset bowel or bladder incontinence;
 - e. Frequent falls.
 2. Objective physical examination findings (Any two of the following)
 - a. Grip and release;
 - b. Ataxic gait;
 - c. Hyperreflexia;
 - d. Hoffmann sign;
 - e. Pathologic Babinski sign;
 - f. Balance insufficiency (tandem gait);
 - g. Inverted brachial radial reflex;
 - h. Increased tone or spasticity;
 - i. Clonus;
 - j. Myelopathic hand.
 3. Recent (within 3 months) confirmatory MRI/CT findings (Any one of the following):
 - a. MRI with gadolinium/CT myelogram confirms evidence of neural structure compression; or
 - b. MRI with gadolinium/CT myelogram identifies stenosis with or without myelomalacia; or
 - c. Recent (within 3 months) CT scan documenting pseudoarthrosis, no less than 6 months after initial fusion
- C. Initial relief of symptoms following previous disk decompression procedure at same level
- D. All major psychosocial and substance abuse issues have been addressed
- E. Patient is a nonsmoker or has refrained from smoking for at least 6 weeks prior to planned surgery.*(Exception for patients with myelopathy)

*Note: Documentation of nicotine-free status (via laboratory results) prior to surgery is required (see Tobacco Cessation criteria below)

III. Adjacent Segment Disease: degenerative spinal segment adjacent to a previous decompression or fusion procedure (ALL of the following)

Radiculopathy, Myelopathy or Myeloradiculopathy(A and/or B required)

A. Radiculopathy(ALL of the following):

1. Subjective symptoms consistent with recent (within 6 months) CT/MRI findings
 - a. Unremitting radiating pain to shoulder girdle and/or upper extremitywith objective physical examination findings resulting in disability; or
 - b. Unremitting radicular arm pain/radiculitis without objective physical examination findings resulting in disability
2. Objective physical examination findings (Any one of the following):
 - a. Neurologic deficit consistent with recent (within 6 months) CT/MRI findings (Any one of the following):
 - i. Dermatomal sensory deficit;
 - ii. Motor deficit (e.g., biceps, triceps weakness);
 - iii. Reflex changes;
 - iv. Shoulder Abduction Relief Sign;
 - v. Nerve root tension sign (e.g. Spurlings maneuver);
 - vi. Radicular arm pain/Radiculitis without objective physical examination findings;
3. Failure of conservative treatment (Any 2 of the following):
 - a. Less than clinically meaningful improvement* from prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks;
 - b. Less than clinically meaningful improvement from a provider-directedprogram prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks;
 - c. Less than clinically meaningful improvement from epidural steroid injections/selective nerve root block.
4. Confirmatory Imaging
 - a. Recent (within 6 months) CT/MRI identifies nerve root impingement caused by herniated disc(s) or osteophytes that correlates with the patient's symptoms or physical findings

B. Myelopathy(ALL of the following):

1. Subjective Symptoms consistent with (Any one of the following):
 - a. Upper/lower extremity weakness, numbness, or pain;
 - b. Fine motor dysfunction (buttoning; handwriting;clumsiness of hands);
 - c. Urinary urgency;
 - d. New-onset bowel or bladder incontinence;
 - e. Frequent falls.

2. Objective physical examination findings (Any two of the following):
 - a. Grip and release;
 - b. Ataxic gait;
 - c. Hyperreflexia;
 - d. Hoffmann sign;
 - e. Pathologic Babinski sign;
 - f. Balance insufficiency (tandem gait);
 - g. Inverted brachial radial reflex;
 - h. Increased tone or spasticity;
 - i. Clonus;
 - j. Myelopathic hand.
3. Confirmatory Imaging:
 - a. Recent (within 6 months) CT/MRI findings that correlates with the patient's symptoms or physical findings (Any one of the following):
 - i. CT/MRI demonstrates spinal cord compression; or
 - ii. CT/MRI identifies stenosis with or without myelomalacia.
 - C. Recent (within 6 months) radiographs of the cervical spine including flexion/extension lateral views demonstrating successful decompression and/or fusion at the adjacent level
 - D. No previous surgeries on the disc(s) involved
 - E. All major psychosocial and substance abuse issues have been addressed
 - F. Patient is a nonsmoker or has refrained from smoking for at least 6 weeks prior to planned surgery.* (Exception for patients with myelopathy)
*Note: Documentation of nicotine-free status (via lab results) prior to surgery is required (see Tobacco Cessation criteria below).

IV. Anterior Cervical Decompression and Fusion following failed cervical disc arthroplasty implant (Criteria to be met):

- A. Recent (within 3 months) imaging studies demonstrating failure of a cervical disc arthroplasty implant (i.e. subsidence, loosening, infection, dislocation, subluxation, vertebral body fracture, dislodgement)

Or ALL of the following:

Radiculopathy, Myelopathy or Myeloradiculopathy(A and/or B required)

- B. Radiculopathy(ALL of the following):
 1. Subjective symptoms consistent with recent (within 3 months) CT/MRI findings
 - a. Unremitting radiating pain to shoulder girdle and/or upper extremity with objective physical examination findings resulting in disability; or
 - b. Unremitting radicular arm pain/radiculitis without objective physical examination findings resulting in disability

2. Objective physical examination findings (Any one of the following):
 - a. Neurologic deficit consistent with recent (within 3 months) CT/MRI findings (Any one of the following):
 - i. Dermatomal sensory deficit;
 - ii. Motor deficit (e.g., biceps, triceps weakness);
 - iii. Reflex changes;
 - iv. Shoulder Abduction Relief Sign;
 - v. Nerve root tension sign (e.g. Spurlings maneuver);
 - vi. Radicular arm pain/Radiculitis without objective physical examination findings.
 3. Failure of conservative treatment: (Any 2 of the following)
 - a. Less than clinically meaningful improvement* from prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks;
 - b. Less than clinically meaningful improvement from a provider-directed program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks;
 - c. Less than clinically meaningful improvement from epidural steroid injections/selective nerve root block.
 4. Confirmatory Imaging
 - a. Recent (within 3 months) CT/MRI identifies nerve root impingement caused by herniated disc(s) or osteophytes that correlates with the patient's symptoms or physical findings
- C. Myelopathy(ALL of the following):**
1. Subjective Symptoms consistent with (Any of the following):
 - a. Upper/lower extremity weakness, numbness, or pain;
 - b. Fine motor dysfunction (buttoning; handwriting; clumsiness of hands);
 - c. Urinary urgency;
 - d. New onset bowel or bladder incontinence;
 - e. Frequent falls.
 2. Objective physical examination findings (Any two of the following):
 - a. Grip and release;
 - b. Ataxic gait;
 - c. Hyperreflexia;
 - d. Hoffmann sign;
 - e. Pathologic Babinski sign;
 - f. Balance insufficiency (tandem gait);
 - g. Inverted brachial radial reflex;
 - h. Increased tone or spasticity;
 - i. Clonus;
 - j. Myelopathic hand.

3. Confirmatory Imaging:
 - a. Recent (within 3months)CT/MRI findings that correlates with the patient's symptoms or physical findings (Any one of the following):
 - i. CT/MRI demonstrates spinal cord compression, or
 - ii. CT/MRI identifies stenosis with or without myelomalacia.
- D. Greater than 6 months since the prior cervical disc arthroplasty procedure
- E. All major psychosocial and substance abuse issues have been addressed
- F. Patient is a nonsmoker or has refrained from smoking for at least 6 weeks prior to planned surgery.*(Exception for patients with myelopathy)

Definitions:

1. **Acceptable imaging modalities are CT scan, MRI and myelogram.**Imaging must be performed and read by an independent radiologist. If discrepancies should arise in the interpretation of the imaging, interpretations by the radiologist will supersede. Discography results will not be used as a determining factor of medical necessity for any requested procedures. Discography use is not endorsed.
2. ***Clinically meaningful improvement:** Global assessment showing at least 50% improvement.

V. Nontraumatic Instability or Cervical Spondylosis (ALL of the following):

- A. Confirmatory radiographic imaging (Any one of the following):
 1. Flexion-Extension X-rays demonstrating instability; or
 2. >3.5 mm sagittal plane translation; or
 3. >20% sagittal plane translation of vertebral body width; or
 4. >11 degrees relative sagittal plane angulation.
- B. Failure of conservative treatment (any two of the following)
 1. Less than clinically meaningful improvement* from prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks;
 2. Less than clinically meaningful improvement* from a provider-directed program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks;
- C. All major psychosocial and substance abuse issues have been addressed
- D. Patient is a nonsmoker or has refrained from smoking for at least 6 weeks prior to planned surgery. (Exception for patients with myelopathy)

Note: Documentation of nicotine-free status (via lab results) prior to surgery is required (see Tobacco Cessation criteria below)

- E. Tobacco Cessation (Any one of the following):Patient is a non-tobacco user, or

- F. If patient is a documented tobacco user, then patient must have abstained from tobacco use for at least 6 weeks prior to the planned spinal fusion surgery as evidenced by lab results (cotinine level) documenting nicotine-free status.

Note: In order to complete the prior authorization process for spinal fusion surgery, planning should allow for enough time to submit lab results performed after the 6-week tobacco abstinence period.

VI. Limitations:

- A. Requests for cervical fusion on a member with a history of two (2) or more cervical fusions requires Medical Review
- B. Cervical fusion is not recommended for chronic non-specific cervical pain.
- C. Assessment of arthrodesis and/or disc arthroplasty (i.e., "success") via radiographic imaging is not attempted until at least 6 weeks following the procedure

*Clinically meaningful improvement: Global assessment showing at least 50% improvement

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Cervical Total Disc Arthroplasty

22856 Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophyctomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical

22858 Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophyctomy for nerve root or spinal cord decompression and microdissection), second level, cervical (List separately in addition to code for primary procedure)

22861 Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical

22864 Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical

0095T Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)

0098T Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)

Prior Authorization Requirements:

1. Prior-authorization requests should be submitted at least two weeks prior to the anticipated date of an elective spinal surgery.
2. Minimum documentation requirements needed to complete a spinal fusion prior authorization request:
 - a. CPT codes, disc levels indicated and ICD-10 codes
 - b. Detailed documentation of type of provider-directed conservative treatment (e.g., interventional pain management procedures/injections, medication, physical therapy, chiropractic, or other provider-directed active exercise program) that includes response to conservative treatment
 - c. Most recent imaging reports performed, read and interpreted by an independent radiologist whose report shall supersede any discrepancies (when present) in interpretation
 - d. Flexion-extension films for spinal fusion surgery requests based upon indications of instability
 - e. Documentation of nicotine-free status (see Tobacco Cessation criteria below)

URGENT/EMERGENT CONDITIONS

All patients being evaluated for spine surgery should be screened for indications of a medical condition that requires urgent/emergent treatment. The presence of such indications/conditions warrants definitive surgical treatment in lieu of conservative pain management treatment. If any of the following are part of the clinical presentation with a request for precertification of the CPT code, the request will go to medical review. Severe neck pain associated with any of the following will still need confirmatory imaging, such as a CT or MRI scan:

1. Acute/Unstable Traumatic Spinal Fractures or Dislocations with or without neural compression;
2. Infection (e.g. discitis, epidural abscess, osteomyelitis);
3. Epidural hematoma
4. Neoplasms of the spine;
5. Primary or metastatic tumor causing pathologic fracture, cord compression or instability;
6. Severe or rapidly progressive symptoms of motor loss, bowel or bladder dysfunction;
7. Documented progressive neurological deficit on two separate physical exams;
8. Occipitocervical or Atlantoaxial (C1-C2) instability (non-traumatic) due to:
 - a. Rheumatoid arthritis, or
 - b. Congenital abnormality of occipitocervical/C1-C2 vertebrae, or
 - c. Os odontoideum.
9. Hospitalization* secondary to severe debilitating pain and/or dysfunction to the point of being incapacitated.

*Must meet all criteria listed below EXCEPT conservative treatment

I. Initial Primary Cervical Total Disc Arthroplasty (ALL of the following)

Individual has degenerative cervical disc disease with intractable radiculopathy and/or myelopathy, producing symptomatic nerve root and/or spinal cord compression due to herniated disc and/or osteophyte formation, and is skeletally mature.

Must use FDA approved implant used in accordance with FDA labeling: PRESTIGE™ ST, ProDisc™ -C, BRYAN® Cervical Disc, Pro-Disc C

Radiculopathy, Myelopathy or Myeloradiculopathy (A and/or B required)

A. Radiculopathy(ALL of the following):

1. Subjective symptoms consistent with recent (within 6 months) CT/MRI findings
 - a. Unremitting radiating pain to shoulder girdle and/or upper extremity with objective physical examination findings resulting in disability; or
 - b. Unremitting radicular arm pain/radiculitis without objective physical examination findings resulting in disability.
2. Objective physical examination findings: (Any one of the following)
 - a. Neurologic deficit consistent with recent (within 6 months) CT/MRI findings: (Any one of the following):
 - i. Dermatomal sensory deficit;
 - ii. Motor deficit (e.g., biceps, triceps weakness);
 - iii. Reflex changes;
 - iv. Shoulder Abduction Relief Sign;
 - v. Nerve root tension sign (e.g., Spurlings maneuver)
 - vi. Radicular arm pain/Radiculitis without objective physical examination findings
3. Failure of conservative treatment: (Any 2 of the following)
 - a. Less than clinically meaningful improvement* from prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
 - b. Less than clinically meaningful improvement* from a provider-directed program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks;
 - c. Less than clinically meaningful improvement* from epidural steroid injections/selective nerve root block.
4. Confirmatory Imaging
5. Recent (within 6 months) CT/MRI identifies nerve root impingement caused by herniated disc(s) or osteophytes that correlates with the patient's symptoms or physical findings

B. Myelopathy(ALL of the following):

1. Subjective Symptoms consistent with (Any one of the following)
 - a. Upper/lower extremity weakness, numbness, or pain;
 - b. Fine motor dysfunction (buttoning; handwriting; clumsiness of hands);
 - c. Urinary urgency;
 - d. New-onset bowel or bladder incontinence;
 - e. Frequent falls.
 2. Objective physical examination findings (Any two of the following)
 - a. Grip and release;
 - b. Ataxic gait;
 - c. Hyperreflexia;
 - d. Hoffmann sign;
 - e. Pathologic Babinski sign;
 - f. Balance insufficiency (tandem gait);
 - g. Inverted brachial radial reflex;
 - h. Increased tone or spasticity;
 - i. Clonus;
 - j. Myelopathic hand.
 3. Confirmatory Imaging:
 - a. Recent (within 6 months) CT/MRI findings that correlates with the patient's symptoms or physical findings (Any one of the following):
 - i. CT/MRI demonstrates spinal cord compression, or
 - ii. CT/MRI identifies stenosis with or without myelomalacia
- C. No previous surgeries on the disc(s) involved
- D. The planned implant(s) will be used in the reconstruction of a cervical disc at C3-C7, following single-level discectomy.
- E. The individual is a candidate for single-level anterior cervical decompression(s) and interbody fusion(s)
- F. All major psychosocial and substance abuse issues have been addressed
- G. Patient is a nonsmoker or has refrained from smoking for at least 6 weeks prior to planned surgery.*

*Note: Documentation of nicotine-free status (via lab results) prior to surgery is required (see Tobacco Cessation criteria below).

Definitions:

1. **Acceptable imaging modalities are CT scan, MRI and myelogram.** Imaging must be performed and read by an independent radiologist. If discrepancies should arise in the interpretation of the imaging, interpretations by the radiologist will supersede. Discography results will not be used as a determining factor of medical necessity for any requested procedures. Use of discography is not endorsed.
2. ***Clinically meaningful improvement:** Global assessment showing at least 50% improvement.

II. Failed cervical total disc arthroplasty implant: (All of the following)

- A. Recent (within 3 months) radiographs of the cervical spine including flexion/extension lateral views demonstrating failure of a cervical disc arthroplasty implant (i.e., subsidence, loosening, infection, dislocation/subluxation, vertebral body fracture, dislodgement), or
- B. Refer to the Anterior Cervical Discectomy and Fusion following failed cervical disc arthroplasty implant policy.

III. Adjacent Segment Disease secondary to Cervical Total Disc Arthroplasty: Refer to the Anterior Cervical Discectomy and Fusion policy**IV. Two Level Cervical Disc Replacement: Refer to criteria for Initial Primary Cervical Total Disc Arthroplasty. Two level cervical disc replacement must be performed using an FDA approved implant in accordance with FDA labeling. At this time, only a Mobi-C implant satisfies this criteria.****V. Cervical disk replacement is considered experimental/investigational if any of the following is present:**

- A. The planned procedure includes the combined use of a prosthesis and spinal fusion (hybrid construct);
- B. Patients under age 22 or over age 60;
- C. The individual had prior fusion at an adjacent cervical level (hybrid construct);
- D. The individual had prior surgery at the treated level;
- E. Osteoporosis defined as a DEXA bone mineral T-score equal to or worse than -3.5 or a T-score equal to or worse than -2.5 with vertebral compression fracture or osteopenia defined as a DEXA bone mineral density T-score < or = to -1.0;
- F. Allergy or sensitivity to titanium, aluminum or vanadium;
- G. Neck or arm pain of unknown etiology;
- H. Absence of neck and/or arm pain;

- I. Progressive neurological deficit or deterioration;
- J. Active systemic infection or localized infection at the surgical site;
- K. Rheumatoid arthritis or other autoimmune disease;
- L. Paget's disease, osteomalacia or any other metabolic bone disease;
- M. Severe poorly controlled diabetes mellitus requiring insulin treatment;
- N. There is radiological evidence of ANYone of the following:
 - 1. Clinically significant cervical instability on neutral resting or lateral or flexion/extension radiographs, such as kyphotic deformity/significant reversal of lordosis or spondylolisthesis (e.g., > 3.5 mm subluxation/translation or > 11 degrees angulation/rotational difference) from that of either adjacent spinal level;
 - 2. Significant cervical anatomical deformity or compromised vertebral bodies at the index level (e.g., ankylosing spondylitis, rheumatoid arthritis, or compromise due to current or past trauma);
 - 3. Symptoms attributed to more than one cervical level (See criteria for two level cervical disc replacement);
 - 4. Spinal metastases;
 - 5. Severe spondylosis at the level to be treated characterized by bridging osteophytes, marked reduction or absence of motion, or collapse of the intervertebral disc space of greater than 50% of its normal height;
 - 6. Severe facet joint arthropathy.

VI. Tobacco Cessation (Any one of the following):

- A. Patient is a non-tobacco user, or
- B. If patient is a documented tobacco user, then patient must have abstained from tobacco use for at least 6 weeks prior to the planned spinal fusion surgery as evidenced by lab results (cotinine level) documenting nicotine-free status.

Note: In order to complete the prior authorization process for spinal fusion surgery, planning should allow for enough time to submit lab results performed after the 6-week tobacco abstinence period.

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Electrical Bone Growth Stimulation (Spine)

20974 Electrical stimulation to aid bone healing; noninvasive (nonoperative)

20975 Electrical stimulation to aid bone healing; invasive (operative)

HCPCS Codes

E0748 Osteogenesis stimulator; electrical, noninvasive, spinal applications

E0749 Osteogenesis stimulator; electrical, surgically implanted

I. Indications and Limitations of Coverage Electrical Osteogenic Stimulators: Invasive and Noninvasive Electrical Stimulation of the Spine

Invasive (inserted at the time of surgery) or noninvasive (beginning at any time from the time of surgery until up to 6 months after surgery) electrical bone growth stimulation may be considered **medically necessary** for spinal fusion surgery in individuals at high risk for pseudoarthroses with **one or more** of the following risk factors for fusion failure:

- A. One or more previously failed spinal fusion(s); or
- B. Multi-level lumbar/lumbosacral fusion including three (3) or more vertebrae; or
- C. Grade II or worse lumbar/lumbosacral spondylolisthesis; or
- D. History of current tobacco use; or
- E. Alcoholism; or
- F. Diabetes, renal disease, or other metabolic diseases when bone healing is likely to be compromised; or
- G. Nutritional deficiency/malnutrition; or
- H. Osteoporosis defined as a T-score of <-2.5 on a recent (within one year) DEXA; or
- I. Body Mass Index (BMI) greater than 30; or
- J. Severe anemia; or
- K. Glucocorticoid dependent.

II. Noninvasive electrical bone growth stimulation may be considered medically necessary as a treatment for individuals with failed spinal fusion when both of the following criteria are met:

- A. A minimum of 6 months has passed since the date of the original surgery; and
- B. Serial radiographs or appropriate imaging studies confirm there is no evidence of progression of healing/consolidation of the spinal fusion for 3 months during the latter portion of the 6 month post-fusion surgery period.

III. Invasive and noninvasive electrical bone growth stimulation is considered investigational and not medically necessary for acute or chronic lumbar spondylolysis (pars interarticularis defect) with or without spondylolisthesis and as an adjunct to cervical fusion surgery, failed cervical spine fusion, or for failed cervical disc arthroplasty.

IV. Semi-invasive electrical bone growth stimulation is considered experimental, investigational and not medically necessary for any indication due to lack of sufficient evidence of their effectiveness.

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Initial Posterior Cervical Decompression with or without Fusion

- 22590 Arthrodesis, posterior technique, craniocervical (occiput-C2)**
- 22595 Arthrodesis, posterior technique, atlas-axis (C1-C2)**
- 22600 Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment**
- 22614 Each additional vertebral segment(List separately in addition to code for primary procedure)**
- 22841 Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)**
- 22842 Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)**
- 22843 Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure)**
- 22853 Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when conjunction with interbody arthrodesis, each interspace (List performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)**

- 22854** Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
- 22859** Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
- 22867** Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level
- 22868** Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)
- 22869** Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level

- 22870** Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)
- 63001** Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; cervical
- 63015** Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; cervical
- 63045** Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; cervical
- 63048** Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)
- 63050** Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments;

63051 Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (e.g., wire, suture, mini-plates), when performed)

URGENT/EMERGENT CONDITIONS

All patients being evaluated for spine surgery should be screened for indications of a medical condition that requires urgent/emergent treatment. The presence of such indications/conditions warrants definitive surgical treatment in lieu of conservative pain management treatment. If any of the following are part of the clinical presentation with a request for precertification of the CPT code, the request will go to medical review. Severe neck pain associated with any of the following will still need confirmatory imaging, such as a CT or MRI scan:

1. Acute/Unstable Traumatic Spinal Fractures or Dislocations with or without neural compression;
2. Infection (e.g. discitis, epidural abscess, osteomyelitis);
3. Vascular malformations (e.g. AVM);
4. Epidural hematoma;
5. Congenital cervical stenosis (AP canal diameter < or = to 10 mm);
6. Primary or metastatic tumor causing pathologic fracture, cord compression, or instability;
7. Severe or rapidly progressive symptoms of motor loss, bowel or bladder dysfunction;
8. Documented progressive neurological deficit on two separate physical exams;
9. Ossification of the posterior longitudinal ligament at three (3) or more levels;
10. Occipitocervical and/or Atlantoaxial (C1-C2) instability (non-traumatic) and/or spinal cord compression due to:
11. Hospitalization* secondary to severe debilitating pain and/or dysfunction to the point of being incapacitated;

*Must meet all criteria listed below EXCEPT conservative treatment

I. Initial Primary Posterior Cervical Decompression (Laminectomy/Hemilaminectomy) with or without posterior fusion may be medically necessary if (ALL of the following):

Radiculopathy, Myelopathy or Myeloradiculopathy (A and/or B required)

A. Radiculopathy(ALL of the following):

1. Subjective symptoms consistent with recent (within 6 months) CT/MRI findings
 - a. Unremitting radiating pain to shoulder girdle and/or upper extremity with objective physical examination findings resulting in disability; or
 - b. Unremitting radicular arm pain/radiculitis without objective physical examination findings resulting in disability.
2. Objective physical examination findings: (Any one of the following)
 - a. Neurologic deficit consistent with recent (within 6 months) CT/MRI findings: (Any one of the following):

- i. Dermatomal sensory deficit;
 - ii. Motor deficit (e.g., biceps, triceps weakness);
 - iii. Reflex changes;
 - iv. Shoulder Abduction Relief Sign;
 - v. Nerve root tension sign (e.g. Spurlings maneuver);
 - vi. Radicular arm pain/Radiculitis without objective physical examination findings.
 3. Failure of conservative treatment: (Any 2 of the following)
 - a. Less than clinically meaningful improvement* from prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks;
 - b. Less than clinically meaningful improvement* from a provider-directed program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks;
 - c. Less than clinically meaningful improvement* from epidural steroid injections/selective nerve root block.
 4. Confirmatory Imaging
 - a. Recent (within 6 months) CT/MRI identifies nerve root impingement caused by herniated disc(s) or osteophytes that correlates with the patient's symptoms or physical findings
- B. Myelopathy**(ALL of the following):
1. Subjective Symptoms consistent with (Any one of the following)
 - a. Numbness and tingling in the hands;
 - b. Upper/lower extremity weakness, numbness, or pain;
 - c. Fine motor dysfunction (buttoning; handwriting; clumsiness of hands);
 - d. Urinary urgency;
 - e. New-onset bowel or bladder incontinence;
 - f. Frequent falls;
 2. Objective physical examination findings (Any two of the following)
 - a. Grip and release;
 - b. Ataxic gait;
 - c. Hyperreflexia;
 - d. Hoffmann sign;
 - e. Pathologic Babinski sign;
 - f. Balance insufficiency (tandem gait);
 - g. Inverted brachial radial reflex;
 - h. Increased tone or spasticity;
 - i. Clonus;
 - j. Myelopathic hand;

3. Confirmatory Imaging:
 - a. Recent (within 6 months) CT/MRI findings that correlates with the patient's symptoms or physical findings (Any one of the following):
 - i. CT/MRI demonstrates spinal cord compression; or
 - ii. CT/MRI identifies stenosis with or without myelomalacia
 - C. Recent (within 6 months) radiographs of the cervical spine including flexion/extension lateral views
 - D. No previous surgeries on the disc(s) involved.
 - E. All major psychosocial and substance abuse issues have been addressed
 - F. Patient is a nonsmoker or has refrained from smoking for at least 6 weeks prior to planned surgery* (Exception for patients with myelopathy)

*Note: Documentation of nicotine-free status (via lab results) prior to surgery is required (see Tobacco Cessation criteria below).

Definitions:

1. **Acceptable imaging modalities:** CT scan, MRI and myelogram. Imaging must be performed and read by an independent radiologist. If discrepancies should arise in the interpretation of the imaging, interpretations by the radiologist will supersede. Discography results will not be used as a determining factor of medical necessity for any requested procedures. Use of discography is not endorsed.
2. **Clinically meaningful improvement:** Global assessment showing at least 50% improvement.

The following sole indications for discectomy, laminectomy and hemilaminectomy with or without fusion are considered Not Medically Necessary:

- Signs and symptoms with no correlation to imaging studies;
- Annular tears;
- Disk bulge with no neural impingement or cord compression on imaging;
- Concordant Discography.

II. Cervical fusion, posterior, with or without instrumentation is considered to be medically necessary when one or more of the following criteria are met:

- A. As a concurrent stabilization procedure with corpectomy, laminectomy or other procedure at the cervicothoracic junction (i.e., C7 and T1);
- B. As a concurrent stabilization procedure with a laminectomy, especially at C2
- C. Symptomatic pseudoarthrosis from a prior procedure;
- D. Subluxation and/or spinal cord compression in patients with rheumatoid arthritis;
- E. Multilevel spondylotic myelopathy without kyphosis;
- F. Symptomatic cervical spondylosis with instability as evidenced radiographically by one (1) or more of the following:

1. Subluxation or translation of more than 3.5 mm on static lateral views or dynamic flexion/extension lateral radiographs;
 2. Sagittal plane angulation of more than 11 degrees between adjacent spinal segments;
 3. More than 4 mm of motion (subluxation) between the tips of the spinous processes on flexion/extension lateral radiographic views.
- G. Klippel-Feil syndrome;
- H. Cervical instability in patients with Down syndrome;
- I. Cervical instability in patients with skeletal dysplasia;
- J. Cervical instability in patients with connective tissue disorders;
- K. Primary or metastatic tumor with associated cord compression and/or instability;
- L. Other symptomatic instability or spinal cord/root compression requiring posterior fusion with ALL of the following:
1. Patient unresponsive to a reasonable and medically appropriate course of conservative therapy (e.g., rest, medication, cervical collar);
 2. Recent (within 6 months) imaging study demonstrating corresponding pathologic anatomy

Criteria to be met for all indications: (ALL of the following)

- M. Tobacco Cessation (Any one of the following): (Exception for patients with myelopathy)
1. Patient is a non-tobacco user, or
 2. If patient is a documented tobacco user, then patient must have abstained from tobacco use for at least 6 weeks prior to the planned spinal fusion surgery as evidenced by lab results (cotinine level) documenting nicotine-free status.
- N. All major psychosocial and substance abuse issues have been addressed.
Note: In order to complete the prior authorization process for spinal fusion surgery, planning should allow for enough time to submit lab results performed after the 6-week tobacco abstinence period.

Repeat Posterior Cervical Decompression with or without Fusion at the same level:

- A. Recent (within 3 months) radiographic (plain film) or CT evidence of implant/instrumentation or structural bone graft malposition or failure;
- Or Same as Initial Primary Posterior Cervical Decompression (Laminectomy) with or without fusion (except I.D. and ALL of the following:
- A. MRI with contrast/CT myelogram confirms evidence of neural structure compression (e.g. either retained disc material or a recurrent disc herniation);

- B. Greater than 12 weeks since last posterior cervical decompression with or without fusion surgery;
- C. Initial relief of symptoms following previous posteriorcervical decompression procedure at same level;
- D. All major psychosocial and substance abuse issues have been addressed;
- E. Tobacco Cessation (Any one of the following):(Exception for patients with myelopathy)
 - a. Patient is a non-tobacco user, or
 - b. If patient is a documented tobacco user, then patient must have abstained fromtobacco use for at least 6 weeks prior to the planned spinal fusion surgery as evidenced by lab results (cotinine level) documenting nicotine-free status.

Note: In order to complete the prior authorization process for spinal fusion surgery, planning should allow for enough time to submit lab results performed after the 6-week tobacco abstinence period.

IV. Posterior Cervical decompression with or without Fusion following failed cervical disc arthroplasty implant: Criteria to be met:

- A. Failed cervical disc arthroplasty implant diagnosed by recent (within 3 months) plain film, CT and/or CT myelogram (i.e., subsidence, loosening, infection, dislocation/subluxation, vertebral body fracture, dislodgement);

OrALL of the following:

- A. Meets criteria for posterior cervical fusion with or without instrumentation and/or posterior cervical decompression with or without fusion;
- B. Confirmatory Imaging;
 - 1. Recent (within 3 months) CT myelogram/MRI with contrast findings that correlates with the patient's symptoms or physical findings demonstrating neural structure compression
- C. Greater than 12 weeks since last cervical spine surgery procedure;
- D. Initial relief of symptoms following previous disk decompression procedure at same level;
- E. All major psychosocial and substance abuse issues have been addressed;
- F. Tobacco Cessation (Any one of the following): (Exception for patients with myelopathy)
 - 1. Patient is a non-tobacco user, or
 - 2. If patient is a documented tobacco user, then patient must have abstained fromtobacco use for at least 6 weeks prior to the planned spinal fusion surgery as evidencedby lab results (cotinine level) documenting nicotine-free status.

Note: In order to complete the prior authorization process for spinal fusion surgery, planning should allow for enough time to submit lab results performed after the 6-week tobacco abstinence period.

Definitions:

1. **Acceptable imaging modalities are CT scan, MRI and myelogram.** Imaging must be performed and read by an independent radiologist. If discrepancies should arise in the interpretation of the imaging, interpretations by the radiologist will supersede. Discography results will not be used as a determining factor of medical necessity for any requested procedures. Use is not endorsed.
2. ***Clinically meaningful improvement:** Global assessment showing at least 50% improvement.

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Initial Primary Cervical Microdiscectomy

63020 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical

63035 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)

63075 Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; cervical, single interspace

63076 Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)

63265 Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical

63270 Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical

63275 Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical

63280 Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, cervical

63285 Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, cervical

63290 Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level

63295 Laminectomy for biopsy/excision of intraspinal neoplasm; osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)

Repeat Cervical Microdiscectomy

63040 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical

63043 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure)

URGENT/EMERGENT CONDITIONS

All patients being evaluated for spine surgery should be screened for indications of a medical condition that requires urgent/emergent treatment. The presence of such indications/conditions warrants definitive surgical treatment in lieu of conservative pain management treatment. If any of the following are part of the clinical presentation with a request for precertification of the CPT code, the request will go to medical review. Severe neck pain associated with any of the following will still need confirmatory imaging, such as a CT or MRI scan:

1. Acute/Unstable Traumatic Spinal Fractures or Dislocations with or without neural compression
2. Infection (e.g. discitis, epidural abscess, osteomyelitis);
3. Vascular malformations (e.g. AVM);
4. Congenital cervical stenosis (AP canal diameter $<$ or $=$ to 10 mm);
5. Primary or metastatic tumor causing pathologic fracture, cord compression, or instability;
6. Severe or rapidly progressive symptoms of motor loss, bowel or bladder dysfunction;
7. Documented progressive neurological deficit on two separate physical exams;
8. Ossification of the posterior longitudinal ligament at three (3) or more levels;
9. Occipitocervical and/or Atlantoaxial (C1-C2) instability (non-traumatic) and/or spinal cord compression due to:
 - a. Rheumatoid arthritis, or
 - b. Congenital abnormality of C1-C2 vertebrae, or
 - c. Os odontoideum
10. Cauda equina syndrome (CES)
 - a. Rheumatoid arthritis, or
 - b. Congenital abnormality of C1-C2 vertebrae, or
 - c. Os odontoideum
11. Hospitalization* secondary to severe debilitating pain and/or dysfunction to the point of being incapacitated
 - i. *Must meet all criteria listed below EXCEPT conservative treatment

I. Initial Primary Cervical Microdiscectomy Criteria to be met: (ALL of the following)

Radiculopathy, Myelopathy or Myeloradiculopathy (A and/or B required)

A. Radiculopathy(ALL of the following):

1. Subjective symptoms consistent with recent (within 6 months) CT/MRI findings

- a. Unremitting radiating pain to shoulder girdle and/or upper extremity with objective physical examination findings resulting in disability; or
 - b. Unremitting radicular arm pain/radiculitis without objective physical examination findings resulting in disability
2. Objective physical examination findings:
 - a. Neurologic deficit consistent with recent (within 6 months) CT/MRI findings: (Any one of the following):
 - i. Dermatomal sensory deficit;
 - ii. Motor deficit (e.g., biceps, triceps weakness);
 - iii. Reflex changes;
 - iv. Shoulder Abduction Relief Sign;
 - v. Nerve root tension sign (e.g. Spurlings maneuver);
 - vi. Radicular arm pain/Radiculitis without objective physical examination findings
 3. Failure of conservative treatment: (Any 2 of the following)
 - a. Less than clinically meaningful improvement* from prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
 - b. Less than clinically meaningful improvement* from a provider-directed program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
 - c. Less than clinically meaningful improvement* from epidural steroid injections/selective nerve root block
 4. Confirmatory Imaging
 - a. Recent (within 6 months) CT/MRI identifies nerve root impingement caused by herniated disc(s) or osteophytes that correlates with the patient's symptoms or physical findings
- B. Myelopathy(ALL of the following):**
1. Subjective Symptoms consistent with [Any one of the following]
 - a. Upper/lower extremity weakness, numbness, or pain;
 - b. Fine motor dysfunction (buttoning; handwriting; clumsiness of hands);
 - c. Urinary urgency;
 - d. New-onset bowel or bladder incontinence;
 - e. Frequent falls.
 2. Objective physical examination findings (Any two of the following)
 - a. Grip and release;
 - b. Ataxic gait;
 - c. Hyperreflexia;
 - d. Hoffmann sign;
 - e. Pathologic Babinski sign;
 - f. Balance insufficiency (tandem gait);

- g. Inverted brachial radial reflex;
 - h. Increased tone or spasticity;
 - i. Clonus;
 - j. Myelopathic hand
3. Confirmatory Imaging:
- a. Recent (within 6 months) CT/MRI findings that correlates with the patient's symptoms or physical findings (Any one of the following):
 - i. CT/MRI demonstrates spinal cord compression, or
 - ii. CT/MRI identifies stenosis with or without myelomalacia
 - C. Recent (within 6 months) radiographs of the cervical spine including flexion/extension lateral views
 - D. No previous surgeries on the disc(s) involved
 - E. All major psychosocial and substance abuse issues have been addressed

Definitions:

1. **Acceptable imaging modalities are CT scan, MRI and myelogram.** Imaging must be performed and read by an independent radiologist. If discrepancies should arise in the interpretation of the imaging, interpretations by the radiologist will supersede. Discography results will not be used as a determining factor of medical necessity for any requested procedures. Use is not endorsed.
2. ***Clinically meaningful improvement:** Global assessment showing at least 50% improvement.

The following sole indications for discectomy, laminectomy and hemilaminectomy are considered Not Medically Necessary:

- Signs and symptoms with no correlation to imaging
- Annular tears
- Disk bulge with no neural impingement or cord compression on imaging
- Concordant Discography

**II. Repeat Cervical Microdiscectomy at the Same Level:
Criteria to be met: Same as Initial Primary Cervical
Microdiscectomy and All of the following:**

- A. Recent (within 3 months) MRI with contrast/CT myelogram confirms evidence of neural structure compression (e.g. either retained disc material or a recurrent disc herniation);
- B. Greater than 12 weeks since the initial primary cervical microdiscectomy;
- C. Initial relief of symptoms following previous disk decompression procedure at same level;

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Initial Primary Lumbar Microdiscectomy and for Excision of Extradural Lesion other than Neoplasm

- 63030** Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar
- 63035** Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)
- 63056** Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (e.g., far lateral herniated intervertebral disc)
- 62380** Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar
- 63057** Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)
- 63267** Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar

- 63272 Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar**
- 63277 Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, lumbar**
- S2350 Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; lumbar, single interspace**
- S2351 Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; lumbar, each additional interspace (list separately in addition to code for primary procedure)**

Repeat Lumbar Microdiscectomy

- 63042 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar**
- 63044 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)**

URGENT/EMERGENT CONDITIONS

All patients being evaluated for spine surgery should be screened for indications of a medical condition that requires urgent/emergent diagnosis. The presence of such indications/conditions warrants definitive surgical treatment in lieu of conservative pain management treatment. If any of the following are part of the clinical presentation with a request for precertification of the CPT code, the request will go to medical review. Severe neck pain associated with any of the following will still need confirmatory imaging, such as a CT or MRI scan:

1. Acute/Unstable Traumatic Spinal Fractures or Dislocations with or without neural compression;
2. Infection (e.g. discitis, epidural abscess, osteomyelitis);
3. Primary or metastatic tumor causing pathologic fracture, cord compression, or instability;
4. Epidural hematoma;
5. Severe or rapidly progressive symptoms of motor loss, bowel or bladder dysfunction;
6. Documented progressive neurological deficit on two separate physical exams;
7. Cauda equina syndrome (CES);
8. Hospitalization* secondary to severe debilitating pain and/or dysfunction to the point of being incapacitated

*Must meet all criteria listed below EXCEPT conservative treatment

**I. Initial Primary Lumbar Microdiscectomy (Laminotomy, Laminectomy or Hemilaminectomy)
Criteria to be met (ALL of the following):**

- A. Radiculopathy/Neurogenic Claudication secondary to herniated disc, synovial cyst/arachnoid cyst: (ALL of the following)
1. Subjective symptoms consistent with recent (within 6 months) MRI/CT findings: (Any three of the following)
 - a. Radiating dermatomal pain into buttock(s) and/or lower extremity(ies);
 - b. Significant level of pain on a daily basis defined on a Visual Analog Scale (VAS) as greater than 4;
 - c. Persistent pain radiating from the back down the lower extremity on a daily basis that has a documented negative impact on activities of daily living despite optimal conservative therapy as described below;
 - d. Pain, cramping, weakness, or tingling in the lower back, buttock(s) and legs brought about by walking or positions that cause thecal sac or nerve root compression (e.g. standing, extension).
 2. Objective physical findings consistent with recent (within 6 months) MRI/CT findings and correspond to the specific affected nerve root(Any one of the following):
 - a. Nerve root tension sign (positive straight leg raise, crossed straight leg raise or femoral stretch test);

- b. Neurologic deficit consistent with recent (within 6 months) CT/MRI findings and correspond to the specific affected nerve root (Any one of the following):
 - i. Dermatomal sensory deficit;
 - ii. Motor deficit (e.g., foot drop, quadriceps weakness);
 - iii. Reflex changes.
- c. Radicular leg pain (radiculitis) without an objective physical finding
3. Recent (within 6 months) MRI/CT identifies nerve root impingement and/or thecal sac impingement caused by herniated disc(s)/synovial cyst/arachnoid cyst that correlates with patient symptoms and physical findings
4. Failure of conservative treatment (any 2 of the following):
 - a. Less than clinically meaningful improvement* from prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks;
 - b. Less than clinically meaningful improvement* from a provider-directed program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks;
 - c. Less than clinically meaningful improvement* from epidural steroid injections/selective nerve root block.
5. No previous surgeries on the disc(s) involved; (if previous surgery on disc see Section III. below- Repeat Lumbar Microdiscectomy (Laminotomy or Laminectomy) at the Same Level
6. All other sources of pain have been excluded;
7. All major psychosocial and substance abuse issues have been addressed;

Definitions:

1. **Acceptable imaging modalities are CT scan, MRI and myelogram.** Imaging must be performed and read by an independent radiologist. If discrepancies should arise in the interpretation of the imaging, interpretations by the radiologist will supersede. Discography results will not be used as a determining factor of medical necessity for any requested procedures. Use is not endorsed.
2. **Clinically meaningful improvement:** Global assessment showing at least 50% improvement.

II. The following sole indications for discectomy, laminectomy and hemilaminectomy are considered Not Medically Necessary:

- A. Signs and symptoms with no correlation to imaging;
- B. Annular tears;
- C. Disk bulge with no neural impingement or cord compression on imaging;
- D. Concordant Discography.

III. Repeat Lumbar Microdiscectomy (Laminotomy or Laminectomy) at the Same Level:

Criteria to be met: Same as Initial Primary Lumbar Microdiscectomy (except I.A.5.) and ALL of the following:

- A. MRI with gadolinium/CT myelogram confirms evidence of neural structure compression (e.g. either retained disc material or a recurrent disc herniation)
- B. Greater than 12 weeks since initial lumbar disc decompression surgery
- C. Initial relief of symptoms following previous disk decompression procedure at same level

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Initial Primary Vertebral Augmentation (Percutaneous Vertebroplasty/Kyphoplasty)

- 22510 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic**
- 22511 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral**
- 22512 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)**
- 22513 Percutaneous Vertebral Augmentation, Including Cavity Creation (Fracture Reduction and Bone Biopsy Included When Performed) Using Mechanical Device, (e.g. Kyphoplasty); 1 Vertebral Body, Unilateral or Bilateral Cannulation, Inclusive Of All Imaging Guidance; Thoracic**
- 22514 Percutaneous Vertebral Augmentation, Including Cavity Creation (Fracture Reduction and Bone Biopsy Included When Performed) Using Mechanical Device, (e.g. Kyphoplasty); 1 Vertebral Body, Unilateral or Bilateral Cannulation, Inclusive Of All Imaging Guidance; Lumbar**

22515 Percutaneous Vertebral Augmentation, Including Cavity Creation (Fracture Reduction and Bone Biopsy Included When Performed) Using Mechanical Device, (e.g. Kyphoplasty); 1 Vertebral Body, Unilateral or Bilateral Cannulation, Inclusive Of All Imaging Guidance; Each Additional Thoracic or Lumbar Vertebral Body (List Separately in Addition to Code for Primary Procedure)

URGENT/EMERGENT CONDITIONS

All patients being evaluated for spine surgery should be screened for indications of a medical condition that requires urgent/emergent diagnosis. The presence of such indications/conditions warrants definitive surgical treatment in lieu of conservative pain management treatment. If any of the following are part of the clinical presentation with a request for precertification of the CPT code, the request will go to medical review. Severe neck pain associated with any of the following will still need confirmatory imaging, such as a CT or MRI scan:

1. Acute/Unstable Traumatic Spinal Fractures or Dislocations with or without neural compression;
2. Infection (e.g. discitis, epidural abscess, osteomyelitis);
3. Primary or metastatic tumor causing pathologic fracture, cord compression, or instability;
4. Epidural hematoma;
5. Severe or rapidly progressive symptoms of motor loss, bowel or bladder dysfunction;
6. Documented progressive neurological deficit on two separate physical exams;
7. Cauda equina syndrome (CES);
8. Hospitalization* secondary to severe debilitating pain and/or dysfunction to the point of being incapacitated.

*Must meet all criteria listed below EXCEPT conservative treatment

The following **contraindications** apply to vertebral augmentation procedures:

- Allergy to materials used in the procedure;
- Uncorrected coagulation disorders or anticoagulation therapy;
- Myelopathy associated with a bone fragment in the spinal canal or cord compression from a tumor;
- Extensive vertebral destruction;
- Burst fracture associated with widened pedicles and/or retropulsed bone fragments;
- Potential space occupying lesions causing cord compression (tumor, bone fragment);
- Collapse of vertebral body to less than the level of the vertebra plana;
- The use of Norian XR cement and Norian SRS cement products is prohibited because they are not FDA approved;
- Radiculopathy from a herniated intervertebral disc;
- Untreated symptomatic foraminal or canal stenosis, facet arthropathy, or other significant coexistent spinal or bony pain generators;
- Unstable fracture or requirement for stabilization procedure in same or adjacent spinal region
- Any active infection (including urinary tract infection [UTI]);

- Presence of painful metastases to areas other than the spine, spinal cord compression, primary bone and osteoblastic tumors, solitary plasmacytomas;
- Severe cardiopulmonary disease;
- Lack of neurosurgical backup for emergency decompression in the event a neurological deficit develops during the injection of PMMA.

I. Initial Vertebral Augmentation Procedure

- A. Indications for vertebral augmentation (injection of methylmethacrylate cement under imaging guidance) with confirmatory recent (within 3 months) imaging findings(Any one of the following):
1. Osteolytic or osteoporotic compression fracture with persistent and debilitating pain
 2. Osteolytic metastases including destruction of a vertebral body by multiple myeloma
 3. Primary malignant neoplasm of bone or bone marrow
 4. Painful and/or aggressive space occupying lesions of a vertebral body (hemangioma/eosinophilic granuloma)
 5. Pre-surgical stabilization of a vertebral body to facilitate a fusion operation
 6. Painful osteonecrotic (i.e., Kummell disease) vertebral compression fracture
 7. Steroid-induced vertebral compression fracture
- B. Criteria to be met: (ALL of the following):
1. Acute (0-6 weeks) axial back pain that correlates with the level of the fracture
 - a. No contraindications
 - b. Compression fractures of the thoracic or lumbar vertebrae resulting in persistent or debilitating pain are treated conservatively
 2. Subacute (>6 weeks) axial pain in the thoracic/lumbar spine for at least 6 weeks [ALL of the following]:
 - a. No contraindications
 - b. Persistent debilitating pain defined as:
 - i. Level of pain on a Visual Analog Scale (VAS) greater than 4 on a daily basis, or
 - ii. Pain on a daily basis that has a documented impact on activities of daily living (IADL) (at least 2 ADL's or IADL's)
 - c. Failure of conservative treatment [All of the following]:
 - i. Less than clinically meaningful improvement* from prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
 - ii. Less than clinically meaningful improvement* from an active program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks

- d. Recent (within 6 weeks) imaging studies to document a recent compression fracture (One of the following):
 - i. Uptake on a nuclear medicine bone scan;
 - ii. Increased intensity on fluid sensitive MRI sequences;
 - iii. Plain x-ray;
 - iv. CT.

***Definitions:**

Clinically meaningful improvement: Global assessment showing at least 50% improvement.

- C. The presence of alternative causes of axial back pain makes vertebral augmentation/kyphoplasty **not medically necessary**(Any one of the following):
 - a. Lumbar/thoracic radiculopathy;
 - b. Lumbar/thoracic facet disease;
 - c. Lumbar/thoracic/sacral trigger points;
 - d. SI joint pain.
- D. Limitations
 - a. No more than 2 levels of the T5-L5 (L4/L5, not L5/S1)spine/single date of service;
 - b. Percutaneous vertebral augmentation with a balloon device is considered **investigational** for the following:
 - i. Non-painful/non-aggressive vertebral hemangioma;
 - ii. Acute vertebral fractures due to osteoporosis or trauma;
 - iii. Vertebrae of the cervical spine and thoracic levels T1-T4;
 - iv. Stabilization of insufficiency fractures or lesions of the sacrum (sacroplasty) or coccyx (coccygeoplasty);
 - v. Prophylactic treatment for osteoporosis of the spine;
 - vi. Prophylactic treatment for chronic back pain of longstanding duration (>6 months), even if associated with old compression fracture(s);
 - vii. Percutaneous mechanical vertebral augmentation using any device other than a balloon device, including but not limited to use of the Kiva system and radiofrequency-assisted vertebral augmentation.
 - c. Spineoplasty (e.g., OptiMesh® 1500E Polyethylene Terephthalate (PET) mesh pouch) is considered **investigational**
 - d. Cervical vertebroplasty
 - e. Percutaneous Vertebral Augmentation will NOT be separately paid when combined with any open spine procedure.

Definitions:

- 1. Acceptable imaging modalities are CT scan, MRI and myelogram.**
Imaging must be performed and read by an independent radiologist. If discrepancies should arise in the interpretation of the imaging, interpretations by the radiologist will supersede.
- 2. Use of discography is not endorsed.**

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Lumbar Decompression

- 63047 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), [e.g. Spinal or lateral recess stenosis]), single vertebral segment; lumbar**
- 63048 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)**
- 63005 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis**
- 63011 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; sacral**
- 63012 Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)**
- 63017 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; lumbar**

URGENT/EMERGENT CONDITIONS

All patients being evaluated for spine surgery should be screened for indications of a medical condition that requires urgent/emergent diagnosis. The presence of such indications/conditions warrants definitive surgical treatment in lieu of conservative pain management treatment. If any of the following are part of the clinical presentation with a request for precertification of the CPT code, the request will go to medical review. Severe back pain associated with any of the following will still need confirmatory imaging, such as a CT or MRI scan:

1. Acute/Unstable Traumatic Spinal Fractures or Dislocations with or without neural compression;
2. Infection (e.g. discitis, epidural abscess, osteomyelitis);
3. Primary or metastatic tumor causing pathologic fracture, cord compression, or instability;
4. Epidural hematoma;
5. Severe or rapidly progressive symptoms of motor loss, bowel or bladder dysfunction;
6. Documented progressive neurological deficit on two separate physical exams;
7. Cauda equina syndrome (CES);
8. *Hospitalization secondary to severe debilitating pain and/or dysfunction to the point of being incapacitated.

*Must meet all criteria listed below EXCEPT conservative treatment

The following procedures are considered investigational/experimental:

- *Percutaneous Lumbar Discectomy*
- *Percutaneous Laser Discectomy*
- *Laser-assisted Disc Decompression*
- *Percutaneous Laser Disc Decompression*
- *Percutaneous nucleotomy*

I. Initial Primary Lumbar Decompression Criteria to be met (ALL of the following):

Spinal Stenosis/Spondylolisthesis (A and/or B)

A. Neurogenic claudication secondary to central/lateral recess/foraminal stenosis (ALL of the following):

1. Subjective symptoms consistent with recent (within 6 months) MRI/CT findings: (Any ONE of the following)
 - a. Radiating dermatomal pain into buttock(s) and/or lower extremity(ies), or
 - b. Symptoms worsen with standing and/or walking, or
 - c. Symptoms are alleviated with sitting and/or forward flexion.
2. Objective physical findings consistent with recent (within 6 months) MRI/CT

3. Less than clinically meaningful improvement from epidural steroid injections/selective nerve root block
- B. Spondylolisthesis
 1. Back pain, neurogenic claudication symptoms or radicular pain from lateral recess, or foraminal stenosis on recent (within 6 months) MRI/CT associated with ALL of the following:
 - a. Significant functional impairment,
 - b. Listhesis demonstrated on plain x-rays
- C. Spinal stenosis/Spondylolisthesis symptoms that are severe and disabling or unresponsive to 6 weeks of conservative care (Any one of the following):
 - a. Less than clinically meaningful improvement* from prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks;
 - b. Less than clinically meaningful improvement* from a provider-directed program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks.
- D. Recent (within 6 months) MRI/CT identifies nerve root impingement and/or thecal sac impingement caused by stenosis/lithesis that correlates with patient symptoms or physical findings
- E. No previous surgeries at the level(s) involved (if previous surgery at the level(s) involved see Section II. below- Repeat Lumbar Decompression: Criteria to be met).
- F. All other sources of pain have been excluded
- G. All major psychosocial and substance abuse issues have been addressed

Definitions:

1. **Acceptable imaging modalities are CT scan, MRI and myelogram.** Imaging must be performed and read by an independent radiologist. If discrepancies should arise in the interpretation of the imaging, interpretations by the radiologist will supersede. Discography results will not be used as a determining factor of medical necessity for any requested procedures. Use is not endorsed.
2. ***Clinically meaningful improvement:** Global assessment showing at least 50% improvement.

**II. Repeat Lumbar Decompression:
Criteria to be met: Same as Initial Primary Lumbar
Microdiscectomy (except I.E) plus:**

- A. Recent (within 3 months) post-operative MRI with gadolinium/CT myelogram confirms radiographic evidence of neural structure compression;
- B. Greater than 12 weeks since last decompression surgery;
- C. Initial relief of symptoms following previous decompression procedure at same level(s).

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Lumbar Fusion (Arthrodesis)

- 22533** Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
- 22534** Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)
- 22558** Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
- 22585** Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)
- 22612** Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)
- 22614** Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)
- 22630** Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar

- 22632 Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)**
- 22633 Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar**
- 22634 Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression); each additional interspace and segment (List separately in addition to code for primary procedure)**
- 22800 Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments**
- 22802 Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments**
- 22804 Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments**
- 22808 Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments**
- 22810 Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments**
- 22812 Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments**

- 22840** Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)
- 22841** Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)
- 22842** Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)
- 22843** Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure)
- 22844** Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (List separately in addition to code for primary procedure)
- 22845** Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)
- 22846** Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)

22847 Anterior instrumentation; 8 of more vertebral segments (List separately in addition to code for primary procedure)

22848 Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure)

22849 Reinsertion of spinal fixation device

Prior Authorization Requirements:

1. Prior-authorization requests should be submitted at least two weeks prior to the anticipated date of an elective spinal surgery. Minimum documentation requirements needed to complete a spinal surgery prior authorization request:
 - a. CPT codes, ICD-10 codes and disc levels indicated
 - b. Detailed documentation of type of provider-directed conservative treatment (e.g., interventional pain management procedures/injections, medication, physical therapy, chiropractic, or other provider-directed active exercise program) that includes response to conservative treatment Most recent imaging reports performed, read and interpreted by an independent radiologist whose report shall supersede any discrepancies (when present) in interpretation
 - c. Standing flexion-extension films for spinal fusion surgery requests based upon indications of instability
 - d. Documentation of nicotine-free status (see Tobacco Cessation criteria below)

URGENT/EMERGENT CONDITIONS

All patients being evaluated for spine surgery should be screened for indications of a medical condition that requires urgent/emergent diagnosis. The presence of such indications/conditions warrants definitive surgical treatment in lieu of conservative pain management treatment. If any of the following are part of the clinical presentation with a request for precertification of the CPT code, the request will go to medical review. Severe back pain associated with any of the following will still need confirmatory imaging, such as a CT or MRI scan:

1. Acute/Unstable Traumatic Spinal Fractures or Dislocations with or without neural compression
2. Infection (e.g. discitis, epidural abscess, osteomyelitis)
3. Primary or metastatic tumor causing pathologic fracture, cord compression, or instability
4. Epidural hematoma
5. Severe or rapidly progressive symptoms of motor loss, bowel or bladder dysfunction
6. Documented progressive neurological deficit on two separate physical exams
7. Hospitalization* secondary to severe debilitating pain and/or dysfunction to the point of being incapacitated

*Must meet all criteria listed below EXCEPT conservative treatment

Lumbar spinal fusion is also considered not medically necessary if the sole indication is any one or more of the following conditions:

- *Disk Herniation*
- *Degenerative Disk Disease*

- *Compression of the neural structure*
- *Facet Syndrome*
- *Initial Diskectomy/Laminectomy*
- *Spinal stenosis without spondylolisthesis*
- *Sacroiliac Joint Fusion*

I. Criteria to be met for Lumbar Fusion (Arthrodesis) based on Condition-Specific Indications:

A. Spinal Stenosis(ALL of the following):

1. Neurogenic claudication secondary to stenosis (central/lateral recess/or foraminal stenosis);
2. Subjective symptoms consistent with recent (within 6 months) MRI/CT findings: (Any ONE of the following)
 - a. Radiating dermatomal pain into buttocks and/or lower extremity(ies), or
 - b. Symptoms worsen with standing and/or walking, or
 - c. Symptoms are alleviated with sitting and/or forward flexion
3. Confirmatory imaging (ALL of the following):
 - a. Recent (within 6 months) MRI/CT identifies nerve root impingement and/or thecal sac impingement caused by stenosis (central/lateral recess/or foraminal stenosis) that correlates with the patient's symptoms and/or objective physical examination findings; and
 - b. Recent (within 6 months) radiographic evidence of anterolisthesis resulting in:
 - i. Segmental instability with 5mm or more of anterior translation/displacement of the vertebra on the adjacent vertebra below, or
 - ii. Grade II or higher spondylolisthesis (i.e. instability)

B. Iatrogenic Instability(Any one of the following):

1. Instability identified intra-operatively created by disruption of the posterior elements due to facet joint excision that exceeds 50% bilaterally or 75% or more of a single facet during spinal decompression; or
2. Confirmatory imaging (Any one of the following):
 - a. Recent (within 6 months) imaging documenting postoperative instability created by the disruption of the posterior elements due to facet joint excision that exceeds 50% bilaterally or 75% or more of a single facet, or
 - b. Removal of the pars interarticularis is performed that requires fusion to stabilize or
 - c. Pars fracture, or
 - d. Previous spinal decompression that resulted in iatrogenic spondylolisthesis.

C. Spondylolysis(Any one of the following):

1. Confirmatory imaging
 - a. Multilevel spondylolysis on recent (within 6 months) radiographic studies, or
 - b. Symptomatic Grade 1 or 2 spondylolisthesis (anterolisthesis) with recent (within 6 months) radiographic documentation supporting progression of anterolisthesis, or
 - c. Symptomatic Grade 3 or higher spondylolisthesis (anterolisthesis) demonstrated on recent (within 6 months) plain X-rays with 50% or more anterior slippage and radiographic documentation supporting progression of anterolisthesis

D. Recurrent disc herniation (ALL of the following):

1. Recurrent neurogenic claudication symptoms or radiating dermatomal pain into buttocks and/or lower extremity(ies); and
2. Objective physical examinations findings consistent with the findings on recent (within 6 months) MRI/CT; and
3. 6 or more months since the most recent disk surgery; and
4. Significant initial relief of symptoms following prior discectomies, and
5. Same-level disk herniation; and
6. Prior discectomy at the same level; and
7. Confirmatory radiographic imaging (ALL of the following):
 - a. Neural structure compression demonstrated by most recent (within 6 months) imaging, and
 - b. Radiographic evidence of anterolisthesis resulting in:
 - i. Segmental instability with 5mm or more of anterior translation displacement of the vertebra on the adjacent vertebra below, or
 - ii. Grade II or higher spondylolisthesis (i.e., instability)

E. Adjacent segment degeneration [ALL of the following]:

1. Recurrent neurogenic claudication symptoms or radiating dermatomal pain into buttocks and/or lower extremity(ies); and
2. Objective physical examinations findings consistent with the findings on recent (within 6 months) MRI/CT; and
3. Radiographic evidence of anterolisthesis resulting in: (All of the following); and
 - i. Segmental instability with 5mm or more of anterior translation displacement of the vertebra on the adjacent vertebra below, or
 - ii. Grade II or higher spondylolisthesis (i.e., instability).
4. Neural structure compression demonstrated by recent (within 6 months) radiographic imaging; and
5. Significant initial relief of symptoms following prior spinal fusion(s); and
6. 6 or more months since the previous fusion.

F. Isthmic spondylolisthesis (ALL of the following):

1. Congenital or acquired pars defect, documented by recent (within 6 months) X-ray, and
2. Persistent back pain (with or without neurogenic symptoms), and
3. Impairment and loss of function, unresponsive to at least 6 months of coordinated provider-directed conservative care

G. Repeat Lumbar Arthrodesis at the same level(Any ONE of the following):

1. Recent (within 6 months) radiographic (plain film) evidence of implant malposition or implant failure, and/or
2. Pseudoarthrosis (ALL of the following):
 - a. Greater than 6 months since last fusion (arthrodesis) surgery, and
 - b. Subjective (ALL of the following), and
 - i. Persistent axial back pain, with or without neurogenic symptoms, and
 - ii. Impaired function or loss of function
 - c. Confirmatory Imaging (Any one of the following)
 - i. MRI with gadolinium/CT myelogram
 - ii. CT scan documenting pseudoarthrosis, no less than 6 months after initial fusion

H. Lumbar Discectomy and Fusion following failed lumbar disc arthroplasty implant

1. Recent (within 6 months) radiographic (plain film) evidence of implant malposition or implant failure (e.g., subsidence, loosening, infection, dislocation/subluxation, vertebral body fracture, dislodgement)

Or All of the following

2. Subjective:
 - a. Persistent axial back pain, with or without neurogenic symptoms, and
 - b. Impaired function or loss of function
3. **Discography results will not be used as a determining factor of medical necessity for any requested procedures.** Confirmatory Imaging: and,
 - a. MRI with gadolinium/CT myelogram confirms evidence of neural structure compression (e.g., either retained disc material or a recurrent disc herniation)
4. Significant initial relief of prior symptoms following prior surgery, and
5. Greater than 6 months since disc arthroplasty surgery

Definitions:

1. **Acceptable imaging modalities are CT scan, MRI and myelogram.** Imaging must be performed and read by an independent radiologist. If discrepancies should arise in the interpretation of the imaging, interpretations by the radiologist will supersede. Discography results will not be used as a determining factor of medical necessity for any requested procedures. Use is not endorsed.
2. **Clinically meaningful improvement:** Global assessment showing at least 50% improvement.

II. Criteria to be met for ALL Condition-Specific Indications (ALL of the following):**A. Documented failure of 3 consecutive months of physician-directed conservative treatment [Any 2 of the following]:**

- a. Less than clinically meaningful improvement* from prescription strength analgesics, steroids, and/or NSAIDs
- b. Less than clinically meaningful improvement* from a provider-directed program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician
- c. Less than clinically meaningful improvement* from epidural steroid injections/selective nerve root block
- d. Less than clinically meaningful improvement* from facet injections

B. Functional Limitation (ALL of the following):

1. Significant level of pain on a daily basis defined on a Visual Analog Scale (VAS) as greater than 4, and
 - a. Clinically significant functional impairment (e.g., inability to perform household chores, prolonged standing or essential job functions)
2. Tobacco Cessation
 - a. Patient is a non-tobacco user, or
 - b. If patient on at least 6 weeks prior to requesting surgery as evidenced by lab results (cotinine level) documenting nicotine-free status.

Note: In order to complete the prior authorization process for spinal fusion surgery, planning should allow for enough time to submit lab results performed after the 6-week tobacco abstinence period.

C. Instrumentation

1. **Pedicle Screws** are appropriate (when indicated) for the following indications:
 - a. Fusion:
 - i. Adjacent to a prior lumbar fusion
 - ii. Post decompression

- b. Repair of a documented pseudoarthrosis documented on recent (within 6 months) radiographic imaging
 - c. Instability at a previous level of surgery (lumbar disc revision surgery)
 - d. Scoliosis and kyphosis requiring spinal instrumentation
 - e. Tumor resection resulting in segmental defects or loss of posterior elements
 - f. Spinal trauma including fractures and dislocations resulting in instability
 - g. Grades I - IV spondylolisthesis
 - h. Pedicle screw fixation is considered experimental, investigational and unproven for all other indications including but not limited to:
 - i. Decompressive laminectomy for spinal stenosis without evidence of instability
 - ii. Degenerative disc disease
 - iii. Failed lumbar spine surgery without documentation of instability or pseudoarthrosis
 - iv. Axial lumbar spine pain without associated radiculopathy/myelopathy without documentation of instability or objective neurologic deficits
 - v. Single level discectomy
2. Spine Cages
- a. **Spine Cages** are considered medically necessary for use with autogenous bone graft when criteria for both spinal fusion and autogenous bone graft have been satisfied as indicated in the respective policies.
 - b. Spine cages are considered experimental, investigational and unproven for all other indications.
3. The following devices/procedures are considered experimental or investigational (not an all inclusive list)
- a. Device/implant not FDA approved
 - b. Devices for disc annular repair
 - c. Dynamic (intervertebral) stabilization
 - d. Interlaminar lumbar instrumented fusion (ILIF)
 - e. Interspinous and interlaminar distraction devices
 - f. Interspinous fixation devices
 - g. Least invasive lumbar decompression interbody fusion (LINDIF)
 - h. Minimally invasive lumbar decompression (MILD)
 - i. Minimally invasive thoracic discectomy for the treatment of axial spinal pain
 - j. Percutaneous endoscopic discectomy
 - k. Total facet arthroplasty

- I. Sacroiliac fusion or other stabilization procedures for the treatment of axial spinal pain/SI joint pain not due to SI joint infection, neoplastic disease involving the sacrum and sacroiliac joint pain due to severe traumatic injury when a trial of an external fixator was successful in providing pain relief.

Definitions:

1. **Acceptable imaging modalities are CT scan, MRI and myelogram.** Imaging must be performed and read by an independent radiologist. If discrepancies should arise in the interpretation of the imaging, interpretations by the radiologist will supersede. Discography results will not be used as a determining factor of medical necessity for any requested procedures. Use is not endorsed.
2. **Clinically meaningful improvement:** Global assessment showing at least 50% improvement.

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Lumbar Total Disc Arthroplasty

22857 Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar

22862 Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar

22865 Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar

0163T Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure)

0164T Removal of total disc arthroplasty, (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)

0165T Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)

URGENT/EMERGENT CONDITIONS

All patients being evaluated for spine surgery should be screened for indications of a medical condition that requires urgent/emergent diagnosis. The presence of such indications/conditions warrants definitive surgical treatment in lieu of conservative pain management treatment. If any of the following are part of the clinical presentation with a request for precertification of the CPT code, the request will go to medical review. Severe pain associated with any of the following will still need confirmatory imaging, such as a CT or MRI scan:

1. Acute/Unstable Traumatic Spinal Fractures or Dislocations with or without neural compression
2. Infection (e.g. discitis, epidural abscess, osteomyelitis)
3. Primary or metastatic tumor causing pathologic fracture, cord compression, or instability
4. Severe or rapidly progressive symptoms of motor loss, bowel or bladder dysfunction
5. Documented progressive neurological deficit on two separate physical exams
6. Epidural hematoma
7. Severe or rapidly progressive symptoms of motor loss, bowel or bladder dysfunction
8. Documented progressive neurological deficit on two separate physical exams
9. Hospitalization* secondary to severe debilitating pain and/or dysfunction to the point of being incapacitated

*Must meet all criteria listed below EXCEPT conservative treatment

I. Initial Primary Lumbar Total Disc Arthroplasty: Criteria to be met (ALL of the following):

- A. Use of an FDA Approved Implant
- B. Presence of chronic, unremitting, discogenic lower back pain and associated disability secondary to single-level degenerative disc disease (DDD) in a skeletally mature individual
- C. Functional Limitation [ALL of the following]:
 1. Significant level of pain on a daily basis defined on a Visual Analog Scale (VAS) as greater than 4, and
- D. Clinically significant functional impairment (e.g., inability to perform household chores, prolonged standing or essential job functions) Failed 6 months of structured* physician supervised conservative management, which includes ALL of the following:
 1. Less than clinically meaningful improvement* from prescription strength analgesics, steroids, and/or NSAIDs
 2. Less than clinically meaningful improvement* from a physician-directed program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician

- E. Single-level disc degeneration has been confirmed on Recent (within 6 months) advanced diagnostic imaging studies (i.e., computerized tomography [CT] scan, magnetic resonance imaging [MRI]).
- F. The planned implant will be used in accordance with FDA requirements
- G. Tobacco Cessation
 - 1. Patient is a non-tobacco user, or

If patient is a documented tobacco user, then patient must have abstained from tobacco use for at least 6 weeks prior to the planned spinal fusion surgery as evidenced by lab results (cotinine level) documenting nicotine-free status.

Note: In order to complete the prior authorization process for spinal fusion surgery, planning should allow for enough time to submit lab results performed after the 6-week tobacco abstinence period.

***Structured medical management consists of medical care that is delivered through regularly scheduled appointments, including follow-up evaluation, with licensed healthcare professionals.**

II. Lumbar Artificial Total Disc Arthroplasty is otherwise considered experimental, investigational or unproven under the following conditions:

- A. The planned procedure includes the combined use of a prosthesis and spinal fusion (hybrid).
- B. Lumbar partial disc prosthetics
- C. Simultaneous multilevel implantation.
- D. The implant will be inserted outside of the spinal motion segments approved by the FDA.
- E. The individual has osteopenia or osteoporosis (T-score < -1.0).
- F. The individual has a history of prior lumbar fusion.
- G. A lumbar disc prosthesis not approved by the FDA or for an FDA approved indication
- H. There is evidence on imaging studies of ANY of the following:
 - 1. Lytic or degenerative spondylolisthesis of Grade 2 or greater
 - 2. Infection
 - 3. Multilevel degenerative disc disease
 - 4. Lumbar nerve root compression or bony spinal stenosis

III. **Contraindications to Lumbar Artificial Total Disc Arthroplasty implantation include but are not limited to:**

- A. Active systemic infection or infection localized to the site of implantation
- B. Osteopenia or osteoporosis defined as DEXA bone density measured T-score < -1.0
 - 1. Bony lumbar spinal stenosis
 - 2. Pars interarticularis defect with either spondylolysis or isthmic spondylolisthesis
 - 3. Scoliosis
 - 4. Severe facet joint arthrosis
 - 5. Spinal fracture
 - 6. Tumor
- C. Allergy or sensitivity to implant materials
- D. Isolated radicular compression syndromes especially due to lumbar disc herniation
- E. Pars defect
- F. Involved vertebral endplate this is dimensionally smaller than the approximate dimensions of the implant in anterior/posterior width and lateral width.
- G. Clinically compromised vertebral bodies at the affected level due to current or past trauma

IV. **Failed lumbar total disc arthroplasty implant:** Refer to the Lumbar Fusion policy

V. **Adjacent Segment Disease following Lumbar Total Disc Arthroplasty:** Refer to the Lumbar Disc Arthroplasty or Lumbar Fusion policy

Definitions:

- 1. **Acceptable imaging modalities are CT scan, MRI and myelogram. Imaging must be performed and read by an independent radiologist. If discrepancies should arise in the interpretation of the imaging, interpretations by the radiologist will supersede. Discography results will not be used as a determining factor of medical necessity for any requested procedures. Use is not endorsed.**
- 2. ***Clinically meaningful improvement: Global assessment showing at least 50% improvement.**

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