CLINICAL GUIDELINES

Spine Surgery Guidelines
Version 1.0.2019

Clinical guidelines for medical necessity review of comprehensive musculoskeletal management services.
© 2019 eviCore healthcare. All rights reserved.
<table>
<thead>
<tr>
<th>Spine Surgery Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMM-600: Preface to Spine Surgery Guidelines 3</td>
</tr>
<tr>
<td>CMM-601: Anterior Cervical Discectomy and Fusion 6</td>
</tr>
<tr>
<td>CMM-602: Cervical Total Disc Arthroplasty 7</td>
</tr>
<tr>
<td>CMM-603: Electrical and Low Frequency Ultrasound Bone Growth Stimulation (Spine) 8</td>
</tr>
<tr>
<td>CMM-604: Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/ Laminoplasty) with or without Fusion 9</td>
</tr>
<tr>
<td>CMM-605: Cervical Microdiscectomy 20</td>
</tr>
<tr>
<td>CMM-606: Lumbar Microdiscectomy (Laminotomy, Laminectomy, or Hemilaminectomy) 26</td>
</tr>
<tr>
<td>CMM-607: Primary Vertebral Augmentation (Percutaneous Vertebroplasty/Kyphoplasty) and Sacroplasty 33</td>
</tr>
<tr>
<td>CMM-608: Lumbar Decompression 34</td>
</tr>
<tr>
<td>CMM-609: Lumbar Fusion (Arthrodesis) 41</td>
</tr>
<tr>
<td>CMM-610: Lumbar Total Disc Arthroplasty 42</td>
</tr>
<tr>
<td>CMM-611: Sacroiliac Joint Fusion or Stabilization 42</td>
</tr>
<tr>
<td>CMM-612: Grafts 51</td>
</tr>
<tr>
<td>CMM-600: Preface to Spine Surgery Guidelines</td>
</tr>
<tr>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>CMM-600.1: Prior Authorization Requirements</td>
</tr>
<tr>
<td>CMM-600.2: Urgent/Emergent Requests</td>
</tr>
</tbody>
</table>
CMM-600.1: Prior Authorization Requirements

- 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 prior authorization request for spinal surgery include ALL of the following:
  - CPT codes, disc level(s) for planned surgery and ICD-10 codes
  - Detailed documentation of the type, duration, and frequency of provider-directed non-surgical treatment (e.g., interventional pain management, medication management, physical therapy, chiropractic care, provider-directed active exercise program, etc.) and the response to each treatment
    - Detailed documentation explaining why a sufficient trial of non-surgical treatment was contraindicated if applicable
    - Review of clinically meaningful improvement will be assessed for each treatment. This is a global assessment showing at least 50% improvement.
  - Written reports/interpretations of the most recent advanced diagnostic imaging studies (e.g., CT, MRI, Myelography) by an independent radiologist whose report shall supersede any discrepancies (when present) in interpretation
    - Acceptable imaging modalities for purposes of the Spine Surgery guidelines are: CT, MRI, and Myelography.
    - Discography results will not be used as a determining factor of medical necessity for any requested procedure. Discography use is not endorsed.
  - For spinal fusion surgery requests: flexion-extension radiographs based upon indications for instability and/or other plain radiographs that document failure of instrumentation, fusion, etc.
  - Documentation of nicotine-free status as evidenced by EITHER of the following, unless this is an urgent/emergent request, for decompression only without fusion, disc arthroplasty, or when myelopathy is present:
    - Patient is a nonsmoker
    - Patient has refrained from smoking for at least 6 weeks prior to planned surgery as evidenced by cotinine lab results of ≤ 10 ng/mL
      - **Note:** In order to complete the prior authorization process for spinal fusion surgery, allow for sufficient time for submission of lab results performed after the 6-week cessation period.
CMM-600.2: Urgent/Emergent Requests

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 provider-directed non-surgical management and/or proof of smoking cessation. Confirmatory imaging studies are required.

An urgent/emergent request is based on the 2018 NCQA standards for utilization management and is as follows:
- A request for medical care or services when application of the time frame for making routine or non-life threatening care determinations:
  - Could seriously jeopardize the life, health, or safety of the member or others, due to the member’s psychological state, or
  - In the opinion of a practitioner with knowledge of the member’s medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
CMM-601: Anterior Cervical Discectomy and Fusion

Prior Authorization Requirements:

For Cervical Total Disc Arthroplasty, Asuris, BridgeSpan, Regence applies Milliman Care Guidelines (MCG) as the basis for service coverage determinations. Visit MCG’s website @ https://www.mcg.com/ for information on purchasing their criteria, or contact Asuris, BridgeSpan, Regence and they will be happy to provide you with a copy of the guidelines for specific services.

See Milliman Care Guidelines (S320) for Cervical Fusion (Anterior)

See Milliman Care Guidelines (S330) for Cervical Fusion (Posterior)
CMM-602: Cervical Total Disc Arthroplasty

Prior Authorization Requirements:

For Cervical Total Disc Arthroplasty, please refer to BridgeSpan Policy Sur127.
CMM-603: Electrical and Low Frequency Ultrasound Bone Growth Stimulation (Spine)

Prior Authorization Requirements:
For Electrical and Low Frequency Ultrasound Bone Growth Stimulation, please refer to BridgeSpan Policy DME83.11.
## CMM-604: Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/Laminoplasty) with or without Fusion

<table>
<thead>
<tr>
<th>Subsection</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMM-604.1</td>
<td>General Guidelines 10</td>
<td></td>
</tr>
<tr>
<td>CMM-604.2</td>
<td>Initial Primary Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/Laminoplasty) with or without Posterior Fusion 11</td>
<td></td>
</tr>
<tr>
<td>CMM-604.3</td>
<td>Posterior Cervical Fusion without Decompression 13</td>
<td></td>
</tr>
<tr>
<td>CMM-604.4</td>
<td>Repeat Posterior Cervical Decompression with or without Posterior Cervical Fusion at the Same Level 13</td>
<td></td>
</tr>
<tr>
<td>CMM-604.5</td>
<td>Failed Cervical Disc Arthroplasty Implant 15</td>
<td></td>
</tr>
<tr>
<td>CMM-604.6</td>
<td>Non-Indications 17</td>
<td></td>
</tr>
<tr>
<td>CMM-604.7</td>
<td>Procedure (CPT®) Codes 17</td>
<td></td>
</tr>
<tr>
<td>CMM-604.8</td>
<td>References 18</td>
<td></td>
</tr>
</tbody>
</table>
CMM-604.1: General Guidelines

- The determination of medical necessity for the performance of posterior cervical decompression with or without fusion is always made on a case-by-case basis.
- For prior authorization requirements, see CMM-600.1: Prior Authorization Requirements.
- The presence of urgent/emergent indications/conditions warrants definitive surgical treatment in lieu of provider-directed non-surgical management and/or proof of smoking cessation. Confirmatory imaging studies are required.
- Urgent/emergent conditions for posterior cervical decompression with or without fusion include ANY of the following:
  - Acute/unstable traumatic spinal fractures or dislocations with or without neural compression
  - Central cord syndrome
  - Congenital cervical stenosis (AP canal diameter ≤ 10 mm)
  - Documentation of progressive neurological deficit on two separate physical examinations
  - Epidural hematoma
  - Infection (e.g., discitis, epidural abscess, osteomyelitis)
  - Occipitocervical and/or Atlantoaxial (C1-C2) instability (non-traumatic) and/or spinal cord compression due to ANY of the following:
    - Rheumatoid arthritis
    - Congenital abnormality of occipitocervical/C1-C2 vertebrae
    - Os odontoideum
  - Ossification of the posterior longitudinal ligament at three (3) or more levels
  - Primary or metastatic neoplastic disease causing pathologic fracture, cord compression or instability
  - Severe or rapidly progressive symptoms of motor loss, bowel incontinence or bladder incontinence/retention due to a neurocompressive pathology
  - Vascular malformations (e.g., AVM)
  - Documentation of severe debilitating pain and/or dysfunction to the point of being incapacitated
CMM-604.2: Initial Primary Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/Laminoplasty) with or without Posterior Fusion

Initial primary posterior cervical decompression (laminectomy/hemilaminectomy/laminoplasty) with or without posterior fusion is considered medically necessary when ALL of the following are met:

- Recent (within 6 months) radiographs of the cervical spine including flexion/extension lateral views have been performed
- No previous surgeries on the disc(s) involved
- Absence of unmanaged significant behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Performed for ANY of the following conditions:
  - Radiculopathy when ALL of the following are met:
    - Subjective symptoms including BOTH of the following:
      - Significant level of pain on a daily basis defined on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
      - Unremitting radicular pain to shoulder girdle and/or upper extremity with or without concordant objective physical examination findings resulting in disability
    - Objective physical examination findings including ANY of the following:
      - Dermatomal sensory deficit
      - Motor deficit (e.g., biceps, triceps weakness)
      - Reflex changes
      - Shoulder Abduction Relief Sign
      - Nerve root tension sign (e.g., Spurling’s maneuver)
      - Unremitting radicular pain to shoulder girdle and/or upper extremity without concordant objective physical examination findings
    - Less than clinically meaningful improvement with at least TWO of the following unless contraindicated:
      - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
      - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
      - Epidural steroid injection(s)/selective nerve root block(s)
      - Recent (within 6 months) MRI/CT identifies nerve root impingement caused by herniated disc(s) and/or osteophytes that is concordant with the patient’s symptoms and physical examination findings
      - Documentation of nicotine-free status with EITHER of the following, unless request is for decompression only:
        - Patient is a nonsmoker
        - Patient has refrained from smoking for at least 6 weeks prior to planned surgery as evidenced by cotinine lab results of ≤ 10 ng/mL
Myelopathy when **ALL** of the following are met:

- Subjective symptoms including **ANY** of the following:
  - Upper/lower extremity weakness, numbness, or pain
  - Fine motor dysfunction (buttoning, handwriting, clumsiness of hands)
  - New-onset bowel or bladder dysfunction due to a neurocompressive pathology
  - Frequent falls
- Objective physical examination findings including at least **TWO** of the following:
  - Grip and release test
  - Ataxic gait
  - Hyperreflexia
  - Hoffmann sign
  - Pathologic Babinski sign
  - Tandem walking test
  - Inverted brachial radial reflex
  - Increased muscle tone or spasticity
  - Clonus
  - Myelopathic hand
- Recent (within 6 months) MRI/CT findings that are concordant with the patient’s symptoms and physical examination findings including **EITHER** of the following:
  - MRI/CT demonstrates spinal cord compression
  - MRI/CT identifies stenosis with or without myelomalacia

A concurrent stabilization procedure with corpectomy, laminectomy, or other procedure at the cervicothoracic junction (i.e., C7 and T1)

A concurrent stabilization procedure with a laminectomy, especially at C2

Subluxation and/or spinal cord compression in patients with rheumatoid arthritis or clinical conditions with an increased incidence of congenital and/or acquired cervical spinal instability (e.g., Down syndrome, mucopolysaccharidoses, spondyloepiphyseal dysplasia, pseudoachondrodysplasia, etc.)

Multi-level spondylotic myelopathy without kyphosis

Primary or metastatic tumor with associated cord compression and/or instability

Other symptomatic instability or spinal cord/root compression requiring posterior fusion with **BOTH** of the following:
  - Patient unresponsive to a reasonable and medically appropriate course of conservative treatment (e.g., rest, medication, cervical collar)
  - Recent (within 6 months) imaging study demonstrating corresponding pathologic anatomy
CMM-604.3: Posterior Cervical Fusion without Decompression
Posterior cervical fusion without decompression is considered medically necessary when ALL of the following criteria are met:

- Absence of unmanaged significant behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)

- Performed for ONE or MORE of the following:
  - Symptomatic pseudoarthrosis from a prior anterior or posterior fusion procedure
  - Symptomatic cervical spondylosis with instability as evidenced radiographically by ONE or MORE of the following:
    - Subluxation or translation of more than 3.5 mm on static lateral views or dynamic flexion/extension lateral radiographs
    - Sagittal plane angulation of more than 11 degrees between adjacent spinal segments
    - More than 4 mm of motion (subluxation) between the tips of the spinous processes on flexion/extension lateral radiographic views
  - Klippel-Feil syndrome
  - Cervical instability in patients with Down syndrome, skeletal dysplasia, or connective tissue disorders

- Documentation of nicotine-free status with EITHER of the following:
  - Patient is a nonsmoker
  - Cotinine level lab results showing that the patient has refrained from smoking for at least 6 weeks prior to planned surgery

CMM-604.4: Repeat Posterior Cervical Decompression with or without Posterior Cervical Fusion at the Same Level
Repeat posterior cervical decompression with or without posterior cervical fusion at the same level is considered medically necessary when there is recent (within 3 months) radiographic plain film or CT evidence of implant/instrumentation or structural bone graft malposition or failure OR when ALL of the following criteria are met:

- Recent (within 3 months) MRI with or without contrast/CT myelogram confirms evidence of neural structure compression (e.g., either retained disc material or a recurrent disc herniation)

- Greater than 12 weeks since last posterior cervical decompression with or without fusion surgery

- Initial relief of symptoms following previous posterior cervical decompression procedure at same level

- Recent (within 6 months) radiographs of the cervical spine including flexion/extension lateral views instability as evidenced by ONE or MORE of the following:
  - Subluxation or translation of more than 3.5 mm on static lateral views or dynamic flexion/extension lateral radiographs
- Sagittal plane angulation of more than 11 degrees between adjacent spinal segments
- More than 4 mm of motion (subluxation) between the tips of the spinous processes on flexion/extension lateral radiographic views

- Absence of unmanaged significant behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)

- Performed for **EITHER** of the following conditions:
  - Radiculopathy when **ALL** of the following are met:
    - Subjective symptoms including **BOTH** of the following:
      - Significant level of pain on a daily basis defined on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
      - Unremitting radicular pain to shoulder girdle and/or upper extremity with or without concordant objective physical examination findings resulting in disability
    - Objective physical examination findings including **ANY** of the following:
      - Dermatomal sensory deficit
      - Motor deficit (e.g., biceps, triceps weakness)
      - Reflex changes
      - Shoulder Abduction Relief Sign
      - Nerve root tension sign (e.g., Spurling's maneuver)
      - Unremitting radicular pain to shoulder girdle and/or upper extremity without concordant objective physical examination findings
    - Less than clinically meaningful improvement with at least **TWO** of the following unless contraindicated:
      - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
      - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
      - Epidural steroid injection(s)/selective nerve root block(s)
    - Recent (within 6 months) MRI/CT identifies nerve root impingement caused by herniated disc(s) and/or osteophytes that is concordant with the patient’s symptoms and physical examination findings
    - Documentation of nicotine-free status with **EITHER** of the following, unless request is for decompression only:
      - Patient is a nonsmoker
      - Patient has refrained from smoking for at least 6 weeks prior to planned surgery as evidenced by cotinine lab results of ≤ 10 ng/mL
Myelopathy when **ALL** of the following are met:
- Subjective symptoms including **ANY** of the following:
  - Upper/lower extremity weakness, numbness, or pain
  - Fine motor dysfunction (buttoning, handwriting, clumsiness of hands)
  - New-onset bowel or bladder dysfunction due to a neurocompressive pathology
  - Frequent falls
- Objective physical examination findings including at least **TWO** of the following:
  - Grip and release test
  - Ataxic gait
  - Hyperreflexia
  - Hoffmann sign
  - Pathologic Babinski sign
  - Tandem walking test
  - Inverted brachial radial reflex
  - Increased muscle tone or spasticity
  - Clonus
  - Myelopathic hand
- Recent (within 6 months) MRI/CT findings that are concordant with the patient’s symptoms and physical examination findings including **EITHER** of the following:
  - MRI/CT demonstrates spinal cord compression
  - MRI/CT identifies stenosis with or without myelomalacia

**CMM-604.5: Failed Cervical Disc Arthroplasty Implant**
Posterior cervical decompression with or without posterior cervical fusion following failed cervical disc arthroplasty implant is considered **medically necessary** when there is 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) **OR** when **ALL** of the following criteria are met:
- Recent (within 3 months) CT myelogram/MRI with or without contrast findings that correlate with the patient’s symptoms or physical examination findings demonstrating neural structure compression
- Greater than 12 weeks since the cervical disc arthroplasty
- Initial relief of symptoms following previous cervical disc arthroplasty at the same level
- Absence of unmanaged significant behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
Performed for **EITHER** of the following conditions:

- **Radiculopathy** when **ALL** of the following are met:
  - Subjective symptoms including **BOTH** of the following:
    - Significant level of pain on a daily basis defined on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as $\geq 7$
    - Unremitting radicular pain to shoulder girdle and/or upper extremity with or without concordant objective physical examination findings resulting in disability
  - Objective physical examination findings including **ANY** of the following:
    - Dermatomal sensory deficit
    - Motor deficit (e.g., biceps, triceps weakness)
    - Reflex changes
    - Shoulder Abduction Relief Sign
    - Nerve root tension sign (e.g., Spurling’s maneuver)
    - Unremitting radicular pain to shoulder girdle and/or upper extremity without concordant objective physical examination findings
  - Less than clinically meaningful improvement with at least **TWO** of the following unless contraindicated:
    - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
    - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
    - Epidural steroid injection(s)/selective nerve root block(s)
    - Documentation of nicotine-free status with **EITHER** of the following, unless request is for decompression only:
      - Patient is a nonsmoker
      - Patient has refrained from smoking for at least 6 weeks prior to planned surgery as evidenced by cotinine lab results of $\leq 10$ ng/mL

- **Myelopathy** when **ALL** of the following are met:
  - Subjective symptoms including **ANY** of the following:
    - Upper/lower extremity weakness, numbness, or pain
    - Fine motor dysfunction (buttoning, handwriting, clumsiness of hands)
    - New-onset bowel or bladder dysfunction due to a neurocompressive pathology
    - Frequent falls
  - Objective physical examination findings including at least **TWO** of the following:
    - Grip and release test
    - Ataxic gait
    - Hyperreflexia
    - Hoffmann sign
    - Pathologic Babinski sign
    - Tandem walking test
    - Inverted brachial radial reflex
    - Increased muscle tone or spasticity
    - Clonus
    - Myelopathic hand
CMM-604.6: Non-Indications
Posterior cervical decompression (laminectomy, hemilaminectomy, and laminoplasty) with or without posterior fusion is considered **not medically necessary** for **ANY** of the following sole indications:

- Signs and symptoms with no correlation to imaging studies
- Annular tears
- Disc bulge with no neural impingement or cord compression on imaging
- Concordant discography
- Degenerative disc disease

CMM-604.7: Procedure (CPT®) Codes
This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Code Description/Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>22590</td>
<td>Arthrodesis, posterior technique, craniocervical (occiput-C2)</td>
</tr>
<tr>
<td>22595</td>
<td>Arthrodesis, posterior technique, atlas-axis (C1-C2)</td>
</tr>
<tr>
<td>22600</td>
<td>Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment</td>
</tr>
<tr>
<td>+22614</td>
<td>Each additional vertebral segment (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>+22841</td>
<td>Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>+22842</td>
<td>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)</td>
</tr>
<tr>
<td>+22843</td>
<td>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)</td>
</tr>
<tr>
<td>63001</td>
<td>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</td>
</tr>
<tr>
<td>63015</td>
<td>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</td>
</tr>
<tr>
<td>63045</td>
<td>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</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>+63048</td>
<td>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)</td>
</tr>
<tr>
<td>63050</td>
<td>Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments;</td>
</tr>
<tr>
<td>63051</td>
<td>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)</td>
</tr>
<tr>
<td>63265</td>
<td>Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical</td>
</tr>
<tr>
<td>63270</td>
<td>Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical</td>
</tr>
<tr>
<td>63275</td>
<td>Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical</td>
</tr>
<tr>
<td>63280</td>
<td>Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, cervical</td>
</tr>
<tr>
<td>63285</td>
<td>Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, cervical</td>
</tr>
<tr>
<td>63290</td>
<td>Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level</td>
</tr>
<tr>
<td>+63295</td>
<td>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)</td>
</tr>
</tbody>
</table>

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual’s policy or benefit entitlement structure as well as claims processing rules.

**CMM-604.8: References**


21. National Hospital Discharge Database Analysis, all payers, all applicable states, 2009-2010. [Context Link 1, 2, 3]


# CMM-605: Cervical Microdiscectomy

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMM-605.1: General Guidelines</td>
<td>21</td>
</tr>
<tr>
<td>CMM-605.2: Initial Primary Cervical Microdiscectomy</td>
<td>21</td>
</tr>
<tr>
<td>CMM-605.3: Repeat Cervical Microdiscectomy at the Same Level</td>
<td>22</td>
</tr>
<tr>
<td>CMM-605.4: Non-Indications</td>
<td>24</td>
</tr>
<tr>
<td>CMM-605.5: Procedure (CPT®) Codes</td>
<td>24</td>
</tr>
<tr>
<td>CMM-605.6: References</td>
<td>24</td>
</tr>
</tbody>
</table>
**CMM-605.1: General Guidelines**

- The determination of medical necessity for the performance of cervical microdiscectomy is always made on a case-by-case basis.

- For prior authorization requirements, see **CMM-600.1: Prior Authorization Requirements**.

- The presence of urgent/emergent indications/conditions warrants definitive surgical treatment in lieu of provider-directed non-surgical management. Confirmatory imaging studies are required. Urgent/emergent conditions for cervical microdiscectomy include **ANY** of the following:
  - Acute myelopathy
  - Central cord syndrome
  - Documentation of progressive neurological deficit on two separate physical examinations
  - Severe or rapidly progressive symptoms of motor loss, bowel incontinence or bladder incontinence/retention due to a neurocompressive pathology
  - Documentation of severe debilitating pain and/or dysfunction to the point of being incapacitated

**CMM-605.2: Initial Primary Cervical Microdiscectomy**

Initial primary cervical microdiscectomy is considered **medically necessary** when **ALL** of the following are met:

- No previous surgeries on the disc(s) involved

- Absence of unmanaged significant behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)

- Performed for **EITHER** of the following conditions:
  - **Radiculopathy** when **ALL** of the following are met:
    - Subjective symptoms including **BOTH** of the following:
      - Significant level of pain on a daily basis defined on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
      - Unremitting radicular pain to shoulder girdle and/or upper extremity with or without concordant objective physical examination findings resulting in disability
    - Objective physical examination findings including **ANY** of the following:
      - Dermatomal sensory deficit
      - Motor deficit (e.g., biceps, triceps weakness)
      - Reflex changes
      - Shoulder Abduction Relief Sign
      - Nerve root tension sign (e.g., Spurling’s maneuver)
      - Unremitting radicular pain to shoulder girdle and/or upper extremity without concordant objective examination findings
Less than clinically meaningful improvement with at least TWO of the following unless contraindicated:
- Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
- Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
- Epidural steroid injection(s)/selective nerve root block(s)
- Recent (within 6 months) MRI/CT identifies nerve root impingement caused by herniated disc(s) and/or osteophytes that is concordant with the patient’s symptoms and physical examination findings

Myelopathy when ALL of the following are met:
- Subjective symptoms including ANY of the following:
  - Upper/lower extremity weakness, numbness, or pain
  - Fine motor dysfunction (buttoning, handwriting, clumsiness of hands)
  - New-onset bowel or bladder dysfunction due to a neurocompressive pathology
  - Frequent falls
- Objective physical examination findings including at least TWO of the following:
  - Grip and release test
  - Ataxic gait
  - Hyperreflexia
  - Hoffmann sign
  - Pathologic Babinski sign
  - Tandem walking test
  - Inverted brachial radial reflex
  - Increased muscle tone or spasticity
  - Clonus
  - Myelopathic hand
- Recent (within 6 months) MRI/CT findings that are concordant with the patient’s symptoms and physical examination findings including EITHER of the following:
  - MRI/CT demonstrates spinal cord compression
  - MRI/CT identifies stenosis with or without myelomalacia

**CMM-605.3: Repeat Cervical Microdiscectomy at the Same Level**
Repeat cervical microdiscectomy at the same level is considered medically necessary when ALL of the following are met:
- Recent (within 3 months) MRI with or without contrast/CT myelogram confirms evidence of neural structure compression (e.g., either retained disc material or a recurrent disc herniation)
- Greater than 12 weeks since the initial primary cervical microdiscectomy
- Initial relief of symptoms following previous disc decompression procedure at the same level
Absence of unmanaged significant behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)

Performed for **EITHER** of the following conditions:

- **Radiculopathy** when **ALL** of the following are met:
  - Subjective symptoms including **BOTH** of the following:
    - Significant level of pain on a daily basis defined on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as \( \geq 7 \)
    - Unremitting radicular pain to shoulder girdle and/or upper extremity with or without concordant objective physical examination findings resulting in disability
  - Objective physical examination findings including **ANY** of the following:
    - Dermatomal sensory deficit
    - Motor deficit (e.g., biceps, triceps weakness)
    - Reflex changes
    - Shoulder Abduction Relief Sign
    - Nerve root tension sign (e.g., Spurling’s maneuver)
    - Unremitting radicular pain to shoulder girdle and/or upper extremity without concordant objective physical examination findings
  - Less than clinically meaningful improvement with at least **TWO** of the following unless contraindicated:
    - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
    - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
    - Epidural steroid injection(s)/selective nerve root block(s)

- **Myelopathy** when **ALL** of the following are met:
  - Subjective symptoms including **ANY** of the following:
    - Upper/lower extremity weakness, numbness, or pain
    - Fine motor dysfunction (buttoning, handwriting, clumsiness of hands)
    - New-onset bowel or bladder dysfunction due to a neurocompressive pathology
    - Frequent falls
  - Objective physical examination findings including at least **TWO** of the following:
    - Grip and release test
    - Ataxic gait
    - Hyperreflexia
    - Hoffmann sign
    - Pathologic Babinski sign
    - Tandem walking test
    - Inverted brachial radial reflex
    - Increased muscle tone or spasticity
    - Clonus
    - Myelopathic hand
CMM-605.4: Non-Indications
Cervical microdiscectomy for ANY of the following sole indications is considered not medically necessary:

- Signs and symptoms with no correlation to imaging studies
- Annular tears
- Disc bulge with no neural impingement or cord compression on imaging
- Concordant discography
- Degenerative disc disease

CMM-605.5: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code’s inclusion on this list does not necessarily indicate prior authorization is required.

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Code Description/Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>63020</td>
<td>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical</td>
</tr>
<tr>
<td>+63035</td>
<td>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)</td>
</tr>
<tr>
<td>63040</td>
<td>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical</td>
</tr>
<tr>
<td>+63043</td>
<td>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)</td>
</tr>
</tbody>
</table>

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual’s policy or benefit entitlement structure as well as claims processing rules.

CMM-605.6: References
## CMM-606: Lumbar Microdiscectomy (Laminotomy, Laminectomy, or Hemilaminectomy)

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMM-606.1: General Guidelines</td>
<td>27</td>
</tr>
<tr>
<td>CMM-606.2: Initial Primary Lumbar Microdiscectomy (Laminotomy, Laminectomy or Hemilaminectomy)</td>
<td>27</td>
</tr>
<tr>
<td>CMM-606.3: Repeat Lumbar Microdiscectomy (Laminotomy or Laminectomy) at the Same Level</td>
<td>28</td>
</tr>
<tr>
<td>CMM-606.4: Non-Indications</td>
<td>30</td>
</tr>
<tr>
<td>CMM-606.5: Procedure (CPT®) Codes</td>
<td>30</td>
</tr>
<tr>
<td>CMM-606.6: References</td>
<td>31</td>
</tr>
</tbody>
</table>
CMM-606.1: General Guidelines

- The determination of medical necessity for the performance lumbar microdiscectomy and excision of extradural lesion other than neoplasm is always made on a case-by-case basis.

- For prior authorization requirements, see CMM-600.1: Prior Authorization Requirements.

- The presence of urgent/emergent indications/conditions warrants definitive surgical treatment in lieu of provider-directed non-surgical management. Confirmatory imaging studies are required.

- Urgent/emergent conditions for lumbar microdiscectomy and excision of extradural lesion other than neoplasm include ANY of the following:
  - Cauda equina syndrome (CES)
  - Documentation of progressive neurological deficit on two separate physical examinations
  - Epidural hematoma
  - Infection (e.g., discitis, epidural abscess, osteomyelitis)
  - Primary or metastatic neoplastic disease causing pathologic fracture, cord compression or instability
  - Severe or rapidly progressive symptoms of motor loss, bowel incontinence or bladder incontinence/retention due to a neurocompressive pathology
  - Documentation of severe debilitating pain and/or dysfunction to the point of being incapacitated

CMM-606.2: Initial Primary Lumbar Microdiscectomy (Laminotomy, Laminectomy or Hemilaminectomy)

Initial primary lumbar microdiscectomy (laminotomy, laminectomy, or hemilaminectomy) is considered medically necessary when ALL of the following are met:

- Performed for ANY of the following:
  - Radiculopathy/neurogenic claudication secondary to herniated disc
  - Synovial cyst/arachnoid cyst
  - Central/lateral/foraminal stenosis

- No previous surgeries on the disc(s) involved

- All other sources of pain have been excluded

- Absence of unmanaged significant behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
Subjective symptoms including at least **TWO** of the following:
- Significant level of pain on a daily basis defined on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
- Persistent radiating pain into the buttock(s) and/or lower extremity(ies) on a daily basis that has a documented negative impact on activities of daily living despite optimal conservative treatment as described below
- Pain, cramping, weakness, or tingling in the lower back, buttock(s), and leg(s) brought about by walking or positions that cause thecal sac or nerve root compression (e.g., standing, extension)

Objective physical examination findings including **EITHER** of the following:
- Nerve root tension sign including **ANY** of the following:
  - Positive straight leg raise
  - Crossed straight leg raise
  - Femoral stretch test
- Neurologic deficit including **ANY** of the following:
  - Dermatomal sensory deficit
  - Functionally limiting motor weakness (e.g., foot drop, quadriceps weakness)
  - Reflex changes

Recent (within 6 months) MRI/CT identifies nerve root impingement and/or thecal sac impingement that is concordant with patient symptoms and physical examination findings and is caused by **ONE OR MORE** of the following:
- Herniated disc(s)
- Synovial cyst or arachnoid cyst
- Central/lateral/foraminal stenosis

Less than clinically meaningful improvement with at least **TWO** of the following unless contraindicated:
- Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
- Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
- Epidural steroid injection(s)/selective nerve root block(s)

**CMM-606.3: Repeat Lumbar Microdiscectomy (Laminotomy or Laminectomy) at the Same Level**
Repeat lumbar microdiscectomy (laminotomy or laminectomy) at the same level is considered **medically necessary** when **ALL** of the following are met:
- Recent MRI without or without and with contrast/CT myelogram (within 3 months) confirms evidence of neural structure compression (e.g., either retained disc material or a recurrent disc herniation)
- Greater than 12 weeks since initial lumbar disc decompression surgery
- Initial relief of symptoms following previous disc decompression procedure at the same level
Performed for **ANY** of the following:
- Radiculopathy/neurogenic claudication secondary to herniated disc
- Synovial cyst/arachnoid cyst
- Central/lateral/foraminal stenosis

All other sources of pain have been excluded

Absence of unmanaged significant behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)

Subjective symptoms including at least **TWO** of the following:
- Significant level of pain on a daily basis defined on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
- Persistent radiating pain into the buttock(s) and/or lower extremity(ies) on a daily basis that has a documented negative impact on activities of daily living despite optimal conservative treatment as described below
- Pain, cramping, weakness, or tingling in the lower back, buttock(s), and leg(s) brought about by walking or positions that cause thecal sac or nerve root compression (e.g., standing, extension)

Objective physical examination findings including **EITHER** of the following:
- Nerve root tension sign including **ANY** of the following:
  - Positive straight leg raise
  - Crossed straight leg raise
  - Femoral stretch test
- Neurologic deficit including **ANY** of the following:
  - Dermatomal sensory deficit
  - Functionally limiting motor weakness (e.g., foot drop, quadriceps weakness)
  - Reflex changes

Less than clinically meaningful improvement with at least **TWO** of the following unless contraindicated:
- Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
- Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
- Epidural steroid injection(s)/selective nerve root block(s)
CMM-606.4: Non-Indications

- The performance of lumbar microdiscectomy (laminotomy, laminectomy, and hemilaminectomy) with laser technique is considered not medically necessary.

- Initial and repeat lumbar microdiscectomy (laminotomy, laminectomy, and hemilaminectomy) is considered not medically necessary for ANY of the following sole indications:
  - Subjective symptoms and objective physical examination findings that are not concordant with imaging
  - Predominate lower back pain associated with disc degeneration with or without annular tears in the absence of a disc herniation
  - Patients who are asymptomatic with a normal physical examination regardless of the size of the disc herniation
  - Disc bulge with no neural impingement or cord compression on imaging
  - Concordant discography
  - Isolated axial lower back pain in the presence of disc herniation

- Endoscopic and/or percutaneous laser disc decompression of spinal cord nerve root(s) is considered experimental, investigational, or unproven.

CMM-606.5: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code’s inclusion on this list does not necessarily indicate prior authorization is required.

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Code Description/Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>62380</td>
<td>Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar</td>
</tr>
<tr>
<td>63030</td>
<td>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar</td>
</tr>
<tr>
<td>+63035</td>
<td>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)</td>
</tr>
<tr>
<td>63042</td>
<td>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar</td>
</tr>
<tr>
<td>+63044</td>
<td>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)</td>
</tr>
<tr>
<td>63056</td>
<td>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)</td>
</tr>
<tr>
<td>+63057</td>
<td>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)</td>
</tr>
</tbody>
</table>


33. NASS Coverage Policy Recommendations, Lumbar Laminotomy
CMM-607: Primary Vertebral Augmentation (Percutaneous Vertebroplasty/Kyphoplasty) and Sacroplasty

Prior Authorization Requirements:
For Primary Vertebral Augmentation, please refer to BridgeSpan Policy Sur107.
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMM-608: Lumbar Decompression</td>
<td></td>
</tr>
<tr>
<td>CMM-608.1: General Guidelines</td>
<td>35</td>
</tr>
<tr>
<td>CMM-608.2: Initial Primary Lumbar Decompression</td>
<td>35</td>
</tr>
<tr>
<td>CMM-608.3: Repeat Lumbar Decompression at the Same Level</td>
<td>36</td>
</tr>
<tr>
<td>CMM-608.4: Non-Indications</td>
<td>37</td>
</tr>
<tr>
<td>CMM-608.5: Procedure (CPT®) Codes</td>
<td>38</td>
</tr>
<tr>
<td>CMM-608.6: References</td>
<td>38</td>
</tr>
</tbody>
</table>
CMM-608.1: General Guidelines

- The determination of medical necessity for the performance of lumbar decompression is always made on a case-by-case basis.
- For prior authorization requirements, see CMM-600.1: Prior Authorization Requirements.
- The presence of urgent/emergent indications/conditions warrants definitive surgical treatment in lieu of provider-directed non-surgical management. Confirmatory imaging studies are required.
- Urgent/emergent conditions for lumbar decompression include ANY of the following:
  - Acute/unstable traumatic spinal fractures or dislocations with or without neural compression
  - Cauda equina syndrome (CES)
  - Epidural hematoma
  - Documentation of progressive neurological deficit on two separate physical examinations
  - Infection (e.g., discitis, epidural abscess, osteomyelitis)
  - Primary or metastatic neoplastic disease causing pathologic fracture, cord compression or instability
  - Severe or rapidly progressive symptoms of motor loss, bowel incontinence or bladder incontinence/retention due to a neurocompressive pathology
  - Documentation of severe debilitating pain and/or dysfunction to the point of being incapacitated

CMM-608.2: Initial Primary Lumbar Decompression

Initial primary lumbar decompression is considered medically necessary when ALL of the following are met:

- No previous surgeries at the level(s) involved
- All other sources of pain have been excluded
- Absence of unmanaged significant behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Subjective symptoms including at least TWO of the following:
  - Significant level of pain on a daily basis defined on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
  - Persistent radiating pain into the buttock(s) and/or lower extremity(ies) on a daily basis that has a documented negative impact on activities of daily living despite optimal conservative treatment as described below
  - Pain, cramping, weakness, or tingling in the lower back, buttock(s), and leg(s) brought about by walking or positions that cause thecal sac or nerve root compression (e.g., standing, extension)
Performed for EITHER of the following:
- Neurogenic claudication secondary to central/lateral recess/foraminal stenosis when ALL of the following are met:
  - Subjective symptoms including EITHER of the following:
    - Symptoms worsen with standing and/or walking
    - Symptoms are alleviated with sitting and/or forward flexion
  - Objective physical examination findings concordant with recent (within 6 months) MRI/CT
  - Less than clinically meaningful improvement from epidural steroid injection(s)/selective nerve root block(s) unless contraindicated
- Spondylolisthesis with neurogenic claudication symptoms or radicular pain from lateral recess, or foraminal stenosis associated with listhesis demonstrated on plain x-rays

Less than clinically meaningful improvement with EITHER of the following unless contraindicated:
- Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
- Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks

Recent (within 6 months) MRI/CT identifies nerve root impingement and/or thecal sac impingement caused by stenosis/listhesis that is concordant with patient symptoms and/or physical examination findings

**CMM-608.3: Repeat Lumbar Decompression at the Same Level**
Repeat lumbar decompression at the same level is considered medically necessary when ALL of the following is met:
- Recent (within 3 months) post-operative MRI without or without and with contrast/CT myelogram confirms radiographic evidence of neural structure compression
- Greater than 12 weeks since last decompression surgery
- Initial relief of symptoms following previous decompression procedure at the same level(s)
- All other sources of pain have been excluded
- Absence of unmanaged significant behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)
- Subjective symptoms including at least TWO of the following:
  - Significant level of pain on a daily basis defined on a Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as $\geq 7$
  - Persistent radiating pain into the buttock(s) and/or lower extremity(ies) on a daily basis that has a documented negative impact on activities of daily living despite optimal conservative treatment as described below
- Pain, cramping, weakness, or tingling in the lower back, buttock(s), and leg(s) brought about by walking or positions that cause thecal sac or nerve root compression (e.g., standing, extension)

- Performed for **EITHER** of the following:
  - Neurogenic claudication secondary to central/lateral recess/foraminal stenosis when **ALL** of the following are met:
    - Subjective symptoms including **EITHER** of the following:
      - Symptoms worsen with standing and/or walking
      - Symptoms are alleviated with sitting and/or forward flexion
    - Objective physical examination findings concordant with recent (within 6 months) MRI/CT
    - Less than clinically meaningful improvement from epidural steroid injection(s)/selective nerve root block(s) unless contraindicated
  - Spondylolisthesis with neurogenic claudication symptoms or radicular pain from lateral recess, or foraminal stenosis associated with
    - listhesis demonstrated on plain x-rays

- Severe and disabling symptoms or less than clinically meaningful improvement with **EITHER** of the following unless contraindicated:
  - Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
  - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks

**CMM-608.4: Non-Indications**

- **ANY** of the following procedures are considered **experimental, investigational, or unproven**:
  - Percutaneous lumbar discectomy
  - Percutaneous laser discectomy
  - Laser-assisted disc decompression
  - Percutaneous laser disc decompression
  - Percutaneous nucleotomy

- Interspinous/interlaminar process spacer devices (ISS) and interspinous/interlaminar stabilization/distraction devices, and interspinous process decompression (IPD) systems/devices (e.g. Coflex Interlaminar Technology Implant, Superion ISS Interspinous Spacer System, X-STOP Interspinous Process Decompression System, X-STOP PEEK Interspinous Process Decompression System) are considered **experimental, investigational and/or unproven** for **ALL** indications including, but not limited to:
  - Lumbar interspinous/interlaminar distraction without fusion for indirect spinal decompression
  - Lumbar interspinous fixation with fusion with or without decompression for stabilization
  - Lumbar spinal stabilization with an interspinous process device/interlaminar device without fusion in conjunction with decompression laminectomy
## CMM-608.5: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code’s inclusion on this list does not necessarily indicate prior authorization is required.

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Code Description/Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>22867</td>
<td>Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level</td>
</tr>
<tr>
<td>+22868</td>
<td>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)</td>
</tr>
<tr>
<td>22869</td>
<td>Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level</td>
</tr>
<tr>
<td>+22870</td>
<td>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)</td>
</tr>
<tr>
<td>63005</td>
<td>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</td>
</tr>
<tr>
<td>63011</td>
<td>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</td>
</tr>
<tr>
<td>63012</td>
<td>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)</td>
</tr>
<tr>
<td>63017</td>
<td>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</td>
</tr>
<tr>
<td>63047</td>
<td>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</td>
</tr>
<tr>
<td>63048</td>
<td>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)</td>
</tr>
</tbody>
</table>

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual’s policy or benefit entitlement structure as well as claims processing rules.

## CMM-608.6: References


CMM-609: Lumbar Fusion (Arthrodesis)

Prior Authorization Requirements:
For Lumbar Fusion, please refer to BridgeSpan Policy SUR187.
**CMM-610: Lumbar Total Disc Arthroplasty**

**Prior Authorization Requirements:**
For Lumbar Total Disc Arthroplasty, please refer to [BridgeSpan Policy Sur127](#).
# CMM-611: Sacroiliac Joint Fusion or Stabilization

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMM-611.1: General Guidelines</td>
<td>44</td>
</tr>
<tr>
<td>CMM-611.2: Minimally Invasive Sacroiliac Joint Fusion or Stabilization</td>
<td>44</td>
</tr>
<tr>
<td>CMM-611.3: Open Sacroiliac Joint Fusion</td>
<td>45</td>
</tr>
<tr>
<td>CMM-611.4: Non-Indications</td>
<td>46</td>
</tr>
<tr>
<td>CMM-611.5: Procedure (CPT®) Codes</td>
<td>46</td>
</tr>
<tr>
<td>CMM-611.6: References</td>
<td>47</td>
</tr>
</tbody>
</table>
CMM-611.1: General Guidelines

- The determination of medical necessity for the performance of sacroiliac joint fusion or stabilization is always made on a case-by-case basis.
- For prior authorization requirements, see **CMM-600.1: Prior Authorization Requirements**.

CMM-611.2: Minimally Invasive Sacroiliac Joint Fusion or Stabilization

Minimally invasive sacroiliac joint (SIJ) fusion using titanium triangular implants (SI BONE [iFUSE Implant™]) for the treatment of lumbopelvic pain originating from the SIJ is considered medically necessary when **ALL** of the following are met:

- Performed by an orthopedic surgeon or neurosurgeon with specific training and expertise in percutaneous sacroiliac joint fusion surgical techniques and regularly use image-guidance for placement of implants
- Presence of non-radiating lumbopelvic pain caudal to L5, buttock, hip, and/or groin pain without radiation into the leg(s) that impairs physical activities
- SIJ pain interfering with activities of daily living
- Patient localizes posterior pain to the posterior superior iliac spine (Fortin’s point)
- Localized tenderness to palpation over the sacral sulcus and posterior SIJ
- Elicitation of typical pain on three (3) or more provocative physical examination maneuvers/tests that stress the SIJ:
  - Thigh thrust test
  - Compression test
  - Gaenslen’s maneuver
  - Distraction test
  - FABER/Patrick’s sign
  - Posterior provocation test
- Absence of localized tenderness to palpation of similar severity to palpation of the sacral sulcus and posterior SIJ over the greater trochanter, lumbar spine, and coccyx
- Diagnostic confirmation of the SIJ as a pain generator through at least an 80% reduction in pain for the expected duration of effect of the anesthetic agent used upon two separate contrast-enhanced fluoroscopically or CT-guided intra-articular SIJ blocks using a local anesthetic performed at a minimum of two weeks apart
- Confirmation of the SIJ as a pain generator through at least a 50% reduction in pain for a minimum of two weeks following one contrast-enhanced fluoroscopically or CT-guided intra-articular SIJ injection using a corticosteroid
- SIJ pain without minimal clinically important difference (MCID) from a minimum of a consecutive six (6) months of conservative, non-surgical treatment including **ALL** of the following unless contraindicated:
Non-steroidal anti-inflammatory drugs (NSAIDs)  
Prescription medication optimization  
Activity modification  
Physician supervised/prescribed active physical therapy (including home exercise program) targeting lumbopelvic (core) area  
Chiropractic care

Absence of generalized pain behavior (e.g., somatoform disorder) or generalized pain disorders (e.g., fibromyalgia)

Documentation of nicotine-free status with EITHER of the following:
- Patient is a nonsmoker
- Patient has refrained from smoking for at least 6 weeks prior to planned surgery as evidenced by cotinine lab results of ≤ 10 ng/mL

Absence of unmanaged significant behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol abuse)

Absence of alternative diagnoses that are a more likely cause of the patient’s ongoing pain or disability

Recent (within 6 months) diagnostic imaging studies that include ALL of the following:
- Plain radiographs and/or cross sectional imaging (CT or MRI) that excludes the presence of destructive lesions (e.g., tumor, infection), acute fracture or inflammatory arthropathy that would not be properly addressed by SIJ fusion
- Plain radiographs of the pelvis including the ipsilateral hip to evaluate potential concomitant hip pathology
- Cross-sectional imaging (e.g., CT or MRI) of the lumbar spine to evaluate potential concomitant neural compression or other degenerative conditions

**CMM-611.3: Open Sacroiliac Joint Fusion**
Open sacroiliac joint (SIJ) fusion is considered medically necessary when ALL of the following are met:

- Recent (within 6 months) plain radiographs and/or cross-sectional imaging (CT or MRI) demonstrate localized SIJ pathology

- Documentation of nicotine-free status with EITHER of the following:
  - Patient is a nonsmoker
  - Patient has refrained from smoking for at least 6 weeks prior to planned surgery as evidenced by cotinine lab results of ≤ 10 ng/mL

- ANY of the following:
  - Post-traumatic injury of the SIJ (e.g., following pelvic ring fracture)
  - As an adjunctive treatment for SIJ infection
  - Management of sacral tumor (e.g., partial sacrectomy)
  - When performed as part of a multisegmental long fusion constructs for the correction of spinal deformity (e.g., idiopathic scoliosis, neuromuscular scoliosis)
### CMM-611.4: Non-Indications

- Minimally invasive or percutaneous SIJ fusion or stabilization using titanium triangular implants is considered **experimental, investigational, or unproven**, including, but not limited to **ANY** of the following:
  - Any case that does not fulfill **ALL** of the above criteria
  - Less than six months of SIJ pain and/or functional impairment
  - Failure to pursue conservative treatment of the SIJ unless contraindications are clearly documented
  - Systemic arthropathy (e.g., ankylosing spondylitis, psoriatic arthritis, rheumatoid arthritis)
  - Generalized pain behavior (e.g., somatoform disorder) or generalized pain disorder (e.g., fibromyalgia)
  - Presence of infection, tumor, or fracture
  - Acute traumatic instability of the SIJ
  - Presence of neural compression as seen on an MRI or CT that correlates with the patient’s symptoms or other more likely source for the patient’s pain
  - Any condition that would prevent insertion of the implants
  - Bilateral procedures on the same date of service

- The use of minimally invasive fusion products other than SI BONE (iFuse Implant™) System (e.g., Rialto SI Fusion System, Slmmetry SI Joint Fusion System, Sileo Sacroiliac Joint Fusion System, SiJoin Direct Posterior Fusion, Samba-Screw System, SI-LOK Sacroiliac Joint Fixation System) for minimally invasive SIJ fusion is considered **experimental, investigational or unproven**.

- Open sacroiliac joint (SIJ) fusion is considered **experimental, investigational, or unproven**, including, but not limited to **ANY** of the following:
  - Mechanical low back pain
  - Sacroiliac joint syndrome
  - Degenerative sacroiliac joint
  - Radicular pain syndromes

### CMM-611.5: Procedure (CPT®) Codes

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Code Description/Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>27279</td>
<td>Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device</td>
</tr>
<tr>
<td>27280</td>
<td>Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed</td>
</tr>
</tbody>
</table>

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual’s policy or benefit entitlement structure as well as claims processing rules.
CMM-611.6: References


13. Cher DJ, Reckling WC. Quality of life in preoperative patients with sacroiliac dysfunction is at least as depressed as in other lumbar spinal conditions. Med Devices Evid Res. 2015; 8: 395-403.


46. Local Coverage Determination (LCD): Percutaneous minimally invasive fusion/stabilization of the sacroiliac joint for the treatment of back pain (L36000)

47. Local Coverage Determination (LCD): Minimally-Invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint. (L36406)


54. Miller LE, Block JE. Minimally invasive arthrodesis for chronic sacroiliac joint dysfunction using the Slmmetry SI Joint Fusion system. Medical Devices 2014; 7; 125-130.


## CMM-612: Grafts

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMM-612.1: General Guidelines</td>
<td>52</td>
</tr>
<tr>
<td>CMM-612.2: Recombinant Human Bone Morphogenetic Protein rhBMP-2 (InFuse®)</td>
<td>52</td>
</tr>
<tr>
<td>CMM-612.3 Bone Marrow Aspirate Concentrate (BMAC)</td>
<td>53</td>
</tr>
<tr>
<td>CMM-612.4: Bone Graft Substitutes</td>
<td>54</td>
</tr>
<tr>
<td>CMM-612.5: Procedure (CPT®) Codes</td>
<td>55</td>
</tr>
<tr>
<td>CMM-612.6: References</td>
<td>55</td>
</tr>
</tbody>
</table>
CMM-612.1: General Guidelines

- The determination of medical necessity for grafts (orthobiologics) is always made on a case-by-case basis.
- For prior authorization requirements, see CMM-600.1: Prior Authorization Requirements.
- Definition/technique for bone marrow aspirate concentrate (see CMM-612.3: Bone Marrow Aspirate Concentrate for criteria):
  - A bone marrow aspirate concentrate (BMAC) is intended as a high concentration of viable connective tissue osteoprogenitor cells. The aspiration technique requires that no more than 2 mL of blood is aspirated from any given area in the iliac crest to avoid dilution with peripheral blood. The aspiration of 80 to 100 cc of marrow from the iliac crest is performed using a sequential technique (Muschler) through a small incision made over the iliac crest through different trajectories until the desired amount is obtained. A single aspiration instead of using a sequential technique produces the lowest yield of viable cells. The aspirate is then transferred to the concentrating device (centrifuge) that removes the red blood cell fractions and plasma. The BMAC can be admixed to the osteoconductive biocompatible substrates of choice e.g. collagen sponges, hydroxyapatite (HA) substrates and other porous ceramics as well as particulate demineralized bone matrix (DBM) to fabricate composite hybrid grafts.

CMM-612.2: Recombinant Human Bone Morphogenetic Protein (rhBMP-2) (InFuse®)

The clinical criteria of this policy addresses the scope and clinical indications for Recombinant Human Bone Morphogenetic Protein – 2 (rhBMP-2) (InFuse®) in spinal fusion surgeries only and not for other indications for its use in the appendicular skeleton (e.g. tibial fracture non-union repair surgery). These criteria are developed to manage patients very unlikely to fuse without rhBMP. Patients very likely to fuse without rhBMP include most pediatric patients, healthy patients undergoing one level lumbar fusion procedures and undergoing routine anterior and posterior cervical fusions.

- Recombinant human bone morphogenetic protein – 2 (rhBMP-2) (InFuse®) is considered medically necessary for a stand alone anterior lumbar interbody fusion (ALIF) for all patients except males with a strong reproductive priority.

- Recombinant human bone morphogenetic protein – 2 (rhBMP-2) (InFuse®) is considered medically necessary for posterolateral lumbar fusion and posterior lumbar interbody fusion (PLIF and TLIF) when ONE or MORE of the following conditions at high risk for fusion failure is present:
  - Revision spinal fusion surgery for pseudoarthrosis following one or more previous failed spinal fusion surgery(ies)
  - Spinal fusion surgery in a compromised graft bed (e.g., prior radiation therapy)
  - Thoracolumbar fusion for correction of spinal deformity performed at more than one level
- Multilevel spinal fusion surgeries (> 3 spinal motion segments)
- Long posterior fusions to the sacrum in adults patients undergoing correction or stabilization of spinal deformity
- Single level anterior interbody lumar or lumbosacral fusion (ALIF) using an FDA approved fusion device when there is Grade III or greater spondylolisthesis.
- Metabolic or other conditions when traditional, autogenous bone grafting has a high risk of failure (ONE or MORE of the following):
  - Current smoker
  - Insulin diabetic with poor glycemic control
  - Chronic renal disease
  - Alcohol Use Disorder (AUD)
  - Corticosteroid dependence
  - Pediatric patients with neuromuscular scoliosis or occiptocervical pathology
- Autogenous bone graft is either not available, is inadequate volume, or of poor quality to be useful (ONE or MORE of the following):
  - Rheumatoid arthritis
  - Osteoporosis
  - Trauma patients with concomitant pelvic injury
  - Patients at high risk for post-harvest iliac crest fracture

► Recombinant human bone morphogenetic protein – 2 (rhBMP-2) (InFuse®) is considered not medically necessary for ANY of the following:
- Skeletally immature patients unless there is a high risk for fusion failure
- Planned use of grafting in the vicinity of a resected or extant neoplasm
- Known contraindications including pregnancy, hypersensitivity/allergy, infection, spinal malignancy
- Routine anterior and/or posterior cervical fusion surgery other than in pediatric patients with a high risk of fusion failure
- Routine pediatric spine fusion procedures including correction of adolescent idiopathic scoliosis
- Single level anterior interbody lumbar or lumbo-sacral fusion (ALIF) using an FDA approved fusion device when there is Grade II or less spondylolisthesis

**CMM-612.3: Bone Marrow Aspirate Concentrate (BMAC)**

► Bone marrow aspirate concentrate (BMAC) is considered medically necessary for hybrid or composite grafting (combined osteoinductive and osteoconductive) including autologous corticocancellous iliac crest bone graft (ICBG) for posterolateral lumbar spinal fusion surgery (spondylodesis) with or without spinal instrumentation.

► Bone marrow aspirate concentrate (BMAC) is considered experimental, investigational, or unproven for ALL of the following:
- BMAC combined with allograft or synthetic scaffold as a substitute for autologous bone graft for spinal fusion surgery (spondylodesis) with or without spinal instrumentation
- Application to cervical/thoracic spinal fusion surgery with or without instrumentation
- Anterior spinal fusion surgery with or without instrumentation
- Application to spinal decompression without fusion
- Disc arthroplasty surgery
- Use of lumbar interspinous devices
- Obtaining BMAC without using the sequential technique as outlined
- Use of unfractionated BMAC
- Infection (e.g., discitis, epidural abscess, osteomyelitis)
- Primary or metastatic neoplastic disease of the spine

**CMM-612.4: Bone Graft Substitutes**

**ALL** of the following bone graft substitutes for the enhancement of bone healing is considered experimental, investigational, or unproven:

- rhBMP-7 (i.e., OP–1™)
- INFUSE/MASTERGRAFT™ Posterolateral Revision Device
- Human amniotic membrane bone graft substitute
- Cell-based substitutes other than a bone marrow aspirate (e.g., mesenchymal stem cell therapy) when used to enhance bone healing
- Human growth factors (e.g., fibroblast growth factor, insulin-like growth) when used to enhance bone healing
- Platelet rich plasma (e.g., autologous platelet derived growth factor) when used to enhance bone healing
- 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)
- Bone graft substitutes used to reduce donor site morbidity (e.g., iliac crest donor site reconstruction)
- Ceramic-based products (e.g., b-TCP)
- OptiMesh® deployable grafting system
CMM-612.5: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code’s inclusion on this list does not necessarily indicate prior authorization is required.

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Code Description/Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>+20930</td>
<td>Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>+20931</td>
<td>Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>+20936</td>
<td>Auto graft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments) obtained from same incision (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>+20937</td>
<td>Auto graft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>+20938</td>
<td>Auto graft 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)</td>
</tr>
<tr>
<td>+20939</td>
<td>Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision (List separately in addition to code for primary procedure).</td>
</tr>
</tbody>
</table>

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual’s policy or benefit entitlement structure as well as claims processing rules.

CMM-612.6: References


65. U.S. Food and Drug Administration. INTER FIX Threaded Fusion Device: important medical information.