CLINICAL GUIDELINES

Spine Surgery Guidelines

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Regence

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Clinical guidelines for medical necessity review of comprehensive musculoskeletal management services.

Spine Surgery Guidelines

CMM-600: Preface to Spine Surgery Guidelines

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) or motion segments involved 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
    - Detailed documentation of less than clinically meaningful improvement for each treatment.
  - 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: documentation of flexion-extension plain X-rays based upon indications for instability and/or other plain plain X-rays 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 blood 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.
  - Some procedures in the eviCore Spine Surgery Guidelines require a trial of epidural steroid injection(s) (ESIs)/selective nerve root blocks (SNRBs) unless there is a documented contraindication(s) to ESIs/SNRBs. Contraindications to ESIs/SNRBs include the presence of **ANY** of the following:
    - Allergy to the medication to be administered
    - A significantly altered or eliminated epidural space (e.g., congenital anatomic anomalies or previous surgery)
    - Anticoagulation therapy
    - Bleeding disorder
    - Localized infection in the region to be injected
    - Systemic infection

- Other co-morbidities which could be exacerbated by steroid usage (e.g., poorly controlled hypertension, severe congestive heart failure, diabetes, etc.)

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 2019 NCQA standards for utilization management and is as follows:
  - A request for medical care or services where application of the time frame for making routine or non-life threatening care determinations:
    - Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
    - 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-600.3: References

1. Raja M, Garg A, Yadav P, et al. Diagnostic Methods for Detection of Cotinine Level in Tobacco Users: A Review. J Clin Diagn Res. 2016 Mar; 10(3): ZE04–ZE06.
2. NCQA 2019 UM-CR-PN Accreditation Standards

CMM-601: Anterior Cervical Discectomy and Fusion

Prior Authorization Requirements:

For Cervial 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 **Regence Policy Sur127**.

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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 **Regence Policy DME83.11**.

CMM-604: Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/ Laminoplasty) with or without Fusion

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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. Confirmatory advanced imaging studies are required. The following criteria are **NOT** required for confirmed urgent/emergent conditions:
  - Provider-directed non-surgical management
  - Proof of smoking cessation
  - Recent (within 6 months) plain X-rays of the cervical spine
  - Absence of unmanaged significant behavioral health disorders
- 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)
  - Myelopathy
  - 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) plain X-rays 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 as **EITHER** of the following:
        - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
        - Severe, disabling, crippling, or incapacitating pain
      - 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 blood 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 cervical spinal cord compression
    - MRI/CT identifies cervical spinal 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, pseudoachondroplasia, 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 pseudarthrosis 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 plain X-rays
    - 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 plain X-rays
  - 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
  - Blood 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) plain X-rays or CT evidence of implant/instrumentation or structural bone graft malposition or failure ***OR*** when **ALL** of the following criteria are met:

- Recent (within 6 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) plain X-rays 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 plain X-rays

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- 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 plain X-rays

- 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 as **EITHER** of the following:
        - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
        - Severe, disabling, crippling, or incapacitating pain
      - 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 blood 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

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- 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 cervical spinal cord compression
  - MRI/CT identifies cervical spinal 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 as **EITHER** of the following:
        - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
        - Severe, disabling, crippling, or incapacitating pain
      - 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 blood 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

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
- Isolated facet fusion, with or without instrumentation, including allograft bone graft substitutes used exclusively as stand-alone stabilization devices (e.g., DTRAX® (cervical), TruFuse (any level), NuFix® (any level))

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.

CPT®	Code Description/Definition
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)
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)
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)
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

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CMM-605: Cervical Microdiscectomy

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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. Confirmatory advanced imaging studies are required. The following criteria are **NOT** required for confirmed urgent/emergent conditions:
  - Provider-directed non-surgical management
  - Absence of unmanaged significant behavioral health disorders
- Urgent/emergent conditions for cervical microdiscectomy include **ANY** of the following:
  - 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 as **EITHER** of the following:
        - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
        - Severe, disabling, crippling, or incapacitating pain
      - 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 cervical spinal cord compression
        - MRI/CT identifies cervical spinal 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 6 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 as **EITHER** of the following:
        - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
        - Severe, disabling, crippling, or incapacitating pain
      - 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.

CPT®	Code Description/Definition
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)
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)

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.

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

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. Confirmatory advanced imaging studies are required. The following criteria are NOT required for confirmed urgent/emergent conditions:
  - Provider-directed non-surgical management
  - Recent (within 6 months) plain X-rays of the lumbar spine
  - Absence of unmanaged significant behavioral health disorders
- Urgent/emergent conditions for lumbar microdiscectomy and excision of extradural lesion other than neoplasm include **ANY** of the following[2]:
  - 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:

- Recent (within 6 months) plain X-rays of the lumbar spine have been performed
- 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 as **EITHER** of the following:
  - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
  - Severe, disabling, crippling, or incapacitating pain
- 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 6 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 unless recent (within 6 months) post-operative imaging demonstrates persistent significant neurologic compression at the surgical 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 as **EITHER** of the following:
    - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
    - Severe, disabling, crippling, or incapacitating pain
  - 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.

CPT®	Code Description/Definition
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
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)
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)
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)
+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 osteophytectomy; lumbar, single interspace
+S2351	Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; lumbar, each additional interspace (list separately in addition to code for primary procedure)

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.

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CMM-607: Primary Vertebral Augmentation (Percutaneous Vertebroplasty/Kyphoplasty) and Sacroplasty

Prior Authorization Requirements:

For Primary Vertebral Augmentation, please refer to **Regence Policy Sur107**.

CMM-608: Lumbar Decompression

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. Confirmatory advanced imaging studies are required. The following criteria are **NOT** required for confirmed urgent/emergent conditions:
  - Provider-directed non-surgical management
  - Absence of unmanaged significant behavioral health disorders
- 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 as **EITHER** of the following:
    - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
    - Severe, disabling, crippling, or incapacitating pain
  - 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
  - Spondylolisthesis with neurogenic claudication symptoms or radicular pain from lateral recess, or foraminal stenosis associated with listhesis demonstrated on plain x-rays and/or MRI/CT

- 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 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 6 months) post-operative MRI without or without and with contrast/CT myelogram confirms radiographic evidence of neural structure compression (e.g., nerve root(s) compression)

- Greater than 12 weeks since last decompression surgery

- Initial relief of symptoms following previous decompression procedure at the same level(s) unless recent (within 6 months) post-operative imaging demonstrates persistent significant neurologic compression at the surgical level

- 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 as **EITHER** of the following:
    - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
    - Severe, disabling, crippling, or incapacitating pain

- 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
  - 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 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-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.

CPT®	Code Description/Definitions
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)
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
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)

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

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CMM-609: Lumbar Fusion (Arthrodesis)

Prior Authorization Requirements:

For Lumbar Fusion, please refer to **Regence Policy SUR187**.

CMM-610: Lumbar Total Disc Arthroplasty

Prior Authorization Requirements:

For Lumbar Total Disc Arthroplasty, please refer to **Regence Policy Sur127**.

CMM-611: Sacroiliac Joint Fusion or Stabilization

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 activites 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 ≥ 75% 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 blood 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 X-rays 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 X-rays 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 X-rays 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 blood 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)
  - Failed prior percutaneous SIJ fusion

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 impairement
  - 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, SImmetry SI Joint Fusion System, Silex 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

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.

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

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

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CMM-612: Grafts

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 pseudarthrosis 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 postero-lateral 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, Osteocel®, ViviGen®, Trinity®) 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.

CPT®	Code Description/Definition
+20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure
+20931	Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)
+20936	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)
+20937	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)
+20938	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)
+20939	Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision (List separately in addition to code for primary procedure).

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

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