Cigna Medical Coverage Policies – Musculoskeletal Lumbar Fusion (Arthrodesis) Guidelines

Effective November 1, 2024

Instructions for use

The following coverage policy applies to health benefit plans administered by Cigna. Coverage policies are intended to provide guidance in interpreting certain standard Cigna benefit plans and are used by medical directors and other health care professionals in making medical necessity and other coverage determinations. Please note the terms of a customer's particular benefit plan document may differ significantly from the standard benefit plans upon which these coverage policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a coverage policy.

In the event of a conflict, a customer's benefit plan document always supersedes the information in the coverage policy. In the absence of federal or state coverage mandates, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of:

1. The terms of the applicable benefit plan document in effect on the date of service
2. Any applicable laws and regulations
3. Any relevant collateral source materials including coverage policies
4. The specific facts of the particular situation

Coverage policies relate exclusively to the administration of health benefit plans. Coverage policies are not recommendations for treatment and should never be used as treatment guidelines.

This evidence-based medical coverage policy has been developed by eviCore, Inc. Some information in this coverage policy may not apply to all benefit plans administered by Cigna.

CMM-609: Lumbar Fusion (Arthrodesis)

400 Buckwalter Place Boulevard, Bluffton, SC 29910 (800) 918-8924 www.eviCore.com

CMM-609.1: General Guidelines

Application of Guideline

- The determination of medical necessity for the performance of lumbar fusion (with or without osteotomy) is always made on a case-by-case basis.
- For additional timing and documentation requirements, see **CMM-600.1: Prior Authorization Requirements**.

Urgent/Emergent Indications/Conditions

- The presence of urgent/emergent indications/conditions warrants definitive surgical treatment. **Imaging findings noted in the applicable procedure section(s) are required**.
  - The following criteria are **NOT** required for confirmed urgent/emergent conditions:
    - Provider-directed non-surgical management
    - Proof of smoking cessation
    - Absence of unmanaged significant mental and/or behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, opioid and alcohol use disorders)
    - Timeframe for repeat procedure
- Urgent/emergent conditions for lumbar fusion and/or osteotomy include **ANY** of the following:
  - Traumatic spinal fractures or dislocations (with or without neural compression) when instability is present or decompression of the spinal canal is anticipated to result in iatrogenic instability
  - Infection (e.g., discitis, epidural abscess, osteomyelitis) when instability is present or debridement and/or decompression is anticipated to result in iatrogenic instability
  - Primary or metastatic neoplastic disease causing pathologic fracture, cord compression, when instability is present or resection and/or decompression is anticipated to result in iatrogenic instability
  - A condition otherwise meeting criteria listed in the applicable procedure section(s) with documentation of severe debilitating pain and/or dysfunction to the point of being incapacitated

CMM-609.2: Osteotomy

Posterior Column Osteotomy (PCO)

Lumbar posterior column osteotomy (PCO) (i.e., Smith-Peterson osteotomy [SPO] or Ponte osteotomy) is considered **medically necessary** (in addition to a fusion) when **ALL** of the following criteria are met:

- Correction of non-fixed deformity requiring 5° to 10° of correction (SPO) per spinal segment for **EITHER** of the following:
  - Lumbar sagittal plane deformities where sagittal vertical axis (SVA) is greater than 8cm or pelvic incidence-lumbar lordosis (PI-LL) is <15°
  - Larger coronal deformities where there is limited flexibility and the Cobb angle is >30°
- Posterior column osteotomy is limited to a maximum of four (4) posterior column osteotomies performed in the apex of the deformity per correction surgery.
  - **Criteria exception:** There is no limit to posterior column osteotomies for correction of Scheuermann's Kyphosis as this deformity is long, gradual, rounded, and amendable to more than 4 posterior column osteotomies.
- **ALL** of the criteria for lumbar fusion have been met per the applicable procedure-specific section(s) below:
  - **CMM-609.3: Pediatric Spinal Deformity**
  - **CMM-609.4: Lumbar Fusion (Arthrodesis) with Decompression (Indirect or Direct)**
  - **CMM-609.5: Lumbar Fusion (Arthrodesis) without Decompression**
  - **CMM-609.6: Adjacent Segment Disease**
  - **CMM-609.7: Lumbar Fusion (with or without Decompression) Following Failed Disc Arthroplasty Surgery**
  - **CMM-609.8: Repeat Lumbar Fusion (Arthrodesis) at the Same Level**

Three-Column Osteotomy

Lumbar three-column osteotomy (i.e., pedicle subtraction osteotomy (PSO) or vertebral column resection [VCR]) is considered **medically necessary** (in addition to a fusion) when **ALL** of the following criteria are met:

- Performed for **EITHER** of the following:
  - Correction of fixed sagittal plane deformity requiring more than 30° of correction (PSO)
  - Large fixed coronal deformities greater than 60° that are amenable to asymmetric osteotomy
- **ALL** of the criteria for lumbar fusion have been met per the applicable procedure-specific section(s) below:
  - **CMM-609.3: Pediatric Spinal Deformity**
  - **CMM-609.4: Lumbar Fusion (Arthrodesis) with Decompression (Indirect or Direct)**
  - **CMM-609.5: Lumbar Fusion (Arthrodesis) without Decompression**
  - **CMM-609.6: Adjacent Segment Disease**

- **CMM-609.7: Lumbar Fusion (with or without Decompression) Following Failed Disc Arthroplasty Surgery**
- **CMM-609.8: Repeat Lumbar Fusion (Arthrodesis) at the Same Level**

CMM-609.3: Pediatric Spinal Deformity

Pediatric Lumbar Fusion

Lumbar fusion (arthrodesis) is considered **medically necessary** when the following criteria is met:

- Imaging studies (advanced imaging or plain X-rays) show the presence of **ANY** of the following pediatric spinal deformities that warrant definitive surgical treatment:
  - Adolescent idiopathic scoliosis with over 50° curve
  - Congenital scoliosis
  - Neuromuscular scoliosis
  - Infantile/juvenile scoliosis

Pediatric Osteotomy

Lumbar osteotomy is considered **medically necessary** (in addition to a lumbar fusion) when **ALL** of the criteria are met per **CMM-609.2: Osteotomy**.

CMM-609.4: Lumbar Fusion (Arthrodesis) with Decompression (Indirect or Direct)

Lumbar fusion with decompression (indirect or direct) is considered **medically necessary** when performed for **ANY** of the following conditions when **ALL** of the associated criteria are met:

Actual Instability

- The individual is a candidate for lumbar decompression or corpectomy per **CMM-608: Lumbar Decompression**.
- Imaging shows **ANY** of the following:
  - Degenerative spondylolisthesis without spondylolysis with **EITHER** of the following:
    - Dynamic segmental instability on flexion-extension plain X-rays **OR** comparison of a supine and upright image, with a difference in translational alignment between vertebrae greater than 3 mm between views
    - Meyerding Grade II or higher spondylolisthesis
  - Spondylolisthesis with spondylolysis (e.g. Isthmic Spondylolisthesis) with **ANY** of the following:
    - Meyerding Grade 1 or 2 spondylolisthesis (anterolisthesis) and plain X-rays support progression of anterolisthesis
    - Meyerding Grade 3 or higher spondylolisthesis (anterolisthesis) with 50% or more anterior slippage **OR** plain X-rays support progression of anterolisthesis

    - Progressive spinal pain without confirmatory imaging showing progression of spondylolisthesis
    - Multi-level spondylolysis on plain X-rays
  - Post-operative instability created by the disruption of the posterior elements due to facet joint excision that exceeds 50% bilaterally or 75% or more of a single facet
  - Pars fracture
  - Previous lumbar spinal decompression that resulted in iatrogenic spondylolisthesis
  - **Criteria exception**: When instability is created and/or identified intra-operatively, the above imaging criteria are **NOT** required.
    - See **Anticipated Iatrogenic Instability**
- Documentation of nicotine-free status with **EITHER** of the following:
  - Individual is a never-smoker
  - Individual has refrained from smoking, use of smokeless tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤10 ng/mL

Anticipated Iatrogenic Instability

- The individual is a candidate for lumbar decompression or corpectomy per **CMM-608: Lumbar Decompression**.
- Anticipated iatrogenic instability with **ANY** of the following:
  - Created by disruption of the posterior elements due to facet joint excision that exceeds 50% bilaterally or 75% or more of a single facet during spinal decompression
  - Created by removal of the pars interarticularis is performed that requires fusion to stabilize
  - Created by decompression for Meyerding Grade I or higher spondylolisthesis with foraminal stenosis
  - Created by complete or partial corpectomy (i.e., removal of at least one-third of the vertebral body [not for resection of osteophytes alone])
    - For lumbar corpectomy, see **CMM-608.3: Corpectomy**.
- Documentation of nicotine-free status with **EITHER** of the following:
  - Individual is a never-smoker
  - Individual has refrained from smoking, use of smokeless tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤10 ng/mL

Adult Degenerative Spinal Deformity

- The individual is a candidate for lumbar decompression or corpectomy per **CMM-608: Lumbar Decompression**

- Imaging findings include **EITHER** of the following:
  - Coronal plane deformity which includes **ANY** of the following:
    - Cobb angle greater than 30°
    - Asymmetric disk collapse causing symptomatic foraminal narrowing
    - Coronal imbalance causing head and trunk shift off the midline
  - Sagittal imbalance which includes **ANY** of the following:
    - Sagittal vertebral axis measurement greater than 8 cm
    - Pelvic incidence-lumbar lordosis greater than 15°
- Documentation of nicotine-free status with **EITHER** of the following:
  - Individual is a never-smoker
  - Individual has refrained from smoking, use of smokeless tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤10 ng/mL

Initial Disc Herniation

- This individual is a candidate for an initial primary lumbar discectomy per the applicable section below:
  - For information related to excision of extradural lesion other than neoplasm, see **CMM 606.1: General Guidelines**.
  - For an initial primary lumbar discectomy, see **CMM-606.2: Initial Primary Lumbar Microdiscectomy (Laminotomy, Laminectomy, or Hemilaminectomy)**.
- Advanced Imaging shows **ANY** of the following:
  - Primary extraforaminal disc herniation at L5-S1, in which a far lateral approach is not feasible because of the presence of the iliac wings
  - Primary foraminal disc herniation for which facet resection is necessary to retrieve the disc, which will result in iatrogenic instability
  - Primary disc herniation in the lumbar spine that is at the level of the spinal cord (i.e., low lying conus medullaris)
- Documentation of nicotine-free status with **EITHER** of the following:
  - Individual is a never-smoker
  - Individual has refrained from smoking, use of tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤10 ng/mL

Recurrent Disc Herniation

- The individual is a candidate for repeat lumbar discectomy per **CMM 606.3: Repeat Lumbar Microdiscectomy (Laminotomy or Laminectomy) at the Same Level**.
- Imaging shows evidence of anterolisthesis at the requested level(s) that results in **EITHER** of the following:
  - Dynamic segmental instability on flexion-extension plain X-rays **OR** comparison of a supine and upright image, with a difference in translational alignment between vertebrae greater than 3 mm between views
  - Meyerding Grade II or higher spondylolisthesis
- Documentation of nicotine-free status with **EITHER** of the following:
  - Individual is a never-smoker
  - Individual has refrained from smoking, use of tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤10 ng/mL

Second or Greater Recurrent Disc Herniation

- Individual is a candidate for repeat lumbar discectomy per **CMM 606.3: Repeat Lumbar Microdiscectomy (Laminotomy or Laminectomy) at the Same Level**.
- Documentation of nicotine-free status with **EITHER** of the following:
  - Individual is a never-smoker
  - Individual has refrained from smoking, use of tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤10 ng/mL

CMM-609.5: Lumbar Fusion (Arthrodesis) without Decompression

Lumbar fusion (arthrodesis) without decompression is considered **medically necessary** when performed for **ANY** of the following conditions when **ALL** of the associated criteria are met:

Degenerative Spondylolisthesis without Spondylolysis

- Imaging at the requested level(s) shows **EITHER** of the following:
  - Dynamic segmental instability on flexion-extension plain X-rays **OR** comparison of a supine and upright image, with a difference in translational alignment between vertebrae greater than 3 mm between views
  - Meyerding Grade II or higher spondylolisthesis
  - Subjective symptoms include significant level of pain on a daily basis defined as clinically significant functional impairment (e.g., inability to perform household chores, prolonged standing, etc.)
- Less than clinically meaningful improvement with **EITHER** of the following for at least 3 consecutive months (unless contraindicated):
  - Prescription strength analgesics, steroids, gabapentinoids, and/or NSAIDs

- Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician

- Absence of untreated, underlying mental and/or behavioral health disorders (e.g., depression, chronic pain syndrome, secondary gain, opioid and alcohol use disorders)
- Documentation of nicotine-free status with **EITHER** of the following:
  - Individual is a never-smoker
  - Individual has refrained from smoking, use of tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤10 ng/mL

Spondylolisthesis with Spondylolysis (e.g. Isthmic Spondylolisthesis)

- Imaging at the requested level(s) shows **ANY** of the following:
  - Meyerding Grade 1 or 2 spondylolisthesis (anterolisthesis) with plain X-rays supporting progression of anterolisthesis
  - Meyerding Grade 3 or higher spondylolisthesis (anterolisthesis) identified on plain x-rays with 50% or more anterior slippage **OR** plain X-rays supporting progression of anterolisthesis
  - Progressive spinal pain without confirmatory imaging of progression of spondylolisthesis
  - Multi-level spondylolysis on plain X-rays
  - Subjective symptoms include significant level of pain on a daily basis defined as clinically significant functional impairment (e.g., inability to perform household chores, prolonged standing, etc.)
- Less than clinically meaningful improvement with **EITHER** of the following for at least 3 consecutive months (unless contraindicated):
  - Prescription strength analgesics, steroids, gabapentinoids, and/or NSAIDs
  - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician
- Absence of untreated, underlying mental and/or behavioral health disorders (e.g., depression, chronic pain syndrome, secondary gain, opioid and alcohol use disorders,)

- Documentation of nicotine-free status with **EITHER** of the following:
  - Individual is a never-smoker
  - Individual has refrained from smoking, use of tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤10 ng/mL

Discogenic Lower Back Pain/Degenerative Disc Disease

- Plain X-rays **and** advanced diagnostic imaging studies (i.e., CT, MRI) at the requested level(s)show moderate to severe single-level disc degeneration
- Presence of chronic, unremitting, discogenic axial lower back pain and associated disability secondary to single-level degenerative lumbar disc disease (DDD) for at least one year
  - Subjective symptoms include significant level of pain on a daily basis defined as clinically significant functional impairment (e.g., inability to perform household chores, prolonged standing, etc.)
- Structured physician-supervised, multi-modal, non-operative management of medical care with licensed healthcare professionals which includes **ALL** of the following:
  - Regularly scheduled appointments
  - Follow-up evaluation
  - Less than clinically meaningful improvement with at least **TWO** of the following (unless contraindicated):
    - Prescription strength analgesics, steroids, gabapentinoids, and/or NSAIDs for at least 12 consecutive months
    - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for at least 12 consecutive months
    - Epidural steroid injection(s)/ or selective nerve root block(s)
    - Facet joint injection(s)/medial branch block(s)/radiofrequency ablation(s)
- Absence of untreated, underlying mental and/or behavioral health disorders (e.g., depression, chronic pain syndrome, secondary gain, opioid and alcohol use disorders)
- Documentation of nicotine-free status with **EITHER** of the following:
  - Individual is a never-smoker
  - Individual has refrained from smoking, use of tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤10 ng/mL

Adult Degenerative Spinal Deformity

- Imaging shows **EITHER** of the following:
  - Coronal plane deformity which includes **ANY** of the following:
    - Cobb angle of greater than 30°
    - Asymmetric disk collapse causing symptomatic foraminal narrowing
    - Coronal imbalance causing head and trunk shift off the midline
  - Sagittal imbalance which includes **ANY** of the following:
    - Sagittal vertebral axis measurement greater than 8 cm
    - Pelvic incidence-lumbar lordosis greater than 15°
- Less than clinically meaningful improvement with **EITHER** of the following for at least 3 consecutive months (unless contraindicated):
  - Prescription strength analgesics, steroids, gabapentinoids, and/or NSAIDs
  - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician
- Absence of unmanaged significant mental and/or behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, opioid and alcohol use disorders)
- Documentation of nicotine-free status with **EITHER** of the following:
  - Individual is a never-smoker
  - Individual has refrained from smoking, use of smokeless tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤10 ng/mL

CMM-609.6: Adjacent Segment Disease

Lumbar fusion (arthrodesis) for adjacent segment disease is considered **medically necessary** when **ALL** of the following are met:

- The individual meets criteria for lumbar fusion per the applicable section below:
  - **CMM-609.4: Lumbar Fusion with Decompression**
  - **CMM-609.5: Lumbar Fusion (Arthrodesis) without Decompression**
- The prior adjacent-level lumbar fusion was performed at least 6 months prior
- Imaging at the requested level(s) shows evidence of anterolisthesis on plain X-rays resulting in **EITHER** of the following:
  - Dynamic segmental instability on flexion-extension plain X-rays **OR** comparison of a supine and upright image, with a difference in translational alignment between vertebrae greater than 3 mm between views
  - Meyerding Grade II or higher spondylolisthesis
- Significant initial relief of symptoms following prior lumbar spinal fusion(s)

CMM-609.7: Lumbar Fusion (with or without Decompression) Following Failed Lumbar Disc Arthroplasty Surgery

Lumbar fusion (with or without decompression) following failed lumbar disc arthroplasty surgery is considered **medically necessary** when performed for **EITHER** of the following conditions when **ALL** of the associated criteria are met:

Failed Lumbar Disc Arthroplasty Implant

- Post-operative imaging shows evidence of lumbar disc arthroplasty implant malposition or failure (e.g., subsidence, loosening, infection, dislocation/subluxation, vertebral body fracture, dislodgement)

Evidence of Neural Structure Compression

- Greater than 6 months since the prior lumbar disc arthroplasty surgery
- The individual meets criteria for lumbar fusion per the applicable section below:
  - **CMM-609.4 : Lumbar Fusion (Arthrodesis) with Decompression**
  - **CMM-609.5: Lumbar Fusion (Arthrodesis) without Decompression**
- Post-operative MRI /CT shows evidence of neural structure compression (e.g., either retained disc material or a recurrent disc herniation)

CMM-609.8: Repeat Lumbar Fusion (Arthrodesis) at the Same Level

Repeat lumbar fusion (arthrodesis) (with or without decompression) at the same level is considered **medically necessary** for **EITHER** of the following conditions when **ALL** of the associated criteria are met:

Malposition or Failure of Implant//Instrumentation or Structural Bone Graft

- Post-operative imaging shows evidence of malposition or failure of the implant/instrumentation or structural bone graft (e.g., migration, pedicle screw breakage, pedicle screw loosening, dislodged hooks, rod breakage, rod bending, rod loosening, loss of curve correction, decompensation, etc.)

Symptomatic Pseudoarthrosis

- Greater than 6 months since the prior lumbar fusion surgery
- Subjective symptoms include significant level of pain on a daily basis defined as clinically significant functional impairment (e.g., inability to perform household chores, prolonged standing, etc.)
- Post-operative physical exam findings are concordant with the individual's symptoms

- Less than clinically meaningful improvement with 6 weeks of non-surgical treatment with **BOTH** of the following (unless contraindicated):
  - Prescription strength analgesics, steroids, gabapentinoids, and/or NSAIDs
  - Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician
- Post-operative imaging (performed at no less than 6 months after the prior lumbar fusion) shows pseudoarthrosis at the requested level(s)
- Post-operative MRI/CT findings are concordant with the individual's symptoms
- Absence of unmanaged significant mental and/or behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, opioid and alcohol use disorders)
- Documentation of nicotine-free status including **EITHER** of the following:
  - Individual is a never-smoker
  - Individual has refrained from smoking, use of smokeless tobacco products, and/or nicotine replacement therapy for at least 6 weeks prior to planned surgery as evidenced by blood cotinine lab results of ≤ 10 ng/mL

CMM-609.9: Non-Indications

Not Medically Necessary

- **Lumbar fusion** performed without meeting the criteria in the **General Guidelines** section (when applicable for urgent/emergent conditions) **and** the criteria in the applicable procedure-specific section(s) (pediatric spinal deformity; fusion with decompression; fusion without decompression; adjacent segment disease; fusion following failed disc arthroplasty; or, repeat fusion) is considered **not medically necessary**.
- **Lumbar osteotomy** performed without meeting the criteria in the **General Guidelines** (when applicable for urgent/emergent conditions) **and** the criteria in the applicable procedure-specific section (osteotomy; pediatric spinal deformity; fusion with decompression; fusion without decompression; adjacent segment disease; fusion following failed disc arthroplasty; or, repeat fusion is considered **not medically necessary**.
- **Lumbar fusion** and/or **osteotomy** performed for **ANY** of the following sole indications is considered **not medically necessary**:
  - Disc herniation in the absence of **ANY** of the following:
    - Primary extraforaminal disc herniation at L5-S1, in which a far lateral approach is not feasible because of the presence of the iliac wings
    - Primary foraminal disc herniation for which facet resection is necessary to retrieve the disc, which will result in iatrogenic instability
    - Primary disc herniation in the lumbar spine that is at the level of the spinal cord (i.e., low lying conus medullaris)
  - Multi-level degenerative disc disease without instability
  - Neurocompressive pathology

- Facet joint disorders without instability
- Initial discectomy/laminectomy without instability
- An adjunct to primary decompression of central and/or lateral recess stenosis in the absence of instability, spondylolisthesis, or an actual or anticipated bony resection that will result in iatrogenic instability
- Spondylolysis without spondylolisthesis

Experimental, Investigational, or Unproven (EIU)

➢ **ALL** of the following devices/procedures are considered **experimental, investigational, or unproven (EIU)** (not an all-inclusive list):

- Pre-sacral interbody fusion including AxiaLIF
- Minimally invasive lumbar spinal fusions using direct visualization via endoscopy (endoscopic fusion) or indirect visualization (e.g., percutaneous fusion)
- Anterior interbody fusion or implantation of intervertebral body fusion devices using laparoscopic approach
- Device/implant not FDA approved
- Dynamic (intervertebral) stabilization (e.g., Dynesys, Stabilimax NZ)
- Interlaminar lumbar instrumented fusion (e.g., ILIF)
- Interspinous and interlaminar distraction devices
- Interspinous fixation/posterior non-pedicle supplemental fixation devices for spinal fusion (e.g., Affix, Aspen Spinous Process Fixation System, Coflex-F)
- Personalized anterior and lateral body interbody cage (implantable) (e.g., Aprevo)
- Least invasive lumbar decompression interbody fusion (e.g., LINDIF)
- Isolated facet fusion, with or without instrumentation, including allograft bone graft substitutes used exclusively as stand-alone stabilization devices (e.g., TruFuse [any level}, NuFix® [any level])
- Total facet arthroplasty

Procedure (CPT®) Codes (CMM-609)

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
22207	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., Pedicle/vertebral body subtraction); lumbar
+22208	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., Pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to code for primary procedure)
22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar
+22216	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure)
22224	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumbar
+22226	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment, each additional vertebral segment (List separately in addition to code for primary procedure)
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
+22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
+22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace
22612	Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)
+22614	Arthrodesis, posterior or posterolateral technique, single interspace; each additional vertebral segment (List separately in addition to code for primary procedure)
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar
+22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)

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**
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar
+22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)
22800	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments
22802	Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments
22804	Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments
22808	Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments
22810	Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments
22812	Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments
+22840	Posterior non-segmental instrumentation (e.g. Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)
+22841	Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)
+22842	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)
+22843	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure)
+22844	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (List separately in addition to code for primary procedure)
+22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)
+22846	Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)
+22847	Anterior instrumentation; 8 of more vertebral segments (List separately in addition to code for primary procedure)
+22848	Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure)
22849	Reinsertion of spinal fixation device

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**
+22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)
+22854	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
+22859	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
0202T	Posterior vertebral joint(s) arthroplasty (e.g., facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine
0221T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar
+0222T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment (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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