UPMC Health Plan
POLICY AND PROCEDURE MANUAL

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REVISION DATE: 10/18
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PAGE NUMBER: 1 of 17

SUBJECT: Lumbar Spinal Fusion
INDEX TITLE: Medical Management
ORIGINAL DATE: October 2012

This policy applies to the following lines of business: (Check those that apply.)

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Reference State Addendums for:
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Maryland ( )

A. Medical Description/Background
B. Specific Indications
C. Limitations
D. Information Required for Review
E. Variations
F. Codes

I. POLICY

It is the policy of UPMC Insurance Services Division to cover Lumbar Spinal Fusion when medically necessary and covered under the member’s specific benefit plan.

All denials are based on medical necessity and appropriateness as determined by a UPMC Insurance Services Division Medical Director (Medical Director).

II. DEFINITIONS

Activities of Daily Living (ADLs) refers to the basic tasks of everyday life, such as eating, bathing, dressing, toileting, personal hygiene, and transferring.
Cauda Equina Syndrome (CES) occurs when the nerve roots of the cauda equina are compressed and disrupt motor and sensory function to the lower extremities and bladder. This syndrome often requires hospital admission as a medical emergency. CES can lead to incontinence and even permanent paralysis. The collection of nerves at the end of the spinal cord is known as the cauda equina, due to its resemblance to a horse’s tail.

Conservative Treatment Requirements Prior to Lumbar Fusion Surgery:

1. For those conditions which require a trial of conservative treatment, failure of conservative treatment is defined as the failure of all four of the following for a three-month period or more, unless contraindicated:
   a) Eight weeks or more of chiropractic/ physical therapy, osteopathic manipulative therapy, or a physician-directed home rehabilitation program; and
   b) Use, if not contraindicated, of oral analgesics (not to include opioids) and/or anti-inflammatory medications for at least six weeks; and
   c) Epidural steroids, if medically indicated and with patient consent; and
   d) Bracing (especially in scoliosis and adjacent segment instability), only if medically indicated.

2. Patients with a current history of smoking must enroll and be actively participating in a structured, supervised smoking-cessation program. According to the American Academy of Orthopaedic Surgeons (AAOS), smoking affects the tissues that make up the musculoskeletal system, increasing the risk of injury and disease. Smokers also have a higher rate of complications after surgery than nonsmokers such as poor wound healing and infection and outcomes are less satisfactory. This is related to the decrease in blood supply to the tissues.

Flatback Syndrome is a loss of lumbar lordosis of the spine. The normal lumbar curvature becomes flat, or in extreme cases there may be a reverse curvature (called lumbar kyphosis). The condition is characterized by the inability to stand up straight, and typically patients will have back pain in their upper or lower spine. It can occur at any age, but it is more likely to be found in older adults who have had scoliosis surgery.

Instability is defined as any of the following:

- Fracture involving 2 of 3 columns (Denis) of cervical, thoracic, or lumbar spine
- Neural compression after spinal fracture
- Vertebral tumors with 2 column involvement
- Vertebral infections with 2 column involvement
- Epidural compression from tumor, infection, tuberculosis (TB)
- Traumatic spondylolisthesis with listhesis
- Grade 2 and above spondylolisthesis
- Fusions at the thoracic lumbar junction (T12-L1)
  - Extension of lumbar fusions into the lower thoracic spine above T12 may be considered for additional structural support of the lumbar fusion
- Iatrogenic instability: resection of the pars interarticularis, removal of 50% or more of the facets bilaterally, removal of an entire unilateral facet
- Spinal deformity: idiopathic scoliosis with progressive Cobb angle >30, progressive degenerative lumbar scoliosis and/or lateral listhesis, neuroforaminal encroachment with neurologic symptoms
- Dynamic spondylolisthesis with >3 mm translation, or >15-degree angular translation on flexion extension films
- Grade I spondylolisthesis with severe spinal stenosis in a level adjacent to a prior fusion

Laminectomy is a surgical procedure where an opening is made in the lamina (the roof of the vertebra) to relieve pressure on the nerve roots of the spine.

Significant Functional Impairment is the inability to perform routine ADLs, household chores or other duties and activities that require prolonged standing, interference with essential job functions.

Spinal level is considered one disc level or two vertebrae (i.e., L4-L5).

Spondylolisthesis is a form of spinal instability defined as slipping or displacement of one vertebra over another. There are different degrees or grades of the displacement. Grading of spondylolisthesis is defined as the following:
- Grade I – 1-25% slip
- Grade II – 26-50% slip
- Grade III – 51-75% slip
- Grade IV – 76-100% slip

III. PURPOSE

The purpose of this policy is to provide the medical necessity indications for lumbar spinal fusion.

IV. SCOPE

This policy applies to various UPMC Insurance Services Division Departments as indicated by the Benefit and Reimbursement Committee. These include but are not limited to Medical Management, Benefit Configuration and Claims Departments.

V. PROCEDURE

B. Medical Description / Background
Although low back pain has a lifetime occurrence of 75 to 85 percent among all Americans and can be quite debilitating and painful, it improves without surgery in about 90 percent of all cases. Conservative treatment options include physical therapy, back exercises, weight reduction, epidural steroid injection, nonsteroidal anti-inflammatory medications, rehabilitation, and limiting activity. Evaluation and appropriate management of associated cognitive, behavioral, or addiction issues should also be addressed when present. All of these options for back pain treatment are aimed at relief of underlying inflammation and nerve-root irritation. For the few patients for whom conservative treatment for low back pain does not provide relief, or for certain specific conditions shown not to benefit from conservative treatment, surgery may be needed. A trial of conservative management is not required for urgent/emergent conditions requiring surgery, including, but not limited to: acute spinal fracture and/or major trauma, spinal infection or abscess, tumor, or cauda equina syndrome.

**Spinal fusion** is a surgical procedure used to correct problems by stabilizing the vertebrae, the small bones of the spinal column. It is essentially a "welding" process which results in the involved vertebrae healing into a single, solid bone. It is indicated for congenital or acquired spinal instability, correction of a deformity, or traumatic injury. This surgical procedure may improve symptoms stemming from conditions such as spinal stenosis, fracture, tumor, infection, scoliosis, pseudoarthrosis, and/or spondylolisthesis.

There are various surgical approaches for the procedure, including anterior, posterior, or lateral. The procedure may be combined with a laminectomy (decompression) procedure to relieve pressure on spinal nerves.

C. **Specific Indications**

**Spinal Lumbar Fusion** is considered medically necessary for spinal instability associated with any of the following emergent/urgent conditions (conservative treatment is not required):

- Spinal fracture and/or major trauma confirmed by imaging studies; or
- Spinal infection or abscess confirmed by imaging studies; or
- Spinal tumor or epidural compression due to neoplasm, confirmed by imaging studies; or
- Cauda equina syndrome.

Spinal Lumbar Fusion is considered medically necessary for the following conditions when the listed criteria are met:

**Lumbar Fusion for Flatback Syndrome**

Single or multilevel lumbar fusion is considered medically necessary for unremitting pain associated with flatback syndrome when imaging studies demonstrate sagittal imbalance (i.e., loss of lumbar lordosis, forward flexed posture, lumbar kyphosis), only if both the following criteria are met:

- The procedure includes a deformity correction; and
- Either one of:
Imbalance is progressive, resulting in neurologic compromise (i.e., compression of neural structures); or

The individual is experiencing clinically significant functional impairment (i.e., inability to perform household chores or prolonged standing, interference with essential job functions) and trial of at least three months of conservative medical management has failed to relieve symptoms.

**Lumbar Fusion for Iatrogenic Instability**

Lumbar fusion is considered medically necessary for iatrogenic spinal instability occurring during decompression spinal surgery, for the level or levels involved when instability results from any of the following components of the surgery:

- Removal of 50% or more of the facets bilaterally; or
- Removal of an entire unilateral facet; or
- Resection of the pars interarticularis or pars fracture.

**Lumbar Fusion for Instability**

Lumbar spinal fusion is considered reasonable and necessary for any of the following conditions:

- Fracture involving two of three columns (Denis) of cervical, thoracic, or lumbar spine; or
- Neural compression after spinal fracture; or
- Vertebral tumors with two-column involvement; or
- Vertebral infections with two-column involvement; or
- Epidural compression from tumor, infection, or TB; or
- Traumatic spondylolisthesis with listhesis; or
- Grade 2 and above spondylolisthesis; or
- Fusions at the thoracic lumbar junction (T12-L1); or
  - Extension of lumbar fusions into the lower thoracic spine above T12 may be considered for additional structural support of the lumbar fusion; or
- Iatrogenic instability as defined above; or
- Spinal deformity: idiopathic scoliosis with progressive Cobb angle of 30 degrees or more, progressive degenerative lumbar scoliosis, and/ or lateral listhesis, neuroforaminal encroachment with neurologic symptoms; or
- Dynamic spondylolisthesis with >3mm translation, or >15-degree angular translation on flexion extension films.
- Grade 1 spondylolisthesis with severe spinal stenosis in a level adjacent to a prior fusion.

**Lumbar Fusion for Instability: Spinal Stenosis**

Single level lumbar fusion (i.e., L4-L5) is considered medically necessary for the treatment of spinal stenosis when there is an associated spondylolisthesis, and all of the following criteria are met:

1. Back pain with neurogenic claudication symptoms or radicular pain; and
2. Failure of at least three months of physician-supervised conservative medical management; and
3. Clinically significant functional impairment (i.e., inability to perform household chores or prolonged standing, interference with essential job functions); and

4. Stenosis (central, lateral recess, or foraminal) or synovial cyst is demonstrated on imaging studies (i.e., radiographs, magnetic resonance imaging [MRI], computerized tomography [CT], myelography); and

5. Radiographic evidence of either one of the following:
   a. Grade 1 spondylolisthesis with dynamic instability consisting of either at least 3mm translation, or more than 15-degree angular translation on flexion-extension films; or
   b. Grade 2 or higher spondylolisthesis;

6. The individual is a nonsmoker, or in the absence of progressive neurological compromise, the patient is enrolled and actively participating in a structured, supervised smoking-cessation program.

**Lumbar Fusion for Instability: Spondylolysis/Isthmic Spondylolisthesis**

Lumbar fusion* is considered medically necessary for spondylolysis (i.e., pars interarticular fracture) or isthmic spondylolisthesis when both of the following criteria are met:

- The individual is a nonsmoker, or in the absence of progressive neurological compromise, the patient is enrolled and actively participating in a structured, supervised smoking-cessation program; and

- Any one of the following:
  - Multilevel spondylolysis; or
  - Rapidly progressive neurologic compromise (i.e., cauda equina syndrome); or
  - Symptomatic Grade 1 or 2 spondylolisthesis (anterolisthesis) and either one of the following:
    - Radiograph documentation supporting progression of anterolisthesis; or
    - Both of the following:
      - Failure of at least six months of physician-supervised conservative treatment; and
      - Clinically significant functional impairment
  - Symptomatic Grade 3 or higher spondylolisthesis (anterolisthesis) demonstrated on plain x-rays with 50% or more anterior slippage and either one of the following:
    - Radiograph documentation supporting progression of anterolisthesis; or
    - Both of the following:
      - Clinically significant functional impairment
      - Failure of at least three months of physician-supervised conservative management

*Note: Typically, single level fusion is generally considered appropriate for treatment of single level spondylolysis or Grade 1 or 2 spondylolisthesis. Two levels of fusion may be appropriate for multilevel spondylolysis or Grade 3 and higher spondylolisthesis.

**Lumbar Fusion for Scoliosis**
Lumbar spinal fusion is considered medically necessary when either of the following criteria is met:

- Severe, progressive idiopathic scoliosis (i.e., lumbar or thoracolumbar) with Cobb angle of 30 degrees or greater in the coronal plane or thoracic hypokyphosis or lordosis in the sagittal plane; or
- Severe degenerative lumbar scoliosis with either one of the following:
  - Documented progression of deformity with persistent axial (non-radiating) pain and impairment or loss of function, unresponsive to at least three months of conservative therapy; or
  - Persistent and significant neurogenic symptoms (claudication or radicular pain) with impairment or loss of function, unresponsive to at least three months of conservative therapy.

Lumbar Fusion Following Prior Spinal Surgery: Pseudoarthrosis

Single level lumbar fusion is considered medically necessary for the treatment of pseudoarthrosis (i.e., nonunion of prior fusion) at the same level when it has been at least 12 months from the prior surgery and all of the following criteria are met:

1. Imaging studies confirm evidence of a pseudoarthrosis (i.e., radiographs, CT); and
2. Failure of three months of physician-supervised conservative management; and
3. The individual experienced some relief of pain symptoms following the prior spinal surgery; and
4. The individual is a nonsmoker, or in the absence of progressive neurological compromise, the patient is enrolled and actively participating in a structured, supervised smoking-cessation program.

Lumbar Fusion Following Prior Spinal Surgery: With Spondylolisthesis

A single level lumbar fusion is considered medically necessary when all of the below criteria are met for either one of the following postsurgical conditions when there is an associated spondylolisthesis (i.e., anterolisthesis):

- Recurrent disc herniation: when it has been at least three months from the previous surgery and all of the below criteria have been met:
  1. Recurrent symptoms consistent with neurological compromise; and
  2. Clinically significant functional impairment; and
  3. Neural compression is documented by recent appropriate post-operative imaging; and
  4. Failure of three months of physician-supervised conservative management; and
  5. Anterolisthesis (anterior translation of the vertebra on the adjacent vertebra below) resulting in a Grade 1 spondylolisthesis or anterior segmental instability (i.e., 3 mm displacement of the involved vertebra on the adjacent vertebra below); and
  6. Individual experienced some relief of pain symptoms following the prior spinal surgery; and
  7. The individual is a nonsmoker, or in the absence of progressive neurological compromise, the patient is enrolled and actively participating in a structured, supervised smoking-cessation program.
• Adjacent segment degeneration: when it has been at least six months from the previous surgery.
  1. Recurrent symptoms consistent with neurological compromise; and
  2. Clinically significant functional impairment; and
  3. Neural compression is documented by recent appropriate post-operative imaging; and
  4. Failure of three months of physician-supervised conservative management; and
  5. Anterolisthesis (anterior translation of the vertebral body on the adjacent vertebra below) resulting in a Grade I spondylolisthesis or anterior segmental instability (i.e., 3mm displacement of the involved vertebra on the adjacent vertebra below); and
  6. Individual experienced some relief of pain symptoms following the prior spinal surgery; and
  7. The individual is a nonsmoker, or in the absence of progressive neurological compromise, the patient is enrolled and participating in a structured, supervised smoking-cessation program.

Lumbar Fusion Following Prior Spinal Surgery: Without Spondylolisthesis

Single-level lumbar fusion is considered medically necessary for treatment of symptomatic adjacent or same-segment disc degeneration following prior spinal surgery (i.e., discectomy, laminectomy), in the absence of spondylolisthesis, for either one of the following indications:

1. Second recurrence, same level, disc herniation, at least six months after previous disc surgery, with recurrent neurogenic symptoms (radicular pain or claudication), with impairment or loss of function, unresponsive to at least three months of conservative nonsurgical care, and with neural structure compression documented by appropriate imaging, and in a patient who had experienced significant interval relief of prior symptoms; or

2. Post-surgical disc degeneration and spondylosis with all of the following criteria:
   a. Unremitting pain and significant functional impairment for at least 12 months that persists despite at least six consecutive months of structured*, physician-supervised conservative medical management, and
   b. Single-level degenerative disc disease, demonstrated on appropriate imaging studies (i.e., CT scan, MRI, or discography) as the likely cause of pain, and
   c. Participation in three or more individual or group cognitive behavioral therapy (CBT) sessions provided by a licensed healthcare professional, with competence in principles and practice of CBT, (i.e., physical therapy [PT], occupational therapy [OT], psychiatrist, psychologist, social worker, psychiatric nurse, other licensed professional) providing individualized treatment that includes all of the following elements:
      i. Disease education; and
      ii. Activity and lifestyle modification; and
      iii. Stress management (stress management typically also includes strategies to deal with emotions such as fear, anxiety, sadness that can interfere with pain management);
d. Statement from a primary care physician, neurologist, physiatrist, psychiatrist, psychologist, or other licensed behavioral and/or medical health care provider attesting to the absence of untreated, underlying mental health conditions/issues (i.e., depression, drug, alcohol abuse) as a major contributor to chronic back pain, and

e. The individual is a nonsmoker, or in the absence of progressive neurological compromise, the patient is enrolled and actively participating in a structured, supervised smoking-cessation program.

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

**Sacral (SI) Joint Fusion (Must Review Limitations)**

Sacral joint fusion by an open approach is considered medically necessary only when all of the following criteria are met:

1. Appropriate imaging studies demonstrate localized sacroiliac joint pathology; and

2. The individual is a nonsmoker, or in the absence of progressive neurological compromise, the patient is enrolled and actively participating in a structured, supervised smoking-cessation program; and

3. Any one of the following:
   • Post-traumatic injury of the SI joint (i.e., following pelvic ring fracture); or
   • As an adjunctive treatment for sacroiliac joint infection or sepsis; or
   • Management of sacral tumor (i.e., partial sacrectomy); or
   • When performed as part of multisegmental long fusions for the correction of spinal deformities which extend to the ilium and are due to such conditions as idiopathic scoliosis or neuromuscular scoliosis.

**C. Limitations**

Lumbar spinal fusion surgery is not covered for any of the following:

- Surgery for nerve root compression or spinal stenosis without documented instability or spondylolisthesis;
- With initial primary laminectomy/discectomy for nerve root decompression or spinal stenosis in the absence of instability or spondylolisthesis (Refer to MP.PA.091, Lumbar Laminectomy – Hemilaminectomy);
- For treatment of spinal stenosis in the absence of spondylolisthesis, foraminal stenosis, or spinal instability;
- Chronic low back pain without a clear cause demonstrated on imaging studies; or
- Patients requiring non-emergent/non-urgent surgery with current smoking history without documentation of enrollment and active participation in a structured, supervised smoking-cessation program;
- Spinal degeneration without instability;
• Use of devices that are not approved by the Food and Drug Administration (FDA), off-label device use of approved devices, or devices recalled by the FDA;
• Multiple-level lumbar spinal fusions are considered not medically necessary when the criteria listed above are not met for each level;
• Surgery on three or more levels of the spine is covered only for the following conditions: spondylolisthesis, scoliosis, kyphosis, or flatback syndrome.
• Patients with psychological factors correlated with poor outcomes which include: history of drug or alcohol abuse, high degrees of somatization on clinical or psychological evaluation, presence of a personality disorder or major psychiatric illness, and/or current evidence of a factitious disorder should be evaluated and complete at least one counseling session prior to surgery;
• Lumbar spinal fusion performed for any other indication than listed in this policy will be considered not medically necessary.

Note: Significant functional impairment or loss of function should generally include documentation of the following: Inability or significantly decreased ability to perform normal daily activities of work, school or at home duties.

The following are considered experimental, investigational, or unproven* (listed codes are not all-inclusive; the descriptive language for the procedure takes precedence):
• Spinal manipulation under anesthesia (MUA); or
• Anterior interbody fusion or implantation of intervertebral body fusion devices using a laparoscopic approach; or
• The minimally invasive lumbar decompression (MILD) procedure and percutaneous discectomy; or
• Lumbar total disc arthroplasty (artificial disc), CPT code 22857; or
• Minimally invasive approaches using only endoscopic visualization (i.e., endoscopic fusion, percutaneous fusion [video imaging]), i.e., CPT code 62380; or
• Pre-sacral or axial interbody approach or axial lumbosacral interbody fusion, ALIF, (i.e., AxiaLif®); or
• Interlaminar/ interspinous lumbar instrumented fixation (fusion) devices (i.e., ILIFTM, AffixTM, CoFlex-F®, others); or
• Dynamic spine stabilization device systems (i.e., Dynsys®, Stabilimax NZ®); or
• Total facet arthroplasty, including Total Facet Arthroplasty SystemTM (CPT code 0202T); or
• Isolated facet fusion, with or without instrumentation, including bone allograft or bone substitutes used exclusively as stand-alone stabilization devices (i.e., TruFuse® [any level], NuFix™ [any level]) (CPT codes 0219T, 0220T, 0221T, 0222T); or
• Posterior spinous process distraction/stabilization devices, (i.e., CoFlex®, Superion®, others), either as a stand-alone procedure or combined with another spinal procedure, regardless of FDA approval, (CPT codes 22867, 22868, 22869, 22870).

*See Variations, Section E
Lumbar spine fusion surgery is considered experimental/investigational if the sole indication is any one of the following conditions:

- Disc herniation, or
- Chronic nonspecific low back pain without radiculopathy, or
- Degenerative disc disease, or
- Initial discectomy/laminectomy for neural structure decompression, or
- Facet syndrome.

**SI Joint Fusion**

Sacroiliac joint fusion for any other indication than listed in this policy, including the following, is considered experimental, investigational or unproven:

- Mechanical low back pain;
- Sacroiliac joint syndrome;
- Degenerative sacroiliac joint;
- Radicular pain syndromes;

Note: Percutaneous or minimally invasive sacroiliac joint stabilization (i.e., *iFuse Implant System™, Simmetry® SI Joint Fusion System) is not covered for sacroiliac joint fusion (CPT code 27279) for any indication because it is considered experimental, investigational or unproven.

*See Variations

**D. Information Required for Review**

In order to determine medical necessity for covered spinal surgical procedures, adequate information must be furnished by the treating physician. Required documentation includes, but is not limited to, the following items in order to authorize surgery in addition to the surgery specific criteria:

- Office notes from referring physician and/or neurosurgical/orthopedic evaluation documenting extent of and response to conservative management;
- Documentation of clinically significant functional impairment and of conservative management history, if applicable, including treatment by a physical therapist, chiropractor, or osteopathic manipulative therapy
  - Note: Significant functional impairment or loss of function should generally include documentation of the following: Inability or significantly decreased ability to perform normal daily activities of work, school or at home duties.
- Radiology/imaging reports;
- Specific procedure to be performed including spinal levels;
- Documentation of enrollment and active participation in a structured, supervised smoking-cessation program and date of last use of tobacco products for patients who have a current history of smoking, if applicable;
- If applicable, documentation of participation in three or more individual or group cognitive behavioral therapy (CBT) sessions provided by a licensed healthcare
professional, with competence in principles and practice of CBT, (i.e., physical therapy [PT], occupational therapy [OT], psychiatrist, psychologist, social worker, psychiatric nurse, other licensed professional) providing individualized treatment that includes all of the following elements:

▪ Disease education; and
▪ Activity and lifestyle modification; and
▪ Stress management (stress management typically also includes strategies to deal with emotions such as fear, anxiety, sadness that can interfere with pain management).

• If applicable, statement from a primary care physician, neurologist, physiatrist, psychiatrist, psychologist, or other licensed behavioral and/or medical health care provider attesting to the absence of untreated, underlying mental health conditions/issues (i.e., depression, drug, alcohol abuse) as a major contributor to chronic back pain;
• Documentation of completion of evaluation and one counseling session for patients with psychological factors correlated with poor outcomes as outlined in the limitations section.
• Documentation of participation in UPMC Health Plan Low Back Program, if indicated;
• Documentation of FDA approval of device.

E. Variations

Commercial:
Procedures/devices which have been determined to be experimental and investigational are not covered.

UPMC for Life (Medicare):
UPMC Health Plan complies with all Medicare National Coverage Determinations (NCDs) and applicable Local Coverage Determinations (LCDs) for all items, services and/or procedures that are covered benefits under Medicare. If the description of coverage criteria in this policy conflicts with any NCD or relevant LCD, the NCD or relevant LCD will apply, regardless of the version of the NCD or LCD listed in the Reference section of this policy.

UPMC for You and UPMC Community HealthChoices (Medical Assistance):
Procedures that are experimental/investigational and not in accordance with standard medical practice are not medically necessary.

Certain Lumbar Spinal Fusion codes are not on the Medical Assistance fee schedule. These procedures may only be requested as a Program Exception under the Program Exception process.

F. Codes

The following codes for treatments and procedures applicable to this policy are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply coverage or reimbursement. Please refer to the specific contract
benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual.

**CPT Code: Description:**

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<th>Description</th>
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<td>22533</td>
<td>Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar</td>
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<tr>
<td>22534</td>
<td>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)</td>
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<tr>
<td>22558</td>
<td>Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar</td>
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<td>22585</td>
<td>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)</td>
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<tr>
<td>22612</td>
<td>Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)</td>
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<tr>
<td>22614</td>
<td>Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>22630</td>
<td>Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar</td>
</tr>
<tr>
<td>22632</td>
<td>Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to primary code)</td>
</tr>
<tr>
<td>22633</td>
<td>Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar</td>
</tr>
<tr>
<td>22634</td>
<td>Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; each additional interspace and segment (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>22800</td>
<td>Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments</td>
</tr>
<tr>
<td>22802</td>
<td>Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments</td>
</tr>
<tr>
<td>22804</td>
<td>Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments</td>
</tr>
<tr>
<td>22808</td>
<td>Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments</td>
</tr>
<tr>
<td>22810</td>
<td>Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments</td>
</tr>
</tbody>
</table>
22812 Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments
22818 Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or 2 segments
22819 Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); 3 or more segments
22840 Posterior non-segmental instrumentation (eg. 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 (eg, 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 (eg, 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 (eg, 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 or 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)
22853 Insertion of intervertebral biomechanical device(s) (eg, 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) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
22859 Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
27280 Arthrodesis, open, sacroiliac joint, including obtaining graft, including instrumentation, when performed.
G. Review Process

1. The Medical Management staff assigned to review obtains the clinical information according to the policy, to determine if there is adequate clinical information. If the case does not meet the established criteria, it is referred to a Medical Director.
2. If referred, the Medical Director determines if the requested service is medically necessary and appropriate according to the policy.
3. The Medical Management staff completes the review process and communicates the review decision according to the policy for the member’s benefit plan.

H. Records Retention

Records Retention for documents, regardless of medium, is provided within the UPMC Health System Policy for Records Retention, Management and Retirement, and as indicated in the UPMC Insurance Services Division Policy and Procedure for Records Retention.

Unless otherwise mandated by Federal or State law, or unless required to be maintained for litigation purposes, any communications recorded pursuant to this Policy are maintained for a minimum of ten (10) years from the date of recording.

I. References

Reference Disclaimer:

Please note the following:
- The links and the dates of publication and/or latest revisions for all references below are current as of the Revision Date of this policy.
- Not all the links are free-access. Some of the references may require site registration, subscription and/or purchase to download the information cited.

Medical Literature/Clinical Information:

4. UPMC Health Plan. Low Back Pain Program – Primary Care Physician Guide. Last updated: 06/19/2012.


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UPMC Health Plan reserves the right to review and update the medical payment and prior authorization guidelines in its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.

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