Spinal Surgery

LOB(s):	State(s):
☒ *Commercial* ☒ *Medicare*	☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*
☒ *Medicaid*	☒ *Oregon*

Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

Standard therapy for back pain includes conservative medical management such as physical therapy and medications. Surgical treatment, such as spinal fusion at the affected level, may be considered for patients who have not improved with conservative medical management or who have a severe neurological impairment.

Age-related degeneration of the spine is often referred to as spondylosis. Lumbar spondylosis can refer to degenerative arthritis, spinal stenosis, herniated discs, and facet joint arthritis. Spinal stenosis is a narrowing of the central spinal canal, the intervertebral foramina, and/or neural canals. A herniated (or slipped) disc occurs when a disc between the vertebrae is damaged and the inner gel-like substance (nucleus pulposus) either bulges or protrudes through the tougher outer layer of the disk (annulus). Most disc herniations occur in the lumbar spine and may put pressure on the nerves that exit the spinal cord. This pressure may cause pain and weakness in the leg, referred to as radicular pain or radiculopathy.

This policy pertains to non-urgent, non-emergent instrumented surgeries of the cervical, thoracic, and lumbar spine, sacroiliac joint, treatment of scoliosis in adults and pediatric members, artificial disc arthroplasty, and bone and tendon grafts.

Criteria

Commercial

Prior authorization is required.

PacificSource considers spine surgery to be medically necessary when the criteria outlined in Carelon Musculoskeletal Spine Surgery Guideline is met. PacificSource also follows the PacificSource Spinal Surgery policy for Experimental, Investigational, or Unproven determinations.

Medicaid

PacificSource Community Solutions follows an internal hierarchal process in the “Clinical Criteria Used in UM Decisions” policy for coverage of Spinal Surgeries. PCS covers these services when the condition and service(s) pair on a funded line on the HERC Prioritized List of Health Services, any relevant Guideline criteria is fulfilled, and service(s) are medically/orally necessary and appropriate for the specific member. Additional coverage options for unfunded conditions and services are provided as described in Covered Services OAR 410-141-3820. Treatment may be limited or excluded if the service meets the criteria outlined in OARs 410-141-3825 and 410-120-1200, except as otherwise provided in the Covered Services Rule.

PacificSource follows the “Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)” criteria for members under 21 and Young Adults with Special Health Care Needs (YSHCN).

PCS follows the “Unlisted and Unspecified Procedure Codes” policy for requests for unlisted codes.

Medicare

PacificSource Medicare follows CMS guidelines and criteria set forth by National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). In the absence of CMS guidelines and criteria, PacificSource Medicare follows Carelon Musculoskeletal Spinal Surgery Clinical Guideline for coverage and medical necessity determinations.

Experimental/Investigational/Unproven

PacificSource considers the following spinal surgeries, procedures, devices, and spacers to be experimental, investigational, or unproven (not an inclusive list):

Percutaneous and Endoscopic Spinal Surgery

- Automated Percutaneous Lumbar Discectomy (APLD), Stryker DeKompressor, or ArthoSpine Wand (62287)
- Percutaneous endoscopic lumbar discectomy (PELD) (62287)
- Image-guided minimally invasive lumbar decompression (MILD®) for Spinal Stenosis (62330. 62331), Cervical / Thoracic (0274T)*
- DTRAX® Facet System (0219T,22899)
- DISC Nucleoplasty (Radiofrequency Coblation) a percutaneous disc decompression (PDD) or radiofrequency coblation -used to treat herniated discs (e.g., ArthroCare System, Per-D Spine Wand) (S2348)*

Percutaneous Vertebral Disc and Vertebral Endplate Procedures

- IDET with the SpineCath®, IntraDiscal, ElectroThermal Therapy (IDET™) System, Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT), The Radionics® discTRODE™ (probe) system, TransDiscal™ System (22526, 22527)

Implanted Devices for Spinal Stenosis

- The coflex® Interlaminar Technology, Superion® Indirect Decompression System, Total Posterior Spine System (TOPS™),ExtenSure Bone Allograft Interspinous Spacer, Dynesys System (Zimmer Spine), XYcor Spinal Implant (Vertebration, Inc., by AlphatecSpine), Dynamic Spinal Stabilization and Interspinous Decompression Devices (22867, 22868, 22869, 22870, 0202T, C1821)

Interspinous Process Fixation Devices

- Aspen® Spinous Process Fixation System, HORIZON® SPIRE™ , PrimaLOK™ SP Interspinous Fusion System, BacFuse® Spinous Process Fusion Plate, Minuteman Fusion Fixation device, Coflex (Paradigm Spine), Superion (VertiFlex, Inc.) Inspan Spinous Process, StabiLink, SP-fix (22899)

Intervertebral Stabilization Devices

- Isobar™ Spinal System, Dynesys® Spinal System, DSSTM Stabilization System, BioFlex (22899)

Facet Joint Allograft Implants for Facet Disease

- NuFix™, TruFUSE® Allograft (0219T, 0220T, 0221T, 0222T)
- Posterior intrafacet implant (0219T, 0220T, 0221T, 0222T)

Lumbar Interbody Fusion

- Axial Lumbar Interbody Fusion (AxiaLIF), AxiaLIF II, a percutaneous pre-sacral access route to the L5 - S1 vertebral bodies for spinal fusion (22586)*

Annulus Closure After Discectomy

- Xclose® Tissue Repair System, Inclose™ Surgical Mesh System, Barricaid® Annular Closure Device (ACD), Disc Annular Repair Technology (DART) System, The Discseel® procedure (C9757)

Scoliosis Surgery

- Vertebral Body Tethering-he Tether™ Vertebral Body Tethering System, Minimally Invasive Deformity Correction System, Vertebral Body Stapling, Magnetically Controlled Growing Rods-MAGnetic Expansion Control (MAGEC®) System (22836, 22837, 22838, 0656T, 0657T, 0790T)

SI Joint Fusion

- 3D printed titanium implants for minimally invasive sacroiliac joint fusion: (e.g., iFuse-3D™ (SI Bone)) (27299)

Note: * indicates the item remains E/I/U but will not be reviewed annually by the NTOC Committee, unless requested.

Note: PacificSource Community Solutions (PCS) and PacificSource Medicare require items listed on this policy's E/I/U list, to be reviewed by medical necessity review guidelines. Please see related policy,

“Clinical Criteria Used in UM Decisions” to review criteria hierarchy and “Medical Necessity Reviews” for determination of coverage and medical necessity guidelines.

Coding Information

The following list of codes are for informational purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

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

0219T Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical

0220T Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic

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)

0274T Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic

0656T Anterior lumbar or thoracolumbar vertebral body tethering; up to 7 vertebral segments

0657T Anterior lumbar or thoracolumbar vertebral body tethering; 8 or more vertebral segments

0790T Revision (eg, augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed

20999 Unlisted procedure, musculoskeletal system, general

22526 Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level

22527 Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)

22586 Arthrodesis, Pre-Sacral Interbody Tech, With Posterior Instrumentation, With Image Guidance, L5-S1 Interspace

22836 Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments

22837 Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments

22838 Revision (e.g., augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed

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)
22899	Unlisted procedure, spine
27299	Unlisted procedure, pelvis, or hip joint –
62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar
62330	Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (i.e., CT or fluoroscopy), bilateral; one interspace, lumbar
62331	Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (i.e., CT or fluoroscopy), bilateral; additional interspace(s), lumbar (List separately in addition to code for primary procedure)
C1821	Interspinous process distraction device (implantable)
S2348	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single or multiple levels, lumbar

Related Policies

New and Emerging Technology-Coverage Status

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MCG Cervical Fusion, Anterior ORG: S-320 (ISC)

MCG Cervical Fusion, Posterior ORG: S-330 (ISC)

MCG Lumbar Fusion ORG: S-820 (ISC)

MCG Musculoskeletal Surgery or Procedure GRG: SG-MS (ISC)

MCG Removal of Posterior Spinal Instrumentation ORG: S530 (ISC)

MCG Spine, Scoliosis, Posterior Instrumentation ORG: S-1056 (ISC)

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Appendix

Policy Number:

Effective: 4/23/2013 **Next review:** 10/1/2026

Policy type: Enterprise

Author(s):

Depts: Health Services

Applicable regulation(s): OARs 410-141-3820, 410-141-3825, 410-120-1200, OARs 410-151-0000 through 410-151-0003;, LCD L38033, NCD 150.10

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