Instrumented Spinal Surgery

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

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, and treatment of scoliosis in adults and pediatric members.

Criteria

Commercial

Prior authorization is required

I. Cervical Instrumented Fusions

Multilevel (2 or more levels) fusions require MD review even when criteria is met.

A. Anterior Cervical Fusion

PacificSource may consider anterior cervical fusion to be medically necessary when **ALL** of the following criteria are met:

1. MCG criteria for Cervical Fusion, Anterior ORG: S-320 (ISC)
2. Documented failure of 3 consecutive months of physician-directed conservative care during current episodes of pain including **ALL** of the following:
   a. Physical therapy or chiropractic treatment
   b. Prescription strength analgesics, steroids and/or NSAIDS

OR

   c. Documentation of contraindication(s) for conservative care.

3. Tobacco/Nicotine Cessation:
   a. Documentation of non-smoking status **OR** abstinence from smoking for 6 weeks prior to procedure.
   b. Does not apply to urgent/emergent cases.

B. Posterior Cervical Fusion

PacificSource may consider posterior cervical fusion to be medically necessary when **ALL** of the following criteria are met:

1. MCG for Cervical Fusion, Posterior ORG: S-330 (ISC)
2. Documented failure of 3 consecutive months of physician-directed conservative care during current episodes of pain including **ALL** of the following:
   a. Physical therapy or chiropractic treatment
   b. Prescription strength analgesics, steroids and/or NSAIDS

OR

   c. Documentation of contraindication(s) for conservative care.

3. Tobacco/Nicotine Cessation:
   a. Documentation of non-smoking status **OR** abstinence from smoking for 6 weeks prior to procedure
   b. Does not apply to urgent/emergent cases

II. Thoracic Instrumented Fusion

Multilevel (2 or more levels) fusions require MD review even when criteria is met

PacificSource may consider thoracic instrumented fusion to be medically necessary when **BOTH** of the following criteria is met:

A. Member has diagnosis of **ONE** of the following conditions:

1. Thoracic kyphosis resulting in spinal cord compression and related symptoms (e.g., pain, numbness, weakness, or tingling of an extremity)

2. Thoracic kyphotic curve greater than 75 degrees

a. Refractory to bracing

b. Documented failure of 3 consecutive months of physician-directed conservative care including **ALL** of the following:

- Prescription strength analgesics, steroids and/or NSAIDS
- Physical therapy or chiropractic treatment

OR

- Documentation of contraindication(s) for conservative care

3. Thoracic pseudoarthrosis when **BOTH** of the following is met:

a. 12 months or more post-thoracic fusion surgery

b. Evidence of thoracic compression

4. Thoracic pseudoarthrosis when **ONE** of the following is met:

a. Hardware failure (e.g., movement of implants or vertebrae at site of prior arthrodesis on radiological imaging)

b. Fracture/disconnection/dislocation of implants

c. Lucent rims around the screws on imaging.

5. Spondylolisthesis with segmental instability confirmed imaging when **ALL** of the following criteria is met:

a. Spondylolisthesis is grade II, III, IV or V

b. Documented failure of 6 consecutive weeks of physician-directed conservative care during current episodes of pain including **ALL** of the following:

- Physical therapy or chiropractic treatment
- Prescription strength analgesics, steroids and/or NSAIDS

OR

- Documentation of contraindication(s) for conservative care, must be specific to the current pain episode

6. Spinal infection confirmed by CT or MRI

7. Spinal tumor, primary or metastatic to spine, confirmed by CT or MRI

8. Spinal fracture or dislocation associated with mechanical instability, locked facets, or displaced fracture fragment, confirmed by imaging
9. Spinal stenosis, where decompression is performed in areas of segmental instability, demonstrated by gross movement on flexion-extension radiological imaging, or has areas of significant degenerative instability.

AND

B. Tobacco/Nicotine Cessation

1. Documentation of non-smoking status OR abstinence from smoking for 6 weeks prior to procedure
2. Does not apply to urgent/emergent cases

III. Lumbar Instrumented Fusions

Multilevel (2 or more levels) fusions require MD review even when criteria is met

A. Lumbar Instrumented Fusion

PacificSource may consider Lumbar Instrumented Fusion to be medically necessary when **ALL** of the following criteria is met:

1. MCG for Lumbar Fusion ORG: S-820 (ISC)
2. Documented failure of 3 consecutive months of physician-directed conservative care during current episodes of pain including **ALL** of the following:
   - **a.** Physical therapy or chiropractic treatment
   - **b.** Prescription strength analgesics, steroids and/or NSAIDS

   OR

   - **c.** Documentation of contraindication(s) for conservative care

AND

3. Tobacco/Nicotine Cessation
   - **a.** Documentation of non-smoking status **OR** abstinence from smoking for 6 weeks prior to procedure
   - **b.** Does not apply to urgent/emergent cases

B. Lumbar Instrumented Fusion for Recurrent Disc Herniation

PacificSource may consider Lumbar Instrumented Fusion for recurrent disc herniation at same level to be medically necessary when **ALL** of the following criteria is met:

1. Two prior disc surgeries (discectomies or microdiscectomies) at the same level with documented initial relief of symptoms
2. At least 3 months since the most recent disc surgery
3. Objective findings of neurological function impairment (e.g., changes in strength, sensation, or reflexes)
4. Documented failure of 3 consecutive months of physician-directed conservative care during current episode of pain must include **ALL** of the following:

a. Physical therapy or chiropractic treatment

b. Prescription strength analgesics, steroids and/or NSAIDS

OR

c. Documentation of contraindication(s) for conservative care must be specific to the current pain episode

5. Tobacco/Nicotine Cessation

a. Documentation of non-smoking status **OR** abstinence from smoking for 6 weeks prior to procedure

b. Does not apply to urgent/emergent cases

IV. SpineJack System

PacificSource may consider the SpineJack system for treatment of debilitating pain in the cervical, thoracic, or lumbar vertebral bodies from debilitating osteoporotic collapse/compression fractures (e.g., Kummell's disease) **OR** debilitating traumatic vertebral compression fractures to be medically necessary when **ALL** of the following is present:

A. Other causes of pain have been ruled out by CT or MRI (e.g., herniated intervertebral disk)

B. Severe debilitating pain or loss of mobility cannot be controlled with medical therapy (e.g., medications, braces, physical therapy)

C. The affected vertebra has not been extensively destroyed and is at least 1/3 of its original height

V. Sacroiliac Joint Fusion (SIJ)

A. SIJ Minimally Invasive Fusion/Stabilization

PacificSource may consider SIJ Minimally Invasive Fusion/Stabilization (e.g., i-Fuse Implant System®) to be medically necessary when **ALL** of the following criteria is met:

1. Significant pain originating from sacroiliac joint (e.g., pain rating of at least 5, on 0 to 10 numeric scale)

2. Sacroiliac joint diagnosed as etiology of pain by response (pain) to 3 or more provocative examination maneuvers that stress the sacroiliac joint (e.g., FABER test, thigh thrust, pelvic gapping test, pelvic compression, Gaenslen test)

3. Confirmation of sacroiliac joint etiology via pain relief of at least 50% (i.e., on visual analogue scale) from needle injection of local anesthetic into sacroiliac joint

4. Failure to respond to at least 6 months of alternative treatments consisting of analgesics (e.g., NSAIDs) and 1 or more of the following:

a. Physical therapy

b. Sacroiliac joint steroid injection

5. Alternative or contributing diagnoses absent (e.g., hip osteoarthritis, L5-S1 spine degeneration, tumor, infection, fracture)

Note: PacificSource considers 3D printed titanium implants (e.g., iFuse-3D™ (SI Bone)) for minimally invasive sacroiliac joint fusion to be experimental, investigational, or unproven

VI. Scoliosis Treatment

A. Scoliosis Adult

PacificSource may consider instrumented spinal surgery for treatment of scoliosis in adult members to be medically necessary when criteria outlined in MCG: Spine, Scoliosis, Posterior Instrumentation guidelines ORG: S-1056 (ISC) is met.

B. Scoliosis Pediatric

PacificSource may consider instrumented spinal surgery for treatment of scoliosis in pediatric members to be medically necessary when criteria outlined in MCG: Spine, Scoliosis, Posterior Instrumentation, Pediatric guidelines ORG: P-1056 (ISC) is met.

Medicaid

PacificSource Community Solutions (PCS) follows the general coverage requirements, limitations, and exclusions outlined in OARs 410-141-3820 and 410-141-3825 for coverage of spinal surgeries in adult members, 21 years and older. Members must also meet criteria specified in any relevant Guideline Notes of the Health Evidence Review Commission (HERC) Prioritized List of Health Services.

For Cervical, Thoracic, or Lumbar Instrumented Fusions, PCS follows Guideline Notes 37, 100, 101, & 136 of the Prioritized List

For coverage of spinal surgery for scoliosis, PCS follows Guideline Note 41 and 100.

For coverage of sacroiliac joint (SIJ) fusions, PCS follows Guideline Note 161.

PacificSource Community Solutions (PCS) follows the PS policy Unlisted and Unspecified Procedure Codes for Reimbursement Purposes for all requests containing Unlisted Procedure codes.

For CPT codes 0275T, 22867, 22868, 22869, 22870, C1821, and C9757, PCS follows Guideline Note 173. There is insufficient evidence of the effectiveness of these treatments.

PacificSource Community Solutions (PCS) follows the EPSDT coverage requirements in OAR 410-151-0002 and 410-151-0003 for members under the age of 21. Coverage is determined through case-by-case reviews for EPSDT Medical Necessity and EPSDT Medical Appropriateness defined in OAR 410-151-0001. The coverage guidance in the Prioritized List, including any relevant Guideline Notes, may be used to assist in informing a determination of medical necessity and medical appropriateness during the individual case review.

Medicare

PacificSource Medicare follows CMS guidelines and criteria. In the absence of CMS guidelines and criteria, PacificSource Medicare will follow internal policy for determination of coverage and medical necessity.

Experimental/Investigational/Unproven

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

- Automated Percutaneous Lumbar Discectomy (APLD) Stryker DeKompressor or ArthoSpine Wand
- Axial Lumbar Interbody Fusion (AxiaLIF) a percutaneous pre-sacral access route to the L5 - S1 vertebral bodies for spinal fusion
- Barricaid Annular Closure Device implant

- Dynesys System (Zimmer Spine)
- Dynamic Spinal Stabilization and Interspinous Decompression Devices for Sacroiliac Joint Fusion,
- ExtenSure Bone Allograft Interspinous Spacer (NuVasive, Inc.)
- Interspinous fixation devices (e.g., CD Horizon Spire Spinal System, Minuteman Fusion Fixation device, Coflex (Paradigm Spine), Superion (VertiFlex, Inc.)
- Isobar (Scient'X')
- LinQ Allograft Spacer; SIFix, SiLO TFX MIS
- MAGnetic Expansion Growing Rods (MaGEC Rods)- The MAGEC™ (MAGnetic Expansion Control) Spinal Growing Rod for treatment of scoliosis for all other indications than listed above~~.~~
- Percutaneous Sacroplasty (also known as Percutaneous sacral augmentation)
- Percutaneous sacroiliac joint fusion procedures (Posterior Approach) for treatment of scoliosis, and spacers (not an inclusive list):
    - Dynesys System (Zimmer Spine)
    - Dynamic Spinal Stabilization and Interspinous Decompression Devices
    - ExtenSure Bone Allograft Interspinous Spacer (NuVasive, Inc.)
    - Isobar (Scient'X')
    - LinQ Allograft Spacer; SIFix, SiLO TFX MIS
- Percutaneous image guided Minimally Invasive spinal Decompression (MILD) surgery (e.g., Vertos)
- Posterior intrafacet implant
- Sacroiliac Joint Fusion, to be experimental, investigational, or unproven for all other indications than listed above.
- SynFix-LR (Synthes Spine) used in Laparoscopic Anterior Lumbar Interbody Fusion (LALIF) surgery
- XYcor Spinal Implant (Vertebration, Inc.~~ purchased~~ by AlphatecSpine)
- 3D printed titanium implants for minimally invasive sacroiliac joint fusion: (e.g., iFuse-3D™ (SI Bone))

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.

0200T Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed

0201T Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed

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

0275T 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; lumbar

22513 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic

22514 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance ;lumbar

22515 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional 0200Tthoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

22532 Arthrodesis, lateral extra cavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic

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)

22548 Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process

22551 Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2

22552 Cervical below C2, each additional interspace (List separately in addition to code for separate procedure)

22554 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2

22556 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic

22558 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar

22585 Each additional interspace (List separately in addition to code for primary procedure)

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

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

22610 Arthrodesis, posterior or posterolateral technique, single level; thoracic (with or without lateral transverse technique)

22612 Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)

22614 each additional vertebral segment (List separately in addition to code for primary procedure) [code not specific to cervical spine]

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)

22633 Arthrodesis, Combined Post or Postlatl Tech W Post Interbdy Tech, Incl. Laminectomy &/Discectomy, Sgl Interspace & Segmt; Lumbar

22634 Arthrodesis, Combined Post Or Postlatl Tech W Post Interbdy Tech, Incl Laminectomy &/Discectomy,Sgl Interspace & Segmt; Ea. Addl.

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,

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 one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)

22841 Internal spinal fixation by wiring of spinous process

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 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

22845 Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)

22846 4 to 7 vertebral segments (List separately in addition to code for primary procedure)

22847 Anterior instrumentation; 8 or more vertebral segments

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

22853 Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace

22854 Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect

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.

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

27278 Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device

27279 Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of –

27299 Unlisted procedure, pelvis, or hip joint -

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:** 7/1/2025

Policy type: Enterprise

Author(s):

Depts: Health Services

Applicable regulation(s):

Commercial OPs: 9/2024

Government OPs: 8/2024