I. Policy: Elective Spinal Fusion

II. Purpose/Objective:
To provide a policy of coverage regarding Elective Spinal Fusion

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) The service or benefit will assist the Member to achieve or maintain maximum functional
capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

DESCRIPTION: Spinal fusion is a surgical procedure used to stabilize the spine by fusing together 2 or more vertebrae which eliminates motion between the vertebral sections. The procedure involves placing extra bone (bone graft) to fill the space between the vertebrae and then secured using screws, rods, plates, or metal cage. Spinal fusion can be recommended for chronic low back pain, instability, weakness, or deformity when unresponsive to other treatments.

INDICATIONS: Requires Prior Medical Director or designee Authorization (Not applicable to Medicare, Medicaid and TPA business segments with the exception of GHP)

Elective cervical, thoracic, or lumbar spinal fusion is considered medically necessary when the following criteria are met:

1. Image studies confirming the diagnosis of any of the following:
   a. Spinal fracture with instability or neural compression
   b. dislocation, abscess and/or tumor requiring spinal repair
   c. Spinal tuberculosis

OR

2. Completed a spine evaluation and surgical intervention is recommended by the healthcare provider providing and overseeing treatment of the spine, and image studies confirm the diagnosis of any of the following:
   a. Spondylolisthesis or spinal stenosis with one or more of the following
      i. Neurogenic claudication or radicular pain
      ii. Documentation of lateral/central recess or foraminal stenosis
      iii. Functional impairment
   b. Severe degenerative scoliosis causing loss of function with one or more of the following
      i. Persistent axial pain
      ii. Persistent neurogenic symptoms including radicular pain or claudication
   c. Pseudoarthrosis causing one or more of the following
      i. Persistent axial or radicular pain
      ii. Functional impairment

EXCLUSIONS:
The Plan does NOT provide coverage for Spinal fusion as a treatment for degenerative disc disease or for any other indication not listed because it is considered experimental, investigational or unproven.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven services is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment

CODING ASSOCIATED WITH: Spinal Fusion

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services.

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)
22612 Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)

22614 Arthrodesis, posterior or posterolateral technique, single level; 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)

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 and segment; 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), single interspace and segment; each additional interspace and segment (List separately in addition to code for primary procedure)


LINE OF BUSINESS:
Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD’s and NCD’s will supersede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:


This policy will be revised as necessary and reviewed no less than annually.

Devised: 8/12

Revised: 5/13, 7/14, 6/19 (added indication)

Reviewed: 11/13, 7/15, 7/16, 6/17, 6/18