

## Provider Bulletin

Subject:	Spinal Surgery Coverage Guidelines		
Plan:	Coordinated Care Option 1	Bulletin Date:	October 28, 2014
Bulletin Number:	14-010	Effective Date:	November 1, 2014

The purpose of this bulletin is to inform all PCPs and participating surgeons performing Spine surgery (Orthopedic surgeons, Orthopedic-Spine Surgeons and Neurosurgeons), of updates to the coverage guidelines.

Effective November 1, 2014 all spine surgery procedures require pre-authorization. The Authorization Request Form must be submitted with appropriate documentation. The Authorization Fax# is 561-835-8606.

1. HCD will consider medical necessity for cervical, lumbar, or thoracic laminectomy for the following conditions:
  - A. Spinal fracture, dislocation (associated with mechanical instability), locked facets, *or* displaced fracture fragment confirmed by imaging studies (e.g., CT or MRI); *or*
  - B. Spinal infection confirmed by imaging studies (e.g., CT or MRI); *or*
  - C. Spinal tumor confirmed by imaging studies (e.g., CT or MRI); *or*
  - D. Epidural hematomas confirmed by imaging studies (e.g., CT or MRI); *or*
  - E. Synovial cysts causing spinal cord or nerve root compression with unremitting pain, confirmed by imaging studies (e.g., CT or MRI) and with corresponding neurological deficit, where symptoms have failed to respond to 12 weeks of continuous conservative therapy (unless there is evidence of acute cord compression, or progressive neurological deficit, which requires urgent intervention). Conservative treatment during course of illness includes NSAIDS or acetaminophen or other anti-inflammatory medications, home exercise or PT, and activity modification.
  - F. Other mass lesions confirmed by imaging studies (e.g., CT or MRI), upon individual case review.
2. HCD will consider medical necessity for spinal fusion for the following conditions:
  - A. Recent spinal fracture, dislocation, spinal instability (as demonstrated by flexion/extension radiographic studies, if appropriate) that correlate with displaced fracture fragment confirmed by imaging studies (e.g., CT or MRI), which may be combined with a laminectomy or corpectomy; *or*
  - B. Spinal infection confirmed by imaging studies (e.g., CT or MRI) and/or other studies (e.g., biopsy), which may be combined with a laminectomy or corpectomy; *or* Spinal tumor confirmed by imaging studies (e.g., CT or MRI), which may be combined with a laminectomy or corpectomy. (*Recent will be defined as within a one month period.*)



3. The following spinal procedures are unproven and are not covered by HCD:

- A. Spinal fusion, when performed via the following methods:
  - i. Laproscopic anterior lumbar interbody fusion (LALIF)
  - ii. Minimally invasive transformaminal lumbar interbody fusion (MITILF) which utilizes only endoscopic visualization (such as a percutaneous incision with video visualization)
  - iii. Axial lumbar interbody fusion (ALIF) and axial sacral interbody fusion (transI)
  - iv. Interlaminar lumbar instrumented fusion (eg. ILIF)  
*This includes interbody cages (for example PEEK, titanium etc), screws or devices with any of the above procedures.*
- B. Spinal Decompression utilizing:
  - i. Interspinous process decompression (IPD) systems, such as the X-STOP for the treatment of spinal stenosis
  - ii. Minimally invasive lumbar decompression (MILD)
- C. Spinal Stabilization utilizing:
  - i. Dynamic Stabilization System such as Dynesys ® or the DSS Stabilization System for the treatment of degenerative spondylolisthesis
  - ii. Total facet joint arthroplasty, including facetectomy, laminectomy, foraminotomy, vertebral column fixation,
  - iii. Percutaneous sacral augmentation (sacroplasty) with or without a balloon or bone cement for the treatment of back pain
- D. Stand alone facet fusion without an accompanying decompressive procedure. This includes procedures performed with or without bone grafting and/or the use of posterior intrafacet implants such as fixation systems, facet screw systems or anti-migration dowels.
- E. Disc replacement surgery.

- 4. HCD does not cover lumbar spinal fusion, foramenotomy, or discectomy associated with chronic degenerative disc disease or spinal stenosis. *Emergency treatment for disc herniation associated with acute spinal cord injury and cauda equina syndrome will be considered on a case by case basis.*
- 5. HCD does not cover repeat spinal surgery in persons with prior spinal surgery for pain management, including pseudoarthrosis, unless there exists an acute condition (eg. spinal cord injury, cauda equina syndrome) when any of the above criteria is met.
- 6. HCD does not cover corrective surgery for congenital spinal scoliosis.
- 7. Patients must be tobacco free or have discontinued smoking/tobacco use for 8 weeks prior to surgery for spinal fusion surgery.
- 8. All spinal surgeries/procedures require authorization.

If you have questions regarding this bulletin, please contact your Provider Representative at (561) 659-1002.

Please insert this bulletin into your Provider Handbook. The policies and procedures in this bulletin supersede any related policies and procedures within the handbook.