Policy Statement

Indications for Lumbar and Pre-Sacral Surgery: (This section of the clinical guidelines provides the clinical criteria each of the lumbar and pre-sacral spine surgery categories.)

- **Indications for Lumbar Discectomy/Microdiscectomy - Surgical indications for inter-vertebral disc herniation**:  
  - Primary radicular symptoms noted upon clinical exam that significantly hinders daily activities; AND  
  - Failure to improve with at least six consecutive weeks of appropriate conservative treatment. Appropriate conservative treatment should include a structured program of physical therapy and/or lumbar epidural steroid injections at minimum. Other treatments (chiropractic, NSAIDS, etc.) may also be employed; AND  
  - Imaging studies showing evidence of inter-vertebral disc herniation that correlate exactly with the patient’s symptoms/signs

*Other indications: Microdiscectomy may be used as the first line of treatment (no conservative treatment required) in the following clinical scenarios:  
  - Progressive nerve compression resulting in an acute motor neurologic deficit sensory or motor due to herniated disc. The neurological deficits should be significant: 0-2/5 on the motor function scale for L5 or S1 roots; 0-3/5 for L3 or L4 roots. Lesser degrees of motor dysfunction may resolve with conservative treatment and are not considered an indication for early surgery; OR  
  - Cauda equina syndrome (loss of bowel or bladder control).

NOTE: Percutaneous lumbar discectomy or radiofrequency disc decompression procedures are deemed investigational procedures and are not approved.

- **Indications for Lumbar Decompression: Laminectomy, Facetectomy and Foraminotomy**  
  These procedures allow decompression by partial or total removal of various parts of vertebral bone and ligaments. Surgical Indications for spinal canal decompression due to lumbar spinal stenosis*:  
  - Neurogenic claudication, and/or radicular leg pain that impairs daily activities for at least twelve (12) weeks; AND  
  - Failure to improve with at least 6 weeks of appropriate conservative therapy. Appropriate conservative treatment should include a structured program of physical therapy and/or lumbar epidural steroid injections at minimum. Other treatments (chiropractic, NSAIDS, etc.) may also be employed; AND  
  - Imaging findings consistent with clinical signs/symptoms; AND  
  - Imaging studies do not show evidence of significant spinal instability. Significant instability is defined as greater than 3mm spondylolisthesis or greater than 3mm shift on lateral flexion/extension films.

*Other Indications: Lumbar decompression may be used as the first line of treatment (no conservative treatment required) in any of the following clinical scenarios:  
  - Progressive nerve compression resulting in an acute neurologic (sensory or motor) deficit. The neurological deficits should be significant: 0-2/5 on the motor function scale for L5 or S1 roots; 0-3/5 for L3 or L4 roots. Lesser degrees of motor dysfunction may resolve with conservative treatment and are not considered an indication for early surgery.  
  - Cauda equina syndrome (loss of bowel or bladder control)  
  - Spinal stenosis due to tumor, infection, or trauma
Indications for Lumbar Spine Fusion: Single Level With or Without Decompression

Because of variable outcomes with fusion surgery, patients should be actively involved in the decision-making process and provided appropriate decision-support materials when considering this intervention. The following indicators must be present:

- Lumbar back pain, neurogenic claudication, and/or radicular leg pain without sensory or motor deficit that impairs daily activities for at least 6 months; AND
- Failure to improve with at least 6 weeks of appropriate conservative therapy. Appropriate conservative treatment should include a structured program of physical therapy and/or lumbar epidural steroid injections at minimum. Other treatments (chiropractic, NSAIDS, etc.) may also be employed; AND
- Imaging studies corresponding to the clinical findings; AND
- At least one of the following clinical conditions:
  a. Spondylolisthesis [Neural Arch Defect - Spondylolytic spondylolisthesis, degenerative spondylolisthesis, and congenital unilateral neural arch hypoplasia]; OR
  b. Evidence of segmental instability - Excessive motion, as in degenerative spondylolisthesis, segmental instability, and surgically induced segmental instability; OR
  c. Revision surgery for failed previous operation(s) for pseudoarthrosis at the same level at least 6-12 months from prior surgery** if significant functional gains are anticipated; OR
  d. Revision surgery for failed previous operation(s) repeat disk herniations if significant functional gains are anticipated; OR
  e. Fusion for the treatment of spinal tumor, cancer, or infection; OR
  f. Chronic low back pain or degenerative disc disease must have failed at least 6 months of active non-operative treatment (completion of a comprehensive cognitive-behavioral rehabilitation program is mandatory) and must be evaluated on a case-by-case basis.

*Other Indications: Lumbar spinal fusion may be used as the first line of treatment (no conservative treatment required) in the following clinical scenarios:

- Progressive nerve compression resulting in an acute neurologic deficit (motor) AND one of the aforementioned clinical conditions, except chronic low back pain or degenerative disc disease. The neurologic deficits must be significant: 0-2/5 on the motor function scale for L5 or S1 roots; or 0-3/5 for L3 or L4 roots. Lesser degrees of motor dysfunction may resolve with conservative treatment and are not considered an indication for early surgery.
- Cauda equina syndrome (loss of bowel or bladder control)

** Repeat Lumbar Spine Fusion Operations: Repeat lumbar fusion operations will be reviewed on a case-by-case basis upon submission of medical records and imaging studies that demonstrate remediable pathology. The below must also be documented and available for review of repeat fusion requests:

- Rationale as to why surgery is preferred over other non-invasive or less invasive treatment procedures.
- Signed documentation that the patient has participated in the decision-making process and understands the high rate of failure/complications.

Instrumentation, bone formation or grafting materials, including biologics, should be used at the surgeon’s discretion; however, use should be limited to FDA approved indications regarding the specific devices or biologics.

NOTE: Pre-sacral, axial lumbar interbody fusion (AxiaLIF) is not an approved surgical approach due to insufficient evidence. Pre-Sacral Fusion Codes: 0195T, +0196T, 22586, 0309T.
• **Indications for Multi-Level Fusions With or Without Decompression** (All multi-level fusion surgeries will be reviewed on a case-by-case basis). Because of variable outcomes with fusion surgery, patients should be actively involved in the decision-making process and provided appropriate decision-support materials when considering this intervention. The following clinical indications must be present*:

  o Lumbar back pain, neurogenic claudication, and/or radicular leg pain without sensory or motor deficit that impairs daily activities for at least 6 months; AND

  o Failure to improve with at least 6 weeks of appropriate conservative therapy. Appropriate conservative treatment should include a structured program of physical therapy and/or lumbar epidural steroid injections at minimum. Other treatments (chiropractic, NSAIDS, etc.) may also be employed; AND

  o Imaging studies corresponding to the clinical findings; AND

  o At least one of the following clinical conditions:

    a. Multiple level spondylolisthesis; OR

    b. Fusion for the treatment of spinal tumor, trauma, cancer, or infection affecting multiple levels; OR

    c. Intra-operative segmental instability

*Other Indications: Lumbar spinal fusion may be used as the first line of treatment (no conservative treatment required) in the following clinical scenario:

  o Progressive nerve compression resulting in an acute neurologic deficit (motor), AND

    one of the aforementioned clinical conditions. The neurological deficits must be significant: 0-2/5 on the motor function scale for L5 or S1 roots; or 0-3/5 for L3 or L4 roots. Lesser degrees of motor dysfunction may resolve with appropriate conservative treatment and are not considered an indication for early surgery.

Instrumentation, bone formation or grafting materials, including biologics, should be used at the surgeon’s discretion; however, use should be limited to FDA approved indications regarding the specific devices or biologics.

• **Indications for Lumbar Artificial Disc Replacement**

Lumbar total disc arthroplasty (artificial disc replacement) may be considered medically necessary when all of the following indications are met:

  o The individual is between the ages of 18 to 60

  o Degenerative disc disease, or significant discogenic back pain with disc degeneration, is confirmed by documented patient history, physical examination and key radiographic studies outlined below, with no more than Grade 1 (low level) spondylolisthesis demonstrated on x-ray at the operative level

  o Imaging confirms absence of significant facet arthropathy at operative level

  o At least six months of non-operative (conservative) treatment have failed to resolve symptoms (See Note*)

  o Disc reconstruction with the device is performed at only one (single) level using an anterior retroperitoneal approach

  o The device used as the disc replacement device is FDA-approved for lumbar disc replacement and is used in accordance with FDA labelling

  o There are no contraindications to lumbar artificial disc replacement, including but not limited to (see Note**):

    ▪ Disease above L4-L5 (L3-L4 for ProDiscL)

    ▪ Active systemic or local infection

    ▪ Osteoporosis or osteopenia (DEXA bone mineral density T-score less than or equal to -1.0), or vertebral bodies compromised by disease or prior trauma

    ▪ Allergy or sensitivity to implant materials

    ▪ Isolated lumbar radiculopathy (especially due to hemiated disc), or chronic radiculopathy (unremitting especially leg symptoms lasting over 1 year)

    ▪ Spinal stenosis, or spinal deformity (scoliosis)

    ▪ Spondylolisthesis greater than Grade 1
- Disc degeneration requiring treatment at more than one level
- Severe facet arthrosis or joint degeneration
- Presence of free disc fragment
- Myelopathy

Artificial lumbar disc replacement is considered not medically necessary in all other circumstances, including artificial disc arthroplasty done at more than one spinal level, and hybrid (combination artificial disc and fusion) procedures.

NOTE*: Conservative care is focused multi-modal nonoperative treatment that must include a physical therapy/rehabilitation program with cognitive-behavioral components. Treatment may also include pain management injections and active exercise programs. This must be clearly outlined in the medical record.

NOTE**: Contraindications are related to the level being considered for surgery.

Contraindications for Spine Surgery (Note: Cases will not be approved if the below contraindications exist):
- Medical contraindications to surgery, e.g., severe osteoporosis; infection of soft tissue adjacent to the spine and may be at risk for spreading to the spine; severe cardiopulmonary disease; anemia; malnutrition and systemic infection
- Psychosocial risk factors. It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions mimicking radiculopathy or instability (e.g., peripheral neuropathy, piriformis syndrome, myofascial pain, sympathetically mediated pain syndromes, sacroiliac dysfunction, psychological conditions, etc.) prior to consideration of elective surgical intervention. Patients with clinically significant depression or other psychiatric disorders being considered for elective spine surgery will be reviewed on a case-by-case basis and the surgery may be denied for risk of failure.
- Active Tobacco or Nicotine use prior to fusion surgery. Patients must be free from smoking and/or nicotine use for at least six weeks prior to surgery and during the entire period of fusion healing.
- Morbid Obesity. Contraindication to surgery in cases where there is significant risk and concern for improper post-operative healing, post-operative complications related to morbid obesity, and/or an inability to participate in post-operative rehabilitation. These cases will be reviewed on a case-by-case basis and may be denied given the risk of failure.

Policy Guidelines

This lumbar surgery guideline does not address spinal deformity surgeries or the clinical indications for spinal deformity surgery [CPT codes 22800-22812].

Conservative Therapy: (musculoskeletal) includes primarily physical therapy and/or injections; and a combination of modalities, such as rest; ice, heat; modified activities; medical devices, (such as crutches, immobilizer, metal braces, orthotics, rigid stabilizer or splints, etc and not to include neoprene sleeves), medications, diathermy, chiropractic treatments, or physician supervised home exercise program. Part of this combination may include the physician instructing patient to rest the area or stay off the injured part.

Home Exercise Program - (HEP) – the following two elements are required to meet guidelines for completion of conservative therapy:
- Information provided on exercise prescription/plan AND
- Follow up with member with information provided regarding completion of HEP (after suitable 4-6 week period), or inability to complete HEP due to physical reason- i.e. increased pain, inability to physically perform exercises. (Patient inconvenience or noncompliance without explanation does not constitute “inability to complete” HEP).
Claims Billing & Coding:
NIA uses a combination of internally developed edits in addition to an enhanced set of industry standard editing. NIA’s Claims Edit Module is a group of system edits that run multiple times per day. Edits that are part of this module include industry standard edits that apply to spine surgery services and NIA custom edits developed specifically for spine surgery. The following describes each of the edits NIA applies:

- **Outpatient Code Editor (OCE):** This edit performs all functions that require specific reference to HCPCS codes, HCPCS modifiers, and ICD-9-CM diagnosis codes. The OCE only functions on a single claim and does not have any cross claim capabilities. NIA is consistent with CMS.

- **National Correct Coding Initiative (NCCI) editing:** The edit prevents improper payment when incorrect code combinations are reported. The NCCI contains two tables of edits. The Column One/Column Two Correct Coding Edits table and the Mutually Exclusive Edits table include code pairs that should not be reported together for a number of reasons explained in the Coding Policy Manual. NIA is consistent with CMS.
  - Incidental edits: This edit applies if a procedure being billed is a component of another procedure that occurred on the same date of service for the same provider and tax ID and claimant.
  - Mutually exclusive editing: This edit applies if a procedure being billed is mutually exclusive with a procedure that occurred on the same date of service for the same provider tax ID and claimant.

- **Multiple Procedure Discounts (MPD):** This edit applies a reduction to the second and any other subsequent services by the same provider, in the same setting, for the same member. We typically apply a 50% reduction. NIA follows the CMS methodology that began in January 2011 which allows for application of MPD to codes within CMS’s two specific advanced imaging code families. However, NIA differs from CMS in that we apply MPD to all provider types unless health plan contracts prohibit this.

### Description

This guideline outlines the key surgical treatments and indications for common lumbar spinal disorders and is a consensus document based upon the best available evidence. Spine surgery is a complex area of medicine and this document breaks out the treatment modalities for lumbar spine disorders into surgical categories: lumbar discectomy/microdiscectomy, lumbar decompression, lumbar fusion surgery, and lumbar artificial disc replacement. See the additional information section for procedures considered not medically necessary.

### Related Policies

- N/A

### Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates [e.g., Federal Employee Program (FEP)] prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.
**Regulatory Status**

- N/A

**Rationale**

**Introduction**

A. Lumbar Discectomy/Microdiscectomy is a surgical procedure to remove part of the damaged spinal disc. The damaged spinal disc herniates into the spinal canal and compresses the nerve roots. Nerve root compression leads to symptoms like low back pain, radicular pain, numbness and tingling, muscular weakness, and paresthesia. Typical disc herniation pain is exacerbated with any movement that causes the disc to increase pressure on the nerve roots.

B. Lumbar Decompression (Laminectomy, Facetectomy and Foraminotomy): Laminectomy is common decompression surgery. The American Association of Neurological Surgeons defines laminectomy as a surgery to remove the back part of vertebra, lamina, to create more space for the spinal cord and nerves. The most common indication for laminectomy is spinal stenosis. Spondylolisthesis and herniated disk are also frequent indications for laminectomy. Decompression surgery is usually performed as part of lumbar fusion surgery.

C. Lumbar Fusion Surgery: Lumbar spinal fusion (arthrodesis) is a surgical procedure used to treat spinal conditions of the lumbar, e.g., degenerative disc disease, spinal stenosis, injuries/fractures of the spine, spinal instability, and spondylolisthesis. Spinal fusion is a "welding" process that permanently fuses or joins together two or more adjacent bones in the spine, immobilizing the vertebrae and restricting motion at a painful joint. It is usually performed after other surgical procedures of the spine, such as discectomy or laminectomy. The goal of fusion is to increase spinal stability, reduce irritation of the affected nerve roots, compression on the spinal cord, disability, and pain and/or numbness. Clinical criteria for single level fusion versus multiple level fusions are outlined under the indications section.

D. Lumbar Artificial Disc Replacement: Involves the insertion of a prosthetic device into an intervertebral space from which a degenerated disc has been removed, sparing only the peripheral annulus. The prosthetic device is designed to distribute the mechanical load of the vertebrae in a physiologic manner and maintain range of motion.

**Additional Information**

**Services Not Covered:** The following procedures are considered either still under investigation or are not recommended based upon the current evidence: Percutaneous lumbar discectomy; Laser discectomy; Percutaneous Radiofrequency Disc Decompression; intradiscal electrothermal annuloplasty (IDEA) or more commonly called IDET (Intradiscal Electrothermal therapy); Nucleus Pulpous Replacement; or Pre-Sacral Fusion.

- Percutaneous Discectomy is an invasive operative procedure to accomplish partial removal of the disc through a needle which allows aspiration of a portion of the disc trocar under imaging control. Its only indication is in order to obtain diagnostic tissue, due to lack of evidence to support long-term improvement compared to gold standard discectomy. This includes radiofrequency disc decompression.

- Laser Discectomy is a procedure which involves the delivery of laser energy into the center of the nucleus pulposus using a fluoroscopically guided laser fiber under local anesthesia. The energy denatures protein in the nucleus, causing a structural change which is intended to reduce intradiscal pressure. Its effectiveness has not been fully established.

- Intradiscal Electrothermal Annuloplasty (IDEA) (more commonly called IDET, or Intradiscal Electrothermal therapy) is an outpatient non-operative procedure in which a wire is guided into the identified painful disc using fluoroscopy. The wire is then heated at the nuclear-annular junction within the disc. It has not been shown to be effective.
Lumbar Spine Surgery

- Nucleus Pulposus Replacement: Involves the introduction of a prosthetic implant into the intervertebral disc, replacing the nucleus pulposus while preserving the annulus fibrosus. It has not been shown to be effective relative to other gold standard interventions.

Lumbar Fusion - Fusions can be performed either anteriorly, laterally, or posteriorly, or via a combined approach; although simple posterolateral fusions are indicated in the great majority of cases requiring fusion. Aggressive surgical approaches to fusion may be an indication for denial of cases (when such techniques have not been demonstrated to be superior to less morbid techniques) or recommendation for alternative procedure. These are the surgical approaches:
  - Intertransverse Fusion or Posterolateral Fusion
  - Anterior Interbody Fusion (ALIF)
  - Lateral or Transpsoas Interbody Fusion (XLIF)
  - Posterior or Transforaminal Interbody Fusion (PLIF or TLIF)
  - Anterior/posterior Fusion (360-degree)
  - Pre-sacral, axial lumbar interbody fusion (AxiaLIF) is still being investigated and is not recommended.

Use of bone grafts including autologous or allograft which might be combined with metal or biocompatible devices to produce a rigid, bony connection between two or more adjacent vertebrae are common. Bone formation or grafting materials including biologics should be used at the surgeon’s discretion; however, use of biologics should be limited to FDA approved indications in order to limit complications (especially BMP).

All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic condition(s). A failure of accurate correlation may be an indication for denial of cases. It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions mimicking radiculopathy or instability (e.g., peripheral neuropathy, piriformis syndrome, myofascial pain, sympathetically mediated pain syndromes, sacroiliac dysfunction, psychological conditions, etc.) prior to consideration of elective surgical intervention.

Operative treatment is indicated when the natural history of surgically treated lesions is better than the natural history for non-operatively treated lesions.
  - All patients being considered for surgical intervention should first undergo a comprehensive neuro-musculoskeletal examination to identify mechanical pain generators that may respond to non-surgical techniques or may be refractory to surgical intervention.
  - While sufficient time allowances for non-operative treatment are required to determine the natural cause and response to non-operative treatment of low back pain disorders, timely decision making for operative intervention is critical to avoid de-conditioning and increased disability (exclusive of "emergent" or urgent pathology such as cauda equina syndrome or associated rapidly progressive neurologic loss).

In general, if the program of non-operative treatment fails, operative treatment is indicated when:
  - Improvement of the symptoms has plateaued or failed to occur and the residual symptoms of pain and functional disability are unacceptable at the end of 6 to 12 weeks of active treatment, or at the end of longer duration of non-operative programs for debilitated patients with complex problems; and/or
  - Frequent recurrences of symptoms cause serious functional limitations even if a non-operative active treatment program provides satisfactory relief of symptoms, and restoration of function on each recurrence.
Lumbar spinal stenosis and associated lumbar spondylolisthesis - Spinal stenosis is narrowing of the spinal column or of the neural foramina where spinal nerves leave the spinal column, causing pressure on the spinal cord. The most common cause is degenerative changes in the lumbar spine. Neurogenic claudication is the most common symptom, referring to “leg symptoms encompassing the buttock, groin and anterior thigh, as well as radiation down the posterior part of the leg to the feet.” In addition to pain, leg symptoms can include fatigue, heaviness, weakness and/or paresthesia. Some patients may also suffer from accompanying back pain. Symptoms are worse when standing or walking and are relieved by sitting. Lumbar spinal stenosis is often a disabling condition, and it is the most common reason for lumbar spinal surgery in adults over 65 years.

Degenerative lumbar spondylolisthesis - is the displacement of a vertebra in the lower part of the spine; one lumbar vertebra slips forward on another with an intact neural arch and begins to press on nerves. The slippage occurs at the L4-L5 level most commonly. The most common cause, in adults, is degenerative disease although it may also result from bone diseases and fractures. Spondylolisthesis seldom occurs before the age of 50 years and it disproportionately affects women, especially black women. Degenerative spondylolisthesis is not always symptomatic. The indications for fusion in this group are evolving and as more evidence emerges, changes to the accepted indications and acceptable techniques used may be made.

Lumbar degenerative disease without stenosis or spondylolisthesis - Spondylosis is an umbrella term describing age-related degeneration of the spine. Lumbar degenerative disease without stenosis or spondylolisthesis is characterized by disabling low back pain and spondylosis at L4-5, L5-S1, or both levels.

References


Documentation for Clinical Review

Please provide the following documentation (if/when requested):

- History and physical and/or consultation notes including:
  - Reason for procedure
  - Clinical findings
Conservative treatments and duration
- Activity limitations
- Duration of back pain
- Comorbidities
  - Radiology report(s) (i.e., MRI, CT, discogram)

Post Service
- Procedure report(s)

## Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement.

**MN/IE**
The following services may be considered medically necessary in certain instances and investigational in others. Services may be considered medically necessary when policy criteria are met. Services may be considered investigational when the policy criteria are not met or when the code describes application of a product in the position statement that is investigational.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td></td>
<td>0163T</td>
<td>Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure)</td>
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<td>0164T</td>
<td>Removal of total disc arthroplasty, (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)</td>
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<td>0165T</td>
<td>Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)</td>
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<td>0195T</td>
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<td>0196T</td>
<td>Arthrodesis, pre-sacral interbody technique, disc space preparation, discectomy, without instrumentation, with image guidance, includes bone graft when performed; L4-L5 interspace (List separately in addition to code for primary procedure)</td>
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<td>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</td>
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<td>0222T</td>
<td>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)</td>
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<td>Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft, when performed, lumbar, L4-L5 interspace (List separately in addition to code for primary procedure) (Deleted code effective 1/1/2018)</td>
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<td>Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar</td>
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<td>Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)</td>
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<td>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)</td>
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<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>
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<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>
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<td>Unlisted procedure, spine</td>
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<td>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)</td>
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<td></td>
<td>62380</td>
<td>Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar</td>
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<td>Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis</td>
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<td></td>
<td>63012</td>
<td>Laminectomy with removal of abnormal facets and/or pars interarticularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)</td>
</tr>
<tr>
<td></td>
<td>63017</td>
<td>Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; lumbar</td>
</tr>
<tr>
<td></td>
<td>63030</td>
<td>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar</td>
</tr>
<tr>
<td></td>
<td>63035</td>
<td>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td></td>
<td>63042</td>
<td>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar</td>
</tr>
<tr>
<td></td>
<td>63044</td>
<td>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td></td>
<td>63047</td>
<td>Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; lumbar</td>
</tr>
<tr>
<td></td>
<td>63048</td>
<td>Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td></td>
<td>63056</td>
<td>Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (e.g., far lateral herniated intervertebral disc)</td>
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<tr>
<td></td>
<td>63057</td>
<td>Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>HCPCS</td>
<td>52348</td>
<td>Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single or multiple levels, lumbar</td>
</tr>
<tr>
<td>Type</td>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td>S2350</td>
<td>Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; lumbar, single interspace</td>
</tr>
<tr>
<td></td>
<td>S2351</td>
<td>Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; lumbar, each additional interspace (list separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

**ICD-10 Procedure**

None

**ICD-10 Diagnosis**

All Diagnoses

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**Policy History**

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Action</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2017</td>
<td>Adoption of National Imaging Associates (NIA) Clinical Guidelines</td>
<td>Medical Policy Committee</td>
</tr>
<tr>
<td>04/01/2017</td>
<td>Policy revision with position change</td>
<td>Medical Policy Committee</td>
</tr>
<tr>
<td>02/01/2018</td>
<td>Coding update</td>
<td>Administrative Review</td>
</tr>
</tbody>
</table>

**Definitions of Decision Determinations**

**Medically Necessary:** A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

**Prior Authorization Requirements (as applicable to your plan)**

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department. Please call (800) 541-6652 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national...
guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.