## Spine Procedures

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| Policy Number: | **M20180227027** |
| Effective Date: | **4/1/2018** |
| Sponsoring Department: | **Health Care Services** |
| Impacted Department(s): | **Health Care Services** |

**Type of Policy:** ☒ Internal ☒ External

**Data Classification:** ☐Confidential ☐Restricted ☒Public

### Applies to (Line of Business):

☐ Corporate (All)
☒ State Products, if yes which plan(s): ☒MediSource; ☒ MediSource Connect; ☒Child Health Plus ☒Essential Plan
☒ Medicare, if yes, which plan(s): ☒MAPD; ☐PDP; ☒ISNP; ☒CSNP
☒ Commercial, if yes, which type: ☒Large Group; ☒Small Group; ☒Individual
☒ Self-Funded Services *(Refer to specific Summary Plan Descriptions (SPDs) to determine any pre-authorization or pre-certification requirements and coverage limitations. In the event of any conflict between this policy and the SPD of a Self-Funded Plan, the SPD shall supersede the policy.)*

### Excluded Products within the Selected Lines of Business (LOB)

N/A

### Applicable to Vendors? Yes ☐ No☒

### Purpose and Applicability:

To set forth medical necessity criteria for the authorization of spinal decompressive procedures or spinal fusion procedures.

## Policy:

**Commercial and Self-Funded:**
General guidelines:
Requests for elective spinal procedures must be provided by the requesting surgeon:

I. Imaging studies (e.g., CT or MRI) supported by official radiologist report indicating clinical findings related to the specific procedure requested; and
II. Clinical documentation that 3 consecutive months of conservative nonoperative therapy within 6 months of the surgical request has failed to adequately treat the member's symptoms specific to the indication related to the surgical request including **all** of the following criteria:
    a. Trial of at least two prescription analgesics or non-steroidal anti-inflammatories unless contraindicated: and
    b. Clinical documentation from the modality's supervising clinician (e.g., chiropractor, physical therapist, etc.) of member's participation in nonoperative modalities including but not limited to:
        i. Chiropractic therapy,
        ii. Outpatient physical therapy,
        iii. Home exercise program directed by a certified or licensed home health agency physical therapist as part of skilled home care services.
        iv. And/or injections
III. Statement from a primary care physician, neurologist, physiatrist, psychiatrist, psychologist, or other licensed behavioral and/or medical health care provider attesting to the absence of untreated, underlying health issues including but not limited to behavioral health, or musculoskeletal indications as a major contributor to chronic back pain.

IV. For all elective spinal procedures, adherence to a tobacco-cessation program resulting in abstinence from tobacco for at least 6 weeks prior to surgery is recommended. In smokers, medical documentation must state the provider reviewed the benefits of smoking cessation prior to elective surgery as it appears to improve a number of outcomes such as wound healing and postoperative pulmonary recovery.

V. For anticipated fusion procedures, clinical documentation is required that the member has been abstinent from tobacco use for at least 6 weeks prior.

**<u>Spinal decompressive procedures:</u>**
Decompressive procedures including laminectomy, laminotomy, hemilaminectomy, microdiscectomy or foraminotomy for any spine region are medically necessary for individuals presenting with clinical signs and symptoms suggestive of nerve root or spinal cord compression (i.e., by herniated disc, lateral gutter stenosis, foraminal stenosis, etc.).

Lumbar, cervical, or thoracic decompression may be medically indicated for any of the following:

I. Elective decompression procedures will be covered when **all** of the following criteria are met:
    a. Member's activities of daily living are limited by persistent pain radiating from the spine to the extremities; and

b. Physical findings of nerve root compression are present (e.g., positive straight leg raising or findings of spinal stenosis); and
c. Presence of neurological abnormalities (e.g., weakness, sensory loss, reflex change) on examination which correspond to the affected nerve root(s); and
d. Imaging studies (e.g., CT or MRI) supported by official radiologist report indicating nerve root compression that corresponds to the clinical findings of the specific affected nerve root(s); and
e. Other sources of pain have been ruled out.

II. Nonelective procedures will be covered for the following indications:
a. Cauda equina syndrome; or
b. Spinal tumor confirmed by imaging studies (e.g., CT or MRI); or
c. Spinal infection confirmed by imaging studies (e.g., CT or MRI); or
d. Spinal fracture, dislocation (associated with mechanical instability), locked facets or displaced fracture fragment confirmed by imaging studies (e.g., CT or MRI); or
e. Spinal stenosis with significant neural compression.

❖ **Note:** Thoracic laminectomy procedures must be reviewed by a Medical Director.

❖ **Note:** Percutaneous laminectomy is considered experimental and investigational by IH.

**Spinal fusion procedures:**
Lumbar, cervical or thoracic spinal fusion with or without decompression may be medically necessary for any of the following:

A. Emergency Situations: Emergency situations including where the patient risks permanent neurological or functional deficit if he or she is not operated on emergently such as clinical signs of cauda equine syndrome or other significant neurological impairment.

B. Trauma: Trauma including treatment of some fractures or displacement of vertebrae resulting from motor vehicle collisions, construction accidents, vertical falls etc.

C. Revisions: Revisions at the same level of a previous surgery that show evidence of complications either causing clinical symptoms or risking harm to the patient, such as a device failure from a previous lumbar surgery or iatrogenic instability. This does not include cases of mere lack of clinical improvement from an initial surgery.

D. Tumor: Treatment of primary spinal tumor, metastasis to the spine, abscess, or other growths creating a mass effect that damages or displaces the spine and or the neural tissues.

E. Infection: Treatment of infection by any kind of foreign organism which is affecting the spine.

F. Flat-Back Syndrome: Correction of flat-back syndrome, due to previous spinal surgery, when the patient presents with clinical symptoms or when the sagittal imbalance is progressive.

G. Pseudoarthrosis: Treatment of pseudoarthrosis is medically indicated when **all** of the following conditions are met:

i. One year of time has passed since the previous fusion surgery;
ii. Initial resolution of symptoms following surgery;
iii. Radiographic fusion has not been achieved, as demonstrated on dynamic radiographs or CT scans supported by official radiologic report;
iv. The patient presents with clinically meaningful symptoms of pain or neurological symptoms from that spinal level;
v. Conservative treatment has been provided for 3 months.

H. Adjacent Segment Degeneration: Treatment of adjacent segment degeneration medically indicated when **all** of the following conditions have been met:
   i. The patient has previously undergone fusion (for any diagnosis), which at some point resulted in substantial clinical improvement for a period of at least 6 months;
   ii. Imaging supported by official radiologic report shows clear signs of disk degeneration, instability, and/or stenosis, at a level immediately adjacent to the fusion, which either were not present at the time of the original operation or have worsened from their initial state an amount that is clinically substantial;

I. Deformity: Treatment of deformity (e.g., scoliosis) is medically indicated for deformity when **all** the following conditions have been met:
   i. Painful and/or progressive deformity in the sagittal and/or coronal planes with evidence of disability and loss of function;
   ii. The patient has not shown adequate clinical improvement from a minimum of 3 consecutive months of conservative medical management (including at least pain medication and muscle strengthening exercise);

   ❖ **Note:** Independent Health considers vertebral body tethering experimental and investigational for the treatment of scoliosis because its effectiveness has not been established.

J. Spondylolisthesis: Treatment of spondylolisthesis is medically indicated for any type of spondylolisthesis when **all** of the following conditions are met:
   i. The patient has clinically important pain or neurological symptoms;
   ii. The patient has not shown sufficient clinical improvement from at least 3 months of conservative care;
   iii. Imaging studies (e.g., CT or MRI) supported by official radiologist report;

K. Recurrent Disc Herniation: Treatment of recurrent disk herniation is medically indicated for recurrent disk herniation, when **all** of the following conditions are met:
   i. The patient has previously been operated at the same level for disk herniation, which resulted in meaningful symptom relief for at least 3 months.
   ii. Recurrent disk herniation is seen on imaging supported by official radiologic report at the same level that was previously operated.
   iii. The patient has new pain or neurological symptoms consistent with the level of recurrence.

iv. The patient either has acute neurological symptoms that cannot wait longer for surgical treatment or has been unresponsive to 3 months of conservative medical management (including at least pain medication and exercise).

L. Stenosis with instability documented pre-operatively or intraoperatively: Treatment of stenosis with instability documented pre-operatively or intraoperatively is medically indicated if either one of the following two conditions is met:
   i. The patient had pre-operative instability demonstrated on dynamic imaging supported by official radiologic report; or
   ii. Spinal instability has arisen intraoperatively because adequate decompression required creation of a pars defect or removal of either 75% of one facet joint or 50+% of both facet joints.

Spinal fusion procedures for spondylolysis and degenerative disc disease procedures must be reviewed by a Medical Director.

❖ **Note:** Based upon an assessment of the peer-reviewed literature, the following devices/procedures have not been medically proven to be effective and, therefore, are considered investigational include, but are not limited to, the following:
   - The device/implant has not been approved by the U.S. Food and Drug Administration (FDA)
   - Interspinous fixation (fusion) devices. Examples of these devices include but are not limited to:
     - Zip MIS
     - Affix
     - Minuteman
     - CoFix
     - SP-Link
     - Aerial
     - SeaSpine

**<u>Sacroiliac fusion procedures:</u>**

Percutaneous/minimally invasive SI joint fusion may be considered medically necessary when ALL of the following criteria are met:

- Pain persisting a minimum of 6 months that interferes with functional activities as documented by BOTH of the following:
  - Pain score via **visual analog scale** (VAS) of 5 or greater
  - **Oswestry Disability Index (ODI)** 30 or greater
- Failure of at least 6 months of conservative management that includes a trial of at least one therapeutic intra-articular SI joint injection (i.e., corticosteroid injection)
- Confirmation of the SI joint as a pain generator as demonstrated by ALL of the following:
  - Pain pattern consistent with SI joint pain (typically unilateral pain caudal to L5 vertebrae, localized over posterior SI joint)

  - Absence of tenderness of similar severity elsewhere in the pelvic region (e.g., greater trochanter, lumbar spine, coccyx)
  - Positive response from at least THREE (3) of the following provocative tests:
    - **Long ligament test**
    - **Faber's test/Patrick's sign**
    - **Active straight leg raise**
    - **Compression test**
    - **Distraction test**
    - **Thigh thrust test** (not recommended for those who are pregnant or those with connective tissue disorder)
    - **Gaenslen's test**
    - Positive **Fortin Finger test** (localized tenderness with palpation over the sacral sulcus)
  - Other sources of pain have been excluded as an etiology
- Diagnostic imaging studies that include ALL of the following:
  - Imaging (plain radiographs and a CT) or MRI of the SI joint that excludes the presence of destructive lesions (e.g., tumor, infection) or inflammatory arthropathy that would not properly be addressed by percutaneous SI joint fusion
  - Imaging of pelvis (AP plain radiograph) to rule out concomitant hip pathology
  - Imaging of lumbar spine (CT or MRI) to rule out neural compression or other degenerative condition that can be causing low back or buttock pain
  - Imaging of SI joint that indicates evidence of injury and/or degeneration
- Diagnostic confirmation of the SI joint as the pain generator demonstrated by at least 75% reduction of pain for the expected duration of the anesthetic used following an image-guided, contrast-enhanced intraarticular SI joint injection on two (2) separate occasions

**Medicare Advantage:**
Medicare Advantage covers spinal procedures utilizing the Commercial criteria above unless a Centers for Medicare and Medicaid (CMS) document is available. There are Centers for Medicare and Medicaid (CMS) documents available for Percutaneous Image-guided Lumbar Decompression for Lumbar Spinal Stenosis and Minimally-invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint. Links to the documents are available in the References section.

**MediSource, MediSource Connect, Child Health Plus and Essential Plan:**
MediSource, MediSource Connect, Child Health Plus and Essential Plan cover spinal procedures including sacroiliac joint fusion utilizing the Commercial criteria above.

**Background:**

In the absence of severe or progressive weakness, or signs of cauda equina syndrome, surgery may be an elective option for patients with persistent disabling symptoms of low back pain and significantly impaired quality of life who have not responded to adequate trials of nonsurgical approaches.

An evaluation of the peer-reviewed scientific literature, including but not limited to subscription materials, has provided Independent Health the basis for its medical necessity coverage outlined above.

## Pre-Authorization Required? Yes ☐ No ☐ Other ☒

Pre-authorization is not required when the risk of neurologic or functional deficit is imminent and operative intervention is required emergently.

Pre-authorization is required for all other services.

## Definitions

**Active straight leg raise** is performed for localization of pain to the spine or radiating pain into the lower extremities; a positive response may suggest a spinal or spinal nerve pathology.

**Anterior, Posterior and/or Lateral laminectomy** are different incision approaches to performing a laminectomy.

**Arthrodesis** is the surgical fixation of a joint by a procedure designed to accomplish fusion of the joint surfaces by promoting the proliferation of bone cells.

**Cauda equina syndrome** occurs when the nerve roots in the lumbar spine are compressed by a herniated disk, tumor, infection, fracture, or narrowing of the spinal canal, cutting off sensation and movement. Nerve roots that control the function of the bladder and bowel are especially vulnerable to damage. Symptoms include bilateral lower extremity weakness, numbness or decreased sensation, saddle anesthesia, bladder, and bowel dysfunction) confirmed by imaging studies (e.g., CT or MRI).

**Compression test** is performed when the patient lies in the lateral decubitus position, with the affected side up, and facing away from the examiner, who applies a downward pressure to the ipsilateral iliac crest and anterior superior iliac spine (ASIS). The test is considered positive if the patient feels pain in the SIJ on the ipsilateral side.

**Conservative treatment** is used to describe any treatment option that does not involve surgery. Conservative treatment approaches include the use of medications, physical therapy, braces and/or exercise.

**Distraction Test** is performed when the patient is placed supine on the table. With the patient's

forearms crossed, the examiner applies slow and steady outward pressure to the left and right ASIS, spreading or distracting them apart. The test is considered positive if the patient feels pain in the SIJ area Faber's test/Patrick's sign.
**Facetectomy** is the excision of the articular facet of a vertebra.

**Foraminotomy** is the opening of the space between the adjacent articulated vertebrae to allow for passage of nerves to and from the spinal cord.

**Fortin Finger Test** is performed when the patient twice identifies the painful region as the area inferomedial to the posterior superior iliac spine (PSIS) within 1 cm using one finger.

**Gaenslen's test** is performed when the patient is supine lying close to the side of the table, with the leg on the side to be tested hanging over the edge of the table and the other hip and knee flexed to the chest. The examiner applies firm pressure to the flexed knee, and a counter pressure is applied to the knee of the hanging leg. The procedure is then repeated on the opposite side. This places stress on bilateral SIJ. The test is considered positive if the patient feels low back pain in their SIJ during testing.

**Hemilaminectomy** is removal of a vertebral lamina on one side only.

**Interspinous fixation device** is surgically implanted and is intended to limit lumbar spinal extension in order to maintain direct neurological decompression, unload the facet joints, and stabilize the motion segment at the treated vertebral level(s).

**Laminectomy** is the excision of a vertebral lamina, commonly used to denote the removal of the posterior arch. It is performed usually to remove a lesion or a herniated disc and /or to decompress the spinal cord or nerve roots. It can be performed at any level of the spine: cervical, thoracic, or lumbar.

**Laminotomy** is the excision of a portion of a vertebral lamina resulting in enlargement of the intervertebral foramen for the purpose of relieving pressure in a spinal nerve root.

**Long ligament test** is a pain provoking test typically used in combination with the posterior pelvic pain provocation test and the active straight leg raise test (ASLR) when a patient presents with lumbopelvic and/or sacroiliac joint pain.

**Micro decompression or microdiscectomy** is where a small portion of the bone over the nerve root and/or disc material from under the nerve root is removed to relieve nerve impingement and provide more room for the nerve to heal. A microdiscectomy is typically performed for a herniated lumbar disc.

**Partial laminectomy** is the partial removal of the vertebral posterior arch.

**Pseudoarthrosis** refers to cervical or lumbar fusion procedures in which there is incomplete incorporation or healing of the bone.

**Oswestry disability index** is used to assess subjects with low back pain to determine its impact on the activities of daily living.

**Spinal Fusion** is a surgical technique used to join two or more vertebrae. Supplementary bone tissue, either from the patient (autograft) or a donor (allograft), is used in conjunction with the body's natural bone growth (osteoblastic) processes to fuse the vertebrae.

**Spondylolisthesis** is the forward or backward translation of a vertebral body with respect to the vertebra below.

**Thigh thrust test** is performed when patient lies in a supine position while the tested-side hip joint and knee are flexed to approximately 90° by the examiner. An anterior to posterior shear force is applied to the SIJ through the axis of the femur. Resulting pain at the ipsilateral SIJ indicates a positive test.

**Visual Analog Scale (VAS)** is a tool used to help a person rate the intensity of certain sensations and feelings, such as pain. The visual analog scale for pain is a straight line with one end meaning no pain and the other end meaning the worst pain imaginable.

## References

**Related Policies, Processes and Other Documents**
N/A

**Non-Regulatory references**

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***This policy contains medical necessity criteria that apply for this service. Please note that payment for covered services is subject to eligibility criteria, contract exclusions and the limitations noted in the member's contract at the time the services are rendered.***

## Version Control

Signature / Approval on File? Yes ☒ No☐

| Revision Date | Owner | Notes |
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| 1/1/2024 | Health Care Services | Revised |
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