Medical Coverage Policy

Lumbar Fusion-PREAUTH

☐ Device/Equipment ☐ Drug ☐ Medical ☒ Surgery ☐ Test ☐ Other

Effective Date:	01/01/2013	Policy Last Updated:	7/2/2013

☒ **Prospective review is recommended/required. Please check the member agreement for preauthorization guidelines.**

☐ **Prospective review is not required.**

Description:
Lumbar fusion (also known as lumbar arthrodesis) is a surgical procedure used to eliminate motion between vertebrae. Lumbar fusion also prevents the stretching of nerves and surrounding ligaments and muscles. It is an option when motion is the source of the pain. Fusing together the vertebrae reduces movement which reduces pain.[1]

- Lumbar spine arthrodesis (fusion) surgery unless one of the Medical Criteria section below is met.
- Lumbar spinal fusion is considered if the sole indication is any one or more of the following conditions:
    - Initial Disk Herniation
    - Initial diskectomy/laminectomy for neural structure decompression unless criteria outlined in the second to the last bullet in the Medical Criteria section have been met.
    - Facet Syndrome except when conditions as outlined in the last bullet in the Medical Criteria section.

There are no randomized controlled trials comparing the outcomes of lumbar fusion using the pre-sacral technique with standard approach techniques. Current published literature consists of feasibility reports and small non-randomized case series with limited follow-up. Therefore, there is insufficient evidence of the effectiveness of a pre-sacral approach

Definitions
Conservative nonsurgical therapy for the duration specified must include the following:
- Use of prescription strength analgesics (including anti-inflammatory medications if not contraindicated), and
- Participation in physical therapy (including active exercise), and
- Evaluation and appropriate management of associated cognitive, behavioral or addiction issues when present.

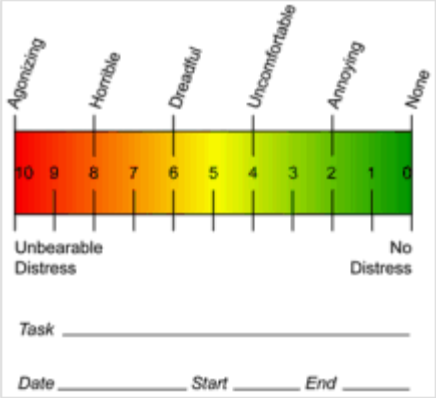
Significant functional impairment or loss of function may include documentation of the following:

- Inability or significantly decreased ability to perform normal daily activities of work, school or at home duties.

Persistent debilitating pain is defined as:

- Significant level of pain on a daily basis defined on a Visual Analog Scale (VAS)*** as greater than 4; **and**
- Pain on a daily basis that has a documented impact on activities of daily living in spite of optimal conservative non-surgical therapy* (outlined above) and appropriate for the patient.

Visual Analog Scale for Pain:
The visual analog scale is a simple assessment tool with the numbers 0 through 10 evenly spaced across a horizontal line. Zero represents no pain and 10 the worst pain ever experienced. The clinician uses this scale to determine the patient's severity of pain.



Medical Criteria:

All BCBSRI Products:

Lumbar spinal fusion procedures are considered medically necessary for one of the following conditions:

- Spinal fracture with instability or neural compression; or
- Spinal repair surgery for dislocation, tumor or infection (including abscess, osteomyelitis, discitis, or fungal infection) when debridement is necessary and the extent of the debridement to help eradicate the infection creates or could create an unstable spine; or
- Spinal tuberculosis; or
- Spinal stenosis with all of the following:
    - Associated spondylolisthesis demonstrated on plain x-rays; and
    - Any one of the following:

        - Neurogenic claudication or radicular pain that results in significant functional impairment* in a patient who has failed at least 3 months of conservative care** and has documentation of central/lateral recess/or foraminal stenosis on MRI or other imaging; or
        - Severe or rapidly progressive symptoms of motor loss, neurogenic claudication or cauda equina syndrome; or
- Severe, progressive idiopathic scoliosis (i.e., lumbar or thoracolumbar) with Cobb angle > 40 degrees; or
- Severe degenerative scoliosis with any one of the following:
    - Documented progression of deformity with persistent axial (non-radiating) pain and impairment or loss of function unresponsive to at least 3 months of conservative therapy; or
    - Persistent and significant neurogenic symptoms (claudication or radicular pain) with impairment or loss of function, unresponsive to at least 3 months of conservative care*; or
- Isthmic spondylolisthesis, either congenital (Wiltse type I) or acquired pars defect (Wiltse II), documented on x-ray, and with persistent back pain (with or without neurogenic symptoms), with impairment or loss of function, unresponsive to at least 6 months of conservative nonsurgical care*; or
- Recurrent, same level, disk herniation, at least 6 months after previous disk surgery, with recurrent neurogenic symptoms (radicular pain or claudication), with impairment or loss of function, unresponsive to at least 3 months of conservative nonsurgical care*, and with neural structure compression documented by appropriate imaging, and in a patient who had experienced significant interval relief of prior symptoms; or
- Adjacent Segment Degeneration, at least 6 months after previous fusion, with neurogenic symptoms (radicular pain, claudication, or worsening refractory back pain), with impairment or loss of function, unresponsive to at least 3 months of conservative nonsurgical care*, and with neural structure compression documented by appropriate imaging, and in a patient who had experienced significant interval relief of prior symptoms; or
- Pseudarthrosis, documented radiographically, no less than twelve (12) months after initial fusion, with persistent axial back pain, with or without neurogenic symptoms, with impairment or loss of function; or
- Latrogenic or degenerative flatback syndrome with significant sagittal imbalance; when fusion is performed with spinal osteotomy; or
- Chronic, refractory low back pain presumed to be discogenic in nature (i.e., absence of serious structural disease such as instability, infection, or neoplasm) with all of the following:
    - unremitting pain and functional disability unresponsive to at least 6 consecutive months of conservative care including, but not limited to, back education, cognitive behavioral therapy, physical therapy, exercise, weight reduction for overweight members, medications (analgesics, anti-inflammatories, muscle relaxants), fear avoidance training, and epidural steroid injections;
    - MR imaging evidence of degenerative disc disease at the level to be fused;

    - in cases of equivocal MR imaging findings, there should be concordant pain reproduced with discography testing combined with CT evidence of abnormal disc morphology that correlates with the MR imaging findings;
    - elimination of all other potential sources of low back pain; *and*
    - absence of underlying untreated psychosocial issues (e.g., depression, drug and alcohol use); or
- Facet syndrome when there is evidence on instability or documented positive provocative study (such as steroid joint injection) and has failed to respond to conservative management over a 12 month period.

Due to the high risk of pseudoarthrosis, a smoker anticipating an elective spinal fusion needs to be abstinent from smoking for a minimum of six (6) weeks prior to surgery. Supporting documentation must be submitted with request.

Policy:
All BCBSRI products

Preauthorization is required for BlueCHiP for Medicare members and recommended for all other BCBSRI products.

Lumbar spinal fusion is considered medically necessary when the medical criterion listed above has been met.

Lumbar spinal fusion is considered not medically necessary for all other conditions not listed in the medical criteria above as there is insufficient clinical evidence to support its efficacy.

Coverage:
Benefits may vary between groups/contracts. Please refer to the appropriate evidence of coverage, subscriber agreement, or benefit booklet for applicable coverage for surgery.

Coding:
The following codes require preauthorization for all BCBSRI products:
22533
22558
22585
22612
22614
22630
22633

The following codes are considered not medically necessary for all BCBSRI products:
22586 (Effective 1/1/2013)
0195T
0196T
0309T (Effective 1/1/2013)

Also Known As:
None

Related Topics:
None

Published:
Provider Update, August 2013
Provider Update, December 2012

References:
Blue Cross and Blue Shield Association, Medical Policy Reference Manual, Policy 7.01.115 Minimally Invasive Lumbar Interbody Fusion –Archived

AHRQ Technology Assessment. Draft Spinal Fusion for the Treatment of Low Back Pain Secondary to Lumbar Degenerative Disc Disease. November 2006

Review History:
07/02/2013: Annual review.