



Spine Surgery Clinical Coverage Criteria

Description

Effective December 1, 2023, Fallon Health will be using InterQual® criteria for the following spine surgeries:

- Artificial Disc Replacement, Cervical
- Artificial Disc Replacement, Lumbar
- Decompression +/- Fusion, Cervical
- Decompression +/- Fusion, Lumbar
- Decompression +/- Fusion, Thoracic
- Fusion, Cervical Spine
- Fusion, Lumbar Spine
- Fusion, Thoracic Spine
- Scoliosis or Kyphosis Surgery
- Scoliosis or Kyphosis Surgery (Pediatric)
- Vertebroplasty or Kyphoplasty

Fallon Health makes InterQual® criteria available through the Transparency Tool on our website, effective January 1, 2024.

Policy

This Policy applies to the following Fallon Health products:

- Medicare Advantage (Fallon Medicare Plus, Fallon Medicare Plus Central)
- MassHealth ACO
- NaviCare (NaviCare HMO SNP, NaviCare SCO)
- PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
- Community Care

Spine surgery requires prior authorization.

Medicare Advantage (Fallon Medicare Plus, Fallon Medicare Plus Central)

Fallon Health complies with CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations for Medicare Advantage members. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health may create internal coverage criteria under specific circumstances described at § 422.101(b)(6)(i) and (ii).

MassHealth ACO

Fallon Health follows Medical Necessity Guidelines published by MassHealth when making medical necessity determinations for MassHealth members. In the absence of Medical Necessity Guidelines published by MassHealth, Fallon Health may create clinical coverage criteria in accordance with the definition of Medical Necessity in 130 CMR 450.204.

NaviCare HMO SNP, NaviCare SCO

For plan members enrolled in NaviCare, Fallon Health first follow's CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations.

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, or if the NaviCare member does not meet coverage criteria in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health then follows Medical Necessity Guidelines published by MassHealth when making necessity determinations for NaviCare members.

PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)

Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

Fallon Health Clinical Coverage Criteria

Artificial Disc Replacement, Cervical (CPT Codes 22856, 22858)

Medicare statutes and regulations do not have coverage criteria for cervical artificial disc replacement. Medicare does not have a National Coverage Determination (NCD) for cervical artificial disc replacement. National Government Services, Inc., the Part A/B Medicare Administrative Contractor (MAC) with jurisdiction in the Plan's service area does not have a Local Coverage Determination (LCD) for cervical artificial disc replacement (Medicare Coverage Database search 10/28/2024). Coverage criteria for cervical artificial disc replacement are not fully established by Medicare; therefore, the Plan's coverage criteria are applicable.

MassHealth does not have Guidelines for Medical Necessity Determination for cervical artificial disc replacement (10/28/2024).

The Plan's coverage criteria for cervical artificial disc replacement apply to all plan members.

For coverage criteria, refer to the InterQual® Criteria in effect on the date of service:

- InterQual® CP:Procedures, Artificial Disc Replacement, Cervical

For cervical artificial disc implant failure, see the "Decompression +/- Fusion, Cervical" criteria subset.

Artificial Disc Replacement, Lumbar (CPT Codes 22857, 22860)

Medicare statutes and regulations do not have coverage criteria for lumbar artificial disc replacement. Medicare has a National Coverage Determination (NCD) for Lumbar Artificial Disc Replacement (LADR) (150.10) (Version 2, effective 08/14/2007). Effective for services performed on or after August 14, 2007, LADR is non-covered for Medicare beneficiaries over 60 years of age. Medicare does not have an NCD for beneficiaries 60 years of age and younger; coverage determination is to be made by the local contractor. National Government Services, Inc., the Part A/B Medicare Administrative Contractor (MAC) with jurisdiction in the Plan's service area does not have an LCD for lumbar artificial disc replacement (Medicare Coverage Database search 10/28/2024). Coverage criteria for lumbar artificial disc replacement are fully established by Medicare for Fallon Medicare Plus and Fallon Medicare Plus Central members > 60 years of age for whom NCD 150.15 applies. Clinical coverage criteria for LADR for Fallon Medicare Plus and Fallon Medicare Plus Central members 60 years of age and younger are not fully established by Medicare, therefore, the Plan's clinical coverage criteria are applicable.

[Link: NCD Lumbar Artificial Disc Replacement \(LADR\) \(150.15\)](#)

MassHealth does not have Guidelines for Medical Necessity Determination for lumbar artificial disc replacement (MassHealth website search 10/28/2024).

The Plan's clinical coverage criteria for lumbar artificial disc replacement apply to all plan members, **with the exception of Fallon Medicare Plus and Fallon Medicare Plus Central members > 60 years of age, for whom for NCD Lumbar Artificial Disc Replacement (LADR) (150.15) applies.**

For coverage criteria lumbar artificial disc replacement, refer to the InterQual® Criteria in effect on the date of service:

- InterQual® CP:Procedures, Artificial Disc Replacement, Lumbar

Note: Medical Director review is required for this procedure.

For lumbar artificial disc implant failure, see the "Decompression +/- Fusion, Lumbar" criteria subset.

Fusion, Cervical Spine

Medicare statutes and regulations do not have coverage criteria for cervical spine fusion. Medicare does not have a National Coverage Determination (NCD) for cervical spine fusion. National Government Services, Inc., the Part A/B Medicare Administrative Contractor (MAC) with jurisdiction in the Plan's service area has an LCD for Cervical Fusion (L39770) (Original Effective Date For services performed on or after 08/01/2024) (Medicare Coverage Database search 10/28/2024). Coverage criteria for cervical fusion are fully established by Medicare in LCD L39770 effective for dates of service on or after 08/01/2024; therefore, the Plan's coverage criteria are not applicable.

[Link: LCD Cervical Fusion \(L39770\)](#)

MassHealth does not have Guidelines for Medical Necessity Determination for cervical spine fusion (MassHealth website search 10/28/2024).

The Plan's clinical coverage criteria for cervical spine fusion apply to MassHealth ACO members, Community Care members, and NaviCare members who do not meet criteria in LCD Cervical Fusion L39770 effective for dates of service on or after 08/01/2024.

For coverage criteria, refer to the InterQual® Criteria in effect on the date of service:

- InterQual® CP:Procedures, Fusion, Cervical

These criteria address anterior and posterior spinal fusion performed for cervical instability and do not cover fusion accompanying decompressive surgery. For fusion performed with decompressive surgery, see the "Decompression +/- Fusion, Cervical" criteria subset.

Fusion, Lumbar Spine

Medicare statutes and regulations do not have coverage criteria for lumbar spine fusion. Medicare statutes and regulations do not have coverage criteria for lumbar spine fusion. Medicare does not have a National Coverage Determination (NCD) for lumbar spine fusion. National Government Services, Inc. the Part A/B Medicare Administrative Contractor with jurisdiction in the Plan's service area does not have an LCD for lumbar spine fusion (Medicare Coverage Database search 10/28/2024). Coverage criteria for lumbar spine fusion are not fully established by Medicare; therefore, the Plan's coverage criteria are applicable.

MassHealth does not have Guidelines for Medical Necessity Determination for cervical spine fusion (MassHealth website search 10/28/2024).

The Plan's clinical coverage criteria for lumbar spine fusion apply to all plan members.

For coverage criteria, refer to the InterQual® criteria in effect on the date of service:

- InterQual® CP:Procedures, Fusion, Lumbar

These criteria address anterior, posterior, and lateral spinal fusion performed for instability and do not cover fusion accompanying decompressive surgery for neurocompression. For fusion performed with decompressive surgery, see the "Decompression +/- Fusion, Lumbar" criteria subset.

Fusion, Thoracic Spine

Medicare statutes and regulations do not have coverage criteria for thoracic spine fusion. Medicare does not have a National Coverage Determination (NCD) for thoracic spine fusion. National Government Services, Inc. is the Medicare Administrative Contractor with jurisdiction over Part A and Part B services in the Plan's service area. National Government Services, Inc. does not have an LCD for cervical spine fusion (Medicare Coverage Database search 10/28/2024). Coverage criteria for thoracic spine fusion are not fully established by Medicare; therefore, the Plan's coverage criteria are applicable.

MassHealth does not have Guidelines for Medical Necessity Determination for thoracic spine fusion (MassHealth website search 10/28/2024).

The Plan's clinical coverage criteria for thoracic spine fusion apply to all plan members.

For coverage criteria, refer to the InterQual® criteria in effect on the date of service:

- InterQual® CP:Procedures, Fusion, Thoracic

These criteria address anterior (thoracotomy, thoracolumbar) and posterior (transpedicular, posteriolateral) spinal fusion performed for instability and do not cover fusion accompanying decompressive surgery for neurocompression. For fusion performed with decompressive surgery, see the "Decompression +/- Fusion, Thoracic" criteria subset.

Decompression +/- Fusion, Cervical

Medicare statutes and regulations do not have coverage criteria for cervical decompression +/- fusion. Medicare does not have a National Coverage Determination (NCD) for cervical decompression +/- fusion. National Government Services, Inc., the Part A/B Medicare Administrative Contractor (MAC) with jurisdiction in the Plan's service area does not have an LCD for cervical decompression but does have an LCD for Cervical Fusion L39770 effective for dates of service on or after 08/01/2024 (Medicare Coverage Database search 10/28/2024). Coverage criteria for cervical decompression are not fully established by Medicare, therefore, the Plan's coverage criteria for cervical decompression are applicable. Coverage criteria for cervical spine fusion are fully established by Medicare in LCD L39770 effective for dates of service on or after 08/01/2024, therefore, the Plan's coverage criteria for cervical spine fusion are not applicable.

[Link: LCD Cervical Fusion \(L39770\)](#)

MassHealth does not have Guidelines for Medical Necessity Determination for cervical decompression +/- fusion (MassHealth website search 10/28/2024).

The Plan's clinical coverage criteria for cervical fusion apply to MassHealth ACO members, Community Care members, and NaviCare members who do not meet criteria in LCD Cervical Fusion L39770 effective for dates of service on or after 08/01/2024.

The Plan's clinical coverage criteria for cervical decompression apply to all plan members.

For coverage criteria, refer to the InterQual® criteria in effect on the date of service:

- InterQual® CP:Procedures, Decompression +/- Fusion, Cervical

These criteria address decompressive surgery for neurocompression; decompressive surgery may be accompanied by a spinal fusion when the decompression causes instability or there is documentation of instability preoperatively. For fusion performed for instability without the need for decompressive surgery, see the "Fusion, Cervical Spine" criteria subset.

Decompression +/- Fusion, Lumbar

Medicare statutes and regulations do not have coverage criteria for lumbar decompression +/- fusion. Medicare does not have a National Coverage Determination (NCD) for lumbar decompression +/- fusion. National Government Services, Inc., the Part A/B Medicare Administrative Contractor (MAC) with jurisdiction in the Plan's service area does not have an LCD for lumbar decompression +/- fusion (Medicare Coverage Database search 10/28/2024). Coverage criteria for lumbar decompression +/- fusion are not fully established by Medicare; therefore, the Plan's coverage criteria are applicable.

MassHealth does not have Guidelines for Medical Necessity Determination for lumbar decompression +/- fusion (MassHealth website search 10/28/2024).

The Plan's clinical coverage criteria for lumbar decompression +/- fusion apply to all plan members.

For coverage criteria, refer to the InterQual® criteria in effect on the date of service:

- InterQual® CP:Procedures, Decompression +/- Fusion, Lumbar.

These criteria address decompressive surgery for neurocompression; decompressive surgery may be accompanied by a spinal fusion when the decompression causes instability or there is evidence of instability preoperatively. For fusion performed for instability without the need for decompressive surgery, see the "Fusion, Lumbar Spine" criteria subset.

These criteria do not cover the PILD (e.g., MILD) procedure. Medicare Advantage members have coverage for PILD under NCD 150.13 when enrolled in a Medicare-approved clinical trial listed on the CMS website at: <https://www.cms.gov/medicare/coverage/evidence/lumbar-spinal-stenosis>.

Decompression +/- Fusion, Thoracic

Medicare statutes and regulations do not have coverage criteria for thoracic decompression +/- fusion. Medicare does not have a National Coverage Determination (NCD) for thoracic decompression +/- fusion. National Government Services, Inc., the Part A/B Medicare Administrative Contractor (MAC) with in the Plan's service area does not have an LCD for thoracic decompression +/- fusion (Medicare Coverage Database search 10/28/2024). Coverage criteria for thoracic decompression +/- fusion are not fully established by Medicare; therefore, the Plan's coverage criteria are applicable.

MassHealth does not have Guidelines for Medical Necessity Determination for thoracic decompression +/- fusion (MassHealth website search 10/28/2024).

The Plan's clinical coverage criteria for thoracic decompression +/- fusion apply to all plan members.

For coverage criteria, refer to the InterQual® criteria in effect on the date of service:

- InterQual® CP:Procedures, Decompression +/- Fusion, thoracic

These criteria address decompressive surgery for neurocompression. The inherent stability provided by the thoracic rib cage makes fusion for thoracic disc disease unnecessary for most patients. However, when decompressive surgery causes instability, fusion may accompany the surgery and does not require separate authorization. For fusion performed for instability without decompressive surgery, see the "Fusion, Thoracic Spine" criteria subset.

Scoliosis or Kyphosis Surgery

Medicare statutes and regulations do not have coverage criteria for scoliosis or kyphosis surgery. Medicare does not have a National Coverage Determination (NCD) for scoliosis or kyphosis surgery. National Government Services, Inc., the Part A/B Medicare Administrative Contractor (MAC) with jurisdiction in the Plan's service area does not have an LCD for scoliosis or kyphosis surgery (Medicare Coverage Database search 10/28/2024). Coverage criteria for scoliosis or kyphosis surgery are not fully established by Medicare; therefore, the Plan's coverage criteria are applicable.

MassHealth does not have Guidelines for Medical Necessity Determination for scoliosis or kyphosis surgery (MassHealth website search 10/28/2024).

The Plan's clinical coverage criteria for scoliosis or kyphosis surgery are applicable for all members \geq 18 years of age.

For coverage criteria, refer to the InterQual criteria in effect on the date of service:

- InterQual® CP:Procedures, Scoliosis or Kyphosis Surgery (Pediatric)

Scoliosis or Kyphosis Surgery (Pediatric)

Medicare statutes and regulations do not have coverage criteria for pediatric scoliosis or kyphosis surgery. Medicare does not have a National Coverage Determination (NCD) for pediatric scoliosis or kyphosis surgery. National Government Services, Inc., the Part A/B Medicare Administrative Contractor (MAC) with jurisdiction in the Plan's service area does not have an LCD for pediatric scoliosis or kyphosis surgery (Medicare Coverage Database search 10/28/2024). Coverage criteria for pediatric scoliosis or kyphosis surgery are not fully established by Medicare; therefore, the Plan's coverage criteria are applicable.

MassHealth does not have Guidelines for Medical Necessity Determination for pediatric scoliosis or kyphosis surgery (MassHealth website search 10/28/2024).

The Plan's clinical coverage criteria for pediatric scoliosis or kyphosis surgery are applicable for all members < 18 years of age.

For coverage criteria, refer to the InterQual® criteria in effect on the date of service:

- InterQual® CP:Procedures, Scoliosis or Kyphosis Surgery (Pediatric)

Vertebroplasty (CPT Codes 22510-22512) or Kyphoplasty (CPT Codes 22513-22515)

Medicare statutes and regulations do not have coverage criteria for vertebroplasty or kyphoplasty. Medicare does not have a National Coverage Determination (NCD) for vertebroplasty or kyphoplasty. National Government Services, Inc., the Part A/B Medicare Administrative Contractor with jurisdiction in the Plan's service area has an LCD Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF) (L33569) (Revision Effective Date 12/01/2020). The National Government Services, Inc. LCD and related billing and coding article only address vertebral augmentation for osteoporotic vertebral compression

fracture, therefore coverage remains available for medically necessary procedures for indications not included in this LCD (Medicare Coverage Database search 10/28/2024). Coverage criteria are fully established by Medicare for PVA for osteoporotic vertebral compression fracture. Coverage criteria for PVA for other indications not included in L33569 are not fully established by Medicare; therefore, Plan's coverage criteria are applicable.

[Link: LCD Percutaneous Vertebral Augmentation \(PVA\) for Osteoporotic Vertebral Compression Fracture \(VCF\) \(L33569\)](#)

MassHealth does not have Guidelines for Medical Necessity Determination for vertebroplasty or kyphoplasty (MassHealth website search 10/28/2024).

The Plan's clinical coverage criteria for vertebroplasty and kyphoplasty apply to MassHealth ACO members, Community Care members, **and Fallon Medicare Plus, Fallon Medicare Plus Central and NaviCare members requesting vertebroplasty or kyphoplasty for indications not included in L33569.**

For coverage criteria, refer to the InterQual® criteria in effect on the date of service:

- InterQual® CP:Procedures, Vertebroplasty or Kyphoplasty

Coding

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage.

| Code | Description |
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| 0095T | Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical |
| 0098T | Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical |
| 0164T | Removal of total disc arthroplasty, (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure) |
| 0165T | Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure) |
| 20930 | Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure) |
| 20931 | Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure) |
| 20936 | Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or lamina fragments) obtained from same incision |
| 20937 | Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) |
| 20938 | Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) |
| 22206 | Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., pedicle/vertebral body subtraction); thoracic |
| 22207 | Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., pedicle/vertebral body subtraction); lumbar |
| 22208 | Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to code for primary procedure) |
| 22210 | Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical |

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| 22212 | Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic |
| 22214 | Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar |
| 22216 | Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure) |
| 22220 | Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical |
| 22222 | Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; thoracic |
| 22224 | Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumbar |
| 22226 | Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure) |
| 22510 | Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic |
| 22511 | Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral |
| 22512 | Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (list separately in addition to code for primary procedure) |
| 22513 | Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic |
| 22514 | Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar |
| 22515 | Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (list separately in addition to code for primary procedure) |
| 22532 | Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic |
| 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) |
| 22548 | Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process |
| 22551 | Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2 |
| 22552 | Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2; each additional interspace |

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| 22554 | Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2 |
| 22556 | Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic |
| 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) |
| 22590 | Arthrodesis, posterior technique, craniocervical (occiput-C2) |
| 22595 | Arthrodesis, posterior technique, atlas-axis (C1-C2) |
| 22600 | Arthrodesis, posterior or posterolateral technique, single interspace; cervical below C2 segment |
| 22610 | Arthrodesis, posterior or posterolateral technique, single interspace; thoracic (with lateral transverse technique, when performed) |
| 22612 | Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed) |
| 22614 | Arthrodesis, posterior or posterolateral technique, single interspace; 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, lumbar; 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, 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, lumbar; each additional interspace (List separately in addition to code for primary procedure) |
| 22800 | Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments |
| 22802 | Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments |
| 22804 | Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments |
| 22808 | Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments |
| 22810 | Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments |
| 22812 | Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments |
| 22818 | Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or 2 segments |
| 22819 | Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); 3 or more segments |
| 22830 | Exploration of spinal fusion |
| 22840 | Reinsertion of spinal fixation device |
| 22841 | Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure) |

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| 22842 | Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure) |
| 22843 | Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure) |
| 22844 | Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (List separately in addition to code for primary procedure) |
| 22845 | Anterior instrumentation, 2 to 3 vertebral segments (List separately in addition to code for primary procedure) |
| 22846 | Anterior instrumentation, 4 to 7 vertebral segments (List separately in addition to code for primary procedure) |
| 22847 | Anterior instrumentation, 8 or more vertebral segments vertebral segments (List separately in addition to code for primary procedure) |
| 22848 | Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure) |
| 22849 | Reinsertion of spinal fixation device |
| 22850 | Removal of posterior nonsegmental instrumentation (e.g., Harrington rod) |
| 22852 | Removal of posterior segmental instrumentation |
| 22853 | Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure) |
| 22854 | Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure) |
| 22855 | Removal of anterior instrumentation |
| 22856 | Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophylectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical |
| 22857 | Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar |
| 22858 | Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophylectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure) |
| 22859 | Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure) |
| 22860 | Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure) |
| 22861 | Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical |
| 22862 | Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar |

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| 22864 | Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical |
| 22865 | Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar |
| 63001 | 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; cervical |
| 63003 | 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; thoracic |
| 63005 | 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 |
| 63012 | Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure) |
| 63015 | 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; cervical |
| 63016 | 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; thoracic |
| 63017 | 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 |
| 63020 | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical |
| 63030 | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar |
| 63035 | 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) |
| 63040 | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical |
| 63042 | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar |
| 63043 | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure) |
| 63044 | 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) |
| 63045 | 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; cervical |
| 63046 | 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; thoracic |

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| 63047 | 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 |
| 63048 | 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 vertebral segment, cervical, thoracic or lumbar (List separately in addition to code for primary procedure) |
| 63050 | Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments |
| 63051 | Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices [e.g., wire, suture, mini plates], when performed) |
| 63052 | Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s][eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure) |
| 63053 | Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s][eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional vertebral segment (List separately in addition to code for primary procedure) |
| 63055 | Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; thoracic |
| 63056 | 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) |
| 63057 | 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) |
| 63064 | Costovertebral approach with decompression of spinal cord or nerve root(s) (e.g., herniated intervertebral disc), thoracic; single segment |
| 63066 | Costovertebral approach with decompression of spinal cord or nerve root(s) (e.g., herniated intervertebral disc), thoracic; each additional segment (List separately in addition to code for primary procedure) |
| 63075 | Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace |
| 63076 | Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure) |
| 63077 | Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, single interspace |
| 63078 | Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, each additional interspace (List separately in addition to code for primary procedure) |
| 63081 | Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment |
| 63082 | Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure) |

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| 63085 | Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment |
| 63086 | Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, each additional segment (List separately in addition to code for primary procedure) |
| 63087 | Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment |
| 63088 | Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; each additional segment (List separately in addition to code for primary procedure) |
| 63090 | Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment |
| 63091 | Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; each additional segment (List separately in addition to code for primary procedure) |
| 63101 | Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (e.g., for tumor or retropulsed bone fragments); thoracic, single segment |
| 63102 | Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (e.g., for tumor or retropulsed bone fragments); lumbar, single segment |
| 63103 | Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (e.g., for tumor or retropulsed bone fragments); thoracic or lumbar, each additional segment (List separately in addition to code for primary procedure) |
| 63265 | Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical |
| 63266 | Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic |
| 63267 | Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar |
| 63270 | Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical |
| 63271 | Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; thoracic |
| 63272 | Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar |
| 63275 | Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical |
| 63276 | Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, thoracic |
| 63277 | Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, lumbar |
| 63280 | Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, cervical |
| 63281 | Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, thoracic |

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| 63282 | Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, lumbar |
| 63285 | Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, cervical |
| 63286 | Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracic |
| 63287 | Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracolumbar |
| 63290 | Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level |
| 63300 | Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, cervical |
| 63301 | Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by transthoracic approach |
| 63302 | Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by thoracolumbar approach |
| 63303 | Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, lumbar or sacral by transperitoneal or retroperitoneal approach |
| 63304 | Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, cervical |
| 63305 | Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, thoracic by transthoracic approach |
| 63306 | Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, thoracic by thoracolumbar approach |
| 63307 | Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, lumbar or sacral by transperitoneal or retroperitoneal approach |
| 63308 | Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; each additional segment (List separately in addition to codes for single segment) |

References

1. Medicare National Coverage Determination (NCD). NCD Lumbar Artificial Disc Replacement (LADR) (150.10). Version Number 2, Effective Date of This Version 08/14/2007. Available at: <https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=313>. Accessed 10/28/2024.
2. National Government Services, Inc. Local Coverage Determination (LCD) Cervical Fusion (L39770). Original Effective Date For services performed on or after 08/01/2024. Available at: <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=39770&ver=4>. Accessed 10/28/2024.
3. National Government Services, Inc. Local Coverage Determination (LCD) Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF) (L33569). Original Effective Date For services performed on or after 10/01/2015. Revision Effective Date For services performed on or after 12/01/2020. Available at: <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33569>. Accessed 10/28/2024.

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Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans.