

Corporate Medical Policy

Lumbar Spine Procedures

File Name: lumbar_spine_procedures
Origination: 9/2010
Last Review: 5/2024

Description of Procedure or Service

Low back pain is a common affliction affecting over 80% of the general population at some time in the course of life. Although much of low back pain does not have a precisely identifiable cause, low back pain can be caused by a variety of conditions including degenerative disc disease, muscle strain, skeletal trauma, infection and tumor. Most cases of low back pain without an identifiable cause improve with conservative therapy including physical therapy, exercise, and/or analgesics. When the spine becomes unstable, for example, due to spondylolisthesis, trauma, infection or tumor, and for certain other identified causes of chronic, unremitting back pain, a surgical procedure is often recommended to provide stability or pain relief to the affected portion of the spine.

Lumbar Laminotomy, Foraminotomy, and Discectomy

Extrusion of an intervertebral disc beyond the intervertebral space can compress the spinal nerves and result in symptoms of pain, numbness, and weakness.

The natural history of untreated disc herniations is not well-characterized, but most herniations will decrease in size over time due to shrinking and/or regression of the disc. Clinical symptoms will also tend to improve overtime in conjunction with shrinkage or regression of the herniation.

Because most disc herniations improve over time, initial care is conservative, consisting of analgesics and a prescribed activity program tailored to individual considerations. Epidural steroid injections can also be used as a second-line intervention and are associated with short-term relief of symptoms.

However, some disc herniations will not improve over time with conservative care. A small proportion of individuals will have rapidly progressive signs and symptoms, thus putting them at risk for irreversible neurologic deficits.

Other individuals will not progress but will have the persistence of symptoms that require further intervention. It is estimated that up to 30% of individuals with sciatica will continue to have pain for more than 1 year. For these individuals, there is a high degree of morbidity and functional disability associated with chronic back pain, and there is a tendency for recurrent pain despite treatment. Therefore, treatments that have more uniform efficacy for individuals with a herniated disc and chronic back pain are needed. In particular, decreased chronic pain and decreased disability are the goals of treatment of chronic low back pain due to a herniated disc.

Discectomy is a surgical procedure in which 1 or more intervertebral discs are removed. Extrusion of an intervertebral disc beyond the intervertebral space can compress the spinal nerves and result in pain, numbness, and weakness. Discectomy is intended to treat symptoms by relieving pressure on the affected nerve root(s). Discectomy can be performed by a variety of surgical approaches, with either open surgery or minimally invasive techniques.

Lumbar discectomy can be performed by a variety of surgical approaches. Open discectomy is the traditional approach. In open discectomy, a 2- to 3-cm incision is made over the area to be repaired. The spinal muscles are dissected, and a portion of the lamina may be removed to allow access to the

Lumbar Spine Procedures

vertebral space. The extruded disc is removed either entirely or partially using direct visualization. Osteophytes that are protruding into the vertebral space can also be removed if deemed necessary. The main alternative to open discectomy is microdiscectomy, which has gained popularity.

Microdiscectomy is a minimally invasive procedure that involves a smaller incision, visualization of the disc through a special camera, and removal of disc fragments using special instruments. Because less resection can be performed in a microdiscectomy, it is usually reserved for smaller herniations, in which a smaller amount of tissue needs to be removed. A few controlled trials comparing open discectomy with microdiscectomy have been published and reported that neither procedure is clearly superior to the other, but that microdiscectomy is associated with more rapid recovery. Systematic reviews and meta-analyses have also concluded that the evidence does not support the superiority of one procedure over another.

A foraminotomy is a surgical procedure in which an opening is made by removing bone around the area of the spinal column where the spinal nerve roots exit from the spinal cord. Thereby, enlarging the area around the vertebrae in the spinal column. A laminotomy involves removing a portion of the lamina, thus, creating an opening on the posterior portion of the vertebral body. Both procedures are thought to remove improve pain and reduce pressure on neural structures.

Lumbar Laminectomy

Laminectomy is a surgical procedure in which a portion of the vertebra (the lamina) is removed to decompress the spinal cord. Removal of the lamina creates greater space for the spinal cord and the nerve roots, thus relieving compression on these structures. Laminectomy is typically performed to alleviate compression due to spinal stenosis or a space-occupying lesion. Decompression surgery may be performed as part of lumbar fusion surgery.

An incision is made in the back over the affected region, and the back muscles are dissected to expose the spinal cord in a laminectomy. The lamina is then removed from the vertebral body, along with any inflamed or thickened ligaments that may be contributing to compression. Following resection, the muscles are reapproximated and the soft tissues sutured back into place.

There are numerous variations on the basic laminectomy procedure. It can be performed by minimally invasive techniques, which minimizes the extent of resection. Laminoplasty is a more limited procedure in which the lamina is cut but not removed, thus allowing expansion of the spinal cord. Foraminotomy and/or foramenectomy, which involve partial or complete removal of the facet joints, may be combined with laminectomy when the spinal nerve roots are compressed at the foramen. Spinal fusion is combined with laminectomy when the instability of the spine is present preoperatively, or if the procedure is sufficiently extensive to expect postoperative spinal instability.

Lumbar Spine Fusion

Arthrodesis (fusion) procedures in the lumbar (lower) spine are surgical procedures that join two or more lumbar vertebrae together into one solid bony structure. These procedures may be used to treat spine instability, cord compression due to severe degenerative disc disease, fractures in the lumbar spine or destruction of the vertebrae by infection or tumor. There are several methods or approaches to this surgery.

The most common approach to arthrodesis (fusion) of the lumbar spine is the posterior approach. After the vertebrae are exposed through the back, pressure on the nerve roots and/or spinal cord is removed (“decompressed”). This usually includes removing part or all of the nearby lamina bone, facet joints, any free disc fragments, or filing down any nearby bone spurs to relieve the nerves inside the spinal canal of tension and pressure. Additional decompression for the nerve roots and spinal cord may be required by cutting a larger opening in the neural foramina, the openings through which the spinal nerves pass out from the spinal cord to the limbs. This procedure is called “foraminotomy” as defined above.

Lumbar Spine Procedures

In preparation for the spinal fusion, a layer of bone off the back surfaces of the affected spinal column is removed. Fusion is performed one of several ways. Interbody devices are placed between the vertebra for spine fusion and preservation of the intervertebral space. Alternatively, small strips of bone called bone grafts are then removed from the top rim of the pelvis and placed over the now exposed bone surfaces of the spinal column. As healing occurs, the bone strips will fuse across the spaces in between the vertebral bodies, such as the disc spaces or the facet joint spaces.

To reinforce the fusion procedure, the bones may be fixated in place using a combination of metal screws, rods, and plates. This instrumentation holds together the vertebrae to be fused, to prevent them from moving during the bone healing process.

Other approaches to the lumbar spinal fusion include: 1) Anterior/anterolateral approach: The decompression of the nerves and intervertebral fusion is similar to the posterior approach, except that the intervertebral space is fused by approaching the spine through the abdomen instead of the lower back. 2) Anterior/ Posterior Lumbar Fusion: The intervertebral space is fused by approaching the spine through both the abdomen and the lower back. 3) Lateral extracavitary approach: The intervertebral space is fused by approaching the spine from the side or laterally.

Related Polices

Artificial Intervertebral Disc
Automated Percutaneous and Endoscopic Discectomy
Bone Morphogenetic Protein
Cervical Spine Procedures
Decompression of the Intervertebral Disc Using Laser Energy (Laser Discectomy) or Radiofrequency Coblation (Nucleoplasty)
Electrical Bone Growth Stimulation
Image-Guided Minimally Invasive Decompression (IG-MLD) for Spinal Stenosis
Interspinous and Interlaminar Stabilization/Distractor Devices (Spacers)
Interspinous Fixation (Fusion) Devices
Percutaneous Intradiscal and Intraosseous Radiofrequency Procedures of the Spine

This policy addresses specifically the circumstances under which surgery of the lumbar spine is considered medically necessary in adults. Pediatric and adolescent cases will be addressed on an individual consideration basis.

******Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.***

Policy

BCBSNC will provide coverage for Lumbar Spine Procedures when it is determined to be medically necessary because the medical criteria and guidelines shown are met.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

When Lumbar Spine Procedures are covered

BCBSNC will provide coverage for Lumbar Spine procedures for any one of the following conditions:

Lumbar Spine Procedures

- I. Lumbar Discectomy, Foraminotomy, or Laminotomy** for any one of the following conditions:
1. Cauda equina or spinal cord compression (myelopathy), as indicated and ALL of the following:
 - a. Progressive or severe neurologic deficits consistent with cauda equina or spinal cord compression (eg, bladder or bowel incontinence); **and**
 - b. Imaging findings of compression that correlate with clinical findings
 2. Lumbar radiculopathy and any of the following:
 - a. Rapidly progressive or severe neurologic deficits (eg, weakness, bowel or bladder dysfunction) secondary to nerve root compression confirmed by imaging; **or**
 - b. Individual has unremitting radicular pain and ALL of the following:
 - MRI or other neuroimaging finding correlates with clinical signs and symptoms; **and**
 - Failure of nonoperative treatment that must include participation in 6 weeks of physical therapy (including active exercise)
 3. Lumbar spondylolisthesis, as indicated by any one of the following:
 - a. Rapidly progressive or very severe neurologic deficits (eg, bowel or bladder dysfunction), **or**
 - b. Symptoms requiring treatment, as indicated by ALL of the following:
 - Individual has persistent disabling symptoms, including any of the following:
 1. Low back pain
 2. Neurogenic claudication
 3. Radicular pain
 - Treatment is indicated by ALL of the following:
 1. Listhesis demonstrated on imaging
 2. Symptoms correlate with findings on MRI or other imaging
 3. Failure of nonoperative treatment that must include participation in 6 weeks of physical therapy (including active exercise)
- II. Lumbar Laminectomy** for any one of the following conditions:
1. Spinal cord compression (myelopathy), as indicated by ALL of the following:
 - a. Progressive or severe neurologic deficits consistent with spinal cord compression (eg, bladder or bowel incontinence); **and**
 - b. Imaging findings of lumbar cord compression that correlate with clinical findings
 2. Cauda equina syndrome, as indicated by any of the following:
 - a. Bowel dysfunction
 - b. Bladder dysfunction
 - c. Saddle anesthesia
 - d. Bilateral lower extremity neurologic abnormalities
 3. Lumbar spinal stenosis, as indicated by any of the following:
 - a. Rapidly progressive or very severe symptoms of neurogenic claudication with imaging findings of lumbar spinal stenosis that correlate with clinical findings
 - b. Leg or buttock neurogenic claudication symptoms and ALL of the following:
 - Symptoms that are persistent and disabling
 - Imaging findings of lumbar spinal stenosis that correlate with clinical findings

Lumbar Spine Procedures

- Failure of nonoperative treatment that must include participation in 6 weeks of physical therapy (including active exercise)
- 4. Lumbar spondylolisthesis, as indicated by 1 or more of the following:
 - a. Rapidly progressive or severe neurologic deficits (eg, bowel or bladder dysfunction)
 - b. Symptoms requiring treatment, as indicated by ALL of the following:
 - Individual has persistent disabling symptoms, including 1 or more of the following:
 1. Low back pain
 2. Neurogenic claudication
 3. Radicular pain
 - Treatment is indicated by ALL of the following:
 1. Listhesis demonstrated on imaging
 2. Symptoms that correlate with findings on MRI or other imaging
 3. Failure of nonoperative treatment that must include participation in 6 weeks of physical therapy (including active exercise)
- 5. Lumbar disc disease and 1 or more of the following:
 - a. Rapidly progressive or severe neurologic deficits (e.g., weakness, bowel or bladder dysfunction) secondary to nerve root compression that has been confirmed by imaging
 - b. Unremitting radicular pain and ALL of the following:
 - Nerve root compression is confirmed by imaging; **and**
 - Failure of nonoperative treatment that must include participation in 6 weeks of physical therapy (including active exercise)
- 6. Dorsal rhizotomy for spasticity (eg, cerebral palsy)
- 7. Signs or symptoms of lumbar disease (eg, pain, motor weakness, bowel or bladder incontinence) secondary to tumor or neoplasm
- 8. Signs or symptoms of lumbar disease (eg, pain, motor weakness, bowel or bladder incontinence) secondary to infectious process (eg, epidural abscess)
- 9. Signs or symptoms of lumbar disease (eg, pain, motor weakness, bowel or bladder incontinence) secondary to acute trauma

III. Lumbar Spine Fusion procedures for any one of the following conditions:

1. Spinal fracture with instability or neural compression
2. Spinal repair surgery for dislocation, tumor or infection (including abscess, osteomyelitis, discitis, tuberculosis, 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.
3. Spinal stenosis with ALL of the following:
 - a. Associated spondylolisthesis demonstrated on plain x-rays or other imaging; **and**
 - b. Any one of the following:
 - Neurogenic claudication or radicular pain that results in significant functional impairment in an individual 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.
4. Severe, progressive idiopathic scoliosis (i.e., lumbar or thoracolumbar) with Cobb angle > 40 degrees
5. Severe degenerative scoliosis with any one of the following:

Lumbar Spine Procedures

- a. 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**
 - b. Persistent and significant neurogenic symptoms (claudication or radicular pain) with impairment or loss of function, unresponsive to at least 3 months of conservative care.
6. 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.
 7. Recurrent, same level, disc herniation, at least 6 months after previous disc 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 an individual who had experienced significant interval relief of prior symptoms.
 8. Adjacent Segment Degeneration, at least 6 months after previous fusion, 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 an individual who had experienced significant interval relief of prior symptoms.
 9. Pseudarthrosis, documented radiographically, no less than 6 months after initial fusion, with persistent axial back pain, with or without neurogenic symptoms, with impairment or loss of function, in an individual who had experienced significant interval relief of prior symptoms.
 10. Iatrogenic or degenerative flatback syndrome with significant sagittal imbalance; when fusion is performed with spinal osteotomy.

NOTE: For non-emergent procedures that include fusion, it is strongly recommended that the surgical candidate refrain from smoking/nicotine for at least six weeks prior to surgery and during the time of healing.

IV. Removal of Posterior Spinal Instrumentation for any of the following conditions:

1. Deformity corrected and solid fusion achieved
2. Spinal infection
3. Neurologic complications (eg, new-onset thoracic radiculopathy)
4. Vascular complication
5. Symptomatic rod, hook, or screw migration, dislodgement, or breakage
6. Interference with growth instrumentation (eg, spontaneous fusion, overcorrection)
7. New pain or protruding mass at operative site after significant spinal trauma (eg, motor vehicle accident)
8. Severe late operative site back pain
9. Metallosis

When Lumbar Spine Procedures are not covered

BCBSNC will not provide coverage for Lumbar Spine procedures when it is considered **not medically necessary**.

1. Lumbar discectomy, laminotomy, or foraminotomy is **not medically necessary** unless the above criteria are met.
2. Lumbar laminectomy is **not medically necessary** unless the above criteria are met.
3. Removal of posterior spinal instrumentation is **not medically necessary** unless one of the above conditions is met.

Lumbar Spine Procedures

4. Lumbar spine arthrodesis (fusion) surgery is considered **not medically necessary** unless one of the above conditions is met.
5. Lumbar spinal fusion is also considered **not medically necessary** if the sole indication is any one or more of the following conditions:
 - a. Disc Herniation
 - b. Degenerative Disc Disease
 - c. Initial discectomy/laminectomy for neural structure decompression
 - d. Facet Syndrome

Policy Guidelines

Lumbar Spine Fusion:

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:

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

Lumbar Discectomy

For individuals who have lumbar herniated disc(s) and symptoms of radiculopathy rapidly progressing or refractory to conservative care who receive lumbar discectomy, the evidence includes randomized controlled trials (RCTs) and systematic reviews. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. In patients with lumbar radiculopathy with disc herniation who receive discectomy, there is sufficient evidence to support the use of discectomy in patients who have not responded to “usual care” for 6 weeks. The evidence is limited by a lack of high-quality trials. In most trials, a high percentage of patients in the conservative care group crossed over to surgery. This high degree of crossover reduced the power to detect differences when assessed by intention-to-treat analysis. Analysis by treatment received was also flawed because of the potential noncomparability of groups resulting from the high crossover rate. Despite the methodologic limitations, the evidence has consistently demonstrated a probable short-term benefit for surgery and a more rapid resolution of pain and disability. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Lumbar Laminectomy

For individuals who have lumbar spinal stenosis and spinal cord or nerve root compression who receive lumbar laminectomy, the evidence includes randomized controlled trials (RCTs) and a systematic review of RCTs. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. In patients with spinal stenosis, there is sufficient evidence that laminectomy is more effective than nonoperative “usual care” in individuals with spinal stenosis who do not improve after 8 weeks of conservative

Lumbar Spine Procedures

treatment. The superiority of laminectomy is sustained through 8 years of follow-up. This conclusion applies best to individuals who do not want to undergo intensive, organized conservative treatment, or who do not have access to such a program. For individuals who want to delay surgery and participate in an organized program of physical therapy and exercise, early surgery with the combination of conservative initial treatment and delayed surgery in selected patients have similar outcomes at 2 years. From a policy perspective, this means that immediate laminectomy and intensive conservative care are both viable options. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have space-occupying lesion(s) of the spinal canal or nerve root compression who receive cervical, thoracic, or lumbar laminectomy, the evidence includes case series. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Most case series are small and retrospective. They have reported that most patients with myelopathy experience improvements in symptoms or abatement of symptom progression after laminectomy. However, this uncontrolled evidence does not provide a basis to determine the efficacy of the procedure compared with alternatives. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Lumbar Fusion

For individuals with spinal stenosis who are undergoing decompression surgery and receive lumbar spinal fusion, the evidence includes 3 small RCTs. Relevant outcomes are symptoms, functional outcomes, quality of life, resource utilization, and treatment-related morbidity. Two RCTs published in 2016 compared decompression surgery plus fusion with decompression surgery alone. These trials reached different conclusions about the benefit of adding fusion to decompression, 1 specifically in patients with low-grade (0% to 25% slippage) spondylolisthesis and 1 in patients with lumbar stenosis with or without spondylolisthesis. Both trials reported a larger number of operative and perioperative adverse outcomes with the addition of fusion. The third trial, a small trial conducted in Japan, also found no difference in lower back pain or leg pain scores between laminectomy alone and laminectomy plus posterolateral fusion in patients with 1-level spinal stenosis and grade 1 spondylolisthesis. About 40% of the patients also had dynamic instability. In patients with spinal stenosis and grade 1 spondylolisthesis and without instability, the evidence does not support routine addition of fusion to decompression surgery. The Swedish Spinal Stenosis Study included patients who did not have spondylolisthesis. The addition of fusion to laminectomy resulted in similar patient-reported outcomes, longer operating time, more bleeding, higher surgical costs, and longer hospitalization but did not result in better functional disability and pain scores. In patients with spinal stenosis and no spondylolisthesis who receive decompression, the evidence suggests that routine fusion is not better than decompression alone. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have adult degenerative scoliosis who undergo lumbar spinal fusion, the evidence includes a prospective comparative cohort study, which evaluated outcomes in adults with symptomatic scoliosis who were treated with spinal fusion surgery or nonoperatively. Relevant outcomes are symptoms, functional outcomes, quality of life, resource utilization, and treatment-related morbidity. Although the surgically treated group had better outcomes than the conservatively managed group, there was potential bias in this study due to the self-selection of treatment and high loss to follow-up in the conservatively managed group. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have isthmic spondylolisthesis who undergo lumbar spinal fusion, the evidence includes an RCT. Relevant outcomes are symptoms, functional outcomes, quality of life, resource utilization, and treatment-related morbidity. The RCT identified compared fusion with an exercise program for patients who had symptomatic isthmic spondylolisthesis. Functional outcomes and pain relief were significantly better after fusion surgery. Results of this trial support the use of fusion for this condition but should be corroborated in a larger number of

Lumbar Spine Procedures

patients. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have spinal fracture and undergo lumbar spinal fusion, the evidence includes RCTs and meta-analyses of RCTs. Relevant outcomes are symptoms, functional outcomes, quality of life, resource utilization, and treatment-related morbidity. Results of a small RCT indicated that spinal fusion for patients with spinal fracture without instability or neural compression might result in worse outcomes than nonsurgical management. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have lumbar disc herniation with radiculopathy who are undergoing discectomy who receive lumbar spinal fusion, the evidence includes observational studies. Relevant outcomes are symptoms, functional outcomes, quality of life, resource utilization, and treatment-related morbidity. In patients with lumbar radiculopathy with herniated disc who receive discectomy, the evidence does not support the routine use of fusion as an adjunct to discectomy. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have chronic low back pain without radiculopathy who undergo lumbar spinal fusion, the evidence includes RCTs and meta-analyses of RCTs. Relevant outcomes are symptoms, functional outcomes, quality of life, resource utilization, and treatment-related morbidity. In most patients with chronic or persistent low back pain who do not have neurogenic leg pain, fusion surgery has little or no net benefit. Clinical trials have not used clear criteria for diagnosing "discogenic" pain, which may contribute to mixed results. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable service codes: 20930, 20931, 20936, 20937, 20938, 22533, 22534, 22558, 22585, 22612, 22614, 22630, 22632, 22633, 22634, 22800, 22802, 22804, 22808, 22810, 22812, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22849, 22850, 22852, 22853, 22854, 22859, 63005, 63012, 63017, 63030, 63035, 63042, 63044, 63047, 63048, 63056, 63057, 63087, 63088, 63090, 63091, 63102, 63103, and 63170.

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

Weinstein JN, et al. Surgical versus nonsurgical treatment for lumbar degenerative spondylolisthesis. *New England Journal of Medicine* 2007; 356(22):2257-70.

Deyo RA, Mirza SK, Martin BI, et al. Trends, major complications, and charges associated with surgery for lumbar spinal stenosis in older adults. *JAMA*. 2010;303(13):1259-1265

North American Spine Society (NASS) Diagnosis and treatment of degenerative lumbar spinal stenosis. NASS Clinical Practice Guidelines [Internet] Burr Ridge, IL: North American Spine Society 2007 Jun. Accessed October 7, 2009 from <http://www.spine.org/>.

Lumbar Spine Procedures

Brox JJ, et al. Lumbar instrumented fusion compared with cognitive intervention and exercises in patients with chronic back pain after previous surgery for disc herniation: a prospective randomized controlled study. *Pain* 2006;122(1-2):145-55

Thome C, et al. Outcome after less-invasive decompression of lumbar spinal stenosis: a randomized comparison of unilateral laminotomy, bilateral laminotomy, and laminectomy. *Journal of Neurosurgery: Spine* 2005; 3(2):129-41.

Transfeldt EE, Mehbood AA. Evidence-based medicine analysis of isthmic spondylolisthesis treatment including reduction versus fusion in situ for high-grade slips. *Spine* 2007; 32(19 Suppl):S126-9.

Specialty Matched Consultants – 8/2010

Senior Medical Director - 9/2010

Specialty Matched Consultants – 1/2011

Senior Medical Director – 1/2011

Specialty Matched Consultant Advisory Panel – 5/2011

Rasmussen C, et al. Rates of lumbar disc surgery before and after implementation of multidisciplinary nonsurgical spine clinics. *Spine* 2005;30:2469-2473.

Fairbank J, et al. Randomised controlled trial to compare surgical stabilization of the lumbar spine with an intensive rehabilitation programme for patients with chronic low back pain: the MRC spine stabilization trial. *BMJ*, doi:10.1136/bmj.38441.620417.BF (published 23 May 2005)

Bono CM, Lee CK. Critical analysis of trends in fusion for degenerative disc disease over the past 20 years. *Spine*; 29(4):455-463.

Grob D, et al. Degenerative lumbar spinal stenosis. *The Journal of Bone and Joint Surgery*. 1995. 77-A(7):1036-1041.

Specialty Matched Consultant Advisory Panel 5/2012

Chou R, et al. Interventional therapies, surgery, and interdisciplinary rehabilitation for low back pain: an evidence-based clinical practice guideline from the American Pain Society. *Spine* 2009; 34(10):1066-77.

Weinstein JN, et al. Surgical versus nonoperative treatment for lumbar spinal stenosis four-year results of the Spine Patient Outcomes Research Trial. *Spine* 2010;35(14):1329-38.

Weinstein JN, et al. Surgical compared with nonoperative treatment for lumbar degenerative spondylolisthesis. four-year results in the Spine Patient Outcomes Research Trial (SPORT) randomized and observational cohorts. *Journal of Bone and Joint Surgery. American Volume* 2009;91(6):1295-304.

Kreiner DS, et al. Diagnosis and treatment of degenerative lumbar spinal stenosis. Evidence-based clinical guidelines for multidisciplinary spine care [Internet] North American Spine Society. 2011 Accessed at: <http://www.spine.org/>. [created 2008]

Lumbar Spine Procedures

Hu SS, Tribus CB, Diab M, Ghanayem AJ. Spondylolisthesis and spondylolysis. *Journal of Bone and Joint Surgery. American Volume* 2008;90(3):656-71.

Parker SL, et al. Determination of minimum clinically important difference in pain, disability, and quality of life after extension of fusion for adjacent-segment disease. *Journal of Neurosurgery: Spine* 2012;16(1):61-7.

Ploumis A, Transfeldt EE, Denis F. Degenerative lumbar scoliosis associated with spinal stenosis. *Spine Journal* 2007;7(4):428-36.

Tran de QH, Duong S, Finlayson RJ. Lumbar spinal stenosis: a brief review of the nonsurgical management. *Canadian Journal of Anaesthesia* 2010;57(7):694-703.

Chou R, et al. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society. *Annals of Internal Medicine* 2007;147(7):478-91.

Brox JI, Nygaard OP, Holm I, Keller A, Ingebrigtsen T, Reikeras O. Four-year follow-up of surgical versus non-surgical therapy for chronic low back pain. *Annals of the Rheumatic Diseases* 2010;69(9):1643-8.

Fu KM, et al. Morbidity and mortality in the surgical treatment of 10,329 adults with degenerative lumbar stenosis. *Journal of Neurosurgery: Spine* 2010;12(5):443-6.

Sansur CA, et al. Morbidity and mortality in the surgical treatment of 10,242 adults with spondylolisthesis. *Journal of Neurosurgery: Spine* 2010;13(5):589-93.

Specialty Matched Consultant Advisory Panel 5/2013

Specialty Matched Consultant Advisory Panel 5/2014

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.141, 5/22/14

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.141, 11/13/2014

Specialty Matched Consultant Advisory Panel 5/2015

Specialty Matched Consultant Advisory Panel 5/2016

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.141, 5/19/2016

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.141, 4/13/2017

Specialty Matched Consultant Advisory Panel 5/2017

Specialty Matched Consultant Advisory Panel 5/2018

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.141, 6/14/2018

Specialty Matched Consultant Advisory Panel 5/2019

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.141, 6/13/2019

Specialty Matched Consultant Advisory Panel 5/2020

Lumbar Spine Procedures

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.141, 09/10/2020

Specialty Matched Consultant Advisory Panel 5/2021

Medical Director review 8/2021

Jackson KL, 2nd, Devine JG. The effects of smoking and smoking cessation on spine surgery: a systematic review of the literature. *Global Spine J.* Nov 2016;6(7):695-701. PMID 27781190

Specialty Matched Consultant Advisory Panel 5/2022

North American Spine Society. Current coverage policy recommendations: Lumbar fusion. 2021; <https://www.spine.org/coverage>.

North American Spine Society. Evidence-based Clinical Guidelines for Multidisciplinary Spine Care: Diagnosis and Treatment of Low Back Pain. 2020; <https://www.spine.org/Portals/0/assets/downloads/ResearchClinicalCare/Guidelines/LowBackPain.pdf>.

Specialty Matched Consultant Advisory Panel 5/2023

Kreiner DS, Hwang SW, Easa JE, et al. An evidence-based clinical guideline for the diagnosis and treatment of lumbar disc herniation with radiculopathy. *Spine J.* Jan 2014; 14(1): 180-91. PMID24239490

American Academy of Neurology (AAN). Use of epidural steroid injections to treat lumbosacral radicular pain. 2007; <https://www.aan.com/Guidelines/Home/GetGuidelineContent/250>

Jacobs WC, van Tulder M, Arts M, et al. Surgery versus conservative management of sciatica due to a lumbar herniated disc: a systematic review. *Eur Spine J.* Apr 2011; 20(4): 513-22. PMID 20949289

Henriksen L, Schmidt K, Eskesen V, et al. A controlled study of microsurgical versus standard lumbar discectomy. *Br J Neurosurg.* Jun 1996; 10(3): 289-93. PMID 8799541

Katayama Y, Matsuyama Y, Yoshihara H, et al. Comparison of surgical outcomes between macro discectomy and micro discectomy for lumbar disc herniation: a prospective randomized study with surgery performed by the same spine surgeon. *J Spinal Disord Tech.* Jul 2006; 19(5): 344-7. PMID16826006

Mu X, Wei J, Li P. What were the advantages of microendoscopic discectomy for lumbar disc herniation comparing with open discectomy: a meta-analysis?. *Int J Clin Exp Med.* 2015; 8(10): 17498-506. PMID26770340

Arts MP, Kursumovic A, Miller LE, et al. Comparison of treatments for lumbar disc herniation: Systematic review with network meta-analysis. *Medicine (Baltimore).* Feb 2019; 98(7): e14410. PMID 30762743

Bono CM, Ghiselli G, Gilbert TJ, et al. An evidence-based clinical guideline for the diagnosis and treatment of cervical radiculopathy from degenerative disorders. *Spine J.* Jan 2011; 11(1): 64-72. PMID21168100

Epstein NE. Laminectomy for cervical myelopathy. *Spinal Cord.* Jun 2003; 41(6): 317-27. PMID12746738

Lumbar Spine Procedures

Gardocki RJ, Park AL. Degenerative disorders of the thoracic and lumbar spine. In: Azar FM, Beaty JH, editors. *Campbell's Operative Orthopaedics*. 14th ed. Philadelphia, PA: Elsevier; 2021:1682-1718 e5.

Ropper AH, Zafonte RD. Sciatica. *New England Journal of Medicine* 2015;372(13):1240-1248. DOI: 10.1056/NEJMra1410151.

Deyo RA, Mirza SK. Clinical practice. herniated lumbar intervertebral disk. *New England Journal of Medicine* 2016;374(18):1763-1772. DOI: 10.1056/NEJMcp1512658.

Di Martino A, Russo F, Denaro L, Denaro V. How to treat lumbar disc herniation in pregnancy? A systematic review on current standards. *European Spine Journal* 2017;26(Suppl 4):496-504. DOI: 10.1007/s00586-017-5040-8.

Ajiboye RM, Drysch A, Mosich GM, Sharma A, Pourtaheri S. Surgical treatment of recurrent lumbar disk herniation: a systematic review and meta-analysis. *Orthopedics* 2018;41(4):e457-e469. DOI: 10.3928/01477447-20180621-01.

Bednar DA. Cauda equina syndrome from lumbar disc herniation. *Canadian Medical Association Journal* 2016;188(4):284. DOI: 10.1503/cmaj.150206.

Ropper AE, Ropper AH. Acute spinal cord compression. *New England Journal of Medicine* 2017;376(14):1358-1369. DOI: 10.1056/NEJMra1516539.

Todd NV. Guidelines for cauda equina syndrome. Red flags and white flags. Systematic review and implications for triage. *British Journal of Neurosurgery* 2017;31(3):336-339. DOI: 10.1080/02688697.2017.1297364.

Bailey CS, et al. Surgery versus conservative care for persistent sciatica lasting 4 to 12 months. *New England Journal of Medicine* 2020;382(12):1093-1102. DOI: 10.1056/NEJMoa1912658.

Goldberg H, et al. Oral steroids for acute radiculopathy due to a herniated lumbar disk: a randomized clinical trial. *Journal of the American Medical Association* 2015;313(19):1915-1923. DOI: 10.1001/jama.2015.4468.

Cato RK. Indications and usefulness of common injections for nontraumatic orthopedic complaints. *Medical Clinics of North America* 2016;100(5):1077-1088. DOI: 10.1016/j.mcna.2016.04.007.

Joswig H, Neff A, Ruppert C, Hildebrandt G, Stienen MN. Repeat epidural steroid injections for radicular pain due to lumbar or cervical disc herniation. *Bone and Joint Journal* 2018;100-B(10):1364-1371. DOI: 10.1302/0301-620X.100B10.BJJ-2018-0461.R1.

Fritz JM, et al. Physical therapy referral from primary care for acute back pain with sciatica : a randomized controlled trial. *Annals of Internal Medicine* 2021;174(1):8-17. DOI: 10.7326/M20-4187.

Minamide A, et al. Minimally invasive spinal decompression for degenerative lumbar spondylolisthesis and stenosis maintains stability and may avoid the need for fusion. *Bone and Joint Journal* 2018;100-B(4):499-506. DOI: 10.1302/0301-620X.100B4.BJJ-2017-0917.R1.

Lumbar Spine Procedures

Chakravarthy V, Patel A, Kemp W, Steinmetz M. Surgical treatment of lumbar spondylolisthesis in the elderly. *Neurosurgery Clinics of North America* 2019;30(3):341-352. DOI: 10.1016/j.nec.2019.02.008.

Williams KD. Spondylolisthesis. In: Azar FM, Beaty JH, editors. *Campbell's Operative Orthopaedics*. 14th ed. Philadelphia, PA: Elsevier; 2021:1802-1831.e1.

Forsth P, et al. A randomized, controlled trial of fusion surgery for lumbar spinal stenosis. *New England Journal of Medicine* 2016;374(15):1413-1423. DOI: 10.1056/NEJMoa1513721.

Lurie J, Tomkins-Lane C. Management of lumbar spinal stenosis. *British Medical Journal* 2016;352:h6234.

Trigg SD, Devilbiss Z. Spine conditions: lumbar spinal stenosis. *FP Essentials* 2017;461:21-25.

Lafian AM, Torralba KD. Lumbar spinal stenosis in older adults. *Rheumatic Diseases Clinics of North America* 2018;44(3):501-512. DOI: 10.1016/j.rdc.2018.03.008.

Karsy M, Bisson EF. Surgical versus nonsurgical treatment of lumbar spondylolisthesis. *Neurosurgery Clinics of North America* 2019;30(3):333-340. DOI: 10.1016/j.nec.2019.02.007.

Gandhi J, et al. Neuro-urological sequelae of lumbar spinal stenosis. *International Journal of Neuroscience* 2018;128(6):554-562. DOI: 10.1080/00207454.2017.1400973.

Jarrett MS, Orlando JF, Grimmer-Somers K. The effectiveness of land based exercise compared to decompressive surgery in the management of lumbar spinal-canal stenosis: a systematic review. *BMC Musculoskeletal Disorders* 2012;13:30. DOI: 10.1186/1471-2474-13-30.

Bydon M, Alvi MA, Goyal A. Degenerative lumbar spondylolisthesis: definition, natural history, conservative management, and surgical treatment. *Neurosurgery Clinics of North America* 2019;30(3):299-304. DOI: 10.1016/j.nec.2019.02.003.

McGowan JE, Kanter AS. Lateral approaches for the surgical treatment of lumbar spondylolisthesis. *Neurosurgery Clinics of North America* 2019;30(3):313-322. DOI: 10.1016/j.nec.2019.02.005.

Foster NE, et al. Prevention and treatment of low back pain: evidence, challenges, and promising directions. *Lancet* 2018;391(10137):2368-2383. DOI: 10.1016/S0140-6736(18)30489-6.

Schilling LS, Markman JD. Corticosteroids for pain of spinal origin: epidural and intraarticular administration. *Rheumatic Diseases Clinics of North America* 2016;42(1):137-155, ix. DOI: 10.1016/j.rdc.2015.08.003.

Manchikanti L, Knezevic NN, Boswell MV, Kaye AD, Hirsch JA. Epidural injections for lumbar radiculopathy and spinal stenosis: a comparative systematic review and meta-analysis. *Pain Physician* 2016;19(3):E365-E410.

Selective Dorsal Rhizotomy for Spasticity in Cerebral Palsy. NICE Interventional Procedure Guidance IPG 373 [Internet] National Institute for Health and Care Excellence. 2010 Dec Accessed at: <https://www.nice.org.uk/guidance/>.

Lumbar Spine Procedures

- Choi D, Bilsky M, Fehlings M, Fisher C, Gokaslan Z. Spine oncology-metastatic spine tumors. *Neurosurgery* 2017;80(3S):S131-S137. DOI: 10.1093/neuros/nyw084.
- Dillard-Cannon E, Atsina KB, Ghobrial G, Gnass E, Curtis MT, Heller J. Lumbar paraganglioma. *Journal of Clinical Neuroscience* 2016;149-151. DOI: 10.1016/j.jocn.2016.01.019.
- Suppiah S, Meng Y, Fehlings MG, Massicotte EM, Yee A, Shamji MF. How best to manage the spinal epidural abscess? A current systematic review. *World Neurosurgery* 2016;93:20--28. DOI: 10.1016/j.wneu.2016.05.074.
- Narayan V, Mohammed N, Savardekar AR, Patra DP, Nanda A. Tuberculous spondylolisthesis: a reappraisal of the clinicoradiologic spectrum and surgical treatment paradigm. *World Neurosurgery* 2018;114:361-367. DOI: 10.1016/j.wneu.2018.02.157.
- Cooper J, Gillick JL, LaBagnara M, Das K, Hillard VH. Traumatic lumbar subdural hematoma in the absence of intracranial disease. *World Neurosurgery* 2016;90:706 e15-706 e18. DOI: 10.1016/j.wneu.2016.03.025.
- Wallace DJ, Sy C, Peitz G, Grandhi R. Management of non-missile penetrating spinal injury. *Neurosurgical Review* 2019;42(4):791-798. DOI: 10.1007/s10143-018-01057-1.
- Warner WC Jr, Sawyer JR. Scoliosis and kyphosis. In: Azar FM, Beaty JH, editors. *Campbell's Operative Orthopaedics*. 14th ed. Philadelphia, PA: Elsevier; 2021:1998-2196.e28.
- Jentzsch T, Gomes de Lima V, Seifert B, Sprengel K, Werner CM. The benefits of elective spinal implant removal: a retrospective study of 137 patients. *European Spine Journal* 2016;25(3):856-864. DOI: 10.1007/s00586-015-4211-8.
- Paul JC, Lonner BS, Vira S, Feldman D, Errico TJ. Does reoperation risk vary for different types of pediatric scoliosis? *Journal of Pediatric Orthopedics* 2018;38(9):459-464. DOI: 10.1097/BPO.0000000000000850.
- Danison AP, Lee DJ, Panchal RR. Temporary stabilization of unstable spine fractures. *Current Reviews in Musculoskeletal Medicine* 2017;10(2):199-206. DOI: 10.1007/s12178-017-9402-y.
- Hanna R, et al. Is prophylactic formal fusion with implant revision necessary in non-ambulatory children with spinal muscular atrophy and growing rods who are no longer lengthened? *Spine Deformity* 2020;8(3):547-552. DOI: 10.1007/s43390-020-00077-6.
- Floccari LV, Milbrandt TA. Surgical site infections after pediatric spine surgery. *Orthopedic Clinics of North America* 2016;47(2):387-394. DOI: 10.1016/j.ocl.2015.09.001.
- Bachmann KR, et al. The variability in the management of acute surgical site infections: an opportunity for the development of a best practice guideline. *Spine Deformity* 2020;8(3):463-468. DOI: 10.1007/s43390-020-00079-4.
- Khan SA, Choudry U, Salim A, Nathani KR, Enam SA, Shehzad N. Current management trends for surgical site infection after posterior lumbar spinal instrumentation: a systematic review. *World Neurosurgery* 2022;164:374-380. DOI: 10.1016/j.wneu.2022.05.138

Lumbar Spine Procedures

Sugawara R, Tsuji T, Saito T, Nohara A, Kawakami K, Kawakami N. Medially misplaced pedicle screws in patients without neurological deficits following scoliosis surgery: to observe or to remove? *European Spine Journal* 2015;24(7):1450-1456. DOI: 10.1007/s00586-015-3860-y.

Nuwer MR, MacDonald DB, Gertsch J. Monitoring scoliosis and other spinal deformity surgeries. *Handbook of Clinical Neurology* 2022;186:179-204. DOI: 10.1016/B978-0-12-819826-1.00014-4.

Yamanaka K, Mori M, Yamazaki K, Kumagai R, Doita M, Chiba A. Analysis of the fracture mechanism of Ti-6Al-4V alloy rods that failed clinically after spinal instrumentation surgery. *Spine* 2015;40(13):E767-E773. DOI: 10.1097/BRS.0000000000000881.

Hill G, et al. Retrieval and clinical analysis of distraction-based dual growing rod constructs for early onset scoliosis. *Spine Journal* 2017;17(10):1506-1518. DOI: 10.1016/j.spinee.2017.04.020.

Klyce W, et al. Pedicle screw plowing in adolescent idiopathic scoliosis: how common is it and is it a problem? *Spine* 2022;47(12):873-878. DOI: 10.1097/BRS.0000000000004252.

Crawford CH, et al. Prevalence and indications for unplanned reoperations following index surgery in the adult symptomatic lumbar scoliosis NIH-sponsored clinical trial. *Spine Deformity* 2018;6(6):741-744. DOI: 10.1016/j.jspd.2018.04.006.

Ayers R, Noschenko A, Ou-Yang D, Burger E, Patel V, Kleck CJ. Laser marking of spine rods is strongly associated with risk of clinical rod failure. *Journal of the American Academy of Orthopedic Surgeons* 2022;30(2):e252-e263. DOI: 10.5435/JAAOS-D-20-00866.

Alsharief AN, El-Hawary R, Schmit P. Pediatric spine imaging post scoliosis surgery. *Pediatric Radiology* 2018;48(1):124-140. DOI: 10.1007/s00247-017-3941-7.

Wall EJ, Jain VV, Crawford AH, Bylski-Austrow DI, Reynolds JE. Spine growth modulation in early adolescent idiopathic scoliosis: prospective US FDA IDE pilot study of titanium clip-screw implant at two to five years. *Spine Deformity* 2019;7(6):899-909. DOI: 10.1016/j.jspd.2019.02.008.

Ak H, Gulsen I, Atalay T, Gencer M. Does the removal of spinal implants reduce back pain? *Journal of Clinical Medicine Research* 2015;7(6):460-463. DOI: 10.14740/jocmr2141w.

Richman SH, Razzano AJ, Morscher MA, Riley PM. Metallosis presenting as a progressive neurologic deficit four years after a posterior spinal fusion for adolescent idiopathic scoliosis: a case report. *Spine* 2017;42(1):E56-E59. DOI: 10.1097/BRS.0000000000001685.

Teoh KH, et al. Metallosis following implantation of magnetically controlled growing rods in the treatment of scoliosis: a case series. *Bone and Joint Journal* 2016;98-B(12):1662-1667. DOI: 10.1302/0301-620X.98B12.38061.

Rushton PRP, Siddique I, Crawford R, Birch N, Gibson MJ, Hutton MJ. Magnetically controlled growing rods in the treatment of early-onset scoliosis: a note of caution. *Bone and Joint Journal* 2017;99-B(6):708-713. DOI: 10.1302/0301-620X.99B6.BJJ-2016-1102.R2.

Medical Director Review 6/2023

Lumbar Spine Procedures

Specialty Matched Consultant Advisory Panel review -5/2024

Medical Director Review 5/2024

Policy Implementation/Update Information

For Policy Titled Lumbar Spine Fusion Surgery

- 9/28/10 New policy written. BCBSNC will provide coverage for Lumbar Spinal Fusion when it is determined to be medically necessary because the medical criteria and guidelines are met. Notice given 9/28/2010. Policy effective 1/1/2011. (btw)
- 2/1/11 The following sentence in the “Description” section was revised from “For conditions such as **degenerative disc disease** and spinal stenosis, medical literature suggests that back surgery with and without fusion result in similar improvement in symptoms over time.” To “For conditions such as **disc herniation** and spinal stenosis, medical literature suggests that back surgery with and without fusion result in similar improvement in symptoms over time.” Added verbiage indicating that this policy is specific to **adults** and the following statement; “**Pediatric and adolescent cases will be addressed on an individual consideration basis.**” In the “When Covered” section revised number 2. From; “Spinal repair surgery for dislocation, abscess or tumor” to “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.**” In 4.b. second bullet changed the statement from “Severe or rapidly progressive symptoms of neurogenic claudication or cauda equina syndrome.” To “Severe or rapidly progressive symptoms of **motor loss**, neurogenic claudication or cauda equina syndrome.” Number 7 revised from “Spondylolisthesis, isthmic (type II), with documented progression of slippage,” to “Isthmic spondylolisthesis, either congenital (Wiltse type I) or acquired pars defect (Wiltse II), documented on x-ray”. Added number 11. “Iatrogenic or degenerative flatback syndrome with significant sagittal imbalance; when fusion is performed with spinal osteotomy.” Reviewed with Senior Medical Director 1/20/2011. (btw)
- 6/21/11 Specialty Matched Consultant Advisory Panel review 5/25/2011. No change to policy statement. References added. (btw)
- 1/1/12 Added new 2012 CPT codes, 22633 and 22634 to “Billing/Coding” section. (btw)
- 1/24/12 CPT code 22624 corrected to 22634 in Billing/Coding section. (btw)
- 9/18/12 Specialty Matched Consultant Advisory Panel review. No change to policy intent. References added. (btw)
- 7/16/13 Specialty Matched Consultant Advisory Panel review 5/15/2013. No change to policy. References added. (btw)
- 6/10/14 Specialty Matched Consultant Advisory Panel review 5/27/2014. No change to policy. (btw)
- 2/24/15 Reference added. Senior Medical Director review. Added tuberculosis to statement 2 under When Covered section. Added “other imaging” to statement 3a under When Covered section. (sk)
- 10/1/15 Specialty Matched Consultant Advisory Panel review 5/26/2015. (sk)
- 7/1/16 Specialty Matched Consultant Advisory Panel review 5/25/2016. Reference added. (sk)

Lumbar Spine Procedures

- 12/30/16 Code 22851 deleted from Billing/Coding section. Codes 22853, 22854, and 22859 added to Billing/Coding section. (sk)
- 2/3/17 Codes 22853, 22854, and 22859 removed from Billing/Coding section. (sk)
- 2/24/17 Codes 22853, 22854, and 22859 added to Billing/Coding section. (sk)
- 9/29/17 Reference added. Specialty Matched Consultant Advisory Panel review 5/31/2017. (sk)
- 6/29/18 Specialty Matched Consultant Advisory Panel review 5/23/2018. (sk)
- 10/12/18 Reference added. (sk)
- 6/11/19 Specialty Matched Consultant Advisory Panel review 5/15/2019. (sk)
- 8/27/19 Reference added. (sk)
- 6/9/20 Specialty Matched Consultant Advisory Panel review 5/20/2020. (sk)
- 6/1/21 Reference added. Related Policies updated. Specialty Matched Consultant Advisory Panel review 5/19/2021. (sk)
- 10/19/21 Medical Director review. Reference added. The following note added to the When Covered section: “For non-emergent procedures that include fusion, it is required that the surgical candidate refrain from smoking/nicotine for at least six weeks prior to surgery and during the time of healing. Attestation from the performing provider is required”. Notification given 10/19/2021 for policy effective date 1/1/2022. (sk)
- 6/14/22 Specialty Matched Consultant Advisory Panel review 5/18/2022. (sk)
- 5/30/23 References added. Specialty Matched Consultant Advisory Panel review 5/17/2023. (sk)

For Policy retitled Lumbar Spine Procedures

- 7/18/23 Policy updated to include Lumbar Laminotomy, Foraminotomy, and Discectomy, Lumbar Laminectomy, and Removal of Posterior Spinal Instrumentation criteria with Lumbar Spine Fusion Surgery medical policy to form combined medical policy for lumbar spine surgeries. Policy title changed from Lumbar Spine Fusion Surgery to Lumbar Spine Procedures. Revised Description section. Added related policies. References added. Added CPT codes: 22850, 22852, 63005, 63012, 63017, 63030, 63035, 63042, 63044, 63047, 63048, 63056, 63057, 63087, 63088, 63090, 63091, 63102, 63103, and 63170. No changes to policy intent or limits set forth herein. Medical Director review 6/2023. (ldh)
- 9/29/23 Policy updated for effective date 10/1/2023. Updated the Note under the Lumbar Spine Fusion procedure in the When Covered section. Now reads: “For non-emergent procedures that include fusion, it is strongly recommended that the surgical candidate refrain from smoking/nicotine for at least six weeks prior to surgery and during the time of healing”. Removed requirement of 6-week tobacco cessation and associated provider attestation. (ldh)
- 5/29/24 Description and Policy Guidelines updated. No change to policy intent. References updated. Specialty Matched Consultant Advisory Panel review 5/2024. Medical Director review 5/2024. (ldh)

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational

Lumbar Spine Procedures

purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.