Spine Procedures

Policy Number: MMP089.11
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➲ Instructions for Use

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Related Policies

None

Coverage Rationale

Cervical Spine

Cervical Spine Surgery

Medicare does not have a National Coverage Determination (NCD) for cervical spine surgery. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Cervical Spine Surgery.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy title Spinal Fusion and Decompression.

Cervical Artificial Disc

Medicare does not have a National Coverage Determination (NCD) for cervical artificial disc replacement. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Cervical Artificial Disc.

For **coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Total Artificial Disc Replacement for the Spine.

Thoracic Spine

Thoracic Spine Surgery

Medicare does not have a National Coverage Determination (NCD) for thoracic spine surgery. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy title Spinal Fusion and Decompression.

Scoliosis or Kyphosis Surgery

Medicare does not have a National Coverage Determination (NCD) for scoliosis or kyphosis surgery. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the InterQual® CP: Procedures, Scoliosis or Kyphosis Surgery.

Click here to view the InterQual® criteria.

Lumbar Spine

Lumbar Spine Surgery

Medicare does not have a National Coverage Determination (NCD) for lumbar spine surgery. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Lumbar Spine Surgery.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Spinal Fusion and Decompression.

Interlaminar Lumbar Instrumented Fusion (ILIF) Utilizing an Interspinous Process Fusion Device

Medicare does not have a National Coverage Determination (NCD) for ILIF utilizing an interspinous process fusion device. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Interspinous Fusion and Decompression Devices.

Spinal Decompression and Interspinous Process Decompression Systems for the Treatment of Lumbar Spinal Stenosis [e.g., Interspinous Process Decompression (IPD)]

Medicare does not have a National Coverage Determination (NCD) for spinal decompression and interspinous process decompression systems. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Interspinous Fusion and Decompression Devices.

Percutaneous Lumbar Decompression of Nucleus Pulposus

Medicare does not have a National Coverage Determination (NCD) for percutaneous lumbar decompression of nucleus pulposus. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Minimally Invasive Spine Surgery Procedures.

Spinal Fusion and Bone Healing Enhancement Products Including Allograft or Synthetic Bone Graft Materials

Medicare does not have a National Coverage Determination (NCD) for spinal fusion and bone healing enhancement products including allograft or synthetic bone graft materials. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Spinal Fusion and Bone Healing Enhancement Products.

Sacral Spine

Percutaneous Sacral Augmentation (Sacroplasty)

Medicare does not have a National Coverage Determination (NCD) for sacroplasty. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Minimally Invasive Spine Surgery Procedures.

Percutaneous Minimally Invasive Fusion/Stabilization of the Sacroiliac Joint for the Treatment of Back Pain

Medicare does not have a National Coverage Determination (NCD) for percutaneous minimally invasive fusion/stabilization of the sacroiliac joint for the treatment of back pain. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs,

refer to the table for Percutaneous Minimally Invasive Fusion/Stabilization of the Sacroiliac Joint for the Treatment of Back Pain.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Sacroiliac Joint Interventions.

Annular Closure Devices (ACDs) (e.g., Barricaid Annular Closure Device)

Medicare does not have a National Coverage Determination (NCD) for annular closure devices. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Discogenic Pain Treatment.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Absent language indicating that a code is non-covered, listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed [Refer to the UnitedHealthcare Commercial Medical Policy titled Minimally Invasive Spine Surgery Procedures]
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed [Refer to the UnitedHealthcare Commercial Medical Policy titled Minimally Invasive Spine Surgery Procedures]
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)
20939	Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision (List separately in addition to code for primary procedure)
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
22210	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical
22212	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic
22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar
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
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
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, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2

CPT Code	Description
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
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
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar
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
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
2284	Reinsertion of spinal fixation device
22850	Removal of posterior nonsegmental instrumentation (e.g., Harrington rod)
22852	Removal of posterior segmental instrumentation
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 osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level [Refer to the UnitedHealthcare Commercial Medical Policy titled Interspinous Fusion and Decompression Devices]

CPT Code	Description
22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure) [Refer to the UnitedHealthcare Commercial Medical Policy titled Interspinous Fusion and Decompression Devices]
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level [Refer to the UnitedHealthcare Commercial Medical Policy titled Interspinous Fusion and Decompression Devices]
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure) [Refer to the UnitedHealthcare Commercial Medical Policy titled Interspinous Fusion and Decompression Devices]
22899	Unlisted procedure, spine [when used to report Spinal Decompression and Interspinous Process Decompression Systems for the Treatment of Lumbar Spinal Stenosis [e.g., Interspinous Process Decompression (IPD)], Cervical Artificial Disc, Annular Closure Devices (ACDs) or Interlaminar Lumbar Instrumented Fusion (ILIF) Utilizing an Interspinous Process Fusion Device]
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device
62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, 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
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

CPT Code	Description
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
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
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)
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)
63064	Costovertebral approach with decompression of spinal cord or nerve root(s) (e.g., herniated intervertebral disc), thoracic; single segment
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace
63077	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, single interspace
63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
63085	Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment
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
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
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
63170	Laminectomy with myelotomy (e.g., Bischof or DREZ type), cervical, thoracic, or thoracolumbar
63172	Laminectomy with drainage of intramedullary cyst/syrinx; to subarachnoid space
63173	Laminectomy with drainage of intramedullary cyst/syrinx; to peritoneal or pleural space
63185	Laminectomy with rhizotomy; 1 or 2 segments
63190	Laminectomy with rhizotomy; more than 2 segments
63191	Laminectomy with section of spinal accessory nerve
63197	Laminectomy with cordotomy, with section of both spinothalamic tracts, 1 stage, thoracic
63200	Laminectomy, with release of tethered spinal cord, lumbar

Diagnosis Code	Description
For CPT Code 27279	
M43.17	Spondylolisthesis, lumbosacral region
M43.18	Spondylolisthesis, sacral and sacrococcygeal region
M43.27	Fusion of spine, lumbosacral region
M43.28	Fusion of spine, sacral and sacrococcygeal region
M46.1	Sacroiliitis, not elsewhere classified
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M53.2X7	Spinal instabilities, lumbosacral region
M53.2X8	Spinal instabilities, sacral and sacrococcygeal region
M53.3	Sacrococcygeal disorders, not elsewhere classified
M53.87	Other specified dorsopathies, lumbosacral region
M53.88	Other specified dorsopathies, sacral and sacrococcygeal region
M54.18	Radiculopathy, sacral and sacrococcygeal region
M99.04	Segmental and somatic dysfunction of sacral region
M99.14	Subluxation complex (vertebral) of sacral region
Q74.2	Other congenital malformations of lower limb(s), including pelvic girdle
S33.2XXA	Dislocation of sacroiliac and sacrococcygeal joint, initial encounter
S33.2XXD	Dislocation of sacroiliac and sacrococcygeal joint, subsequent encounter
S33.2XXS	Dislocation of sacroiliac and sacrococcygeal joint, sequela
S33.6XXA	Sprain of sacroiliac joint, initial encounter
S33.6XXD	Sprain of sacroiliac joint, subsequent encounter
S33.6XXS	Sprain of sacroiliac joint, sequela
S33.8XXA	Sprain of other parts of lumbar spine and pelvis, initial encounter
S33.8XXD	Sprain of other parts of lumbar spine and pelvis, subsequent encounter
S33.8XXS	Sprain of other parts of lumbar spine and pelvis, sequela

Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the Medicare Coverage Database, if no NCD, LCD or LCA is found refer to the criteria as noted in the Coverage Rationale section above.

NCD	LCD	Article	Contractor Type	Contractor Name
Cervical Spine Surgery				
N/A	L39741 Cervical Fusion **Effective 07/07/2024**	A59608 Billing and Coding: Cervical Fusion	A and B MAC	CGS
N/A	L39758 Cervical Fusion **Effective 07/07/2024**	A59624 Billing and Coding: Cervical Fusion	A and B MAC	Noridian
N/A	L39762 Cervical Fusion **Effective 07/07/2024**	A59645 Billing and Coding: Cervical Fusion	A and B MAC	Noridian
N/A	L39773 Cervical Fusion **Effective 07/07/2024**	A59634 Billing and Coding: Cervical Fusion	A and B MAC	Palmetto**
Cervical Artificial Disc				
N/A	L37826 Cervical Disc Replacement	A57021 Billing and Coding: Cervical Disc Replacement	A and B MAC	Palmetto**

NCD	LCD	Article	Contractor Type	Contractor Name
Lumbar Spine Surgery				
N/A	L37848 Lumbar Spinal Fusion	A56396 Billing and Coding: Lumbar Spinal Fusion	A and B MAC	Palmetto**
Percutaneous Minimally Invasive Fusion/Stabilization of the Sacroiliac Joint for the Treatment of Back Pain				
N/A	L36494 Minimally-Invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint	A56535 Billing and Coding: Minimally-Invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint	A and B MAC	CGS
N/A	L36406 Minimally-invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint	A57431 Billing and Coding: Minimally-invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint	A and B MAC	NGS
N/A	L39025 Minimally Invasive Surgical (MIS) Fusion of the Sacroiliac Joint (SIJ)	A58739 Billing and Coding: Minimally Invasive Surgical (MIS) Fusion of the Sacroiliac Joint (SIJ)	A and B MAC	Palmetto**
N/A	L36000 Percutaneous minimally invasive fusion/stabilization of the sacroiliac joint for the treatment of back pain	Article - Billing and Coding: Percutaneous minimally invasive fusion/stabilization of the sacroiliac joint for the treatment of back pain (A57596) (cms.gov)	A and B MAC	WPS*

Medicare Administrative Contractor (MAC) With Corresponding States/Territories	
MAC Name (Abbreviation)	**States/Territories**
CGS Administrators, LLC (CGS)	KY, OH
First Coast Service Options, Inc. (First Coast)	FL, PR, VI
National Government Services, Inc. (NGS)	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian Healthcare Solutions, LLC (Noridian)	AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas Solutions, Inc. (Novitas)	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, VA**
Palmetto GBA (Palmetto)	AL, GA, NC, SC, TN, VA**, WV
Wisconsin Physicians Service Insurance Corporation (WPS)*	IA, IN, KS, MI, MO, NE
Notes	
*Wisconsin Physicians Service Insurance Corporation: Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers. **For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction.	

Policy History/Revision Information

Date	Summary of Changes
10/01/2024	**Centers for Medicare & Medicaid (CMS) Related Documents** • Added notation for the state of Virginia to indicate “Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction”
08/01/2024	**Template Update** • Reformatted and reorganized policy content previously included in the UnitedHealthcare: ○ Medicare Advantage Coverage Summary titled *Spine Procedures*

Date	Summary of Changes
	○ Medicare Advantage Policy Guideline titled *Percutaneous or Minimally Invasive Surgical Fusion of the Sacroiliac Joint* • Transferred content to new template and changed policy type classification to "Medical Policy" • Updated *Instructions for Use* **Related Policies** • Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled: ○ *Category III CPT Codes* ○ *Percutaneous or Minimally Invasive Surgical Fusion of the Sacroiliac Joint* **Coverage Rationale** • Removed content/language addressing: ○ Percutaneous vertebroplasty and percutaneous vertebral augmentation ○ Lumbar artificial disc ○ Percutaneous image-guided lumbar decompression (PILD) ○ Epidural lysis (CPT codes 62264 and 62290) ○ Intra-facet implants (CPT codes 0219T, 0220T, 0221T, and 0222T) ***Cervical Spine*** Cervical Spine Surgery • Revised language to indicate: ○ Medicare does not have a NCD for cervical spine surgery ○ LCDs/LCAs exist and compliance with these policies is required where applicable; for specific LCDs/LCAs, refer to the table [in the *Centers for Medicare & Medicaid (CMS) Related Documents* section of the policy] ○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled *Spinal Fusion and Decompression* ***Lumbar Spine*** Lumbar Spine Surgery • Revised language to indicate: ○ Medicare does not have a NCD for lumbar spine surgery ○ LCDs/LCAs exist and compliance with these policies is required where applicable; for specific LCDs/LCAs, refer to the table [in the *Centers for Medicare & Medicaid Services (CMS) Related Documents* section of the policy] ○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled *Spinal Fusion and Decompression* ***Interlaminar Lumbar Instrumented Fusion (ILIF) Utilizing an Interspinous Process Fusion Device*** • Revised language to indicate: ○ Medicare does not have a NCD for interlaminar lumbar instrumented fusion (ILIF) utilizing an interspinous process fusion device ○ LCDs/LCAs do not exist ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Interspinous Fusion and Decompression Devices* ***Spinal Decompression and Interspinous Process Decompression Systems for the Treatment of Lumbar Spinal Stenosis [e.g., Interspinous Process Decompression (IPD)]*** • Revised language to indicate: ○ Medicare does not have a NCD for spinal decompression and interspinous process decompression systems ○ LCDs/LCAs do not exist ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Interspinous Fusion and Decompression Devices* ***Spinal Fusion and Bone Healing Enhancement Products Including Allograft or Synthetic Bone Graft Materials*** • Replaced language indicating "Medicare does not have a NCD for *bone healing and fusion enhancement products*" with "Medicare does not have a NCD for *spinal fusion and bone healing enhancement products including allograft or synthetic bone graft materials*" **Applicable Codes**

Date	Summary of Changes
	CPT Codes • Updated list of applicable CPT codes; removed 22216, 22226, 22552, 27278, 27280, 22842, 22853, 22859, 22899, 63048, and 63091 **Centers for Medicare & Medicaid Services (CMS) Related Documents** • Updated list of documents available in the *Medicare Coverage Database* to reflect the most current information **Supporting Information** • Archived previous policy version MCS089.10

Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

- Medical necessity coverage guidelines; including documentation requirements, and/or
- Medicare coding or billing requirements.

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

You are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate's requirements need to be followed.