Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions
Medicare Local Coverage Determination -L33382 Checklist

LCD-L33382	**Patient Name:**	**MR:**

Effective Date: January 1, 2018

Lumbar spinal fusion for instability and degenerative disc conditions must have the indications and medical need for the procedures documented in the medical record in order to be considered medically necessary. Spinal fusion should only be considered as a last step in the treatment of chronic back pain and is not indicated for most persons suffering from back pain. See LCD-L33382

GENERAL REQUIREMENTS

Prior Treatments: Initial management can include rest, exercise program, avoidance of activities that aggravate pain, application of heat/cold modalities, pharmacotherapy, local injections, lumbar bracing, chiropractic manipulation, and physical therapy. When conservative therapy (non-surgical medical management) is unsuccessful after at least 3 to 12 months, depending on the diagnosis, lumbar spinal fusion may be considered for certain conditions (*see Coverage Indications below*).

Limitations: Lumbar spinal fusion for the following conditions are not considered medically necessary and are noncovered:
a. The presacral interbody technique (CPT codes 0195T, 0196T, and 22586)(e.g., AxiaLIF)
b. Emerging techniques and associated tools (devices, spinal instrumentation, bone graft substitutes, etc.) that are considered investigational
c. When performed with initial primary laminectomy/discectomy for nerve root decompression or spinal stenosis, without documented spondylolisthesis or documentation of instability (e.g., documented intraoperative iatrogenic instability)
d. Lumbar fusion at multi-levels (2 or more) for pure DDD unless case specific indications for two level or the rare three or more level planned fusion procedure is directly addressed in the pre-procedure record

Coding:
1. CPT codes for the lumbar spinal fusions are mostly inpatient only procedures. These procedures must be performed in an inpatient only hospital setting ordered by the treating physician.
CPT codes (Inpatient Procedures): 22533,22534,22558,22630,22632,22633,22634,22800,22802,22804,22808, 22810,22812
2. There are a few lumbar spinal fusions procedures that can be performed as outpatient procedures and are as follows: 22585,22612,22614,22853,22854,22859

COVERAGE INDICATIONS

Lumbar spinal fusion surgery IS considered medically reasonable and necessary for ANY of the following 6 conditions:

I. Lumbar spinal instability for **ANY** of the following indications when confirmed by appropriate diagnostic testing (e.g., radiographic imaging, biopsy, bone aspirate, bone scan and gallium scan):
• Acute spinal fracture
• Progressive or significant acute neurological impairment
• Neural compression after spinal fracture
• Epidural compression or vertebral destruction from tumor or abscess
• Spinal tuberculosis
• Spinal debridement for infection
• Spinal deformity

II. Spinal stenosis for a single level (for example, L4-L5) with associated spondylolisthesis (see classifications in section III) or other documented evidence of instability, **AND** symptoms of spinal claudication and radicular pain. The pain must represent a significant functional impairment despite a history of 3 months of conservative therapy (non-surgical medical management) as clinically appropriate addressing the following:
• Activity lifestyle modification
• Daily exercise
• Supervised physical therapy (PT)
• Anti-inflammatory medications, oral or injection therapy as appropriate, and analgesics

III. Spondylolisthesis manifested by back pain WITH OR WITHOUT spinal claudication, radicular pain, motor deficit when **ANY** of the following criteria are met:

• Confirmed progressive deformity usually Grade II or higher
• Multilevel spondylolysis
• Symptomatic low-grade spondylolisthesis associated with back pain and significant functional impairment despite a history of 3 months of conservative therapy (non-surgical medical management) as clinically appropriate addressing the following: activity lifestyle modification; daily exercise; supervised PT; and anti-inflammatory medications, oral or injection therapy as appropriate, and analgesics

Classification of slippage in spondylolisthesis is defined as follows:
• Grade I =1% to 25%
• Grade II=26% to 50%
• Grade III=51% to 75%
• Grade IV= 76% to 100%
• Grade V = spondyloptosis and occurs when the L5 vertebra completely slides over the top of the sacrum

IV. Degenerative disc disease (DDD) in the absence of instability when all of the following criteria have been met as clinically appropriate for the patient's current episode of care:

• Single level DDD demonstrated on imaging studies (e.g., CT scan, MRI, or discography) as the likely cause of pain.
• Pain and significant functional impairment despite a history of at least 6 months of conservative therapy (non-surgical medical management) as clinically appropriate addressing the following: ◦ Anti-inflammatory medications, oral or injection therapy as appropriate, and analgesics
◦ Daily exercise
◦ Activity lifestyle modification
◦ Weight reduction as appropriate
◦ Supervised PT [ADLs diminished despite completing a plan of care]

OR
◦ Unsuccessful improvement after completion of intense multidisciplinary rehabilitation (IMR).

V. Lumbar fusion following prior spinal surgery for the following:

• Recurrent disc herniation despite clinically appropriate post operative nonsurgical medical management
• Adjacent segment degeneration or disc herniation despite clinically appropriate post-operative nonsurgical medical management
• Associated spondylolisthesis (for example anterolisthesis) after prior spinal surgery with ALL the following as clinically appropriate:
◦ Recurrent symptoms consistent with neurological compromise
◦ Significant functional impairment
◦ Neural compression is documented by recent post-operative imaging
◦ Unsuccessful improvement despite 3 months of clinically appropriate post-operative nonsurgical medical management
◦ Instability is documented by appropriate imaging
◦ Patient had some relief of pain symptoms following the prior spinal surgery

VI. Treatment of pseudoarthrosis (i.e., nonunion of prior fusion) at the same level after 12 months from prior surgery and **ALL** of the following are met (unless imaging demonstrates failed spinal instrumentation [for example, fractured rod or loosened screw]):

• Imaging studies confirm evidence of pseudoarthrosis (e.g., radiographs, CT)
• Unsuccessful improvement despite 3 months of clinically appropriate post-operative nonsurgical medical management (post-operative case specific conservative therapy is prescribed as clinically appropriate in addition to documentation of pain and functional impairment)
• Patient had some relief of pain symptoms following the prior spinal surgery

NOTE! If in certain circumstances the patient does not meet all of the required criteria outlined in the local coverage determination (LCD) for a procedure, but the treating physician feels that the procedure is a covered procedure given the current standards of care, then the documentation must clearly outline the patient's episode of care that supports the major procedure and must clearly address the reason(s) for coverage. The clinical judgment of the treating physician is always a consideration if clearly addressed in the pre-procedure record and if consistent with the episode of care for the patient as documented in patient records and claim history.

DOCUMENTATION REQUIREMENTS

☐ Medical need for lumbar spinal fusion surgery documented by the physician.

☐ Office notes/hospital record, including history and physical by the attending/treating physician.

☐ Documentation of the history and duration of unsuccessful conservative therapy (non-surgical medical management) when applicable.

☐ Interpretation and reports for X-rays, MRI's, CT's, etc.

☐ Medical clearance reports (as applicable).

☐ Documentation of smoking history, and that the patient has received counseling on the effects of smoking on surgical outcomes and treatment for smoking cessation if accepted (if applicable).

☐ Inpatient Physician Order for those procedures that performed as an inpatient, along with documentation supporting the patient requires inpatient care.

☐ Complete operative report outlining operative approach used and all the components of the spine surgery.

☐ For single level DDD demonstrated on imaging studies (e.g., CT scan, MRI, or discography), the case specific indications for two level or the rare three or more level planned fusion procedure must be directly addressed in the pre procedure record with clinical correlation to diagnostic testing results (such as disk-space narrowing, end plate changes, annular changes, etc.)

Checklist completed by :	**Date:**

Disclaimer: *The content of the checklists were created as an educational tool. Use of these documents are not intended as a replacement for the documentation requirements published in National or Local Coverage Determinations, or the CMS's documentation guidelines, written law or regulations. Medicare policy changes frequently; Providers/Departments are reminded to review current National and Local Coverage Determination and Policy Articles for specific documentation and coding guidelines.*