Policy:
There are many back and neck problems that do require surgical intervention. However, many surgical procedures of the spine are not generally indicated for back and neck pain. Surgeries on the vertebral column include kyphoplasty, foraminotomy, laminectomy, corpectomy, discectomy, microdiscectomy, and fusion.

Procedure:
1. Spine Surgery Naive (initial request in specific region)
   a. The elective procedure must be prior-authorized by Meridian Health Plan unless to do so would compromise patient health/outcome. Those emergent cases will be subject to post service review by MHP with the possibility of retrospective denial. Emergent surgeries on the vertebral column are typically associated with infection, tumor, or trauma.
   b. InterQual guidelines apply to requests for fusion to treat patients with a spinal fracture or dislocation, spinal infection, or spinal deformity, (e.g., one related to degenerative scoliosis). All requests for spinal fusion must show evidence of spondylolisthesis, mechanical instability, bilateral nerve involvement at the same level or evidence of multi-level involvement. Mechanical instability with an x-ray is defined as instability by flexion and extension x-rays; sagittal plane translation > 3mm or sagittal plane translation > 15% of vertebral body width.
   c. The requested procedure, unless specifically commented on elsewhere in this document, will be covered for Meridian Health Plan members meeting all of the following criteria:
      i. The procedure specific InterQual criteria are met except as modified below.
ii. A minimum of a 3 consecutive month trial of a comprehensive rehabilitation program is required consisting of back education, progressive exercise training, core strengthening, flexibility, and/or toning, within the previous 9 months unless contraindications to or demonstrated failure of the specific modalities. Manual therapies, epidural steroid injections (See policy G.09), behavior modification and other treatment modalities may be used as an adjunct to the patient’s treatment plan.

iii. Documentation, through physician certification and two negative urine tests spaced two weeks apart, of being nicotine free for a minimum of 4 weeks prior to the anticipated surgery, when the requested procedure includes a thoracic or lumbar spinal fusion.

iv. Neurological findings on physical exam that match CT/MRI findings for Spinal Stenosis or nerve root compression consistent with the findings on exam.

v. Lumbar disc herniation with radiculopathy occurs when there is localized displacement of disc material beyond the normal margins of the intervertebral disc space and results in pain, weakness or numbness in a myotomal or dermatomal distribution. Disc bulging may or may not represent clinical significance.

All requests for spinal fusion must show evidence of mechanical instability at multiple vertebral levels or spondylolisthesis. Due to trauma, infection, or tumors. Fusion for degenerative disease is controversial and would require clear evidence of anticipated benefits. Chronic pain in the absence of neurological findings is not an indication for spinal fusion. Experimental Investigational procedures are not covered.

2. Members that are requesting an evaluation for back surgery by a neurosurgeon or an orthopedic back surgeon must first be seen by a specialist competent and trained in management of acute and chronic back pain. Commonly this could be a neurologist, physiatrist, or anesthesiologist working in a pain center. Exceptions to this are if the PCP requests an urgent evaluation be done by a surgical back specialist and/or if the patient has a history of back trauma, neoplasm, spinal infection or is >60.

3. Other Re-do Spine surgery or surgery, inclusive of region of a previous Surgery

Special Instructions:

Medicaid/All: The patient must comply with MHPs Member Compliance Medical Policy (I.7)

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Approved by: __________________________ |
Corporate Chief Operating Officer |
Date: 03/27/2015 |

Reviewed and approved by Policy and Procedure Committee: Date: 01/23/2015 |

Reviewed and approved by Medical Policy Operations Committee: Date: 02/27/2015 |

Reviewed and approved by Physician Advisory Committee: Date: 03/27/2015 |

Reviewed and approved by Corporate Compliance Committee: Date: 04/21/2015 |

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References:
6. Deyo, RA, Nachemson A, Mirza, SK; Spinal Surgery-The case for restraint; NEJM 2004, Feb 12; 350(7) 722-6
14. McKesson-InterQual 2010
18. Foundation for Healthy Communities (November 2004). Management of Acute Low Back Pain, N.H. Guideline for Primary Care (Adults age 18 and older).

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