

**Objective:**

To ensure that when Tuality Health Alliance (THA) members are referred for back surgery, conservative measures have been tried and failed and that members are in the most optimal health possible to increase good postoperative outcomes.

**PRIOR AUTHORIZATION REQUIRED**

**Policy:**

- I. Lumbar Spinal Surgery is indicated for a variety of conditions including:
  - A. Disc herniation
  - B. Spondylolisthesis
  - C. Spinal stenosis
  - D. Trauma to spine
  - E. Congenital deformity
  
- II. Acute radicular pain due to disc herniation or extrusion should be managed conservatively initially with medication and physical therapy. Rapidly progressive symptoms and weakness or other neurologic findings may necessitate early surgical intervention. However, a 6-8 week course of conservative care is usually recommended prior to surgical consultation.
  
- III. Chronic back and radicular pain may be managed surgically by laminectomy and discectomy or rarely by spinal fusion. All non-surgical methods of alleviating the pain should be used prior to surgery. Fusion surgery should be limited to significant spondylolisthesis or other major back deformities. There is no evidence to support fusion surgery for chronic back pain in the absence of major instability.
  
- IV. Lumbar spinal stenosis in the aged patient represents a chronic syndrome of pain and/or loss of neurologic function. Other causes of leg pain and weakness such as atherosclerotic disease must be ruled out. Surgery is appropriate where there are significant symptoms and where the patient can tolerate a major surgical procedure.
  
- V. Criteria:
  - A. Laminectomy/Discectomy – All of the following must be present;

1. Significant radicular pain due to nerve compression. There should be some evidence that the pain causes either physical disability, use of potent pain medications or interruption of normal daily activities. A proper physical exam should document the findings of nerve compression.
  2. CT – MRI findings of nerve impingement that correlate with neurologic signs.
  3. Failure of 6-8 weeks of conservative care unless there is either intolerable progressive pain or significant motor dysfunction such as significant “drop foot” (not just minimal weakness). Oral steroids should be tried in most cases where there is no contraindication. Epidural steroids should be used in selected cases possibly avoiding surgery.
  4. Must cease smoking for at least 4 weeks prior to surgery and be willing to refrain from smoking 3 months post surgery.
- B. Spinal Fusion – All of the following must be present;
1. Documented spinal instability or deformity that can be corrected by fusion techniques
  2. Failure of conservative care if indicated
  3. Must cease smoking for at least 4 weeks prior to surgery and be willing to refrain from smoking 3 months post surgery.
- C. Spinal Stenosis – All of the following:
1. Pain and/or neurological changes compatible with spinal cord or nerve compression.  
Neurogenic claudication or cauda equine syndrome should be well documented. The candidate for surgery should have pain and/or numbness in the legs when walking. Vascular Claudication should be ruled out by proper physical exam.
  2. CT or MRI findings of significant stenosis
  3. Absence of medical conditions that would exclude the major surgery and recovery for candidates who are usually aged and possibly frail.
  4. Must cease smoking for at least 4 weeks prior to surgery and be willing to refrain from smoking 3 months post surgery.
- VI. CPT Codes:
- A. 22558 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
  - C. 22612 Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)

- D. 22630 Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar
- E. 22632 each additional interspace
- F. 22841 Internal spinal fixation by wiring of spinous processes
- G. 22842 Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments
- H. 22843 7 to 12 vertebral segments
- I. 22844 13 or more vertebral segments
- J. 63005 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminectomy or discectomy, (eg, spinal stenosis), one or two vertebral segments; lumbar, except for spondylolisthesis
- K. 63011 Sacral
- L. 63012 Laminectomy with removal of abnormal facets and/or pars interarticularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)
- M. 63017 lumbar
- N. 63030 Laminectomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, lumbar (including open or endoscopically-assisted approach)
- O. 63042 Laminectomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration single interspace; lumbar
- P. 63047 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis), single vertebral segment; lumbar
- Q. 63056 Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disk), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disk)
- R. 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
- S. 63090 more than two segments
- T. 63267 Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar

**Subject: Back Surgery**

**Page 4 of 4**

- U. 63272 Laminectomy for excision of intraspinal lesion other than neoplasm, intramural; lumbar
- V. 63307 Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, lumbar or sacral by transperitoneal or retroperitoneal approach

References: Providence Health Plan Policy Back: Lumbar Spine Surgery  
Milliman Care Guidelines Continuum of Care Guidelines Back Surgery

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**THA Plan Director**

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**THA Medical Director**