To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Clinical Coverage Policies
Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:

1.0 Description of the Procedure, Product, or Service

There are many causes of back pain, which can be categorized as mechanical, degenerative, inflammatory, infectious, traumatic, oncologic (tumor or cancer), congenital or developmental, idiopathic, or psychogenic. Within each of these categories, there are a number of specific diagnoses that can cause back pain; such as infection, hemorrhage, fracture and tumor with or without associated symptoms. Although there are numerous causes of back pain, it is imperative to distinguish whether the pain is actually generated by a primary spine-related condition, or whether it is caused by some other body system (such as a kidney disorder or aortic aneurysm) mimicking back pain.

Mild to moderate back pain arising from numerous etiologies are often treated effectively with conservative medical management. Non-surgical measures commonly used to treat back pain are medication, activity and behavioral modification, heat or ice application, orthotics (back brace or corset), or spinal injections.

Surgical intervention is only considered if the diagnosis is amenable to surgery and non-operative treatments have failed. Rarely, some spinal conditions are more serious (such as fractures, neurologic compromise, or cancer) and require immediate surgical management.

Spinal decompression surgery is a general term that refers to various procedures intended to relieve symptoms caused by pressure, or compression on the spinal cord or nerve roots. Depending on the location and cause of the compression, this may be accomplished by performing a discectomy, laminectomy, laminotomy, foraminotomy, foraminectomy, corpectomy, facetectomy, or spinal fusion.

Spinal fusion is a surgical procedure that joins two or more back vertebrae together to heal into one solid bony structure. This procedure is also known as arthrodesis. This surgery may be used to treat spinal instability, cord compression due to severe herniated discs, protruded or extruded discs, or arthritis, fractures in the spine, or destruction of the vertebrae by infection or tumor.

1.1 Definitions

1.1.1 Artificial Intervertebral Discs

A treatment alternative to spinal fusion for painful movement between two vertebrae due to a degenerated or injured disc.

1.1.2 Cauda Equina Syndrome (CES)

A condition caused by compression of multiple lumbosacral nerve roots in the spinal canal due to an abrupt prolapse of the lumbar disc. Clinical CES ***is a medical emergency*** characterized by bilateral sciatica in the lower back and upper buttocks, saddle anesthesia, urinary retention, and bowel dysfunction.

1.1.3 Conservative Medical Management

A non-surgical approach to treating back pain and related spinal conditions utilizing treatment options such as (at a minimum):

a. Prescription strength medications (analgesics, anti-inflammatories, steroids, or muscle relaxants), if not contraindicated;
b. Spinal injections (facet joint or epidural steroid injections), as appropriate;
c. Cessation or modification of any identifiable inciting activities; Heat or ice application, as appropriate;
d. Participation in physical therapy or a home exercise program;
e. Behavior modification (such as weight reduction and smoking cessation); **and**
f. Evaluation and management of associated cognitive, behavioral, or addiction issues, when present.

1.1.4 Corpectomy

The removal of the entire vertebral body and surrounding discs to relieve nerve or spinal cord impingement.

1.1.5 Decompression Surgery

A general term that refers to various procedures intended to relieve symptoms caused by pressure on the spinal cord or nerve roots. Bulging or collapsed discs, thickened joints, loosened ligaments, or bony growths can narrow the spinal canal and the spinal nerve openings causing irritation. The following surgeries are performed under the umbrella of decompression surgery: discectomy, microdiscectomy, corpectomy, hemicorpectomy, foraminectomy, foraminoplasty, foraminotomy, laminectomy, hemilaminectomy, or laminotomy, laminoplasty, and osteophytectomy.

1.1.6 Degenerative Disc Disease

A general term indicating a progressive drying out and degeneration of the intervertebral disc that leads to loss of spine flexibility and function.

1.1.7 Discectomy

A surgical procedure that involves removal of the herniated portion of a disc to relieve irritation and inflammation of a nerve. It is performed as an open procedure and typically involves full or partial removal of the back portion of a vertebra (lamina) to access the ruptured disc.

1.1.8 Facet Joints

Facet joints are the small joints on the back of the spine, one on each side. Each vertebra is connected by facet joints that provide stability to the spine.

1.1.9 Fusion (Arthrodesis)

A surgical procedure where two or more vertebrae are permanently fused together. A bone graft is inserted between the vertebrae or facet joints to stimulate the

growth of bone across a joint. The goal is to stabilize an unstable joint, correct a deformity, and relieve pain.

1.1.10 Herniated Disc

A rupture of nucleus pulposus through the fibrocartilagenous material (annulus fibrosus) that surrounds the intervertebral disc.

1.1.11 Laminectomy

This procedure involves the removal of the bone overlying the spinal canal. It enlarges the spinal canal and is performed to relieve nerve pressure caused by spinal stenosis.

1.1.12 Laminoplasty

A surgical procedure for treating spinal stenosis by relieving pressure on the spinal cord.

1.1.13 Laminotomy

A surgical procedure to remove a portion of the lamina overlying a compressed nerve to access a disc herniation or osteophyte, in order to remove it and decompress the nerve root. This procedure can be done on both sides of the spine (laminotomy), or on one side (hemilaminotomy)

1.1.14 Meyerding Grading System

Grading system used to classify the degree of vertebral slip forward over the vertebral body beneath

1.1.15 Myelopathy

A neurologic deficit related to the spinal cord, usually due to compression of the spinal cord.

1.1.16 Oswerty Disability Index (ODI)

A standard self-administered low back pain questionnaire used by clinicians and researchers to measure a beneficiary's functional disability at a certain point in time.

1.1.17 Persistent Pain

A significant level of pain on a daily basis defined on a Visual Analog Scale (or equivalent) as greater than four (4) **and** has a documented impact on activities of daily living (ADLs) in spite of optimal conservative care.

1.1.18 Pseudoarthrosis

Also known as "false joint," a term used to describe a situation where the spinal segment does not grow together after a spinal fusion.

1.1.19 Radiculopathy

Any disease of the spinal nerve roots and spinal nerves. Radiculopathy is characterized by pain that seems to radiate from the spine to extend outward to cause symptoms away from the source of the spinal nerve root irritation.

1.1.20 Significant Functional Impairment

Inability or significantly decreased ability to perform normal activities of work, school, or at-home duties.

1.1.21 Skeletal Maturity

Occurs when bone growth ceases after puberty and refers to demonstration of fusion of skeletal bones. Females reach skeletal maturity at approximately 16 years of age, while males reach skeletal maturity around 18 years of age. Exact measurement of skeletal maturity is usually based on calculations from knee or hand and wrist radiographs.

1.1.22 Spinal Instability

Increased motion of the vertebra over one another to the point that the spinal cord or nerve roots may be compressed.

1.1.23 Spinal Instrumentation

Devices that surgeons implant during spinal surgery. These devices may be made of various materials and come in a variety of sizes and shapes. These devices consist of rods, hooks, cables, plates, screws, and interbody cages.

1.1.24 Spinal Stenosis

Reduction in the diameter of the spinal canal by bone spurs, disc herniation, thickened ligaments, traumatic displacement of bone or tissue, or a congenital defect.

1.1.25 Spondylolisthesis

The anterior or posterior slipping or displacement of one vertebra over another.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid policies*)

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)
None Apply

a. <u>Medicaid</u>
None Apply

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

EPSDT provider page: https://medicaid.ncdhhs.gov/

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

3.2.1.1 Cervical Spine Surgery

a. Medicaid shall cover single-level cervical artificial disc implantation from C3-4 to C6-7 when the following criteria are met:

1. The device is approved by the Food and Drug Administration (FDA) for the intended purpose;
2. The beneficiary has reached skeletal maturity;
3. The beneficiary has persistent cervical radicular pain or myelopathy refractory to at least six (6) consecutive weeks of conservative medical management under the direction of a physician (unless there is evidence of spinal infection) **or** has severe or rapidly progressive symptoms of nerve root or spinal cord compression requiring hospitalization or immediate surgical treatment;
4. Disc degeneration is confirmed by magnetic resonance imaging (MRI), computed tomography (CT), or myelography;
5. The beneficiary is free from contraindications to cervical artificial disc implantation; **and**
6. The planned implant is used in the reconstruction of a cervical disc at C3-C7 following single-level discectomy.

b. Medicaid shall cover anterior cervical fusion, with or without instrumentation, when **one or more** of the following criteria are met:

1. Unstable traumatic anterior column fracture;

2. Disc herniation with radiculopathy when **both** of the following are present:
   A. Unremitting radicular pain or progressive weakness secondary to nerve root compression; **and**
   B. Refractory to at least six (6) consecutive weeks of conservative medical management **or** has severe or rapidly progressive symptoms of nerve root or spinal cord compression requiring hospitalization or immediate surgical treatment;
3. Multilevel spondylotic myelopathy as evidenced by **one or more** of the following:
   A. Clinical symptoms of myelopathy such as clumsiness of hands, urinary urgency, bowel or bladder incontinence, or frequent falls;
   B. Clinical signs of myelopathy such as hyperreflexia, Hoffman sign, increased tone or spasticity, loss of thenar or hypothenar eminence, gait abnormality, or positive Babinski sign; **or**
   C. Diagnostic imaging is positive for cord compression from either herniated disc or osteophyte.
4. Ossification of the posterior longitudinal ligament up to three (3) levels associated with myelopathy;
5. Degenerative cervical spondylosis with kyphosis causing cord compression;
6. Traumatic disc herniation associated with myelopathy;
7. Primary or metastatic tumor causing pathological fracture, cord compression, or instability;
8. Spinal infectious disease;
9. Multilevel spondylotic radiculopathy;
10. Degenerative spinal segment adjacent to a prior decompressive of fusion procedure with **one or both** of the following:
    A. Symptomatic myelopathy corresponding to the adjacent level; **or**
    B. Symptomatic radiculopathy corresponding to the adjacent level and unresponsive to conservative care;
11. Other symptomatic instability or cord or root compression requiring anterior fusion with **both** of the following:
    A. Unresponsiveness to conservative care **or** has severe or rapidly progressive symptoms of nerve root or spinal cord compression requiring hospitalization or immediate surgical treatment; **and**
    B. Imaging study demonstrating corresponding pathologic anatomy.

c. Medicaid shall cover posterior cervical fusion, with or without instrumentation when **one or more** of the following criteria are met:

1. As a concurrent stabilization procedure with corpectomy, laminectomy, or other surgical procedure;

2. Symptomatic pseudoarthrosis from a prior fusion;
3. Subluxation or compression in rheumatoid arthritis;
4. Multilevel spondylotic myelopathy without kyphosis as evidenced by **one or more** of the following:
   A. Clinical symptoms of myelopathy such as clumsiness of hands, urinary urgency, bowel or bladder incontinence, or frequent falls;
   B. Clinical signs of myelopathy such as hyperreflexia, Hoffman sign, increased tone or spasticity, loss of thenar or hypothenar eminence, gait abnormality, or positive Babinski sign; **or**
   C. Diagnostic imaging is positive for cord compression from either herniated disc or osteophyte.
5. Degenerative spondylosis with kyphosis that is causing spinal cord compression;
6. Unstable injuries consisting of:
   A. Atlas and axis fractures;
   B. Disruption of posterior ligamentous structures;
   C. Facet fractures with dislocation;
   D. Bilateral locked facets; **or**
   E. Central cord syndrome with multisegment injury.
7. Symptomatic cervical spondylosis with instability as evidenced radiographically by **one or more** of the following:
   A. Subluxation or translation of more than 3.5 millimeters on static lateral views or dynamic radiographs;
   B. Sagittal plane angulation of more than 11 degrees between adjacent segments; **or**
   C. More than four (4) millimeters of subluxation between the tips of the spinous processes of dynamic views.
8. Klippel-Feil syndrome;
9. Cervical instability in Down syndrome;
10. Cervical instability in skeletal dysplasia or connective tissue disorders;
11. Spinal tumor, abscess, or infection with associated cord compression or instability; or
12. Other symptomatic instability or cord or root compression requiring posterior fusion with **both** of the following:
    A. Unresponsiveness to conservative care; **and**
    B. Imaging study demonstrating corresponding pathologic anatomy.

d. Medicaid shall cover cervical decompression (discectomy, microdiscectomy, corpectomy, hemicorpectomy, foraminectomy, foraminoplasty, foraminotomy, laminectomy, hemilaminectomy, laminotomy, laminoplasty, and osteophytectomy) when all other reasonable sources of pain have been ruled out and **one or more** of the following criteria are met:

1. Cervical radiculopathy resulting from degenerative disc disease, disc herniation, or facet joint hypertrophy, if **all of** the following are present:
   A. Unremitting radicular pain or progressive weakness secondary to nerve root compression; **and**
   B. Failure of a six (6) consecutive weeks' trial of conservative medical management (unless imaging indicates the need for urgent intervention); **or**
   C. The beneficiary has severe or rapidly progressive symptoms of nerve root or spinal cord compression requiring hospitalization or immediate surgical treatment.
2. Cervical myelopathy resulting from spinal cord compression as evidenced by **one or more** of the following:
   A. Clinical symptoms of myelopathy such as clumsiness of hands, urinary urgency, bowel or bladder incontinence, or frequent falls;
   B. Clinical signs of myelopathy such as hyperreflexia, Hoffman sign, increased tone or spasticity, loss of thenar or hypothenar eminence, gait abnormality, or positive Babinski sign; **or**
   C. Diagnostic imaging is positive for cord compression from either herniated disc or osteophyte.
3. Ossification of the posterior longitudinal ligament at three (3) or more levels;
4. Degenerative spondylolisthesis or cord compression in conjunction with a stabilization procedure;
5. Cervical stenosis (degenerative or congenital) with an anteroposterior canal diameter of 10 millimeters or less;
6. Injury with **one or more** of the following findings:
   A. Cervical instability (in conjunction with a stabilizing procedure);
   B. Foreign bodies;
   C. Bony fracture fragments; **or**
   D. Epidural hematoma.
7. Cervical spine tumors, abscesses, cysts, or other mass; **or**
8. Cervical spine infection.

3.2.1.2. Thoracic Spine Surgery

Medicaid shall cover thoracic decompression surgery or fusion when the beneficiary meets **one of** the following specific criteria:

a. Spinal stenosis (recess, foraminal, or central) with persistent pain, with stenosis confirmed by imaging studies at the level corresponding to neurological findings, refractory to at least three (3) consecutive months of conservative medical management (unless radiologic evidence indicates the need for urgent intervention); **or**

b. Spinal fracture, dislocation with mechanical instability, locked facets, displaced fracture fragment, spinal infection, spinal tumor, epidural hematoma, synovial or arachnoid cysts, or other mass or lesion confirmed by imaging; **or**

c. The beneficiary meets **all** of the following:

1. All other reasonable sources of pain have been ruled out;
2. Imaging studies indicate nerve root or spinal cord compression at the level corresponding with clinical findings;
3. Beneficiary has failed at least six (6) consecutive weeks of conservative medical management (unless imaging indicates the need for urgent intervention);
4. The beneficiary has physical and neurological abnormalities confirming the findings of nerve root or spinal cord compression at or below the level of the lesion (with or without gait or sphincter disturbance); **and**
5. The beneficiary's activities of daily living are limited by persistent pain radiating from the back down to the lower extremity.

3.2.1.3 Lumbar Spine Surgery

a. Medicaid shall cover lumbar fusion surgery when the beneficiary meets **one of** the following specific criteria:

1. Spinal fracture with instability or neural compression;
2. Spinal repair surgery for dislocation, tumor, or infection (abscess, osteomyelitis, discitis, tuberculosis, or fungal infection);
3. Spinal stenosis with **all** of the following:
   A. Associated spondylolisthesis; **and**
   B. Any **one or more** of the following:
      i. Neurogenic claudication symptoms or radicular pain that results in significant functional impairment and listhesis on plain x-rays in a beneficiary who has failed at least three (3) consecutive months of conservative medical management and has documentation of central, lateral recess, or foraminal stenosis on imaging; or
      ii. Severe or rapidly progressive symptoms of motor loss, neurogenic claudication, or cauda equina syndrome.
4. Spondylolysis with **one or more** of the following:
   A. Progressive spondylolisthesis with neurologic compromise;
   B. Spondylolisthesis with all of the following:
      i. High-grade spondylolisthesis (50 percent or more anterior slippage) demonstrated on plain x-rays;
      ii. Back pain, neurogenic claudication symptoms, or radicular pain from lateral recess or foraminal stenosis;
      iii. Significant functional impairment; and

iv. Failure of at least three (3) consecutive months of conservative medical management;

5. Severe, progressive idiopathic scoliosis with Cobb angle greater than 40 degrees;
6. Severe degenerative scoliosis with any **one** of the following:
   A. Documented progression of deformity to greater than 50 degrees with loss of function;
   B. Persistent radicular pain or loss of function unresponsive to at least three (3) consecutive months of conservative medical management; **or**
   C. Persistent neurogenic claudication unresponsive to at least three (3) consecutive months of conservative medical management;
7. Isthmic spondylolisthesis, either congenital (Wiltse type I) or acquired (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 six (6) consecutive months of conservative medical management;
8. Adjacent segment degeneration or recurrent, same level, disc herniation, at least six (6) months after previous disc surgery, with recurrent neurogenic symptoms (radicular pain or claudication), with impairment or loss of function, unresponsive to at least three (3) consecutive months of conservative medical management, and with neural structure compression documented by imaging, and in a beneficiary who had experienced significant interval relief of prior symptoms;
9. Pseudoarthrosis, documented by imaging, no less than six (6) months after initial fusion, with persistent axial back pain, with or without neurogenic symptoms, with impairment or loss of function, in a beneficiary who had experienced significant interval relief of prior symptoms; **or**
10. Iatrogenic or degenerative flatback syndrome with significant sagittal imbalance; when fusion is performed with spinal osteotomy.

b. Medicaid shall cover lumbar decompression surgery (discectomy, microdiscectomy, corpectomy, hemicorpectomy, foraminectomy, foraminoplasty, foraminotomy, laminectomy, hemilaminectomy, laminotomy, laminoplasty, and osteophytectomy) when all other reasonable sources of pain have been ruled out and the beneficiary meets the **one or more** of following specific criteria:

1. Rapidly progressive neurological findings of nerve root or spinal cord compression, with imaging evidence of pathology that correlates with clinical findings (with or without gait or sphincter disturbance);

2. Elective surgery needed as indicated by **all** the following when the beneficiary has failed at least six (6) consecutive weeks of conservative medical management (unless imaging indicates the need for urgent intervention):
   A. Herniated disc with **all** of the following:
      i. Nerve or spinal cord impingement seen on imaging studies;
      ii. Clinical findings consistent with impingement; **and**
      iii. All major psychosocial and substance use issues have been addressed.
   B. Persistent pain and symptoms or findings that have not improved after at least six (6) consecutive weeks of conservative medical management, consisting of **one or more** of the following:
      i. Severe disabling radiculopathy; or
      ii. Clinical findings of nerve root compromise;
3. Spinal stenosis (recess, foraminal, or central) with **one or more** of the following:
   A. Progressive or severe symptoms of neurogenic claudication;
   B. Leg or buttock symptoms, with or without back pain, that are persistent and disabling, correlated with spinal stenosis on imaging, **and** unresponsive to three (3) consecutive months of conservative medical management;
4. Spondylolisthesis with **one or more** of the following:
   A. Progressive or severe neurologic deficits; **or**
   B. Back pain, neurogenic claudication symptoms, or radicular pain from lateral recess or foraminal stenosis associated with significant functional impairment, listhesis demonstrated on plain x-rays, **and** failure of three (3) consecutive months of conservative medical management;
5. Spinal fracture, dislocation with mechanical instability, locked facets, displaced fracture fragment, spinal infection or tumor, epidural hematoma, synovial or arachnoid cysts, or other mass or lesion confirmed by imaging; **or**
6. Cauda Equina Syndrome with bowel or bladder dysfunction, saddle anesthesia, or bilateral lower extremity neurologic abnormalities.

3.2.2 Medicaid Additional Criteria Covered

None Apply

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

a. Medicaid shall not cover artificial disc implantation for the following conditions:
   1. Planned simultaneous, multilevel disc implantation;
   2. Combined use of artificial disc and fusion (hybrid procedure);
   3. Prior surgery at the level to be treated;
   4. Previous fusion at the same or adjacent level;
   5. Instability as defined by translation greater than 3 millimeters' difference between lateral flexion-extension views at the symptomatic level or eleven (11) degrees of angular difference between lateral flexion-extension views at the symptomatic level;
   6. Anatomical deformity such as ankylosing spondylitis or previous fracture;
   7. Ossification of the posterior longitudinal ligament (OPLL)
   8. Severe spondylosis defined as greater than fifty (50) percent disc height loss compared to minimally or non-degenerated levels, bridging osteophytes, **or** absence of motion on flexion-extension views at the symptomatic site;
   9. Rheumatoid arthritis or other autoimmune disease;
   10. Presence of facet arthritis;
   11. Sensitivity or allergy to implant materials
   12. Active systemic or site infection;
   13. Metabolic bone disease such as osteoporosis, osteopenia, or osteomalacia; or
   14. Malignancy of the cervical spine.

b. Medicaid shall not cover spinal surgery if the sole indication is any **one or more** of the following conditions:
   1. Disc herniation;
   2. Annular tears;
   3. Degenerative disc disease;
   4. Initial discectomy or laminectomy for neural structure decompression;
   5. Facet syndrome; **or**
   6. Back pain without any clear cause on imaging.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Medicaid shall require prior approval for all spinal surgeries except for when the procedure is **emergent** in nature. The provider shall obtain prior approval before rendering spinal surgery. The following diagnoses do not require prior authorization:

a. Acute, traumatic cervical spine fracture or dislocation;
b. Acute, traumatic thoracic or lumbar spinal fracture with neural compression or radiologic evidence of instability;
c. Tumor or infection-related nerve, spinal cord, vertebral, or epidural compression, vertebral destruction, or pathologic fracture;
d. Spinal tuberculosis;
e. Acute cauda equina syndrome;
f. Atlantoaxial subluxation (C1-C2 vertebrae) with odontoid migration or cord compression related to **one of the following**:
    1. Congenital abnormality at C1-C2;
    2. Os odontoideum;
    3. Rheumatoid arthritis; or
    4. Trauma.
g. Spinal biopsy or lesion removal.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.
c. if the Medicaid beneficiary is under 21 years of age, information supporting that all EPSDT criteria are met and evidence-based literature supporting the request, if available.

5.2.2 Specific

The provider shall submit the following information along with the request for surgery:

a. A signed letter of medical necessity clearly documenting diagnosis and date of symptom onset, the specific procedure(s) requested with CPT code(s) and disc level(s) indicated;
b. Office notes, including a current history and physical exam within the past thirty days;

c. Detailed documentation of extent and response to conservative medical management, including length of treatment, outcomes of any procedural interventions, medication use (including dose and frequency), participation in physical therapy or a home exercise program, and beneficiary acceptance of recommended lifestyle modifications;
d. All radiology reports relevant to the surgical request. Imaging must be read by an independent radiologist. If discrepancies should arise in the interpretation of the imaging, the radiologist report will supersede;
e. Post-operative plan of care; **and**
f. Medical clearance reports (as appropriate).

5.3 Additional Limitations or Requirements

None Apply

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply

6.2 Provider Certifications

None Apply

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation and History

Original Effective Date: January 1, 1974

History:

Date	Section or Subsection Amended	Change
08/01/2017	All Sections and Attachment(s)	New policy documenting current coverage of spinal surgeries and prior authorization requirements.
01/01/2018	Attachment A, letter B	Updated ICD-10 diagnosis codes exempt from prior approval to reflect highest level of specificity.
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.
12/04/2019	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
12/04/2019	Attachment A	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
08/15/2020	Attachment A	Added, ICD-10-CM code M46.56.
06/01/2023	All Attachments and Sections	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 6/1/2023 with an effective date of 4/1/2023.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

ICD-10-CM Code(s) Exempt From Prior Authorization			
Cervical			
S12.000A	S12.110A	S12.301A	S12.601A
S12.000B	S12.110B	S12.301B	S12.601B
S12.000D	S12.110D	S12.301D	S12.601D
S12.000G	S12.110G	S12.301G	S12.601G
S12.000K	S12.110K	S12.301K	S12.601K
S12.000S	S12.110S	S12.301S	S12.601S
S12.001A	S12.111A	S12.390A	S12.690A
S12.001B	S12.111B	S12.390B	S12.690B
S12.001D	S12.111D	S12.390D	S12.690D
S12.001G	S12.111G	S12.390G	S12.690G
S12.001K	S12.111K	S12.390K	S12.690K
S12.001S	S12.111S	S12.390S	S12.690S
S12.01XA	S12.112A	S12.391A	S12.691A
S12.01XB	S12.112B	S12.391B	S12.691B
S12.01XD	S12.112D	S12.391D	S12.691D
S12.01XG	S12.112G	S12.391G	S12.691G
S12.01XK	S12.112K	S12.391K	S12.691K
S12.01XS	S12.112S	S12.391S	S12.691S
S12.02XA	S12.120A	S12.400A	S12.9XXA
S12.02XB	S12.120B	S12.400B	S12.9XXD
S12.02XD	S12.120D	S12.400D	S12.9XXS
S12.02XG	S12.120G	S12.400G	S13.101A
S12.02XK	S12.120K	S12.400K	S13.101D
S12.02XS	S12.120S	S12.400S	S13.101S
S12.030A	S12.121A	S12.401A	S13.111A
S12.030B	S12.121B	S12.401B	S13.111D
S12.030D	S12.121D	S12.401D	S13.111S

ICD-10-CM Code(s) Exempt From Prior Authorization			
S12.030G	S12.121G	S12.401G	S13.120A
S12.030K	S12.121K	S12.401K	S13.120D
S12.030S	S12.121S	S12.401S	S13.120S
S12.031A	S12.190A	S12.490A	S13.121A
S12.031B	S12.190B	S12.490B	S13.121D
S12.031D	S12.190D	S12.490D	S13.121S
S12.031G	S12.190G	S12.490G	S13.131A
S12.031K	S12.190K	S12.490K	S13.131D
S12.031S	S12.190S	S12.490S	S13.131S
S12.040A	S12.191A	S12.491A	S13.141A
S12.040B	S12.191B	S12.491B	S13.141D
S12.040D	S12.191D	S12.491D	S13.141S
S12.040G	S12.191G	S12.491G	S13.151A
S12.040K	S12.191K	S12.491K	S13.151D
S12.040S	S12.191S	S12.491S	S13.151S
S12.041A	S12.200A	S12.500A	S13.161A
S12.041B	S12.200B	S12.500B	S13.161D
S12.041D	S12.200D	S12.500D	S13.161S
S12.041G	S12.200G	S12.500G	S13.171A
S12.041K	S12.200K	S12.500K	S13.171D
S12.041S	S12.200S	S12.500S	S13.171S
S12.090A	S12.201A	S12.501A	S13.181A
S12.090B	S12.201B	S12.501B	S13.181D
S12.090D	S12.201D	S12.501D	S13.181S
S12.090G	S12.201G	S12.501G	Q76.49
S12.090K	S12.201K	S12.501K	
S12.090S	S12.201S	S12.501S	
S12.091A	S12.290A	S12.590A	
S12.091B	S12.290B	S12.590B	
S12.091D	S12.290D	S12.590D	
S12.091G	S12.290G	S12.590G	
S12.091K	S12.290K	S12.590K	
S12.091S	S12.290S	S12.590S	
S12.100A	S12.291A	S12.591A	
S12.100B	S12.291B	S12.591B	
S12.100D	S12.291D	S12.591D	
S12.100G	S12.291G	S12.591G	
S12.100K	S12.291K	S12.591K	
S12.100S	S12.291S	S12.591S	
S12.101A	S12.300A	S12.600A	
S12.101B	S12.300B	S12.600B	
S12.101D	S12.300D	S12.600D	
S12.101G	S12.300G	S12.600G	
S12.101K	S12.300K	S12.600K	
S12.101S	S12.300S	S12.600S	

ICD-10-CM Code(s) Exempt From Prior Authorization			
Thoracic			
S22.001A	S22.022G	S22.049A	S22.071G
S22.001B	S22.022K	S22.049B	S22.071K
S22.001D	S22.022S	S22.049D	S22.071S
S22.001G	S22.028A	S22.049G	S22.072A
S22.001K	S22.028B	S22.049K	S22.072B
S22.001S	S22.028D	S22.049S	S22.072D
S22.002A	S22.028G	S22.051A	S22.072G
S22.002B	S22.028K	S22.051B	S22.072K
S22.002D	S22.028S	S22.051D	S22.072S
S22.002G	S22.029A	S22.051G	S22.078A
S22.002K	S22.029B	S22.051K	S22.078B
S22.002S	S22.029D	S22.051S	S22.078D
S22.008A	S22.029G	S22.052A	S22.078G
S22.008B	S22.029K	S22.052B	S22.078K
S22.008D	S22.029S	S22.052D	S22.078S
S22.008G	S22.031A	S22.052G	S22.079A
S22.008K	S22.031B	S22.052K	S22.079B
S22.008S	S22.031D	S22.052S	S22.079D
S22.009A	S22.031G	S22.058A	S22.079G
S22.009B	S22.031K	S22.058B	S22.079K
S22.009D	S22.031S	S22.058D	S22.079S
S22.009G	S22.032A	S22.058G	S22.081A
S22.009K	S22.032B	S22.058K	S22.081B
S22.009S	S22.032D	S22.058S	S22.081D
S22.011A	S22.032G	S22.059A	S22.081G
S22.011B	S22.032K	S22.059B	S22.081K
S22.011D	S22.032S	S22.059D	S22.081S
S22.011G	S22.038A	S22.059G	S22.082A
S22.011K	S22.038B	S22.059K	S22.082B
S22.011S	S22.038D	S22.059S	S22.082D
S22.012A	S22.038G	S22.061A	S22.082G
S22.012B	S22.038K	S22.061B	S22.082K
S22.012D	S22.038S	S22.061D	S22.082S
S22.012G	S22.039A	S22.061G	S22.088A
S22.012K	S22.039B	S22.061K	S22.088B
S22.012S	S22.039D	S22.061S	S22.088D
S22.018A	S22.039G	S22.062A	S22.088G
S22.018B	S22.039K	S22.062B	S22.088K
S22.018D	S22.039S	S22.062D	S22.088S
S22.018G	S22.041A	S22.062G	S22.089A
S22.018K	S22.041B	S22.062K	S22.089B
S22.018S	S22.041D	S22.062S	S22.089D
S22.019A	S22.041G	S22.068A	S22.089G
S22.019B	S22.041K	S22.068B	S22.089K
S22.019D	S22.041S	S22.068D	S22.089S
S22.019G	S22.042A	S22.068G	S22.9XXA
S22.019K	S22.042B	S22.068K	S22.9XXB

ICD-10-CM Code(s) Exempt From Prior Authorization			
S22.019S	S22.042D	S22.068S	S22.9XXD
S22.021A	S22.042G	S22.069A	S22.9XXG
S22.021B	S22.042K	S22.069B	S22.9XXK
S22.021D	S22.042S	S22.069D	S22.9XXS
S22.021G	S22.048A	S22.069G	
S22.021K	S22.048B	S22.069K	
S22.021S	S22.048D	S22.069S	
S22.022A	S22.048G	S22.071A	
S22.022B	S22.048K	S22.071B	
S22.022D	S22.048S	S22.071D	

ICD-10-CM Code(s) Exempt From Prior Authorization			
Lumbar			
S32.001A	S32.018B	S32.031D	S32.048G
S32.001B	S32.018D	S32.031G	S32.048K
S32.001D	S32.018G	S32.031K	S32.048S
S32.001G	S32.018K	S32.031S	S32.049A
S32.001K	S32.018S	S32.032A	S32.049B
S32.001S	S32.019A	S32.032B	S32.049D
S32.002A	S32.019B	S32.032D	S32.049G
S32.002B	S32.019D	S32.032G	S32.049K
S32.002D	S32.019G	S32.032K	S32.049S
S32.002G	S32.019K	S32.032S	S32.051A
S32.002K	S32.019S	S32.038A	S32.051B
S32.002S	S32.021A	S32.038B	S32.051D
S32.008A	S32.021B	S32.038D	S32.051G
S32.008B	S32.021D	S32.038G	S32.051K
S32.008D	S32.021G	S32.038K	S32.051S
S32.008G	S32.021K	S32.038S	S32.052A
S32.008K	S32.021S	S32.039A	S32.052B
S32.008S	S32.022A	S32.039B	S32.052D
S32.009A	S32.022B	S32.039D	S32.052G
S32.009B	S32.022D	S32.039G	S32.052K
S32.009D	S32.022G	S32.039K	S32.052S
S32.009G	S32.022K	S32.039S	S32.058A
S32.009K	S32.022S	S32.041A	S32.058B
S32.009S	S32.028A	S32.041B	S32.058D
S32.011A	S32.028B	S32.041D	S32.058G
S32.011B	S32.028D	S32.041G	S32.058K
S32.011D	S32.028G	S32.041K	S32.058S
S32.011G	S32.028K	S32.041S	S32.059A
S32.011K	S32.028S	S32.042A	S32.059B
S32.011S	S32.029A	S32.042B	S32.059D
S32.012A	S32.029B	S32.042D	S32.059G
S32.012B	S32.029D	S32.042G	S32.059K
S32.012D	S32.029G	S32.042K	S32.059S
S32.012G	S32.029K	S32.042S	

ICD-10-CM Code(s) Exempt From Prior Authorization			
S32.012K	S32.029S	S32.048A	
S32.012S	S32.031A	S32.048B	
S32.018A	S32.031B	S32.048D	

ICD-10-CM Code(s) Exempt From Prior Authorization			
General			
A17.1	D33.1	G03.8	M46.31
A17.81	D33.3	G03.9	M46.32
A18.01	D33.4	G04.00	M46.33
C41.2	D36.10	G04.01	M46.34
C41.3	D36.11	G04.02	M46.35
C41.4	D36.13	G04.81	M46.36
C47.0	D36.16	G04.89	M46.37
C47.20	D36.17	G04.90	M46.38
C47.21	D36.7	G04.91	M46.39
C47.22	D42.1	G05.3	M46.40
C47.5	D43.1	G05.4	M46.41
C47.6	D43.3	G06.1	M46.42
C47.9	D43.4	G06.2	M46.43
C70.1	D48.0	G07	M46.44
C72.0	D48.2	G08	M46.45
C72.1	D48.7	G83.4	M46.46
C71.7	D49.2	G95.11	M46.47
C72.59	D49.6	G95.19	M46.48
C76.3	D49.7	M45.1	M46.49
C79.49	D49.89	M46.20	M46.56
C79.31	G00.0	M46.21	M53.2X1
C79.51	G00.1	M46.22	M53.2X2
C79.52	G00.2	M46.23	M84.48
C79.89	G00.3	M46.24	M84.58
D09.8	G00.8	M46.25	M84.68
D16.6	G00.9	M46.26	
D16.7	G03.0	M46.27	
D16.8	G03.1	M46.28	
D32.1	G03.2	M46.30	

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

CPT Code(s) Requiring Prior Authorization		
22532	22830	+63076
22533	22856	63077
+22534	22861	+63078
22548	63001	63081
22551	63003	+63082
+22552	63005	63085
22554	63012	+63086
22556	63015	63087
22558	63016	+63088
+22585	63017	63090
22586	63020	+63091
22590	63030	63101
22595	+63035	63102
22600	63040	+63103
22610	63042	63170
22612	+63043	63172
+22614	+63044	63173
22630	63045	63180
+22632	63046	63182
22633	63047	63185
+22634	+63048	63190
22800	63050	63191
22802	63051	63194
22804	63055	63195
22808	63056	63196
22810	+63057	63197
22812	63064	63198
22818	+63066	63199
22819	63075	63200

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Inpatient, Outpatient

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/