2020-2021 NIA Clinical Guidelines for Medical Necessity Review

MUSCULOSKELETAL AND SURGERY GUIDELINES
Guidelines for Clinical Review Determination

Preamble
Magellan is committed to the philosophy of supporting safe and effective treatment for patients. The medical necessity criteria that follow are guidelines for the provision of diagnostic imaging. These criteria are designed to guide both providers and reviewers to the most appropriate diagnostic tests based on a patient’s unique circumstances. In all cases, clinical judgment consistent with the standards of good medical practice will be used when applying the guidelines. Determinations are made based on both the guideline and clinical information provided at the time of the request. It is expected that medical necessity decisions may change as new evidence-based information is provided or based on unique aspects of the patient’s condition. The treating clinician has final authority and responsibility for treatment decisions regarding the care of the patient.

Guideline Development Process
These medical necessity criteria were developed by Magellan Healthcare for the purpose of making clinical review determinations for requests for therapies and diagnostic procedures. The developers of the criteria sets included representatives from the disciplines of radiology, internal medicine, nursing, cardiology, and other specialty groups. Magellan’s guidelines are reviewed yearly and modified when necessary following a literature search of pertinent and established clinical guidelines and accepted diagnostic imaging practices.

All inquiries should be directed to:
Magellan Healthcare
PO Box 67390
Phoenix, AZ 85082-7390
Attn: Magellan Healthcare Chief Medical Officer
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musculoskeletal &amp; Surgery Guidelines</td>
<td>4</td>
</tr>
<tr>
<td>Cervical Spinal Surgery</td>
<td>4</td>
</tr>
<tr>
<td>Lumbar Spinal Surgery</td>
<td>20</td>
</tr>
<tr>
<td>Spinal Epidural Injections</td>
<td>36</td>
</tr>
<tr>
<td>Implantable Infusion Pump Insertion</td>
<td>44</td>
</tr>
<tr>
<td>Spine Surgery Other</td>
<td>52</td>
</tr>
<tr>
<td>Paravertebral Facet Joint Injections/Blocks</td>
<td>56</td>
</tr>
<tr>
<td>Paravertebral Facet Joint Neurolysis</td>
<td>63</td>
</tr>
<tr>
<td>Sacroiliac Joint Injections</td>
<td>69</td>
</tr>
<tr>
<td>Hip Arthroplasty</td>
<td>77</td>
</tr>
<tr>
<td>Hip Arthroscopy</td>
<td>88</td>
</tr>
<tr>
<td>Knee Arthroplasty</td>
<td>102</td>
</tr>
<tr>
<td>Knee Arthroscopy</td>
<td>117</td>
</tr>
<tr>
<td>Shoulder Arthroplasty</td>
<td>144</td>
</tr>
<tr>
<td>Shoulder Arthroscopy</td>
<td>155</td>
</tr>
<tr>
<td>Thoracic Spine Surgery</td>
<td>174</td>
</tr>
<tr>
<td>Deformity Surgery</td>
<td>178</td>
</tr>
</tbody>
</table>
CPT Codes:
- Anterior Cervical Decompression with Fusion - Single Level (ACDF): 22548, 22551, 22554, 22864
- Anterior Cervical Decompression with Fusion - Multiple Level (ACDF): 22548, 22551, 22554, 22552, 22585, 22864
- Cervical Posterior Decompression with Fusion - Multiple Levels: 22590, 22595, 22600, 22614
- Cervical Posterior Decompression with Fusion - Single Level: 22590, 22595, 22600
- Cervical Artificial Disc - Single Level: 22856, 22861, 22864
- Cervical Artificial Disc - Two Levels: 22856, 22858, 22861, 22864, 0098T, 0095T
- Cervical Posterior Decompression (w/o fusion): 63001, 63015, 63020, 63040, 63045, 63050, 63051, 63035, 63043, 63048
- Cervical Anterior Decompression (w/o fusion): 63075, 63076

INDICATIONS FOR CERVICAL SPINE SURGERY:

Anterior Cervical Decompression with Fusion (ACDF) - Single Level

The following criteria must be met*:
- Positive clinical findings of myelopathy with evidence of progressive neurologic deficits consistent with spinal cord compression - immediate surgical evaluation is indicated (AAOS, 2013; Bono, 2011; Cunningham, 2010; Holly, 2009; Matz, 2009a; Matz, 2009b; Matz, 2009d; Matz, 2009e; Mummaneni, 2009; Tetreault, 2013; Yalamanchili, 2012; Zhu, 2013). Symptoms may include:
  - Upper extremity weakness;
  - Unsteady gait related to myelopathy/balance or generalized lower extremity weakness;
  - Disturbance with coordination;
  - Hyperreflexia;
  - Hoffmann sign;
  - Positive Babinski sign and/or clonus; OR
- Progressive neurological deficit (motor deficit, bowel or bladder dysfunction) with evidence of spinal cord or nerve root compression on Magnetic Resonance Imaging (MRI) or Computed Tomography (CT) imaging - immediate surgical evaluation is indicated. (Bono, 2011; Matz, 2009b; Tetreault, 2013); OR

When ALL of the following criteria are met (Bono, 2011; Nikolaidis, 2010):
Cervical radiculopathy or myelopathy from ruptured disc, spondylosis, spinal instability, or deformity; **AND**

Persistent or recurrent symptoms/pain with functional limitations that are unresponsive to at **least 6 weeks** of appropriate conservative treatment; **AND**

Documented failure of at least 6 consecutive weeks in the last 6 months of **any 2** of the following physician-directed conservative treatments:
- Analgesics, steroids, and/or NSAIDs
- Structured program of physical therapy
- Structured home exercise program prescribed by a physical therapist, chiropractic provider or physician
- Epidural steroid injections and or selective nerve root block; **AND**

Imaging studies confirm the presence of spinal cord or spinal nerve root compression (disc herniation or foraminal stenosis) at the level corresponding with the clinical findings (Bono, 2011). Imaging studies may include:

MRI (preferred study for assessing cervical spine soft tissue); **OR**

CT with or without myelography—indicated in patients in whom MRI is contraindicated; preferred for examining bony structures, or in patients presenting with clinical symptoms or signs inconsistent with MRI findings (e.g., foraminal compression not seen on MRI).

**Cervical spine decompression with fusion as first-line treatment without conservative care measures in the following clinical cases** (Matz, 2009b; Tetreault, 2013; Zhu, 2013; White, 1987):

- As outlined above for myelopathy or progressive neurological deficit scenarios.
- Significant spinal cord or nerve root compression due to tumor, infection or trauma.
- Fracture or instability on radiographic films measuring:
  - Sagittal plane angulation of greater than 11 degrees at a single interspace or greater than 3.5mm anterior subluxation in association with radicular/cord dysfunction; **OR**
  - Subluxation at the (C1) level of the atlantodental interval of more than 3 mm in an adult and 5 mm in a child.

**Not Recommended** (Nikolaidis, 2010; van Middelkoop, 2012):

- In asymptomatic or mildly symptomatic cases of cervical spinal stenosis.
- In cases of neck pain alone, without neurological deficits, and no evidence of significant spinal nerve root or cord compression on MRI or CT. See V. Cervical Fusion for Treatment of Axial Neck Pain Criteria

**Anterior Cervical Decompression with Fusion (ACDF) - Multiple Level**

**The following criteria must be met***:

- Positive clinical findings of myelopathy with evidence of progressive neurologic deficits consistent with worsening **spinal cord compression** - immediate surgical evaluation is indicated
Symptoms may include:
- Upper extremity weakness;
- Unsteady gait related to myelopathy/balance or generalized lower extremity weakness;
- Disturbance with coordination;
- Hyperreflexia;
- Hoffmann sign;
- Positive Babinski sign and or clonus; OR
  - Progressive neurological deficit (motor deficit, bowel or bladder dysfunction) with corresponding evidence of spinal cord or nerve root compression on an MRI or CT scan images - immediate surgical evaluation is indicated (Bono, 2011; Matz, 2009b; Tetreault, 2013); OR

When **ALL of the following criteria are met** (Bono, 2011; Nikolaidis, 2010):

- Cervical radiculopathy or myelopathy due to ruptured disc, spondylosis, spinal instability, or deformity; **AND**
- Persistent or recurrent pain/symptoms with functional limitations that are unresponsive to at least **6 weeks of conservative treatment**; **AND**
- Documented failure of at least 6 consecutive weeks in the last 6 months of **any 2 of** the following physician-directed conservative treatments:
  - Analgesics, steroids, and/or NSAIDs
  - Structured program of physical therapy
  - Structured home exercise program prescribed by a physical therapist, chiropractic provider or physician
  - Epidural steroid injections and or selective nerve root block; **AND**
- Imaging studies confirm the presence of spinal cord or spinal nerve root compression (disc herniation or foraminal stenosis) at multiple levels corresponding with the clinical findings. Imaging studies may include any of the following (Bono, 2011):
  - MRI (preferred study for assessing cervical spine soft tissue); **OR**
  - CT with or without myelography - indicated in patients in whom MRI is contraindicated; preferred for examining bony structures, or in patients presenting with clinical symptoms or signs inconsistent with MRI findings (e.g., foraminal compression not seen on MRI)

**Cervical spine decompression with fusion performed as first-line treatment without conservative care measures in the following clinical cases** (Matz, 2009b; Tetreault, 2013; White, 1987; Zhu, 2013):

- As outlined above for myelopathy or progressive neurological deficit scenarios.
- Significant spinal cord or nerve root compression due to tumor, infection or trauma.
- Fracture or instability on radiographic films measuring:
  - Sagittal plane angulation of greater than 11 degrees at a single interspace or greater than 3.5mm anterior subluxation in association with radicular/cord dysfunction; **OR**
  - Subluxation at the (C1) level of the atlantodental interval of more than 3 mm in an adult and 5 mm in a child.
Not Recommended (Nikolaidis, 2010; Van Middelkoop, 2012):

- In asymptomatic or mildly symptomatic cases of cervical spinal stenosis.
- In cases of neck pain alone, without neurological deficits, and no evidence of significant spinal nerve root or cord compression on MRI or CT. See V. Cervical Fusion for Treatment of Axial Neck Pain Criteria.

Cervical Posterior Decompression with Fusion - Single Level

The following criteria must be met*:

- Positive clinical findings of myelopathy with evidence of progressive neurologic deficits consistent with worsening spinal cord compression - immediate surgical evaluation is indicated (AAOS, 2013; Cunningham, 2010; Fehlings, 2013; Holly, 2009; Matz, 2009d; Mummaneni, 2009; Tetreault, 2013; Yalamanchili, 2012; Zhu, 2013). Symptoms may include:
  - Upper extremity weakness;
  - Unsteady gait related to myelopathy/balance or generalized lower extremity weakness;
  - Disturbance with coordination;
  - Hyperreflexia;
  - Hoffmann sign;
  - Positive Babinski sign and / or clonus; OR

- Progressive neurological deficit (motor deficit, bowel or bladder dysfunction) with corresponding evidence of spinal cord or nerve root compression on an MRI or CT scan images - immediate surgical evaluation is indicated (Bono, 2011; Matz, 2009b; Tetreault, 2013); OR

When ALL of the following criteria are met (Bono, 2011; Nikolaidis, 2010):

- Cervical radiculopathy or myelopathy from ruptured disc, spondylosis, spinal instability, or deformity; AND
- Persistent or recurrent symptoms/pain with functional limitations that are unresponsive to at least 6 weeks of conservative treatment; AND
- Documented failure of at least 6 consecutive weeks in the last 6 months of any 2 of the following physician-directed conservative treatments:
  - Analgesics, steroids, and/or NSAIDs
  - Structured program of physical therapy
  - Structured home exercise program prescribed by a physical therapist, chiropractic provider or physician
  - Epidural steroid injections and or selective nerve root block; AND
Imaging studies confirm the presence of spinal cord or spinal nerve root compression (disc herniation or foraminal stenosis) at single level corresponding with the clinical findings (Bono, 2011). Imaging studies may include:
- MRI (preferred study for assessing cervical spine soft tissue); OR
- CT with or without myelography - indicated in patients in whom MRI is contraindicated; preferred for examining bony structures, or in patients presenting with clinical symptoms or signs inconsistent with MRI findings (e.g., foraminal compression not seen on MRI); AND

**Cervical spine decompression with fusion performed as first-line treatment without conservative care measures in the following clinical cases** (Fehlings, 2013; Tetreault, 2013; White, 1987; Zhu, 2013):
- As outlined above for myelopathy or progressive neurological deficit scenarios.
- Significant spinal cord or nerve root compression due to tumor, infection or trauma.
- Fracture or instability on radiographic films measuring:
  - Sagittal plane angulation of greater than 11 degrees at a single interspace or greater than 3.5mm anterior subluxation in association with radicular/cord dysfunction; OR
  - Subluxation at the (C1) level of the atlantodental interval of more than 3 mm in an adult and 5 mm in a child.

**Not Recommended** (Nikolaidis, 2010; Wang, 2011):
- In asymptomatic or mildly symptomatic cases of cervical spinal stenosis.
- In cases of neck pain alone, without neurological deficits, and no evidence of significant spinal nerve root or cord compression on MRI or CT. *See V. Cervical Fusion for Treatment of Axial Neck Pain Criteria.*

**Cervical Posterior Decompression with Fusion - Multiple Levels**

**The following criteria must be met***:
- Positive clinical findings of myelopathy with evidence of progressive neurologic deficits consistent with worsening **spinal cord compression** - immediate surgical evaluation is indicated (AAOS, 2013; Cunningham, 2010; Fehlings, 2013; Holly, 2009; Matz, 2009d; Mummaneni, 2009; Tetreault, 2013; Yalamanchili, 2012; Zhu, 2013). Symptoms may include:
  - Upper extremity weakness;
  - Unsteady gait related to myelopathy/balance or generalized lower extremity weakness;
  - Disturbance with coordination;
  - Hyperreflexia;
  - Hoffmann sign;
  - Positive Babinski sign and / or clonus; OR
- Progressive neurological deficit (motor deficit, bowel or bladder dysfunction) with corresponding evidence of spinal cord or nerve root compression on an MRI or CT scan images - immediate surgical evaluation is indicated (Bono, 2011; Matz, 2009b; Tetreault, 2013); OR
When **ALL of the following criteria are met** (Bono, 2011; Nikolaidis, 2010):

- Cervical radiculopathy or myelopathy from ruptured disc, spondylosis, spinal instability, or deformity; **AND**
- Persistent or recurrent symptoms/pain with functional limitations that are unresponsive to at least 6 weeks of conservative treatment; **AND**
- Documented failure of at least 6 consecutive weeks in the last 6 months of any 2 of the following physician-directed conservative treatments:
  - Analgesics, steroids, and/or NSAIDs;
  - Structured program of physical therapy;
  - Structured home exercise program prescribed by a physical therapist, chiropractic provider or physician;
  - Epidural steroid injections and or facet injections /selective nerve root block; **AND**
- Imaging studies indicate significant spinal cord or spinal nerve root compression at multiple levels corresponding with the clinical findings. Imaging studies may include (Bono, 2011):
  - MRI (preferred study for assessing cervical spine soft tissue); **OR**
  - CT with or without myelography - indicated in patients in whom MRI is contraindicated; preferred for examining bony structures, or in patients presenting with clinical symptoms or signs inconsistent with MRI findings (e.g., foraminal compression not seen on MRI); **AND**

**Cervical spine decompression with fusion performed as first-line treatment without conservative care measures in the following clinical cases** (Fehlings, 2013; Tetreault, 2013; White, 1987; Zhu, 2013):

- As outlined above for myelopathy or progressive neurological deficit scenarios.
- Significant spinal cord or nerve root compression due to tumor, infection or trauma.
- Fracture or instability on radiographic films measuring:
  - Sagittal plane angulation of greater than 11 degrees at a single interspace or greater than 3.5mm anterior subluxation in association with radicular/cord dysfunction; **OR**
  - Subluxation at the (C1) level of the atlantodental interval of more than 3 mm in an adult and 5 mm in a child

**Not Recommended** (Nikolaidis, 2010; Wang, 2011):

- In asymptomatic or mildly symptomatic cases of cervical spinal stenosis.
- In cases of neck pain alone, without neurological deficits, and no evidence of significant spinal nerve root or cord compression on MRI or CT. See: Cervical Fusion for Treatment of Axial Neck Pain Criteria.

**Cervical Fusion for Treatment of Axial Neck Pain**

In patients with non-radicular cervical pain for whom fusion is being considered, **ALL of the following criteria must be met** (Riew, 2010):

- Improvement of the symptoms has failed or plateaued, and the residual symptoms of pain and functional disability are unacceptable at the end of 6 to 12 consecutive months of appropriate, active treatment, or at the end of longer duration of non-operative programs for debilitated
patients with complex problems [NOTE: Mere passage of time with poorly guided treatment is not considered an active treatment program]; AND
  o All pain generators are adequately defined and treated; AND
  o All physical medicine and manual therapy interventions are completed; AND
  o X-ray, MRI, or CT demonstrating disc pathology or spinal instability; AND
  o Spine pathology limited to one or two levels unless other complicating factors are involved; AND
  o Psychosocial evaluation for confounding issues addressed

NOTE: The effectiveness of three-level or greater cervical fusion for non-radicular pain has not been established (Van Middelkoop, 2012).

Cervical Posterior Decompression

The following criteria must be met*:

  o Positive clinical findings of myelopathy with evidence of progressive neurologic deficits consistent with worsening spinal cord compression - immediate surgical evaluation is indicated (AAOS, 2013; Bono, 2011; Heary, 2009; Mummaneni, 2009; Ryken, 2009; Tetreault, 2013; Wang, 2013; Yalamanchili, 2012; Zhu, 2013). Symptoms may include:
    • Upper extremity weakness;
    • Unsteady gait related to myelopathy/balance or generalized lower extremity weakness;
    • Disturbance with coordination;
    • Hyperreflexia;
    • Hoffmann sign;
    • Positive Babinski sign and / or clonus; OR
  o Progressive neurological deficit (motor deficit, bowel or bladder dysfunction) with corresponding evidence of spinal cord or nerve root compression on an MRI or CT scan images - immediate surgical evaluation is indicated (Tetreault, 2013; Wang, 2013); OR

When ALL of the following criteria are met (Bono, 2011):

  o Cervical radiculopathy from ruptured disc, spondylosis, or deformity; AND
  o Persistent or recurrent symptoms/pain with functional limitations that are unresponsive to at least 6 weeks of appropriate conservative treatment; AND
  o Documented failure of at least 6 consecutive weeks in the last 6 months of any 2 of the following physician-directed conservative treatments:
    • Analgesics, steroids, and/or NSAIDs
    • Structured program of physical therapy
    • Structured home exercise program prescribed by a physical therapist, chiropractic provider or physician
• Epidural steroid injections and or facet injections /selective nerve root block; **AND**
  o Imaging studies confirm the presence of spinal cord or spinal nerve root compression at the level(s) **corresponding with the clinical findings** (Bono, 2011; Sahai, 2019). Imaging studies may include **any** of the following:
    • MRI (preferred study for assessing cervical spine soft tissue); **OR**
    • CT with or without myelography—indicated in patients in whom MRI is contraindicated; preferred for examining bony structures, or in patients presenting with clinical symptoms or signs inconsistent with MRI findings (e.g., foraminal compression not seen on MRI)

Cervical decompression performed as first-line treatment without conservative care in the following clinical cases (Ryken, 2009; Tetreault, 2013; Wang, 2013; Zhu, 2013):
  o As outlined above for myelopathy or progressive neurological deficit scenarios.
  o Spinal cord or nerve root compression due to tumor, infection or trauma.

**Not Recommended** (Nikolaidis, 2010; Wang, 2011):
  o In asymptomatic or mildly symptomatic cases.
  o In cases of neck pain alone, without neurological deficits and abnormal imaging findings.  See *E. Cervical Fusion for Treatment of Axial Neck Pain Criteria*.  
  o In patients with kyphosis or at risk for development of postoperative kyphosis.

**Cervical Artificial Disc Replacement (Single or Two Level)**
Indications for cervical artificial disc replacement are as follows (Bono, 2011; Cheng, 2009; Davis, 2015; Gornet, 2019; Lavelle, 2019; Matz, 2009e):
  o Skeletally mature patient; **AND**
  o Patient has intractable radiculopathy caused by one or two level disease (either herniated disc or spondolytic osteophyte) located at C3-C7; **AND**
  o Persistent or recurrent symptoms/pain with functional limitations that are unresponsive to at least 6 weeks of appropriate conservative treatment; **AND**
  o Documented failure of at least 6 consecutive weeks in the last 6 months of **any 2** of the following physician-directed conservative treatments:
    • Analgesics, steroids, and/or NSAIDs,
    • Structured program of physical therapy,
    • Structured home exercise program prescribed by a physical therapist, chiropractic provider or physician,
    • Epidural steroid injections and or facet injections /selective nerve root block; **AND**
  o Imaging studies confirm the presence of compression at the level(s) corresponding with the clinical findings (MRI or CT); **AND**
  o Use of an FDA-approved prosthetic intervertebral discs.
Cervical Artificial Disc Replacement is NOT indicated when any of the following clinical scenarios exists (Davis, 2015):

- Symptomatic multiple level disease affecting 3 or more levels
- Infection (at site of implantation or systemic)
- Osteoporosis or osteopenia
- Instability
  - Translation greater than 3mm difference between lateral flexion-extension views at the symptomatic levels;
  - 11 degrees of angular difference between lateral flexion-extension views at the symptomatic levels
- Sensitivity or allergy to implant materials
- Severe spondylosis defined as (Davis, 2015):
  - > 50% disc height loss compared to minimally or non-degenerated levels; OR
  - Bridging osteophytes; OR
  - Absence of motion on lateral flexion-extension views at the symptomatic site
- Severe facet arthropathy
- Ankylosing spondylitis
- Rheumatoid arthritis
- Previous fracture with anatomical deformity
- Ossification of the posterior longitudinal ligament (OPLL)
- Active cervical spine malignancy

**Cervical Fusion without Decompression**

Cervical fusion without decompression will be reviewed on a case-by-case basis. Atraumatic instability due to Down Syndrome-related spinal deformity, rheumatoid arthritis, or basilar invagination are uncommon, but may require cervical fusion (Trumees, 2017).

**Cervical Anterior Decompression (without fusion)**

All requests for anterior decompression without fusion will be reviewed on a case-by-case basis (Bono, 2011; Botelho, 2012; Gebremariam, 2012; Matz, 2009a; Matz, 2009e).

**BACKGROUND:**

This guideline outlines the key surgical treatments and indications for common cervical spinal disorders and is a consensus document based upon the best available evidence. Spine surgery is a complex area of medicine, and this document breaks out the clinical indications by surgical type. Operative treatment is indicated only when the natural history of an operatively treatable problem is better than the natural history of the problem without operative treatment. Choice of surgical approach is based on anatomy, the patient’s pathology, and the surgeon’s experience and preference. All operative interventions must
be based on a positive correlation with clinical findings, the natural history of the disease, the clinical course, and diagnostic tests or imaging results.

**Overview:**

*Conservative Therapy: (Musculoskeletal) includes primarily physical therapy and/or injections; and a combination of modalities, such as rest, ice, heat, modified activities, medical devices (such as a cervical collar), medications, diathermy, chiropractic treatments, or physician supervised home exercise program.

**Home Exercise Program (HEP) –** the following two elements are required to meet guidelines for completion of conservative therapy:

- Information provided on exercise prescription/plan; **AND**
- Follow up with member with documentation provided regarding completion of HEP, (after 4 – 6 week period) or inability to complete HEP due to physical reason- i.e. increased pain, inability to physically perform exercises. (Patient inconvenience or noncompliance without explanation does not constitute “inability to complete” HEP).

A comprehensive assimilation of factors should lead to a specific diagnosis with positive identification of the pathologic condition(s).

- Early intervention may be required in acute incapacitating pain or in the presence of progressive neurological deficits.
- Operative treatment is indicated when the natural history of surgically treated lesions is better than the natural history for non-operatively treated lesions.
- Patients may present with localized pain or severe pain in combination with numbness, extremity weakness, loss of coordination, gait issues, or bowel and bladder complaints. Nonoperative treatment continues to play an important role in the care of patients with degenerative cervical spine disorders. If these symptoms progress to neurological deficits, from corresponding spinal cord or nerve root compression, then surgical intervention may be warranted.
- All patients being considered for surgical intervention should first undergo a comprehensive neuromusculoskeletal examination to identify those pain generators that may either respond to non-surgical techniques, or may be refractory to surgical intervention.
- If operative intervention is being considered, particularly those procedures that require a fusion, it is required that the person refrain from smoking/nicotine for at least six weeks prior to surgery and during the time of healing (Jackson, 2016; Kusin, 2015; Liang, 2017; Olsson, 2015; Rajaee, 2014; Tetreault, 2015).
- In situations requiring the possible need for operation, a second opinion may be necessary. Psychological evaluation is strongly encouraged when surgery is being performed for isolated axial pain to determine if the patient will likely benefit from the treatment.
- It is imperative for the clinician to rule out non-physiologic modifiers of pain presentation, or non-operative conditions mimicking radiculopathy, myelopathy or spinal instability.
Degenerative cervical spine disorders, while often benign and episodic in nature, can become debilitating, resulting in axial pain and neurological damage to the spinal cord or roots. Compression on the nerve root and/or spinal cord may be caused by (1) a herniated disc with or without extrusion of disc fragments and/or (2) degenerative cervical spondylosis.

**Anterior Approaches:**

Anterior surgical approaches to cervical spine decompression emerged in the 1950s in response to technical limitations experienced with posterior approaches, including restricted access to and exposure of midline bony spurs and disc fragments.

The first reports in the literature describe anterior cervical discectomy combined with a spinal fusion procedure (ACDF). Fusion was added to address concerns about potential for loss of spinal stability and disc space height, leading to late postoperative complications such as kyphosis and radicular pain (Sonntag, 1996; Dowd, 1999; Matz, 2009a; Matz, 2009b; Denaro, 2011; Botelho, 2012; Van Middelkoop, 2012).

Anterior cervical fusion (ACF) accounted for approximately 80% of cervical spine procedures performed in the United States between 2002 and 2009, while posterior cervical fusion (PCF) accounted for 8.5% of these procedures (Oglesby, 2013).

**Anterior Cervical Discectomy and Fusion (ACDF)** – removal of all or part of a herniated or ruptured disc or spondolytic bony spur to alleviate pressure on the nerve roots or on the spinal cord in patients with symptomatic radiculopathy. Discectomy is most often combined with fusion to stabilize the spine.

**Cervical Artificial Disc Replacement** - This involves the insertion of a prosthetic device into the cervical intervertebral space with the goal of maintaining physiologic motion at the treated cervical segment. The use of artificial discs in motion-preserving technology is based on the surgeon's preference and training. Only FDA-approved artificial discs are appropriate.

**Posterior Approaches**

**Laminectomy** – removal of the bone between the spinal process and facet pedicle junction to expose the neural elements of the spine. This allows for the inspection of the spinal canal, identification and removal of pathological tissue, and decompression of the cord and roots.

**Laminoplasty** – the opening of the lamina to enlarge the spinal canal. There are several laminoplasty techniques; all aim to alleviate cord compression by reconstructing the spinal canal. Laminoplasty is commonly performed to decompress the spinal cord in patients with multilevel degenerative spinal stenosis and neutral or lordotic alignment.

**Laminoforaminotomy (also known as posterior discectomy)** – the creation of a small window in the lamina to facilitate removal of arthritic bone spurs and herniated disc material pressing on the nerve root.
root as it exits through the foramen. The procedure widens the opening of the foramen so that the nerve exits without being compressed.

POLICY HISTORY:

Review Date: November 2018

Review Summary:
- “Cervical Artificial Disc Replacement”: Removed “no prior neck surgery” requirement
- Changed smoking/nicotine cessation from ‘recommended’ to ‘required’
- Added and updated references

Review Date: September 2019

Review Summary:
- Codes 22856, 22861, 22864 added to -Cervical Artificial Disc - Two Levels

Review Date: October 2019

Review Summary:
- “in the last 6 months” added to further define the conservative care requirement
- New references added

Review Date: November 2020

- **Review Summary:** Added CPT code 22864 to ACDF Single level and ACDF multiple level
REFERENCES:


CPT Codes:
- Lumbar Fusion (Single level) = 22533, 22558, 22612, 22630, 22633 Plus Decompression
- Lumbar Fusion (Multiple levels) = 22533, +22534, 22558, +22585, 22612, +22614, 22630, +22632, 22633, +22634 (+indicates multiple levels) Plus Decompression
- Lumbar Decompression = 63030, +63035, 63005, 63012, 63017, 63042, +63044, 63047, +63048, 63056, +63057
- Lumbar Discectomy/Microdiscectomy = 63030, +63035, 62380
- Lumbar Artificial Disc Replacement = 22857, 22862, 22865
- Sacroiliac Joint (SIJ) Fusion = 27279, 27280

INDICATIONS FOR LUMBAR SPINE SURGERY:

Lumbar Discectomy/Microdiscectomy: Surgical indications for inter-vertebral disc herniation*:
- When ALL of the following are present:
  - Primary radicular symptoms noted upon clinical exam that significantly hinders daily activities (Chou, 2009; Kreiner, 2014; Tosteson, 2011); AND
  - Failure to improve with at least 6 consecutive weeks in the last 6 months of documented, physician directed appropriate conservative treatment to include at least 2 of the following (Kreiner, 2014, 2013; Delitto, 2015):
    - Analgesics, steroids, and/or NSAIDs
    - Structured program of physical therapy
    - Structured home exercise program prescribed by a physical therapist, chiropractic provider or physician
    - Epidural steroid injections and or selective nerve root block; AND
  - Imaging studies showing evidence of inter-vertebral disc herniation that correlate exactly with the patient’s symptoms / signs (Fardon, 2014; Kreiner, 2014); OR

*Other Indications: Microdiscectomy may be used as the first line of treatment (no conservative treatment required) in the following clinical scenarios (Kreiner, 2014):
- Progressive nerve compression resulting in an acute neurologic deficit (motor) due to herniated disc. The neurological deficits should be significant: 0-2/5 on the motor function scale for L5 or S1 roots; 0-3/5 for L3 or L4 roots. Lesser degrees of motor dysfunction may resolve with conservative treatment and are not considered an indication for early surgery; OR
- Cauda equina syndrome (loss of bowel or bladder control).
NOTE: Percutaneous lumbar discectomy, radiofrequency disc decompression, and related procedures are deemed investigational procedures and are not approved. Discectomy and microdiscectomy are the gold standards.

Lumbar Decompression: Laminectomy, Laminotomy, Facetectomy, and Foraminotomy. These procedures allow decompression by partial or total removal of various parts of vertebral bone and ligaments. Surgical Indications for spinal canal decompression due to lumbar spinal stenosis*:

- When ALL of the following are present:
  - Neurogenic claudication, and/or radicular leg pain that impairs daily activities (Atlas, 2005; Chou, 2009; Genevay, 2010; Kreiner, 2013; Tosteson, 2011; Tosteson, 2008; Weinstein, 2007); **AND**
  - Failure to improve with at least 6 consecutive weeks in the last 6 months of documented, physician directed appropriate conservative therapy to include at least two (2) of the following (Kreiner, 2013; Delitto, 2015):
    - Analgesics, steroids, and/or NSAIDs
    - Structured program of physical therapy
    - Structured home exercise program prescribed by a physical therapist, chiropractic provider or physician
    - Epidural steroid injections and or selective nerve root block; **AND**
  - Imaging findings demonstrating moderate to severe stenosis consistent with clinical signs/symptoms (Genevay, 2010; Kreiner, 2013; Weinstein, 2007); **OR**

*Other Indications: Lumbar decompression may be used as the first line of treatment (no conservative treatment required) in any of the following clinical scenarios (Kreiner, 2014, 2013):

- Progressive nerve compression resulting in an acute neurologic (motor) deficit. The neurological deficits should be significant—0-2/5 on the motor function scale for L5 or S1 roots; 0-3/5 for L3 or L4 roots. Lesser degrees of motor dysfunction may resolve with conservative treatment and are not considered an indication for early surgery; **OR**
- Cauda equina syndrome (loss of bowel or bladder control); **OR**
- Spinal stenosis due to tumor, infection, or trauma

NOTE: Percutaneous decompressions, endoscopic decompression, and related procedures (laser, etc.) are deemed investigational procedures and are not approved. Open or microdecompressions via laminectomy or laminotomy are the gold standards (Kreiner, 2014).

Lumbar Spine Fusion:

Single Level Fusion with or without Decompression:

Because of variable outcomes with fusion surgery, patients should be actively involved in the decision-making process and provided appropriate decision-support materials when considering this intervention.
• When All of the following are present*:
  - Lumbar back pain, neurogenic claudication, and/or radicular leg pain without sensory or motor deficit that impairs daily activities for at least 6 months (Bogduk, 2009; Brox, 2010; Carreon, 2008; Chou, 2009; Fritzell, 2001; Kreiner, 2013; Mannion, 2016; Matz, 2014, 2016; NASS, 2009; Eck, 2014; Tosteson, 2011, 2008; Weinstein 2007); AND
  - Failure to improve with at least 6 consecutive weeks in the last 6 months of documented, physician directed appropriate conservative therapy (6 months for isolated LBP) to include at least two (2) of the following (Brox, 2010; Chou, 2009; Kreiner, 2013; Matz, 2014, 2016; NASS, 2009; Eck, 2014; Delitto, 2015)
    - Analgesics, steroids, and/or NSAIDs
    - Structured program of physical therapy
    - Structured home exercise program prescribed by a physical therapist, chiropractic provider or physician
    - Epidural steroid injections and or facet injections /selective nerve root block; AND
  - Imaging studies corresponding to the clinical findings (Genevay, 2010; Kreiner, 2013; Matz, 2014, 2016; NASS, 2009; Eck, 2014; Weinstein, 2007); AND
  - At least one of the following clinical conditions:
    - Spondylolisthesis [Neural Arch Defect -Spondylolytic spondylolisthesis, degenerative spondylolisthesis, and congenital unilateral neural arch hypoplasia] (Carreon, 2008; Kwon, 2005; Matz, 2014, 2016; NASS, 2009; Weinstein, 2007; Yavin, 2017); OR
    - Evidence of segmental instability -Excessive motion, as in degenerative spondylolisthesis, segmental instability, and surgically induced segmental instability (Carreon, 2008; Kwon, 2005; Matz, 2014, 2016; NASS, 2009; Weinstein, 2007; Yavin, 2017); OR
    - Revision surgery for failed previous operation(s) for pseudoarthrosis at the same level at least 6-12 months from prior surgery** if significant functional gains are anticipated (Trumees, 2017) ; OR
    - Revision surgery for failed previous operation(s) repeat disk herniations if significant functional gains are anticipated (Note: Many recurrent disc herniations can be treated with discectomy alone, so specific indications for the addition of fusion will be required) (Kreiner, 2014); OR
    - Fusion for the treatment of spinal tumor, cancer, or infection (Trumees, 2017); OR
    - Chronic low back pain or degenerative disc disease (disc degeneration without significant neurological compression presenting with low back pain) must have failed at least 6 months of appropriate active non-operative treatment (completion of a comprehensive cognitive -behavioral rehabilitation program is mandatory) and must be evaluated on a case-by-case basis (Bogduk, 2009; Brox, 2010; Chou, 2009; Fardon, 2014; Fritzell, 2001; Mannion, 2016; Yavin, 2017).

NOTE: The results of several randomized trials suggests that in many degenerative cases uninstrumented posterolateral intertransverse fusion has similar results to larger instrumented (PLIF, TLIF, etc.) fusion techniques with fewer morbidities and less likelihood of revision surgery. Accordingly, specific findings suggesting more significant instability should be present when larger techniques are
*Other Indications:* Lumbar spinal fusion may be used as the first line of treatment (*no conservative treatment required*) in the following clinical scenarios (Kreiner, 2014):

- Progressive nerve compression resulting in an acute neurologic deficit (motor); **AND**
  - One of the aforementioned clinical conditions, *except* chronic low back pain or degenerative disc disease. The neurological deficits must be significant: 0-2/5 on the motor function scale for L5 or S1 roots; or 0-3/5 for L3 or L4 roots. Lesser degrees of motor dysfunction may resolve with conservative treatment and are not considered an indication for early surgery.
- Cauda equina syndrome (loss of bowel or bladder control); **AND**
  - One of the aforementioned clinical conditions, *except* chronic low back pain or degenerative disc disease.

**REPEAT LUMBAR SPINE FUSION OPERATIONS:** Repeat lumbar fusion operations will be reviewed on a case-by-case basis upon submission of medical records and imaging studies that demonstrate remediable pathology. The below must also be documented and available for review of repeat fusion requests (Bogduk, 2009; Chou, 2009; Mannion, 2016; Yavin, 2017):

- Rationale as to why surgery is preferred over other non-invasive or less invasive treatment procedures.
- Signed documentation that the patient has participated in the decision-making process and understands the high rate of failure/complications.

**Multi-level Fusion with or without decompression (all multi-level fusion surgeries will be reviewed on a case-by-case basis):**

Because of variable outcomes with fusion surgery, patients should be actively involved in the decision-making process and provided appropriate decision-support materials when considering this intervention.

- When **ALL of the following** are present*:
  - Lumbar back pain, neurogenic claudication, and/or radicular leg pain without sensory or motor deficit that impairs daily activities for at least 6 months (Bogduk 2009; Brox 2010; Chou 2009; Fritzell 2001; Mannion 2016; Tosteson 2011, 2008; Weinstein, 2007); **AND**
  - Failure to improve with at least 6 consecutive weeks in the last 6 months of documented, physician directed appropriate conservative therapy to include at least two (2) of the following (Brox, 2010; Matz, 2014, 2016; NASS, 2009; Delitto, 2015):
    - Analgesics, steroids, and/or NSAIDs
    - Structured program of physical therapy
    - Structured home exercise program prescribed by a physical therapist, chiropractic provider or physician
    - Epidural steroid injections and or facet injections /selective nerve root block; **AND**
Imaging studies corresponding to the clinical findings (Genevay, 2010; Kreiner, 2013; Matz, 2014, 2016; NASS, 2009; Eck, 2014; Weinstein, 2007); **AND**

At least **one of the following** clinical conditions (Carreon, 2008; Kwon, 2005; Matz, 2014, 2016; NASS, 2009; Yavin, 2017):

- Multiple level spondylolisthesis (Note: Fusions in cases with single level spondylolisthesis should be limited to the unstable level); **OR**
- Fusion for the treatment of spinal tumor, trauma, cancer, or infection affecting multiple levels; **OR**
- Intra-operative segmental instability; **OR**

**Other Indications:** Lumbar spinal fusion may be used as the first line of treatment (no conservative treatment required) in the following clinical scenarios (Kreiner, 2014):

- Progressive nerve compression resulting in an acute neurologic deficit (motor); **AND**
  - One of the aforementioned clinical conditions except chronic low back pain or degenerative disc disease. The neurological deficits must be significant: 0-2/5 on the motor function scale for L5 or S1 roots; or 0-3/5 for L3 or L4 roots. Lesser degrees of motor dysfunction may resolve with appropriate conservative treatment and are not considered an indication for early surgery; OR
- Cauda equina syndrome (loss of bowel or bladder control); **AND**
  - One of the aforementioned clinical conditions, except chronic low back pain or degenerative disc disease.

**Lumbar Artificial Disc Replacement**

Because of variable outcomes with lumbar artificial disc replacement surgery, patients should be actively involved in the decision-making process and provided appropriate decision-support materials when considering this intervention.

Lumbar total disc arthroplasty (artificial disc replacement) may be considered **medically necessary** when **ALL** of the following indications are met (Jacobs, 2013; NASS, 2019; Zigler, 2012; Zigler, 2017):

- The individual is between the ages of 18 to 60
- Degenerative disc disease or significant discogenic back pain with disc degeneration, is confirmed by documented patient history, physical examination, and key radiographic studies, with no more than Grade 1 (low level) spondylolisthesis demonstrated on x-ray at the operative level
- Imaging confirms absence of significant facet arthropathy at operative level
- At least six months of non-operative (conservative) treatment have failed to resolve symptoms (See Note*)
- Disc reconstruction with the device is performed at only one (single) level using an anterior retroperitoneal approach
- The device used as the disc replacement device is FDA-approved for lumbar disc replacement and is used in accordance with FDA labelling
• There are no contraindications to lumbar artificial disc replacement, including but not limited to (see Note**):
  o Disease above L3-4
  o Active systemic or local infection
  o Osteoporosis or osteopenia (DEXA bone mineral density T-score less than or equal to -1.0), or vertebral bodies compromised by disease or prior trauma
  o Allergy or sensitivity to implant materials
  o Isolated lumbar radiculopathy (especially due to herniated disc), or chronic radiculopathy (unremitting especially leg symptoms lasting over 1 year)
  o Spinal stenosis, or spinal deformity (scoliosis)
  o Spondylolisthesis greater than Grade 1
  o Disc degeneration requiring treatment at more than one level
  o Severe facet arthrosis or joint degeneration
  o Presence of free disc fragment
  o Poorly managed psychiatric disorder

Artificial lumbar disc replacement is considered **not medically necessary** in all other circumstances, including artificial disc arthroplasty done at more than one spinal level, and hybrid (combination artificial disc and fusion) procedures.

**NOTE**: Conservative care is focused multi-modal nonoperative treatment that must include a physical therapy/rehabilitation program with cognitive-behavioral components. Treatment may also include pain management injections and active exercise programs. This must be clearly outlined in the medical record.

**NOTE**: Contraindications are related to the level being considered for surgery.

**Percutaneous Sacroiliac Joint (SIJ) Fusion (all SIJ fusion surgeries will be reviewed on a case-by-case basis):**

Because of variable outcomes with fusion surgery, patients should be actively involved in the decision-making process and provided appropriate decision-support materials when considering this intervention.

• When **ALL of the following** are present (NASS, 2015; Polly, 2016; Whang, 2019):
  o Low back/buttock pain that is typically unilateral and caudal to the lumbar spine localized over the SIJ that impairs daily activities for **at least 6 months**; **AND**
  o Failure to improve with at least 6 months of appropriate active non-operative treatment that must include medications, PT, and a home exercise program; **AND**
  o Physical exam demonstrating pain to palpation over the sacral sulcus in the absence of tenderness of similar severity elsewhere; **AND**
  o Absence of generalized pain behavior; **AND**
o Positive pain response to a cluster of 3 provocative tests (e.g., thigh thrust, compression test, Gaenslen’s test, distraction test, Faber test); AND
o Diagnostic imaging studies that include ALL of the following:
  ▪ Imaging (plain radiographs and a CT or MRI) of the SI joint that excludes the presence of destructive lesions (eg, tumor, infection) or inflammatory arthropathy that would not be properly addressed by percutaneous SIJ fusion
  ▪ Imaging of the pelvis (AP plain radiograph) to rule out concomitant hip pathology
  ▪ Imaging of the lumbar spine (CT or MRI) to rule out neural compression or other degenerative condition that can be causing low back or buttock pain
  ▪ Imaging of the SI joint that indicates evidence of injury and/or degeneration; AND
o At least 75% reduction of pain for the expected duration of the anesthetic used following an image-guided, contrast -enhanced intra-articular SIJ injection on 2 separate occasions; AND
o A trial of at least one therapeutic intra-articular SIJ injection (i.e., corticosteroid injection

NOTE: Instrumentation, bone formation or grafting materials, including biologics, should be used at the surgeon’s discretion; however, use should be limited to FDA approved indications regarding the specific devices or biologics.

NOTE: This lumbar surgery guideline does not address spinal deformity surgeries or the clinical indications for spinal deformity surgery.

NOTE: Pre-sacral, axial lumbar interbody fusion (AxiaLIF) is not an approved surgical approach due to insufficient evidence.

RELATIVE CONTRAINDICATIONS FOR SPINE SURGERY (NOTE: Cases will not be approved if the below contraindications exist):

• **Medical contraindications** to surgery, e.g., severe osteoporosis; infection of soft tissue adjacent to the spine and may be at risk for spreading to the spine; severe cardiopulmonary disease; anemia; malnutrition and systemic infection (Puvanesarajah, 2016).

• **Psychosocial risk factors.** It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions mimicking radiculopathy or instability (e.g., peripheral neuropathy, piriformis syndrome, myofascial pain, sympathetically mediated pain syndromes, sacroiliac dysfunction, psychological conditions, etc.) prior to consideration of elective surgical intervention (Kreiner, 2014). Patients with clinically significant depression or other psychiatric disorders being considered for elective spine surgery will be reviewed on a case-by-case basis and the surgery may be denied for risk of failure.

• **Active Tobacco or Nicotine** use prior to fusion surgery. Patients must be free from smoking and/or nicotine use for at least six weeks prior to surgery and during the entire period of fusion healing (Andersen, 2001; Glassman, 2000; Jackson, 2016; Patel, 2013; Hermann, 2016).

• **Morbid Obesity.** Contraindication to surgery in cases where there is significant risk and concern for improper post-operative healing, post-operative complications related to morbid obesity, and/or an inability to participate in post-operative rehabilitation (Epstein, 2017).
These cases will be reviewed on a case-by-case basis and may be denied given the risk of failure.

BACKGROUND:

**Lumbar Discectomy/Microdiscectomy** is a surgical procedure to remove part of the damaged spinal disc. The damaged spinal disc herniates into the spinal canal and compresses the nerve roots. Nerve root compression leads to symptoms like low back pain, radicular pain, numbness and tingling, muscular weakness, and paresthesia. Typical disc herniation pain is exacerbated with any movement that causes the disc to increase pressure on the nerve roots.

**Lumbar Decompression (Laminectomy, Laminotomy, Facetectomy, and Foraminotomy):** Laminectomy is a common decompression surgery. The American Association of Neurological Surgeons defines laminectomy as a surgery to remove the back part of vertebra, lamina, to create more space for the spinal cord and nerves. The most common indication for laminectomy is spinal stenosis. Spondylolisthesis and herniated disk are also frequent indications for laminectomy. Decompression surgery is usually performed as part of lumbar fusion surgery.

**Lumbar Fusion Surgery:** Lumbar spinal fusion (arthrodesis) is a surgical procedure used to treat spinal conditions of the lumbar, e.g., degenerative disc disease, spinal stenosis, injuries/fractures of the spine, spinal instability, and spondylolisthesis. Spinal fusion is a “welding” process that permanently fuses or joins together two or more adjacent bones in the spine, immobilizing the vertebrae and restricting motion at a painful joint. It is usually performed after other surgical procedures of the spine, such as discectomy or laminectomy. The goal of fusion is to increase spinal stability, reduce irritation of the affected nerve roots, compression on the spinal cord, disability, and pain and/or numbness. Clinical criteria for single level fusion versus multiple level fusions are outlined under the indications section.

**Lumbar Artificial Disc Replacement:** Lumbar artificial disc replacement (LADR) is a surgical procedure used to treat low back pain from lumbar degenerative disc disease. The degenerative lumbar disc is replaced with an artificial disc that maintains motion at the surgical level. Studies have shown the results of LADR to be at least equivalent to spinal fusion for the treatment of discogenic low back pain. LADR is a technically challenging operation and proper training should be obtained before performing the procedure.

OVERVIEW:

This guideline outlines the key surgical treatments and indications for common lumbar spinal disorders and is a consensus document based upon the best available evidence. Spine surgery is a complex area of medicine and this document breaks out the treatment modalities for lumbar spine disorders into surgical categories: **lumbar discectomy/microdiscectomy, lumbar decompression, lumbar fusion surgery, and lumbar artificial disc replacement.** See below for procedures considered not medically necessary.

- Spinal surgeries should be performed only by those with extensive surgical training (neurosurgery, orthopaedic surgery)
• **Services Not Covered:** The following procedures are considered either still under investigation or are not recommended based upon the current evidence: Percutaneous lumbar discectomy; Laser discectomy; Percutaneous Radiofrequency Disc Decompression; intradiscal electrothermal annuloplasty (IDEA) or more commonly called IDET (Intradiscal Electrothermal therapy); Nucleus Pulposus Replacement; and Pre-Sacral Fusion.
  o **PERCUTANEOUS DISCECTOMY** is an invasive operative procedure to accomplish partial removal of the disc through a needle which allows aspiration of a portion of the disc under imaging control. Its only indication is to obtain diagnostic tissue, such as, for a biopsy for discitis. Its effectiveness has not been fully established.
  o **LASER DISCECTOMY** is a procedure which involves the delivery of laser energy into the center of the nucleus pulposus using a fluoroscopically guided laser fiber under local anesthesia. The energy denatures protein in the nucleus, causing a structural change which is intended to reduce intradiscal pressure. Its effectiveness has not been fully established.
  o **INTRADISCAL ELECTROTHERMAL ANNULOPLASTY (IDEA) (more commonly called IDET, or Intradiscal Electrothermal therapy)** is an outpatient non-operative procedure in which a wire is guided into the identified painful disc using fluoroscopy. The wire is then heated at the nuclear-annular junction within the disc. It has not been shown to be effective.
  o **NUCLEUS PULPOSUS REPLACEMENT** involves the introduction of a prosthetic implant into the intervertebral disc, replacing the nucleus pulposus while preserving the annulus fibrosus. It has not been shown to be effective relative to other gold standard interventions.

• **Conservative Therapy:** (Musculoskeletal) includes primarily physical therapy and/or injections; and a combination of modalities, such as rest, ice, heat, modified activities, medical devices (such as braces), medications, diathermy, chiropractic treatments, or physician supervised home exercise program.

• **Home Exercise Program - (HEP)** – the following two elements are required to meet guidelines for completion of conservative therapy:
  o Documentation provided of an exercise prescription/plan; **AND**
  o Follow up with member with information provided regarding completion of HEP (after suitable 4-6 week period), or inability to complete HEP due to physical reason- i.e. increased pain, inability to physically perform exercises. (Patient inconvenience or noncompliance without explanation does not constitute “inability to complete” HEP).

• **Isolated Low Back Pain** - Pain isolated to the lumbar region of the spine and the surrounding paraspinal musculature. Also referred to ‘mechanical low back pain’ or ‘discogenic pain’. No associated neurogenic claudication or radiculopathy.

• **Claims Billing & Coding:**
  o NIA uses a combination of internally developed edits in addition to an enhanced set of industry standard editing. **NIA’s Claims Edit Module** is a group of system edits that run multiple times per day. Edits that are part of this module include industry standard edits that apply to spine surgery services and NIA custom edits developed specifically for spine surgery. The following describes each of the edits NIA applies:
• **Outpatient Code Editor (OCE):** This edit performs all functions that require specific reference to HCPCS codes, HCPCS modifiers, and ICD-9-CM diagnosis codes. The OCE only functions on a single claim and does not have any cross claim capabilities. NIA is consistent with CMS.

• **National Correct Coding Initiative (NCCI) editing:** The edit prevents improper payment when incorrect code combinations are reported. The NCCI contains two tables of edits. The Column One/Column Two Correct Coding Edits table and the Mutually Exclusive Edits table include code pairs that should not be reported together for a number of reasons explained in the Coding Policy Manual. NIA is consistent with CMS.
  o Incidental edits: This edit applies if a procedure being billed is a component of another procedure that occurred on the same date of service for the same provider and tax ID and claimant.
  o Mutually exclusive editing: This edit applies if a procedure being billed is mutually exclusive with a procedure that occurred on the same date of service for the same provider tax ID and claimant.

• **Multiple Procedure Discounts (MPD):** This edit applies a reduction to the second and any other subsequent services by the same provider, in the same setting, for the same member. We typically apply a 50% reduction. NIA follows the CMS methodology that began in January 2011 which allows for application of MPD to codes within CMS’s two specific advanced imaging code families. However, NIA differs from CMS in that we apply MPD to all provider types unless health plan contracts prohibit this.

• **Lumbar Fusion** - Fusions can be performed either anteriorly, laterally, or posteriorly, or via a combined approach; although simple posterolateral fusions are indicated in the great majority of cases requiring fusion. Aggressive surgical approaches to fusion may be an indication for denial of cases (when such techniques have not been demonstrated to be superior to less morbid techniques) or recommendation for alternative procedure. These are the surgical approaches:
  o Intertransverse Fusion or Posterolateral Fusion
  o Anterior Interbody Fusion (ALIF)
  o Lateral or Transpsoas Interbody Fusion (XLIF)
  o Posterior or Trans-foraminal Interbody Fusion (PLIF or TLIF)
  o Anterior/posterior Fusion (360-degree)
  o Pre-sacral, axial lumbar interbody fusion (AxiaLIF) is still being investigated and is not recommended.

• Use of bone grafts including autologous or allograft which might be combined with metal or biocompatible devices to produce a rigid, bony connection between two or more adjacent vertebrae are common. Bone formation or grafting materials including biologics should be used at the surgeon’s discretion; however, use of biologics should be limited to FDA approved indications in order to limit complications (especially BMP).

• All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests and must be performed by surgeons with appropriate training (neurosurgery, orthopaedic surgery). A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic
condition(s). A failure of accurate correlation may be an indication for denial of cases. It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions mimicking radiculopathy or instability (e.g., peripheral neuropathy, piriformis syndrome, myofascial pain, sympathetically mediated pain syndromes, sacroiliac dysfunction, psychological conditions, etc.) prior to consideration of elective surgical intervention.

- Operative treatment is indicated when the natural history of surgically treated lesions is better than the natural history for non-operatively treated lesions.
  - All patients being considered for surgical intervention should first undergo a comprehensive neuro-musculoskeletal examination to identify mechanical pain generators that may respond to non-surgical techniques or may be refractory to surgical intervention.
  - While sufficient time allowances for non-operative treatment are required to determine the natural cause and response to non-operative treatment of low back pain disorders, timely decision making for operative intervention is critical to avoid de-conditioning and increased disability (exclusive of "emergent" or urgent pathology such as cauda equina syndrome or associated rapidly progressive neurologic loss).

- In general, if the program of non-operative treatment fails, operative treatment is indicated when:
  - Improvement of the symptoms has plateaued or failed to occur and the residual symptoms of pain and functional disability are unacceptable at the end of 6 to 12 weeks of active treatment, or at the end of longer duration of non-operative programs for debilitated patients with complex problems; and/or
  - Frequent recurrences of symptoms cause serious functional limitations even if a non-operative active treatment program provides satisfactory relief of symptoms, and restoration of function on each recurrence.

- **Lumbar spinal stenosis and associated lumbar spondylolisthesis** - Spinal stenosis is narrowing of the spinal column or of the neural foramina where spinal nerves leave the spinal column. The most common cause is degenerative change in the lumbar spine. Neurogenic claudication is the most common symptom, referring to “leg symptoms encompassing the buttock, groin and anterior thigh, as well as radiation down the posterior part of the leg to the feet.” In addition to pain, leg symptoms can include fatigue, heaviness, weakness and/or paresthesia. Some patients may also suffer from accompanying back pain. Symptoms are worse when standing or walking and are relieved by sitting. Lumbar spinal stenosis is often a disabling condition, and it is the most common reason for lumbar spinal surgery in adults over 65 years.

- **Degenerative lumbar spondylolisthesis** - is the displacement of a vertebra in the lower part of the spine; one lumbar vertebra slips forward on another with an intact neural arch and begins to press on nerves. The slippage occurs at the L4-L5 level most commonly. The most common cause, in adults, is degenerative disease although it may also result from bone diseases and fractures. Spondylolisthesis seldom occurs before the age of 50 years and it disproportionately affects women, especially black women. Degenerative spondylolisthesis is
not always symptomatic. The indications for fusion in this group are evolving and as more evidence emerges, changes to the accepted indications and acceptable techniques used may be made.

- **Lumbar degenerative disease without stenosis or spondylolisthesis** - Spondylosis is an umbrella term describing age-related degeneration of the spine. Lumbar degenerative disease without stenosis or spondylolisthesis is characterized by disabling low back pain and spondylosis at L4-5, L5-S1, or both levels.

**POLICY HISTORY:**

**Review Date:** November 2018

**Review Summary:**
- Lumbar Discectomy/Microdiscectomy and Lumbar Decompression: Removed ‘sensory’ from neurological deficit
- Added and updated references

**Review Date:** October 2019

**Review Summary:**
- “in the last 6 months” added to further define the conservative care requirement
- Added section: Lumbar artificial disc replacement with supporting references; added SI Joint Fusion section
- Modified contraindication section to include ‘relative’

**Review Date:** October 2020

**Review Summary:**
- The following codes have been added to the header:
  - Sacroiliac Joint (SIJ) Fusion=27279, 27280
REFERENCES:


Mannion AF, Brox JI, Fairbank JC. Long-term results of all RCTs show that fusion is no better than non-operative care in improving pain and disability in chronic low back pain. Spine J. 2016; 16:588-90.


Zigler JE, Delamater RB. Five-year results of the prospective, randomized, multicenter, food and drug administration investigational device exemption study of the prodisc-l total disc replacement versus

CPT Codes:
Cervical Thoracic Region: 62320, 62321, 64479 (+64480)

Lumbar Sacral Region: 62322, 62323, 64483 (+64484)

INDICATIONS:

EPIDURAL INJECTIONS OR SELECTIVE NERVE BLOCKS (caudal, interlaminar, and transforaminal) *(Injection of local anesthetics with corticosteroids)*

- Pain causing functional disability or average pain levels of ≥ 6 on a scale of 0 – 10 (Manchikanti, 2013, 2011; NASS, 2013, 2012; Summers, 2013); **AND**
  - Diagnostic transforaminal injection to identify the pain generator for surgical planning (Manchikanti, 2013); **OR**
  - Conservative therapy
    - Acute pain or exacerbation of chronic radicular pain with the following clinical timeframes:
      - Neck or back pain with acute radicular pain (Summers, 2013):
      - *After 2 weeks* or more of acute radicular pain that has failed to respond or poorly responded to conservative management unless the medical reason this conservative treatment cannot be done is clearly documented, (active components not required) (Manchikanti, 2013; Summers, 2013); **OR**
      - Failed back surgery syndrome or epidural fibrosis causing radicular pain (Manchikanti, 2013):
        - Typically not done immediately post-surgery. Documentation requires a medical reason that clearly indicates why an injection is needed (Manchikanti, 2013).
        - Patient must engage in some form of other active conservative treatment* for a minimum of 6 weeks in the last 6 months; OR details of engagement in other forms of active conservative non-operative treatment, if the patient had any prior spinal injections prior to epidural injections, unless the medical reason this conservative treatment cannot be done is clearly documented (Manchikanti, 2013; Summers, 2013); **OR**
      - Spinal stenosis (foraminal, central or disc disease) causing axial or radicular pain (Lee, 2009; Manchikanti, 2013):
        - Patient must engage in some form of other active conservative treatment* for a minimum of 6 weeks in the last 6 months; OR details of engagement in other forms of active conservative non-operative treatment, if the patient had any prior spinal injections prior to epidural injections, unless the medical reason this conservative treatment cannot be done is clearly documented; (Manchikanti, 2013; Summers, 2013);
FREQUENCY OF REPEAT THERAPEUTIC INJECTIONS:

Epidural injections may be repeated only as medically necessary. Each epidural injection requires an authorization and the following criteria must be met for repeat injections:

- Documented proof that the prior injection had a positive response by significantly decreasing the patient’s pain (at least 30% reduction in pain after initial injections or significant documented functional improvement) (NASS, 2013). Or a second injection may be performed at a different spinal level or with a different epidural technique, if there is documentation of a question about the pain generator or there is evidence of multilevel pathology (ODG, 2017); **AND**
- No more than 3 procedures in a 12-week period of time per region, with at least 14 days between injections in the initial therapeutic phase. At least 50% or more cumulative pain relief obtained for a minimum of 6 weeks after initial injections (Manchikanti, 2013); **AND**
- The patient continues to have documented functional disability or pain level ≥6 on a scale of 0 to 10 (Manchikanti, 2013, 2011; NASS, 2013; Summers, 2013); **AND**
- The patient is actively engaged in other forms of active conservative non-operative treatment, unless pain prevents the patient from participating in conservative therapy* (Qassem, 2017; Summers, 2013); **AND**
- In the first year of treatment, which may include an initial series of 3 injections in the initial therapeutic phase and additional injections in the maintenance phase, a total of 6 epidural injections, per region, may be performed (Manchikanti, 2013).
- Repeat injections after the initial therapeutic phase should be done at intervals of at least 2 months, provided that previous injections resulted in at least 50% relief or functional improvement for at least 2 months, and are limited to a maximum total of 4 therapeutic procedures per region per 12 months (Manchikanti, 2013; NASS, 2013). If special circumstances are documented (e.g., elderly patient with severe spinal stenosis and not an operative candidate) then repeat injections are limited to a maximum of 6 procedures in 12 months (NASS, 2013).

**NOTE:** Each epidural injection requires an authorization.

- If the neural blockade is applied for different regions, injections may be administered at intervals of no sooner than 7 days for most types of procedures (Manchikanti, 2013).
- Injecting multiple regions or performing multiple procedures during the same visit may be deemed medically **unnecessary** unless documentation is provided outlining an unusual situation (ODG, 2017).
- No more than 2 levels of transforaminal blocks should be done in one day (Singh, 2017).
- An intraspinal injection* of opioid or other substance for the purpose of completing a trial for an implantable infusion pump is approvable using NIA_CG_310.

**NOTE:** See Background section

EXCLUSIONS
These requests are excluded from consideration under this guideline:

- Implantation of intrathecal catheters or ports for chemotherapy
- Intrathecal injections for muscular dystrophy
- Post-operative pain control

CONTRAINDICATIONS FOR EPIDURAL INJECTIONS

- Bleeding diathesis and full anticoagulation (risk of epidural hematoma);
- Severe spinal stenosis resulting in intraspinal obstruction;
- Local infection at injection site;
- Predominantly psychogenic pain;
- Sepsis;
- Hypovolemia;
- Uncontrolled diabetes;
- Uncontrolled glaucoma;
- High concentrations of local anesthetics in patients with multiple sclerosis;
- For diagnosis or treatment of facet mediated pain;
- Known or suspected allergic reaction to steroid medications; OR
- Spinal infection

BACKGROUND:

Therapeutic Spinal Epidural Injections or Select Nerve Root Blocks (Transforaminal) are types of interventional pain management procedures. The therapeutic use of epidural injections is for short-term pain relief associated with acute back pain or exacerbation of chronic back pain. With therapeutic injections a corticosteroid is injected close to the target area with the goal of pain reduction. Epidural injections should be used in combination with other active conservative treatment* modalities and not as stand alone treatment for long-term back pain relief. There are different approaches used when administering spinal epidural injections:

- **Interlaminar** epidural injections, with steroids, access the epidural space between two vertebrae (Interlaminar) to treat cervical, lumbar or thoracic pain with radicular pain. These procedures should be performed using fluoroscopic guidance (AHRQ, 2013). Interlaminar epidural injections are the most common type of epidural injection.
- **Transforaminal** epidural injections (also called selective nerve root blocks) access the epidural space via the intervertebral foramen where the spinal nerves exit (cervical, lumbar/sacral or thoracic region). It is used both diagnostically and therapeutically. Some studies report lack of evidence and risks of transforaminal epidural injections. These procedures are always aided with fluoroscopic guidance (AHRQ, 2013).
- **Caudal** epidural injections, with steroids, are used to treat back and lower extremity pain, accessing the epidural space through the sacral hiatus, providing access to the lower nerve roots of the spine.
These procedures should be performed using fluoroscopic guidance (AHRQ, 2013). Failed back surgery syndrome is the most common reason for the caudal approach.

- **Intraspinal Drug Trial** in anticipation of implanted infusion pump for spinal drug administration.

**NOTE:** There is a separate Clinical Guideline for Implanted Infusion Pumps, see: NIA_CG_310. Because the CPT code for the intraspinal drug trial is the same CPT Code as other intraspinal injections covered by this clinical guideline, this guideline is used for the intraspinal drug trial. It is advised that the Clinical Guideline for Implanted Infusion Pumps be consulted prior to performing the intraspinal drug trial. If the patient is unlikely to meet the other requirements for an implanted infusion pump, an intraspinal drug trial should not be done.

The rationale for the use of spinal epidural injections is that the sources of spinal pain, e.g., discs and joints, are accessible and amendable to neural blockade.

Medical necessity management for epidural injections includes an initial evaluation including history and physical examination and a psychosocial and functional assessment. The following must be determined: nature of the suspected organic problem; non-responsiveness to active conservative treatment*; level of pain and functional disability; conditions which may be contraindications to epidural injections; and responsiveness to prior interventions.

Interventional pain management specialists do not agree on how to diagnose and manage spinal pain; there is a lack of consensus with regards to the type and frequency of spinal interventional techniques for treatment of spinal pain. The American Society of Interventional Pain Physicians (ASIPP) guidelines and International Spine Intervention Society (SIS) guidelines provide an algorithmic approach which provides a step-by-step procedure for managing chronic spinal pain based upon evidence-based guidelines. It is based on the structural basis of spinal pain and incorporates acceptable evidence of diagnostic and therapeutic interventional techniques available in managing chronic spinal pain.

The guidelines and algorithmic approach referred to above include the evaluation of evidence for diagnostic and therapeutic procedures in managing chronic spinal pain and recommendations for managing spinal pain. The Indications and Contraindications presented within this document are based on the guidelines and algorithmic approach. Prior to performing this procedure, shared decision-making between patient and physician must occur, and patient must understand the procedure and its potential risks and results (moderate short-term benefits, and lack of long-term benefits).

**Overview:**

*Conservative Therapy:* (Spine) should include a multimodality approach consisting of a combination of active and inactive components. Inactive components, such as rest, ice, heat, modified activities, medical devices, acupuncture or stimulators, medications, injections (including trigger point), and diathermy can be utilized. Active modalities consist of physical therapy, a physician supervised home exercise program**, or chiropractic care (Qassem, 2017; Summers, 2013).

**Home Exercise Program** - (HEP) – the following two elements are required to meet guidelines for completion of conservative therapy:
• Documentation provided of an exercise prescription/plan (Qassem, 2017; Sculco, 2001); **AND**

• Follow up with member with documentation provided regarding completion of HEP, (after suitable 6 week period) or inability to complete HEP due to physical reason- i.e., increased pain, inability to physically perform exercises. (Patient inconvenience or noncompliance without explanation does not constitute “inability to complete” HEP) (Qassem, 2017; Summers, 2013).

**Terminology:**

**Interlaminar Epidural; Selective Nerve Root Injection (transforaminal only); Transforaminal Injection; Injections of Spinal Canal**

**Hip-spine syndrome** - Hip-spine syndrome is a condition that includes both debilitating hip osteoarthritis and low back pain. Abnormal spinal sagittal alignment and difficulty in maintaining proper balance, as well as a wobbling gait, may be caused by severe osteoarthritis of the hip joint. Epidural injections are used to determine a primary pain generator in this condition.

**Spondylolisthesis and nerve root irritation** - Degenerative lumbar spondylolisthesis is the displacement of a vertebra in the lower part of the spine; one lumbar vertebra slips forward on another with an intact neural arch and begins to press on nerves. The most common cause, in adults, is degenerative disease although it may also result from bone diseases and fractures. Degenerative spondylolisthesis is not always symptomatic. Epidural injections may be used to determine a previously undocumented nerve root irritation as a result of spondylolisthesis.

**Lumbar spinal stenosis with radiculitis** - Spinal stenosis is narrowing of the spinal column or of the neural foramina where spinal nerves leave the spinal column, causing pressure on the spinal cord. The most common cause is degenerative changes in the lumbar spine. Neurogenic claudication is the most common symptom, referring to “leg symptoms encompassing the buttock, groin and anterior thigh, as well as radiation down the posterior part of the leg to the feet.” In addition to pain, leg symptoms can include fatigue, heaviness, weakness or paresthesia. Some patients may also suffer from accompanying back pain. Symptoms are worse when standing or walking and are relieved by sitting. Lumbar spinal stenosis is often a disabling condition, and it is the most common reason for lumbar spinal surgery in adults over 65 years. The most common levels of stenosis are L3 through L5, but it may occur at multilevels in some patients. Radiculitis is the inflammation of a spinal nerve root that causes pain to radiate along the nerve paths. Epidural injections help to ascertain the level of the pain generator in this condition.

**Postoperative epidural fibrosis** - Epidural fibrosis is a common cause of failed back surgery syndrome. With the removal of a disc, the mechanical reason for pain may be removed, but an inflammatory condition may continue after the surgery and may cause pain. Epidural corticosteroids, with their anti-inflammatory properties, are used to treat postoperative fibrosis and may be used along with oral Gabapentin to reduce pain.

**Lumbar herniated disc** - Epidural steroid injections have been proven to be effective at reducing symptoms of lumbar herniated discs. Evidence shows that they can be successful in 42% to 56% of patients who do not improve after 6 weeks of conservative treatment. Observation and epidural steroid injection are effective nonsurgical treatments for this condition.

**Failed back surgery syndrome** - Failed back surgery syndrome (FBSS) is characterized by persistent or recurring low back pain, with or without sciatica, following lumbar surgery. The most common cause of
FBSS is epidural fibrosis which be triggered by a surgical procedure such as discectomy. The inflammation resulting from the surgical procedure may start the process of fibrosis and cause pain. Epidural steroid injections are administered to reduce pain.

POLICY HISTORY:

Review Date: November 2018

Review Summary:
- Epidural injections or selective nerve blocks: Added language “active components are not required” to indication: ‘After 2 weeks or more of acute radicular pain…’
- Added text to specify that the time limitation on multiple ESIs is ‘per region’. See indication: “In the first year of treatment, which may include an initial series of 3 injections in the initial diagnostic phase and additional injections in the treatment phase, a total of 6 epidural injections, per region, may be performed”
- Frequency of repeat therapeutic injections: Changed ‘an injection of opioid’ to an ‘intraspinal injection of opioid’ to clarify
- Background section: Added content “Intraspinal Drug Trial in anticipation of implanted infusion pump for spinal drug administration”; Added content on Intraspinal Drug Trials
- Overview section: removed examples for ‘Home Exercise Program’, including ‘Yoga, Tai Chi, Aerobic Exercise’
- Added and updated references

Review Date: October 2019

Review Summary:
- Added ‘axial’ to specify radicular pain for spinal stenosis
- Added section on Exclusions
- For ‘frequency of repeat therapeutic injections’
  - Changed diagnostic to therapeutic
  - Removed: ongoing pain or documented functional disability or pain level ≥6 on a scale of 0 to 10

Review Date: November 2020

Review Summary: Removed CPT codes 0228T; 0229T; 0230T; 0231T
REFERENCES:


Implantable Infusion Pump Insertion

CPT Codes:
62350, 62351, 62355, 62360, 62361, 62362

INDICATIONS FOR IMPLANTABLE INFUSION PUMP INSERTION:

For the Treatment of **Chronic Intractable Pain** – An intraspinal drug trial is appropriate when **ALL** of the following criteria are met:

- Pain causing functional disability that significantly interferes with activities of daily living including ability to work and overall quality of life or persistent pain levels of ≥ 6 on a scale of 0 to 10 in spite of treatment
- At least 12 weeks of conservative therapy* including both inactive and active components
- A life expectancy of at least 3 months

For the Treatment of **Chronic Intractable Pain** - Appropriate when **ALL** of the following criteria are met:

- Severe, chronic, intractable malignant or nonmalignant pain that significantly interferes with activities of daily living including ability to work and overall quality of life that has not responded to **at least 12 weeks** of standard nonsurgical therapies (e.g., systemic medications including oral opioid therapy unless contraindicated, physical and psychological therapies, or cognitive behavioral, etc.); **AND**
- Documentation of completion of a satisfactory trial *of intraspinal (intrathecal or epidural) opioid drugs, administered as a bolus or by continuous infusion, with acceptable pain relief, acceptable degree of side effects and patient acceptance of mode of treatment
  - Intraspinal drug trial provides ≥ 50% pain relief; **AND**
  - Side effects are tolerable; **AND**
- Patient must have a life expectancy of at least 3 months; **AND**
- Documentation of completed psychological assessment prior to IIP implantation, including the patient’s cognitive ability, willingness, and ability to participate in IIP therapy.

**NOTE:** Satisfactory trials include a bolus dose or continuous dosing depending upon clinical response (dosage and catheter placement may be manipulated).
For the Treatment of Spasticity - An intraspinal drug trial is appropriate when ALL of the following criteria are met:

- Evidence of intractable spasticity that results in the patient’s inability to maintain an upright posture, balance in ambulation, or increased function related to one of the following conditions (McIntyre, 2014):
  - Spinal cord injury; OR
  - Multiple sclerosis; OR
  - Stiff person syndrome; OR
  - Other medical conditions causing intractable spasms.
- Severe, uncontrollable spasms that have not responded to at least 12 weeks of standard therapies (e.g. oral medications, physical therapy, etc).
- Patient must have a life expectancy of at least 3 months.

For the Treatment of Spasticity - Appropriate when ALL of the following criteria are met:

- Evidence of intractable spasticity that results in the patient’s inability to maintain an upright posture, balance in ambulation, or increased function related to one of the following conditions (McIntyre, 2014):
  - Spinal cord injury; OR
  - Multiple sclerosis; OR
  - Stiff person syndrome; OR
  - Other medical conditions causing intractable spasms; AND
- Severe, uncontrollable spasms that have not responded to at least 12 weeks of standard therapies (e.g. oral medications, physical therapy, etc); AND
- Documentation of completion of a satisfactory* intrathecal trial of the antispasmodic drug defined as:
  - Intraspinal drug trial provides ≥ 50% spasm relief; AND
  - Side effects are tolerable; AND
- Patient must have a life expectancy of at least 3 months; AND
- Documentation of completed psychological assessment prior to IIP implantation, including the patient’s cognitive ability, willingness, and ability to participate in IIP therapy

*NOTE: Satisfactory trials include a bolus dose or continuous dosing depending upon clinical response (dosage and catheter placement may be manipulated).

INDICATIONS FOR PUMP REPLACEMENT:

Replacement of an Implanted Infusion Pump is indicated with one of the following:

- Documentation of a pump malfunction impairing function or safety
• Documentation must clearly state it is the pump that is defective; **AND**
• If the pump is programmable, the pump analysis report must accompany the request; **AND**
• Absence of contraindications to anesthesia and surgery.

**Battery depletion**
• Documentation of both safety and efficacy of this treatment for this patient.
  ▪ Degree of pain relief; **AND**
  ▪ Functional improvement; **AND**
  ▪ Side effects; **AND**
• If the pump is programmable, the pump analysis report must accompany the request; **AND**
• Absence of contraindications to anesthesia and surgery.

**CONTRAINDICATED FOR ANY OF THE FOLLOWING:**

• There are no other medical indications for other intrathecal treatments except for pain and spasticity
• Patients with an active infection
• Patients with a known allergy or hypersensitivity to a drug being used (e.g., morphine, etc.)
• Patients with a body size that is insufficient to support the weight and bulk of the device

**BACKGROUND:**

An implantable infusion pump (IIP), also referred to as an implantable drug delivery system (IDDS), is a device for the delivery of medication to manage severe, chronic, intractable pain and/or chronic intractable spasm. The purpose of this guideline is to address criteria for the permanent placement of an implantable infusion pump.

Description: An implanted pump releases medication through a catheter directly to the epidural or intrathecal space, which interrupts pain signals before they reach the brain. This mode of drug delivery provides pain relief with less medication than oral dosing and helps to minimize the side effects associated with oral medications. An IIP consists of a programmable pump, an epidural or intrathecal catheter, and an external programmer. The pump is surgically implanted subcutaneously, the catheter tip is inserted in the epidural or intrathecal space, often with fluoroscopic guidance, and the catheter is connected to the pump. A screening or trial period is required to assess pain relief and to determine whether the patient is a candidate for pump implantation.

Evidence Review: Chronic pain is pain that continues or recurs ≥ 90 days. It may result from an initial injury or illness; however, there may be no apparent cause. Chronic pain may limit movement and affect
the ability to carry out activities of daily living (ADL). It may lead to disability. Psychological effects may include anger, anxiety, depression, and fear of reinjury. Common chronic pain complaints include arthritis pain, back pain, headache, nerve pain (neurogenic), phantom pain, and psychogenic pain (no apparent cause). Chronic pain usually cannot be cured. The goal of treatment is to reduce pain and improve function. Treatment may include acupuncture, behavior modification, biofeedback, electrical stimulation, medications, nerve blocks, physical therapy, psychotherapy, relaxation therapy, or surgery.

Thimineur, et al. (2004) performed a small nonrandomized prospective study of 69 patients with chronic intractable nonmalignant pain who met inclusion criteria for implantation of an IIP. An IIP was implanted in 39 patients while 31 patients served as the comparison group. The authors reported that pain intensity, mood, and function all improved significantly in the IIP recipient group compared with pretreatment and with the comparison-group patients. Minimal complications were reported.

In consideration of the paucity of randomized controlled trials (RCTs), Hayek, et al. (2011) conducted a systematic review of intrathecal infusion through IDDS for chronic malignant and nonmalignant pain. The authors evaluated the available evidence for the efficacy and safety of intrathecal infusions used in long-term management (> 6 months) of chronic pain. The authors’ “moderate” recommendation for intrathecal infusion systems for malignant-related pain is based on Level II-2 evidence (i.e. well-designed cohort and case-control analytic studies) and their recommendation is “limited to moderate” based on Level II-3 evidence of moderate quality from nonrandomized studies for nonmalignant-related pain.

**U.S. Preventive Services Task Force (USPSTF) Evidence Criteria:**
- Authors based their recommendations on level of evidence criteria developed by the USPSTF, which rates the quality of evidence on a scale of I to III as follows:
  - I: Evidence obtained from at least one properly randomized controlled trial.
  - IIa: Evidence obtained from well-designed controlled trials without randomization.
  - IIb: Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.
  - IIc: Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.
  - III: Opinions of respected authorities, based on clinical experience, descriptive studies, and case reports or reports of expert committees.

Complications and side effects of IIP may include catheter dislodgement or occlusion, pump malfunction, arthralgia, decreased libido, erectile dysfunction, hematoma, infection, leakage, menstrual abnormalities, nausea and vomiting, nerve root irritation, peripheral edema, pruritus, decreased cognition, concentration, or memory, and other complications associated with seating of the device and changes in weight.
*Conservative Therapy:* (Spine) should include a multimodality approach consisting of a combination of active and inactive components. Inactive components, such as rest, ice, heat, modified activities, medical devices, acupuncture or stimulators, medications, injections (including trigger point), and diathermy can be utilized. Active modalities consist of physical therapy, a physician supervised home exercise program**, or chiropractic care (Qassem, 2017; Summers, 2013).

**Home Exercise Program** - (HEP) – the following two elements are required to meet guidelines for completion of conservative therapy:

- Documentation provided of an exercise prescription/plan (Qassem, 2017; Sculco, 2001); **AND**
- Follow up with member with documentation provided regarding completion of HEP, (after suitable 6 week period) or inability to complete HEP due to physical reason- i.e. increased pain, inability to physically perform exercises. (Patient inconvenience or noncompliance without explanation does not constitute “inability to complete” HEP).

**POLICY HISTORY:**

**Review Date:** November 2018

**Review Summary:**

- Changed guideline title from ‘Implantable Infusion Insertion Pump’ to Implantable Infusion Pump Insertion’
- For the treatment of chronic intractable pain, removed list of specified drugs
- Deleted content: ‘Drug is FDA approved’
- In the description of an implantable pump, removed ‘abdominal area’ as the specified location of pump implantation; Removed the specified duration of “a minimum of 3 days in length’ for the screening or trial period required to assess pain relief
- Deleted an outdated study in the ‘Evidence Review’
- Added and updated references

**Review Date:** October 2019

**Review Summary:**

- Added:
  - Indications for the treatment of chronic intractable pain; and indications for pump replacement
  - Specified method of delivery: Documentation of completion of a satisfactory trial *of intraspinal (intrathecal or epidural) opioid drugs, administered as a bolus or by continuous infusion, with acceptable pain relief, acceptable degree of side effects and patient acceptance of mode of treatment
- Updated background information to include conservative therapy and home exercise program
REFERENCES:


CPT Codes:
63265, 63266, 63267, 63268, 63270, 63271, 63272, 63273, 63275, 63276, 63277, 63280, 63281, 63282, 63283, 63285, 63286, 63287, 63290, 63295, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22633, 22634, 22554, 22556, 22558, 22585, 22532, 22533, 22534

INDICATIONS:
FUSION SURGERY (ANY REGION) FOR THE TREATMENT OF SPINAL NEOPLASM, LESION OR INFECTION:

The following criteria must be met for urgent intervention:

- Positive Clinical Findings of Myelopathy with evidence of progressive neurologic deficits consistent with worsening **spinal cord compression due to tumor or infection** — immediate surgical evaluation is indicated (Frymoyer, 2004; Garfin, 2017; NASS, 2015). Symptoms may include any of the following:
  - Upper extremity weakness;
  - Unsteady gait related to myelopathy/balance or generalized;
  - Lower extremity weakness;
  - Disturbance with coordination;
  - Hyperreflexia;
  - Hoffmann sign;
  - Positive Babinski sign;
  - Clonus; **OR**
- Progressive neurological deficit (motor deficit, bowel or bladder dysfunction) with evidence of spinal cord or nerve root compression due to tumor or infection on Magnetic Resonance Imaging (MRI) or Computed Tomography (CT) imaging — immediate surgical evaluation is indicated; **OR**
- **When ALL of the following criteria are met:**
  - Evidence of gross biomechanical instability resulting in acute neurological risk requiring surgical reconstruction / fusion; **AND**
  - Imaging studies demonstrate evidence of infection or neoplasm of the spine. Findings must align with corresponding clinical findings. Imaging studies may include:
    - Magnetic resonance imaging (MRI); preferred study for assessing spine soft tissue (including the spinal cord and roots); **OR**
- Computed tomography (CT) – with or without myelography – indicated in patients who have a contraindication to MRI; preferred for examining the spine’s bony structures.

**DECOMPRESSION SURGERY (ANY REGION) FOR THE TREATMENT OF SPINAL NEOPLASM, LESION OR INFECTION:**

The following criteria must be met:

- Positive Clinical Findings of Myelopathy with evidence of progressive neurologic deficits consistent with worsening *spinal cord compression due to tumor or infection*—immediate surgical evaluation is indicated (Frymoyer, 2004; Garfin, 2017; NASS, 2015). Symptoms may include *any* of the following:
  - Upper extremity weakness;
  - Unsteady gait related to myelopathy/balance or generalized lower extremity weakness;
  - Disturbance with coordination;
  - Hyperreflexia;
  - Hoffmann sign;
  - Positive Babinski sign;
  - Clonus;
  - OR

- Progressive neurological deficit (motor deficit, bowel or bladder dysfunction) with evidence of spinal cord or nerve root compression due to tumor or infection on Magnetic Resonance Imaging (MRI) or Computed Tomography (CT) imaging—immediate surgical evaluation is indicated; OR

- When **ALL of the following** criteria are met:
  - Clinical Exam Findings confirm significant radiculopathy or severe axial pain; AND
  - Imaging studies demonstrate evidence of infection or neoplasm of the spine that align with corresponding clinical findings. Imaging studies may include:
    - Magnetic resonance imaging (MRI); preferred study for assessing spine soft tissue (including cord and roots); OR
    - Computed tomography (CT) – with or without myelography – indicated in patients who have a contraindication to MRI; preferred for examining the spine’s bony structures.

**BACKGROUND:**

Significant spinal cord or nerve root compression due to tumor, lesion or infection may require surgical intervention. All operative interventions must be based on a positive correlation with clinical findings, the natural history of the disease, the clinical course, and diagnostic tests or imaging results.
FUSION SURGERY (ANY REGION) FOR THE TREATMENT OF SPINAL NEOPLASM, LESION OR INFECTION: Significant spinal cord or nerve root compression due to tumor or infection may require decompression of the cord / roots and fusion of the involved levels. Fusion is reserved for cases wherein the structural integrity of the spine has been compromised by the disease process or the surgical intervention needed to address the disease process.

DECOMPRESSIO SURGERY (ANY REGION) FOR THE TREATMENT OF SPINAL NEOPLASM, LESION OR INFECTION: Significant spinal cord or nerve root compression due to tumor or infection may require decompression of the spinal cord or nerve roots.

POLICY HISTORY:
Review Date: November 2018
Review Summary:
• Added references, no changes to indications

Review Date: October 2019
Review Summary:
• No changes
REFERENCES:


CPT Codes:
Cervical Thoracic Region: 64490 (+ 64491, +64492) 0213T, +0214T, +0215T
Lumbar Region: 64493 (+64494, +64495) 0216T, +0217T, +0218T

INDICATIONS FOR FACET JOINT INJECTIONS OR MEDIAL BRANCH NERVE BLOCKS (Cervical, Thoracic, Lumbar):
To confirm disabling non-radiculotic low back (lumbar), mid back (thoracic) or neck (cervical) pain*, suggestive of facet joint origin as documented in the medical record based upon **ALL** of the following:

- History, consisting of mainly axial or non-radiculotic pain unless stenosis is caused by synovial cyst (Khan, 2006; Manchikanti, 2013, 2009); **AND**
- Lack of evidence, either for discogenic or sacroiliac joint pain as the main pain generators (Manchikanti, 2013, 2009); **AND**
- Lack of disc herniation or evidence of radiculitis as the main pain generators unless stenosis is caused by synovial cyst (Khan, 2006; Manchikanti, 2013, 2009); **AND**
- Facet blocks should not be performed at same levels as previous surgical fusion; **AND**
- Pain causing functional disability or average pain levels of ≥ 6 on a scale of 0 to 10 (Manchikanti, 2013, 2009; Summers, 2013); **AND**
- Duration of pain of at least **3 months** (Manchikanti, 2013, 2009); **AND**
- Failure to respond to conservative non-operative therapy management* for a minimum of 6 weeks in the last 6 months prior to facet injections, or details of active engagement in other forms of active conservative non-operative treatment, if the patient had prior spinal injections, unless the medical reason this treatment cannot be done is clearly documented (Manchikanti, 2013; Summers, 2014); **AND**
- All procedures must be performed using fluoroscopic or CT guidance (Amrhein, 2016; Weininger, 2013).

**NOTE:** Ultrasound guidance is not a covered benefit and procedure performed using ultrasound guidance are not reimbursable.

**FREQUENCY OF FACET BLOCK:**
• There must be a minimum of 14 days between injections or 7 days if the most recent injection was diagnostic facet nerve blocks with local anesthetic only (Manchikanti, 2013).

• The patient continues to have ongoing pain or documented functional disability (pain causing functional disability or pain level ≥ 6 on a scale of 0 to 10) (Manchikanti, 2013, 2009; Summers, 2013). There must be a positive response of ≥ 50% pain relief or improved ability to function or a change in technique, for example from an initial intraarticular facet block to a medial branch nerve block to be considered. Repeat therapeutic injections should be performed at a frequency of 2 months or longer provided that at least 50% relief is obtained for a minimum of 2 months after the previous injection (Manchikanti, 2013).

• Conservative therapy
  o For a diagnostic injection more than one month from the prior diagnostic injection, the patient is actively engaged in other forms of active conservative non-operative treatment, unless pain or another medical reason prevents the patient from participating in conservative therapy*
  o For therapeutic injections, the patient is actively engaged in other forms of active conservative non-operative treatment, unless pain or another medical reason prevents the patient from participating in conservative therapy* (Qassem, 2017; Summers, 2013).

• In the diagnostic phase a maximum of 2 procedures may be performed. In the therapeutic phase a maximum of 4 procedures per region every 12 months except under unusual circumstances such as a recurrent injury. (NOTE: Unilateral facet blocks performed at the same level on the right vs. left within 2 weeks of each other would be considered as one procedure) (Manchikanti, 2013).

• If the procedures are applied for different regions, they may be performed at one week intervals for most types of procedures (Manchikanti, 2013).

• Radiofrequency neurolysis procedures should be considered in patients with at least 70% pain relief or improved ability to function, from medial branch nerve blocks, but with insufficient sustained relief (less than 2-3 months improvement) (Manchikanti, 2013; Summers, 2013).

CONTRAINDICATIONS FOR FACET JOINT INJECTIONS:
• History of allergy to contrast administration, local anesthetics, steroids, or other drugs potentially utilized;
• Hypovolemia;
• Infection over puncture site;
• Bleeding disorders or coagulopathy;
• History of allergy to medications to be administered;
• Inability to obtain percutaneous access to the target facet joint;
- Progressive neurological disorder which may be masked by the procedure;
- Pregnancy;
- Spinal infection; OR
- Acute fracture

BACKGROUND:

Facet joints (also called zygapophysial joints or z-joints), posterior to the vertebral bodies in the spinal column and connecting the vertebral bodies to each other, are located at the junction of the inferior articular process of a more cephalad vertebra and the superior articular process of a more caudal vertebra. These joints provide stability and enable movement, allowing the spine to bend, twist, and extend in different directions. They also restrict hyperextension and hyperflexion.

Facet joints are clinically important spinal pain generators in patients with chronic spinal pain. In patients with chronic low back pain, facet joints have been implicated as a cause of the pain in 15% to 45% of patients. Facet joints are considered as the cause of chronic spinal pain in 48% of patients with thoracic pain and 54% to 67% of patients with chronic neck pain. Facet joints may refer pain to adjacent structures, making the underlying diagnosis difficult as referred pain may assume a pseudoradicular pattern. Lumbar facet joints may refer pain to the back, buttocks, and lower extremities while cervical facet joints may refer pain to the head, neck and shoulders.

Imaging findings are of little value in determining the source and location of ‘facet joint syndrome’, a term originally used by Ghormley and referring to back pain caused by pathology at the facet joints. Imaging studies may detect changes in facet joint architecture, but correlation between radiologic findings and symptoms is unreliable. Although clinical signs are also unsuitable for diagnosing facet joint-mediated pain, they may be of value in selecting patients for controlled local anesthetic blocks of either the medial branches or the facet joint itself.

Medical necessity management for paravertebral facet injections includes an initial evaluation including history and physical examination and a psychosocial and functional assessment. The following must be determined: nature of the suspected organic problem; non-responsiveness to conservative treatment*; level of pain and functional disability; conditions which may be contraindications to paravertebral facet injections; and responsiveness to prior interventions.

The most common source of chronic pain is the spine and about two-thirds of the U.S. population suffers from spinal pain sometime during their life span. Facet joint interventions are used in the treatment of pain in certain patients with a confirmed diagnosis of facet joint pain. Interventions include
intraarticular injections and medial branch nerve blocks in the lumbar, cervical and thoracic spine. Prior to performing this procedure, shared decision-making between patient and physician must occur, and patient must understand the procedure and its potential risks and results. Facet joint injections or medial branch nerve blocks require guidance imaging.

Overview:

*Conservative Therapy: (Spine) should include a multimodality approach consisting of a combination of active and inactive components. Inactive components, such as rest, ice, heat, modified activities, medical devices, acupuncture or stimulators, medications, injections (including trigger point), and diathermy can be utilized. Active modalities consist of physical therapy, a physician supervised home exercise program**, or chiropractic care (Qassem, 2017; Summers, 2013).

**Home Exercise Program - (HEP) – the following two elements are required to meet guidelines for completion of conservative therapy:

- Documentation provided of an exercise prescription/plan (Qassem, 2017; Sculco, 2001); AND
- Follow up with member with documentation provided regarding completion of HEP, (after suitable 6 week period) or inability to complete HEP due to physical reason- i.e. increased pain, inability to physically perform exercises. (Patient inconvenience or noncompliance without explanation does not constitute “inability to complete” HEP).

Terminology: Facet Injections; Facet Joint Blocks; Paravertebral Facet Injections; Paravertebral Facet Joint Injections; Paravertebral Facet Joint Nerve Injections; Zygapophyseal injections; Lumbar Facet Blockade; Medial Branch blocks

POLICY HISTORY:

Review Date: November 2018

Review Summary:

- Indications title – Added: ‘cervical, thoracic, lumbar’
- Frequency of Facet Block: changed example from ‘facet joint nerve’ to ‘medial branch nerve’ in the following: ‘There must be a positive response of ≥ 50% pain relief or improved ability to function or a change in technique, for example, from an initial intraarticular facet block to a medial branch nerve block.
- Frequency of Facet Block: Added: ‘There must be a minimum of 14 days between injections or 7 days if the most recent injection was diagnostic facet nerve block(s) with local anesthetic only’
- Background section: Removed examples of yoga, Tai Chi, aerobic exercise from HEP
- Added and updated references

Review Date: October 2019
Review Summary:

- Removed ‘positive facet blocks’ and added ‘medial branch nerve blocks’: *Radiofrequency neurolysis procedures should be considered in patients with at least 70% pain relief or improved ability to function, from medial branch nerve blocks, but with insufficient sustained relief (less than 2-3 months improvement)*

- Added details to conservative therapy section
REFERENCES:


CPT Codes:
Cervical Thoracic Region: 64633, +64634
Lumbar Region: 64635, +64636

INDICATIONS FOR PARAVERTEBRAL FACET JOINT DENERVATION/RADIOFREQUENCY NEUROLYSIS:

- Lack of evidence that the primary source of pain being treated is from discogenic pain, sacroiliac joint pain, disc herniation or radiculitis (Manchikanti, 2013, 2009); AND

- Pain causing functional disability or an average pain level of ≥ 6 on a scale of 0 to 10 prior to each radiofrequency procedure, including radiofrequency procedures done unilaterally on different days (Manchikanti, 2013, 2009; Summers, 2013); AND

- Duration of pain of at least 3 months (Manchikanti, 2013; Summers, 2013); AND

- One of the following:
  - Positive response to one or two controlled local anesthetic blocks of the facet joint nerves (medial branch blocks), with at least 70% pain relief or improved ability to function for a minimal duration at least equal to that of the local anesthetic, but with insufficient sustained relief (less than 2-3 months relief); AND a failure to respond to active conservative non-operative management* for a minimum of 6 weeks in the last 6 months unless the medical reason this treatment cannot be done is clearly documented (Manchikanti, 2013, 2009; Summers, 2013); OR
  - Positive response to prior radiofrequency neurolysis procedures with at least 50% pain relief or improved ability to function for at least 4 months, and the patient is actively engaged in other forms of appropriate active conservative non-operative treatment, unless pain prevents the patient from participating in conservative therapy* (Manchikanti, 2013; Qassem, 2017; Sculco, 2001; Summers, 2013).

FREQUENCY:

- Limit to 2 facet neurolysis procedures every 12 months, per region (Manchikanti, 2013).

IMAGING:

- All procedures must be performed using fluoroscopic or CT guidance (Amrhein, 2016; Weininger, 2013)

NOTE: Unilateral radiofrequency denervations performed at the same level on the right vs left within 2 weeks of each other would be considered as one procedure toward the total number of radiofrequency procedures allowed per 12 months. Every radiofrequency procedure requires pre-authorization.
CONTRAINDICATIONS:

- History of allergy to local anesthetics or other drugs potentially utilized;
- Lumbosacral radicular pain (dorsal root ganglion);
- Conditions/diagnosis for which procedure is used are other than those listed in Indications;
- Absence of positive diagnostic blocks; OR
- For any nerve other than the medial branch nerve.

BACKGROUND:

Facet joints (also called zygapophysial joints or z-joints), posterior to the vertebral bodies in the spinal column and connecting the vertebral bodies to each other, are located at the junction of the inferior articular process of a more cephalad vertebra and the superior articular process of a more caudal vertebra. These joints provide stability and enable movement, allowing the spine to bend, twist, and extend in different directions. They also restrict hyperextension and hyperflexion.

Facet joints are clinically important spinal pain generators in patients with chronic spinal pain. Pain mediated by the facet joints may be caused by repetitive stress or cumulative low-level trauma resulting in osteoarthritis and inflammation. In patients with chronic low back pain, facet joints have been implicated as a cause of the pain in 15% to 45% of patients. They are considered as the cause of chronic spinal pain in 48% of patients with thoracic pain and 54% to 67% of patients with chronic neck pain. Facet joints may refer pain to adjacent structures, making the underlying diagnosis difficult as referred pain may assume a pseudoradicular pattern. Lumbar facet joints may refer pain to the back, buttocks, and proximal lower extremities while cervical facet joints may refer pain to the head, neck and shoulders.

Imaging findings are of little value in determining the source and location of ‘facet joint syndrome’, a term originally used by Ghormley and referring to back pain caused by pathology at the facet joints. Imaging studies may detect changes in facet joint architecture, but correlation between radiologic findings and symptoms is unreliable. Although clinical signs are also unsuitable for diagnosing facet joint-mediated pain, they may be of value in selecting patients for controlled local anesthetic blocks of either the medial branches or the facet joint itself. This is an established tool in diagnosing facet joint syndrome.

Facet joints are known to be a source of pain with definitive innervations. Interventions used in the treatment of patients with a confirmed diagnosis of facet joint pain include: medial branch nerve blocks in the lumbar, cervical and thoracic spine; and radiofrequency neurolysis (see additional terminology). The medial branch of the primary dorsal rami of the spinal nerves has been shown to be the primary innervations of facet joints. Substance P, a physiologically potent neuropeptide considered to play a role in the nociceptive transmission of nerve impulses, is found in the nerves within the facet joint.

Radiofrequency neurolysis is a minimally invasive treatment for cervical, thoracic and lumbar facet joint pain. It involves using energy in the radiofrequency range to cause necrosis of specific nerves (medial
branches of the dorsal rami), preventing the neural transmission of pain. The objective of radiofrequency neurolysis is to both provide relief of pain and reduce the likelihood of recurrence.

Members of the American Society of Anesthesiologists (ASA) and the American Society of Regional Anesthesia and Pain Medicine (ASRA) have agreed that conventional or thermal radiofrequency ablation of the medial branch nerves to the facet joint should be performed for neck or low back pain. Radiofrequency neurolysis has been employed for over 30 years to treat facet joint pain. Prior to performing this procedure, shared decision-making between patient and physician must occur, and patient must understand the procedure and its potential risks and results.

Overview:

THERAPEUTIC PARAVERTEBRAL FACET JOINT DENERVATION (RADIOFREQUENCY NEUROLYSIS) - local anesthetic block followed by the passage of radiofrequency current to generate heat and coagulate the target medial branch nerve

*Conservative Therapy: (Spine) should include a multimodality approach consisting of a combination of active and inactive components. Inactive components, such as rest, ice, heat, modified activities, medical devices, acupuncture or stimulators, medications, injections (including trigger point), and diathermy can be utilized. Active modalities consist of physical therapy, a physician supervised home exercise program** or chiropractic care (Qassem, 2017; Summers, 2013).

**Home Exercise Program (HEP) – the following two elements are required to meet guidelines for completion of conservative therapy:

- Documentation provided of an exercise prescription/plan (Qassem, 2017; Sculco, 2001); AND
- Follow up with member with documentation provided regarding completion of HEP, (after suitable 6 week period) or inability to complete HEP due to physical reason- i.e. increased pain, inability to physically perform exercises. (Patient inconvenience or noncompliance without explanation does not constitute “inability to complete” HEP).

Terminology: Paravertebral Facet Joint Denervation, Radiofrequency Neurolysis, Destruction Paravertebral Facet Joint Nerve, Facet Joint Rhizotomy, Facet Neurolysis, Medial Branch Radiofrequency Neurolysis, Medial Branch Radiofrequency Neurotomy or Radiofrequency Denervation.

POLICY HISTORY:
Review Date: November 2018
Review Summary:
• Frequency: Changed limit to ‘per region’ instead of ‘per facet joint’
• Overview section: Removed examples of yoga, Tai Chi, aerobic exercise from HEP
• Added and updated references

Review Date: October 2019

Review Summary:
• Added: All procedures must be performed using fluoroscopic or CT guidance
REFERENCES:


CPT Codes: 27096

INDICATIONS FOR SACROILIAC JOINT INJECTIONS (SJI) (Intraarticular or ligamentous injections only)

- For the treatment of Sacroiliac Joint (SIJ) pain - All of the following must be met:
  - Low back pain maximal below level of L5 which may radiate to the groin or lower extremity persisting at least 3 months (Manchikanti, 2013a); AND
  - Positive exam findings to suggest the diagnosis which include the pelvic distraction test, pelvic compression test, thigh thrust test, FABER (Patrick’s test) or Gaenslen’s test (MacVicar, 2017; Telli, 2018); AND
  - Failure to respond to conservative non-operative therapy management* for a minimum of 6 weeks in the last 6 months, or details of active engagement in other forms of active conservative non-operative treatment, if the patient had prior spinal injections, unless the medical reason this treatment cannot be done is clearly documented (Manchikanti, 2013a; Summers, 2013); AND
  - Pain causing functional limitations or average pain levels of ≥ 6 on a scale of 0 to 10 (Manchikanti, 2013a, 2009; Summers, 2013); AND
  - All procedures must be performed using fluoroscopic or CT guidance

  **NOTE:** SI joint injections performed at the same time as facet injections will be deemed **not** medically necessary.

- For the treatment of spondyloarthropathy (ACR, 2012) - All of the following must be met:
  - The patient has experienced ≥ 3 months of low back pain; AND
  - Age of onset < 45 years; AND
  - Comprehensive pain management program including physical therapy, home exercise, patient education, psychosocial support or oral medication is in place; AND
  - Prior history of evidence of sacroiliitis on imaging (i.e., active inflammation on magnetic resonance imaging [MRI] or definite radiographic sacroiliitis grade > 2 bilaterally or grade 3-4 unilaterally); AND
  - 1 or more spondyloarthropathy features:
    - Inflammatory back pain with at least 4 of the following criteria present:
      - Age at onset < 45 years
• Insidious onset
• Improvement with exercise
• No improvement with rest
• Pain at night (with improvement upon getting up)
  ▪ Arthritis
  ▪ Enthesitis of the heel (irritability of muscles, tendons, or ligaments where they enter the bone)
  ▪ Uveitis (inflammation of the uvea, the middle layer of the eye)
  ▪ Dactylitis (inflammation of a finger or toe)
  ▪ Psoriasis
  ▪ Crohn’s/colic
tis
  ▪ Good response to NSAIDs
  ▪ Family history of spondyloarthritis
  ▪ Positive testing for HLA-B27
  ▪ Elevated C-reactive protein (CRP)

FREQUENCY OF REPEAT THERAPEUTIC INJECTIONS

• SIJ injections may be repeated up to 2 times in the initial treatment phase no sooner than 2 weeks apart provided that at least 50% relief is obtained (Manchikanti, 2013a); AND

• SIJ injections may only be repeated after the initial treatment phase if symptoms recur and the patient has had at least a 50% improvement for a minimum of 6 weeks after each therapeutic injection (Manchikanti, 2013a); AND

• The patient is actively engaged in other forms of active conservative non-operative treatment, unless pain prevents the patient from participating in conservative therapy (AHRQ, 2013; Qassem, 2017; Summers, 2013); AND

• Repeat injections should not be done more frequently than every two months for a total of 4 injections in a 12 month period (Manchikanti, 2013a); AND

• Pain causing functional limitations or average pain levels of ≥ 6 on a scale of 0 to 10 (AHRQ, 2013; Manchikanti, 2013a, 2009; Summers, 2013).

CONTRAINDICATIONS FOR SACROILIAC JOINT INJECTIONS

• Active systemic infection
• Skin infection at the site of needle puncture
• Bleeding disorder or anticoagulation therapy
• Uncontrolled high blood pressure
• Uncontrolled diabetes
• Unstable angina
• Congestive heart failure
• Allergies to contrast, anesthetics, or steroids (AAOS, 2009)

BACKGROUND:

This guideline addresses the use of sacroiliac joint injections for the treatment of low back pain that originates in the region of the sacroiliac joint. An injection of anesthetic or steroid may be used for the diagnosis and treatment of sacroiliac joint (SIJ) pain syndrome disorders (such as degenerative joint disease, postsurgical injuries, or traumatic injuries), or for treatment of spondyloarthropathy (inflammatory disorders of the joints and ligaments of the spine).

Sacroiliac joint injections are typically used for the following conditions:

Sacroiliac joint pain syndrome may be caused by various events, including pain secondary to postsurgical or traumatic injury, degeneration (wear and tear), or pregnancy. Physical examination (history and physical, provocative maneuvers) and diagnostic injection help to identify the source of pain as the SIJ.

Diagnostic SIJ injections are used to determine if the SIJ pain originates with the SIJ. Diagnostic blocks can reveal (or fail to reveal) that the source of pain is originating from the SIJ, and then an appropriate treatment plan can be developed (Curatolo, 2010; Manchikanti, 2013a).

Therapeutic SIJ injections may be used to treat SIJ pain once it has been determined that the SIJ is the origin of the pain. A therapeutic injection typically includes a corticosteroid and a local anesthetic that can be injected directly into the joint (intra-articular) or into the tissues surrounding the joint (periarticular).

Spondyloarthropathy (also known as spondyloarthritis) is the name for a family of rheumatic diseases that cause arthritis. Sacroilitis is a key indicator of spondyloarthritis and is diagnosed with imaging. Patients with spondyloarthropathy are generally managed by rheumatologists and account for only a small percentage of the cases that present in interventional pain management settings.

Overview:

*Conservative Therapy: (Spine) should include a multimodality approach consisting of a combination of active and inactive components. Inactive components, such as rest, ice, heat, modified activities, medical devices, acupuncture or stimulators, medications, injections (including trigger point), and diathermy can be utilized. Active modalities consist of physical therapy, a physician supervised home exercise program**, or chiropractic care (Qassem, 2017; Summers, 2013).

Home Exercise Program (HEP) – the following two elements are required to meet guidelines for completion of conservative therapy:
• Documentation provided of an exercise prescription/plan (Qassem, 2017; Sculco, 2001); **AND**

• Follow up with member with information provided regarding completion of HEP (after suitable 6 week period), or inability to complete HEP due to physical reason - i.e. increased pain, inability to physically perform exercises. (Patient inconvenience or noncompliance without explanation does not constitute “inability to complete” HEP).

Low back pain is one of the most common of all spinal pain problems. According to the Centers for Disease Control and Prevention (CDC), the prevalence of low back pain in adults 18 years of age and older is 28.4% and may range as high as 32.1% in adults ≥ 75 years (CDC, 2012). Symptoms of low back pain may arise from multiple sites, including lumbar intervertebral discs, facet joints, sacroiliac joints, ligaments, fascia, muscles, and nerve root dura. The sacroiliac joint has been shown to be a source of pain in 10% to 27% of chronic low back pain (Hansen, 2007; Simopoulos, 2012; Manchikanti, 2013a).

The sacroiliac joint (SIJ) is located between the sacrum (located at the base of the spine) and the pelvis, and supports the weight of the upper body in the standing position. There are SIJs in both the right and left side of the lower back. Strong ligaments hold the joints in place. The SIJ is well innervated and has been shown to be capable of being a source of low back pain and referred pain in the lower extremity. Low back pain originating from the SIJ can result from inflammatory conditions such as sacroiliitis, spondyloarthropathy (ankylosing spondylitis; rheumatoid spondylitis), or from postsurgical or traumatic injury, degeneration (wear and tear), or pregnancy. SIJ pain most often occurs in the buttocks and lower back, and may radiate down through the buttocks and the leg. Physical examination and radiographic techniques may confirm a diagnosis related to spondyloarthropathy. Physical examination, including provocative maneuvers to elicit pain response, and controlled SIJ injections can help diagnose noninflammatory pain arising from the SIJ (Hansen, 2007; Medline Plus, 2012; Mayo Clinic, 2013).

In order to confirm correct placement of the injectable medication into the intra-articular space, fluoroscopic or computed tomography (CT) guidance is used. A periartricular injection into the soft tissue may be used if ligamentous or muscular attachments are suspected to be involved. The goal of the therapeutic injection is to reduce inflammation or pain and provide longer pain relief. Long-term relief is generally defined as 6 weeks or longer, but positive responders generally have a much longer duration of response; serial injections may be required in order to maintain therapeutic effectiveness (Hansen, 2007; AAOS, 2009; Hawkins, 2009).

Spinal injections for the treatment of SIJ pain syndrome are typically performed as one part of a comprehensive treatment program, which will nearly always include an exercise program to improve or maintain spinal mobility. Potential candidates for SIJ injections include those with low back pain originating from the SIJ that is unresponsive to conservative treatments.

Treatment for SIJ pain depends upon the signs and symptoms, as well as the underlying cause for the pain. Medications, such as over-the-counter analgesics, a short course of narcotics, muscle relaxants or tumor necrosis factor (TNF) inhibitors, such as etanercept (Enbrel), adalimumab (Humira), or infliximab (Remicade), may be prescribed. Therapy sessions with a physical therapist involving range-of-motion, stretching, and strengthening exercises may be used to maintain joint flexibility and strengthen the muscles. Other interventional procedures used to treat SIJ pain include corticosteroid injections to
reduce inflammation and pain, radiofrequency denervation, electrical stimulation, or in rare cases, joint fusion (Mayo Clinic, 2013).

The indications for coverage for the treatment of spondyloarthropathy have been established through use of the reviewed clinical studies and through criteria developed by the Assessment of SpondyloArthritis International Society (ASAS) for the classification of axial spondyloarthritis (Sieper, 2009). They are in keeping with the benefit guidelines developed by the Centers for Medicare & Medicaid Services (CMS).

While evidence supports that SIJ injection is an effective method of determining the source of pain, evidence supporting the efficacy of SIJ in the treatment of SIJ pain syndrome is considerably limited. There are limited controlled or prospective clinical studies to support SIJ injection for therapeutic purposes. Despite the limited quality of the clinical studies supporting SIJ injection for the treatment of SIJ pain, the procedure is recommended by the American Society of Anesthesiologists (ASA) and the American Society of Regional Anesthesia and Pain Management (ASRAPM) Practice Guidelines. The indications for coverage have been established from the 2009 Comprehensive Evidence-Based Guidelines for Interventional Techniques in the Management of Chronic Spinal Pain, and updated with the 2013 An Update of Comprehensive Evidence-Based Guidelines for Interventional Techniques in Chronic Spinal Pain. Part II: Guidance and Recommendations.

POLICY HISTORY:

Review Date: November 2018

Review Summary:
- Sacroiliac Joint Injection title - Added: ‘Intraarticular or ligamentous injections only’
- For the treatment of SIJ pain, added Note: ‘SI joint injections performed at the same time as facet injections will be deemed not medically necessary’
- Removed HEP examples of yoga, Tai Chi, aerobic exercises
- Added and updated references

Review Date: October 2019

Review Summary:
- Added: All procedures must be performed using fluoroscopic or CT guidance
REFERENCES:


CPT CODES: 27130, 27132, 27134, 27137, 27138, S2118

General Requirements
Elective hip arthroplasty may be considered if the following general criteria are met:

- Defined as a deviation from normal hip function, which may include painful weight bearing; painful or inadequate range of motion to accomplish age-appropriate activities of daily living (ADLs) and/or employment; and mechanical catching, locking.
- Patient is medically stable with no uncontrolled comorbidities (such as diabetes)
- Patient does not have an active local or systemic infection
- Patient does not have active, untreated drug dependency (including but not limited to narcotics, opioids, muscle relaxants) unless engaged in treatment program
- Patient has good oral hygiene and does not have major dental work scheduled or anticipated (ideally, within one year of joint replacement), due to increased post-surgical infection risk.

Clinical notes should address:

- Symptom onset, duration, and severity;
- Loss of function and/or limitations;
- Type and duration of non-operative management modalities.

Non-operative management must include at least two or more of the following unless otherwise specified in clinical indications below:

- Rest or activity modifications/limitations;
- Weight reduction for patient with elevated BMI;
- Protected weight-bearing with cane, walker or crutches;
- Physical therapy modalities;
- Physician-supervised exercise program (including home exercise program);
- Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, or analgesics;
- Intra-articular injection(s)

INDICATIONS:

TOTAL HIP ARTHROPLASTY (THA)
THA may be considered medically necessary when the following criteria are met:
• Hip pathology is due to rheumatoid arthritis (Jain, 2012; Hochberg, 2012), femoral neck fracture (Kim, 2013; Murphy, 2013), malignancy, dysplasia, avascular necrosis (confirmed by imaging) (Moya-Angeler, 2015) or radiographs (X-rays) demonstrate bone-on-bone articulation

AND

• There is persistent pain and documented loss of function with any of the above.

NOTE: There is no medical necessity to perform THA in patients with severe radiological disease and no symptoms.

OR

• When **ALL** of the following criteria are met:
  o Pain due to advanced osteoarthritis (Tönnis grade-2 or 3 [see grading appendix] and documented loss of function that has been present for at least 3 months (Gossec, 2011);
  o Failure of at least 3 months of non-operative treatment, including at least **two** of the following:
    ▪ Rest or activity modifications/limitations (AAOS, 2017);
    ▪ Weight reduction for patient with elevated BMI (AAOS, 2017);
    ▪ Protected weight-bearing with cane, walker or crutches;
    ▪ Physical therapy modalities (Abbott, 2013);
    ▪ Physician-supervised exercise program (including home exercise program) (Juhakoski, 2011);
    ▪ Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, or analgesics (AAOS, 2017);
    ▪ Intra-articular corticosteroid injection (AAOS, 2017);
  o Physical exam demonstrates findings of hip pathology as evidenced by **one or more** of the following:
    ▪ Painful, limited range of motion or antalgic gait;
    ▪ Contracture;
    ▪ Crepitus;
    ▪ Leg length difference;
  o Imaging demonstrates advanced hip joint arthritis of at least Tönnis grade 2 or 3 [see grading appendix]. Radiograph evaluation should include advanced osteoarthritis findings (joint space narrowing, subchondral sclerosis, subchondral cysts, osteophyte formation, etc.);
  o No corticosteroid injection into the joint within 12 weeks of surgery (Bedard, 2017; Schairer, 2016).
  o All requests for THA or revision THA are to have documentation in the medical record pertaining to the potential risks, benefits, and potential complications specific to these procedures
  o All requests for simultaneous bilateral total hip replacements should clearly indicate why simultaneous THA is preferable to staged procedures. Associated risks with simultaneous bilateral total hip replacements should also be discussed with the patient and documented in the medical record.
Relative Contraindications:

- Metal allergy (dependent upon implant choice)
- Chronic renal insufficiency (due to metal ions circulating and potential renal toxicity)
- Female of child-bearing age (due to metal ions circulating in blood with potential risk to fetus)
  (NOTE: This only applies to metal on metal replacements) (USFDA, 2018)

Absolute Contraindications:

- Any corticosteroid injection into the joint within 12 weeks of surgery (Schairer, 2016)
- Local or remote active infection. If a local or remote infection is documented in the patient’s history, records should clearly demonstrate that the previous infection had been treated and symptoms have resolved or that the patient has no clinical signs or symptoms of the previous infection at the time of the operation.

HIP RESURFACING ARTHROPLASTY

Hip resurfacing procedures will be reviewed on a case by case basis.

Hip resurfacing arthroplasty may be considered medically necessary when ALL of the following criteria are met:

- Pain and documented loss of function are present for at least 3 months;
- 3 months of non-operative treatment have failed to improve symptoms;
- Physical exam has typical findings of hip pathology as evidenced by one or more of the following:
  - Painful, limited range of motion or antalgic gait;
  - Contracture;
  - Crepitus;
  - Leg length difference
- Imaging demonstrates advanced hip joint pathology of at least Tönnis grade 2 or 3, or avascular necrosis involving less than 50% of the femoral head [see grading appendix];
- Male patient is less than 65 years old or female patient is less than 55 years old (Sershon, 2016);
- BMI < 40 (Nunley, 2008);
- No corticosteroid injection into the joint within 12 weeks of surgery (Schairer, 2016, Bedard 2017);

Absolute Contraindications:

- Any corticosteroid injection into the joint within 12 weeks of surgery (Schairer, 2016)
- Osteoporosis or osteopenia (DEXA scan bone mineral density evaluation) (Sershon, 2016)
  - Osteoporosis or poor bone quality may increase the risk of fixation failure or femoral neck fracture after hip resurfacing (Nunley, 2009)
- Other co-morbidity (including medications that contribute to decreased bone mineral density (glucocorticoid steroids, heparin, aromatase inhibitors, thiazolidinediones, proton pump inhibitors,
loop diuretics, cyclosporine, anti-retrovirals, anti-psychotics, anti-seizures, certain breast cancer drugs, certain prostate cancer drugs, depo-provera, aluminum-containing antacids) that may contribute to active bone demineralization

- Cystic degeneration at the junction of the femoral head and neck on radiographs or MRI or CT
- Malignancy at the proximal femur
- Evidence of current, ongoing, or inadequately treated hip infection, or sepsis
- Female of child-bearing age (due to metal ions circulating in blood with potential risk to fetus) (USFDA, 2018)
- Chronic renal insufficiency (due to metal ions circulating and potential renal toxicity) (USFDA, 2018)
- Metal allergy (USFDA, 2018)

**TOTAL HIP ARTHROPLASTY REVISION / CONVERSION ARTHROPLASTY**

Hip Revision/Conversion Arthroplasty may be considered medically necessary when a previous hip reconstruction meets **ALL** of the following criteria in either of the following subsections:

- Previous removal of infected hip prosthesis **AND** no evidence of current, ongoing, or inadequately treated hip infection (ruled out by normal inflammatory markers* (ESR and CRP)) **AND** off antibiotics (Della Valle, 2010; Lee, 2015). **NOTE:** If these inflammatory markers are elevated, further evaluation is required, including an aspiration with synovial fluid WBC count, gram stain and cultures, or an intraoperative frozen biopsy;

**OR**

- When **ALL** of the following criteria are met:
  - Failed hip arthroplasty as defined by symptomatic or unstable joint upon physical exam (documented persistent, severe and disabling pain, loss of function, instability) or failed previous hip fracture surgery
  - Physical exam and radiographic evidence supports extensive disease or damage due to fracture, malignancy, osteolysis, other bone or soft-tissue reactive or destructive process, inappropriate positioning of components, recurrent instability, subluxation, dislocation, or other mechanical failure. (**NOTE:** MRI is used less often in these circumstances unless it is a metal-on-metal prosthesis and looking for soft-tissue lesions; x-ray, CT, nuclear studies are used more frequently);
  - No evidence of current, ongoing, or inadequately treated hip infection (ruled out by normal inflammatory markers (ESR and CRP)) (Lee, 2015, Della Valle, 2010)
  - All requests for THA or revision THA are to have documentation in the medical record pertaining to the potential risks, benefits, and potential complications specific to these procedures
  - No corticosteroid injection into the joint within 12 weeks of surgery (Bedard, 2017; Schairer, 2016)

**NOTE:** Removal of infected hip prosthesis and subsequent insertion of antibiotic spacer is not considered to be a revision arthroplasty.
GRADING APPENDIX:
Tönnis Classification of Osteoarthritis by Radiographic Changes

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No signs of osteoarthritis</td>
</tr>
<tr>
<td>1</td>
<td>Mild: Increased sclerosis, slight narrowing of the joint space, no or slight loss of head sphericity</td>
</tr>
<tr>
<td>2</td>
<td>Moderate: Small cysts, moderate narrowing of the joint space, moderate loss of head sphericity</td>
</tr>
<tr>
<td>3</td>
<td>Severe: Large cysts, severe narrowing or obliteration of the joint space, severe deformity of the head</td>
</tr>
</tbody>
</table>

BACKGROUND:

HIP ARTHROPLASTY - Total & Revision/Conversion Hip Replacement

This guideline addresses elective, non-emergent hip arthroplasty (hip replacement) procedures, including total hip arthroplasty, resurfacing arthroplasty, and revision/conversion arthroplasty procedures.

Arthritis is the most common cause of chronic hip pain and disability. Degenerative, age-related osteoarthritis causes cartilage to wear away and eventually the bones within the joint rub against each other causing pain and stiffness. In a total hip replacement, the femoral head and acetabulum are removed and replaced with prosthetic components. In hip resurfacing arthroplasty, a metal cup is placed in the acetabulum and a metal cap is placed over the head of the femur with limited removal of the femoral head and neck.

In some cases, the hip prosthesis may wear out or loosen. If loosening is painful, a second surgery, such as a revision or conversion may be necessary. In this procedure some or all of the components of the original replacement prosthesis are removed and replaced with new ones.

Hemiarthroplasty or partial hip replacement involves the reconstruction of the femoral head but not the acetabulum. This procedure is indicated for select traumatic events, guidelines for which fall outside of the scope of this document.
POLICY HISTORY:

Review Date: November 2018

Review Summary:

- Total Hip Arthroplasty – Added: Radiograph evaluation should include advanced osteoarthritis findings (joint space narrowing, subchondral sclerosis, subchondral cysts, osteophyte formation, etc.)
- Absolute Contraindications - Added ‘corticosteroid’ to specify ‘injection’; Added sentence “If a local or remote infection is documented in the patient’s history, additional documentation showing the previous infection is resolved must be provided”
- Hip Resurfacing Arthroplasty - Added Absolute Contraindication: “Osteoporosis or poor bone quality may increase the risk of fixation failure or femoral neck fracture after hip resurfacing”
- Total Hip Arthroplasty Revision/Conversion Arthroplasty: Changed ‘ruled out’ criteria from ‘synovial fluid aspiration/biopsy (cell count and culture)’ to ‘ruled out by normal inflammatory markers (ESR and CRP)’; Added content: ‘If these inflammatory markers are elevated, further evaluation is required, including an aspiration with synovial fluid WBC count, gram stain and cultures, or an intraoperative frozen biopsy’ – Modified to match total knee guideline

Review Date: October 2019

Review Summary:

- Added and updated references
- Added new statement that if “bone on bone” arthritis is documented, conservative treatment requirements are not necessary for approval.
- Decreased required documentation of symptoms from 6 months to 3 months
- Added requirement specifically stating that risks/benefits/alternative discussion must be documented in office notes prior to surgical approval
- Deleted Kellgren-Lawrence grading system
- Moved metal-on-metal components in child-bearing age from absolute to relative contraindication
- Removed Non covered services section
REFERENCES:


CPT CODES:
Femoroacetabular Impingement (FAI) Hip Surgery: 29914, 29915, 29916
Hip Surgery – Other: 29860, 29861, 29862, 29863

General Requirements:
Elective arthroscopic surgery of the hip may be considered if the following general criteria are met:

- There is clinical correlation of patient’s subjective complaints with objective exam findings and/or imaging (when applicable);
- Patient has limited function (age-appropriate activities of daily living (ADLs), occupational, athletic);
- Patient is medically stable with no uncontrolled comorbidities;
- Patient does not have an active local or systemic infection;
- Patient does not have active, untreated drug dependency (including but not limited to narcotics, opioids, muscle relaxants) unless engaged in treatment program

Clinical notes should address:

- Symptom onset, duration, and severity;
- Loss of function and/or limitations;
- Type and duration of non-operative management modalities (where applicable).

Non-operative management must include **TWO** or more of the following, unless otherwise specified:

- Physical therapy or properly instructed home exercise program;
- Rest or activity modification;
- Ice/Heat;
- Protected weight bearing;
- Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics;
- Brace/orthosis;
- Weight optimization;
- Corticosteroid injections

INDICATIONS:
**DIAGNOSTIC HIP ARTHROSCOPY**

All requests for diagnostic hip arthroscopy will be considered and decided on a case-by-case basis and are rarely deemed medically necessary.

Diagnostic hip arthroscopy may be medically necessary when **ALL** of the following criteria are met:

- At least 6 months of hip pain with documented loss of function;
- Failure of at least 12 weeks of non-operative treatment, including at least **two** of the following:
  - Rest or activity modifications/limitations
  - Ice/heat
  - Protected weight bearing
  - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol
  - Brace/orthosis
  - Physical therapy or properly instructed home exercise program
  - Weight optimization
  - Corticosteroid injection
- Indeterminate radiographs AND MRI findings

Patient must have **no radiographic findings of any of the following:**

- Significant arthritis (joint space less than 2 mm or subchondral edema)
- Femoroacetabular impingement (nonspherical femoral head or prominent head-neck junction (pistol-grip deformity), alpha angle > 50 degrees, overhang of the anterolateral rim of the acetabulum, posterior wall sign, prominent ischial spine sign, acetabular protrusion, or retroversion with a center edge (CE) angle > 35° and/or cross-over sign),
- Hip dysplasia (lateral center edge angle < 20 degrees, anterior center edge angle < 20 degrees, Tonnis angle > 15 degrees or femoral head extrusion index > 25%),
- Fractures of the femoral head or acetabulum,
- Labral tear (on MRI or MR arthrogram),
- PVNS or synovial chondromatosis,
- Intra-articular loose body,
- Adductor tear or hamstring tear,
- Pubic edema or osteitis pubis,
- Gluteus medius or minimus tear,
- Ischiofemoral impingement (narrowed ischiofemoral and quadratus femoris spaces).

**FEMOROACETABULAR IMPINGEMENT (FAI)**

There is **no evidence to support hip arthroscopy for FAI and/or labral tear in an asymptomatic patient** and there is a very high prevalence of abnormal radiographs found in asymptomatic patients (Blankenstein, 2019; Lee, 2015; Register, 2012): 33% of asymptomatic hips have a cam lesion, 66% of asymptomatic hips have a pincer lesion, and 68% of asymptomatic hips have a labral tear.
Even though hip dysplasia, as well as symptomatic FAI and labral tears are believed to be precursors to hip arthritis (Fayad, 2013), arthroscopy is never indicated for the treatment of osteoarthritis of the hip (Egerton, 2013; Philippon, 2013; Stevens, 2010) and rarely (if ever) indicated for dysplasia (Parvizi, 2010).

LABRAL REPAIR

Arthroscopic labral repair may be medically necessary when ALL of the following criteria are met:

- Hip or groin pain in positions of flexion and rotation that may be associated with mechanical symptoms of locking, popping, or catching;
- Positive provocative test on physical exam with pain at the hip joint with flexion, adduction, and internal rotation (FADIR test);
- Acetabular labral tear on MRI, with or without intra-articular contrast;
- Failure of at least 6 weeks of non-operative treatment, including at least two of the following:
  - Physical therapy or properly instructed home exercise program
  - Rest or activity modification
  - Ice/Heat
  - Protected weight bearing
  - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics
  - Weight optimization
  - Corticosteroid injection
- No evidence of hip joint arthritis, defined as joint space narrowing 2 mm or less (Philippon, 2013) or Tönnis Grade 2 or 3 on weight-bearing AP radiograph [see Grading Appendix];
- Patient is less than 50 years of age (Philippon, 2013; Wilkin, 2014).

NOTE: Arthroscopy of the hip for labral repair is considered not medically necessary in the presence of significant hip joint arthritis (Tönnis grade 2 or greater) [see Grading Appendix], (Egerton, 2013; Philippon, 2013; Stevens, 2010) dysplasia [see grading appendix] or other structural abnormality that would require skeletal correction.

CAM, PINCER, COMBINED CAM & PINCER REPAIR

Arthroscopic CAM, pincer or combined CAM and pincer repair may be medically necessary when ALL of the following criteria are met:

- Positional hip pain;
• Failure of at least 6 weeks of non-operative treatment, including at least two of the following (Wall, 2013):
  o Physical therapy or properly instructed home exercise program
  o Rest or activity modification
  o Ice/Heat
  o Protected weight bearing
  o Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics
  o Weight optimization
  o Corticosteroid injection

• Positive impingement sign on physical exam (hip or groin pain with flexion, adduction and internal rotation (FADIR test);

• ANY of the following radiograph, CT and/or MRI findings of FAI:
  o Nonspherical femoral head or prominent head-neck junction (pistol-grip deformity) with alpha angle > 55 degrees indicating CAM impingement [see radiographic measurement appendix] (Nepple, 2011; Saito, 2017);
  o Overhang of the anterolateral rim of the acetabulum, posterior wall sign, prominent ischial spine sign, acetabular protrusion, or retroversion with a center edge (CE) angle > 35° and/or cross-over sign indicating pincer deformity [see radiographic measurement appendix];
  o Combination of CAM and pincer criteria;

• No evidence of hip joint arthritis, defined as a Tönnis Grade 2 or 3 (joint space less than 2 millimeters) on weight-bearing AP radiograph [see Grading Appendix] (Egerton, 2013; Philippon, 2013; Stevens, 2010);

• Skeletally mature patient;

• Under age < 50* years old (Philippon, 2013);

• BMI < 40* (Bech, 2015; Perets, 2018);

• Radiographic images show no evidence of ANY indicators for hip dysplasia [see grading appendix] (Parvizi, 2009).

*Patients age > 50 years (with no evidence of OA) or patients with BMI > 40 will be reviewed on a case by case basis.

*NOTE: Arthroscopy of the hip for FAI is considered not medically necessary or contraindicated in the presence of significant hip joint arthritis (Tonnis grade 2 or greater) [see grading appendix] or in the skeletally immature patient (open proximal femoral physis).
ARTHROSCOPY FOR SYNOVECTOMY, BIOPSY, OR REMOVAL OF LOOSE OR FOREIGN BODY

Arthroscopic synovectomy, biopsy, removal of loose or foreign body, or a combination of these procedures may be medically necessary when the following criteria are met:

- Radiographic evidence of acute post-traumatic intra-articular foreign body or displaced fracture fragment (Mullis, 2009; Ross, 2017); OR
- When **ALL** of the following criteria are met:
  - Hip pain associated with grinding, catching, locking, or popping;
  - Physical examination demonstrates painful, limited range of motion of the hip;
  - Failure of at least 12 weeks of non-operative treatment, including at least two of the following:
    - Physical therapy or properly instructed home exercise program
    - Rest or activity modification
    - Ice/Heat
    - Protected weight bearing
    - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics
    - Weight optimization
    - Corticosteroid injection
  - Radiographs, CT, and/or MRI demonstrate synovial proliferation, calcifications, nodularity, inflammation, pannus or a loose body.

EXTRA-ARTICULAR (ENDOSCOPIC) HIP SURGERY:

Requests for the use of arthroscopy to treat extra-articular hip pathology (endoscopy) will be decided on a case-by-case basis and when criteria in either of the following subsections are met:

- Activity related painful snapping sensation around the hip joint caused by the iliotibial tract over the greater trochanter or bursa (external snapping hip) (Mascarenhas, 2014; Pierce, 2018) and/or the iliopsoas tendon over medial bony prominence or bursa (internal snapping hip) unresponsive to non-operative care (Byrd, 2013; De Sa, 2014), OR
- Activity related pain and tenderness at the greater or lesser trochanter due to bursal inflammation, tendinosis and/or tendinitis, or tear of the tendon (gluteus medius or minimus) unresponsive to non-operative care (Byrd, 2013; Domb, 2010, 2013; McCormick, 2013);
- Failure of **at least 6 months** of non-operative treatment, including at least two of the following:
  - Physical therapy or properly instructed home exercise program
  - Rest or activity modification
  - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics
  - Corticosteroid injection
• Physical exam findings align with patient symptoms and at least one of the following documented:
  o Limp or painful ambulation
  o Tenderness and/or crepitus to palpation
  o Visible, audible, or palpable snapping at the greater trochanter or pelvic brim
  o Pain and/or weakness with active or resisted motion of the hip
  o Pain relief with diagnostic local anesthetic injection

ARTICULAR CARTILAGE RESTORATIVE/REPAIR (CHONDROPLASTY, MICROFRACTURE, ACI (AUTOGENOUS CHONDROCYTE IMPLANTATION) PROCEDURES:

All requests for microfracture or articular cartilage restorative procedures of the hip will be reviewed on a case-by-case basis and when the following criteria are met: (Chahla, 2016; Domb, 2015; Fontana, 2012; Karthikeyan, 2012; MacDonald, 2016; Marquez-Lara, 2016; O’Connor, 2016; Schallmo, 2018; Trask, 2016; Yen, 2010).
  • Skeletally mature adult
  • MRI results confirm a full thickness chondral or osteochondral lesion of the hip.
  • Patient has been symptomatic (pain, mechanical symptoms of popping, locking, catching, or limited range of motion) for at least 6 months;
  • Failure of at least 6 months of non-operative treatment, including at least two of the following:
    o Rest or activity modifications/limitations
    o Ice/heat
    o Protected weight bearing
    o Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol
    o Physical therapy modalities
    o Supervised home exercise
    o Weight optimization
    o Corticosteroid injection
  • BMI < 35
  • No evidence of hip joint arthritis, defined as a Tönnis Grade 2 or 3 (joint space less than 2 millimeters) on weight-bearing AP radiograph [see Grading Appendix]

BACKGROUND:

This guideline addresses the following elective, non-emergent, arthroscopic hip repair procedures:
  • Diagnostic arthroscopy
  • Femoroacetabular impingement (FAI)
  • Labral repair only
• CAM, pincer, CAM & pincer combined
• Synovectomy, biopsy, or removal of loose or foreign body
• Extra-articular (Endoscopic) Hip Surgery
• Articular cartilage restoration/repair (chondroplasty, microfracture, autogenous chondrocyte implantation)

Arthroscopy introduces a fiber-optic camera into the hip joint through a small incision for diagnostic visualization purposes. This camera may also be used in the surrounding extra-articular areas, in a procedure called endoscopy. Other instruments may then be introduced to remove, repair, or reconstruct joint pathology.

Open, non-arthroplasty hip repair surgeries are performed as dictated by the type and severity of injury and/or disease.

Surgical indications are based on relevant clinical symptoms, physical exam, radiologic findings, and response to non-operative, conservative management when medically appropriate.

OVERVIEW:

FEMOROACETABULAR IMPINGEMENT (FAI) (Byrd, 2013; Fabricant, 2012; Lynch, 2013; Malviya, 2012; Philippon, 2011; Stevens, 2010):

FAI is a condition characterized by a mechanical impingement between the proximal femur/femoral head (cam) and/or the acetabulum (pincer) that may result in labral injury (labral tear) or articular cartilage injury (chondral defect, arthritis). Up to 95% of labral tears are observed in the presence of FAI and “isolated” labral tears are very uncommon (as are labral tears caused by trauma) (Bedi, 2013; Dolan, 2011).

CAM, PINCER, COMBINED CAM & PINCER REPAIR:

Technically not a repair, this procedure involves bony decompression, shaving, osteoplasty, femoroplasty, acetabuloplasty, and/or osteochondroplasty. Greater than 95% of labral repairs should be performed with at least a femoral osteoplasty or an acetabuloplasty.

EXTRA-ARTICULAR (ENDOSCOPIC) HIP SURGERY (Mascarenhas, 2014):

Arthroscopy for extra-articular hip pathology is recognized as a less invasive adjunctive tool to correct or minimize symptoms of structural pathology, but is not supported in current high level evidence-based literature.

Extra-articular hip applications may be used to minimize symptoms of internal snapping hip (internal coxa saltans, ilioptoas tendonitis, snapping iliopsoas), iliopsoas tendon at iliopectineal eminence or anterior inferior iliac spine, external snapping hip (external coxa saltans, snapping iliotibial band,
iliotibial band at greater trochanter) (De Sa, 2014). May also include proximal hamstring endoscopy for partial tear of proximal hamstring with or without bursitis or proximal hamstring, sciatic neurolysis, ischiofemoral decompression (for ischiofemoral impingement), or anterior inferior iliac spine (subspine) decompression for subspine impingement (Carlton, 2016; El-Shaar, 2015).

**ARTICULAR CARTILAGE RESTORATIVE/REPAIR (CHONDROPLASTY, MICROFRACTURE, ACI (AUTOGENOUS CHONDROCYTE IMPLANTATION) PROCEDURES:**

There are no clinical indications for performing an independent debridement procedure within the hip. Debridement should always be combined or secondary to another procedure such as FAI procedures, reparative marrow stimulation (microfracture) or restorative marrow procedures (autologus chondrocyte implantation). While more commonly performed in the knee, microfracture or ACI procedures of the hip are less commonly performed and there are fewer indications (Chahla, 2016; Domb, 2015; Fontana, 2012; Karthikeyan, 2012; MacDonald, 2016; Marquez-Lara, 2016; O’Connor, 2016; Schallmo, 2018; Trask, 2016, Yen, 2010).

**GRADING APPENDIX**

**Tönnis Classification of Osteoarthritis by Radiographic Changes**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No signs of osteoarthritis</td>
</tr>
<tr>
<td>1</td>
<td>Mild: Increased sclerosis, slight narrowing of the joint space, no or slight loss of head sphericity</td>
</tr>
<tr>
<td>2</td>
<td>Moderate: Small cysts, moderate narrowing of the joint space, moderate loss of head sphericity</td>
</tr>
<tr>
<td>3</td>
<td>Severe: Large cysts, severe narrowing or obliteration of the joint space, severe deformity of the head</td>
</tr>
</tbody>
</table>

**Hip Dysplasia:**

Defined as any of the following criteria:

- Lateral center edge angle < 20 degrees
- Anterior center edge angle < 20 degrees
• Tonnis angle > 15 degrees
• Femoral head extrusion index > 25%

**Radiographic Measurement Appendix** (Harris, 2016)

**Alpha Angle:**
- Alpha angle was measured on the AP pelvis and Dunn 45° radiographs. First, a Mose circle was placed around the circumference of the femoral head. A line was drawn from the center of the femoral head down the center of the femoral neck. A line was then drawn connecting the center of the femoral head to the point of the Mose circle where the head goes out of round. The angle bisecting these two lines was the alpha angle.
  - An alpha angle of 55° (Dunn 45°) or greater or an alpha angle of 50° (AP pelvis) was defined as cam morphology.

**Femoral Head Extrusion:**
- Femoral head extrusion index was measured as the proportion (%) of laterally uncovered femoral head versus the femoral head (horizontal distance).
  - A femoral head extrusion index greater than 25% defined dysplasia.

**Global Acetabular Retroversion:**
- Global acetabular retroversion was defined by the presence of a prominent ischial spine sign or posterior wall sign.
  - Prominent ischial spine sign: Visible ischial spine medial to the iliopectineal line on AP pelvis radiograph.
  - Posterior wall sign: Center of the femoral head lateral to the posterior wall of the acetabulum.

**Lateral Center Edge Angle:**
- Lateral center edge angle was measured after multiple lines were drawn on the AP pelvis radiograph. First, a Mose circle was placed around the circumference of the femoral head. Next, a line was drawn connecting the ischial tuberosities. A perpendicular line was then drawn up through the center of the femoral head from the ischial tuberosity line. Then, a line was drawn from the center of the femoral head to the most lateral aspect of the sourcil. The angle bisecting the latter two lines was the lateral center edge angle.
  - A lateral center edge angle less than 20° defined dysplasia, 20 to 25° borderline dysplasia, 26 to 39° normal, and greater than 40° lateral overcoverage pincer impingement.
Lateral overcoverage was defined as a lateral center edge angle greater than 40°.

POLICY HISTORY:

Review Date: November 2018

Review Summary:
- “Diagnostic Hip Arthroscopy”: Added section to clarify the indications for a diagnostic hip arthroscopy and added definition of indeterminate X-rays and MRI
- “Articular Cartilage Restorative/Repair (Chondroplasty, Microfracture, ACI Procedures)” is a new section, added for completeness to mirror Knee Arthroscopy and will be reviewed on a case by case basis; included descriptive content in ‘Overview’ section
- Added and updated references

Review Date: October 2019

Review Summary:
- Updated references
- Kellgren-Lawrence grading system deleted
REFERENCES:


Knee Arthroplasty

CPT CODES:
Revision Knee Arthroplasty: 27486, 27487
Total Knee Arthroplasty (TKA): 27447
Partial-Unicompartmental Knee Arthroplasty (UKA): 27438, 27446

General Requirements:
Elective knee arthroplasty may be considered if the following general criteria are met:

- Knee pain with documented loss of function, which may include painful weight bearing, painful or inadequate range of motion to accomplish age-appropriate activities of daily living (ADLs) and/or employment, and painful mechanical catching, locking, or popping
- Patient is medically stable with no uncontrolled comorbidities (such as diabetes)
- Patient does not have an active local or systemic infection
- Patient does not have active, untreated drug dependency (including but not limited to narcotics, opioids, muscle relaxants) unless engaged in treatment program
- Patient has good oral hygiene and does not have major dental work scheduled or anticipated (ideally within one year of joint replacement), due to increased post-surgical infection risk.

Clinical notes should address:

- Symptom onset, duration, and severity;
- Loss of function and/or limitations;
- Type and duration of non-operative management modalities

Non-operative management must include at least TWO or more of the following unless otherwise specified in clinical indications below:

- Rest or activity modifications/limitations;
- Weight reduction for patient with elevated BMI;
- Protected weight-bearing with cane, walker or crutches;
- Brace/orthosis;
- Physical therapy modalities;
- Physician-supervised exercise program (including home exercise program);
- Pharmacologic treatment: oral/topical NSAIDs, acetaminophen, or analgesics;
- Intra-articular injection(s)
INDICATIONS:

TOTAL KNEE ARTHROPLASTY (TKA)

TKA may be considered medically necessary when the following criteria are met:

- Extensive disease or damage due to rheumatoid arthritis (Lee, 2012), post-traumatic arthritis (i.e., previous proximal tibia or distal femur fracture causing subsequent arthritis), fracture (Softness, 2017), avascular necrosis (Woehnl, 2012) confirmed by imaging (radiographs, MRI or other advanced imaging) or radiographs (X-rays) demonstrate bone-on-bone articulation; AND

- There is persistent pain and documented loss of function with any of the above.

  NOTE: There is no medical necessity to perform TKA in patients with severe radiological disease and no symptoms.

OR

- When ALL of the following criteria are met:

  o Pain due to advanced osteoarthritis (Kellgren-Lawrence (K-L) grade 3 or grade 4 degeneration [see grading appendix]) that is persistent and severe and/or patient has documented loss of function that has been present for at least 3 months resulting in a diminished quality of life (Hoornije, 2018);

  o Failure of **at least 3 months** of non-operative treatment, including **at least two** of the following (Van Manen, 2012; AAOS, 2012; Felson, 1987; Hochberg, 2012):
    - Rest or activity modifications/limitations
    - Weight reduction for patient with elevated BMI (AAOS, 2012)
    - Protected weight-bearing with cane, walker or crutches
    - Brace/orthosis
    - Physical therapy modalities
    - Physician-supervised exercise program (including home exercise program)
    - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, or analgesics (AAOS, 2012)
    - Injections: corticosteroid or viscosupplementation

  o Physical exam findings demonstrate one or more of the following: tenderness, swelling/effusion, limited range of motion (decreased from uninvolved side or as compared to a normal joint), flexion contracture, palpable or audible crepitus, instability and/or angular deformity;

  o Radiographic findings show evidence of advanced arthritic changes, described as Kellgren-Lawrence grade 3 or grade 4 degeneration or described as X-rays demonstrating advanced changes such as severe narrowing or bone-on-bone compartment collapse, subchondral sclerosis, osteophyte formation and/or bony deformity (Hoornije, 2018; Kellgren, 1957). The severity of knee osteoarthritis is commonly determined with weight-bearing radiographs,
however, if severe arthritic changes (e.g., bone on bone joint space narrowing) are noted on non-weightbearing images, further weight-bearing radiographs are not required;

- *MRI should not be the primary radiographic test used to determine the presence or severity of arthritic changes in the joint. Likewise, determinations as to the degree of arthritis should not routinely be determined by findings described from prior arthroscopic surgery of the knee.
- No corticosteroid injection into the joint within 12 weeks of surgery (Bedard, 2017; Cancienne, 2015).

Additional Information

- All requests for simultaneous bilateral total knee replacements should clearly indicate why simultaneous TKA is preferable to staged procedures. Associated risks with simultaneous bilateral total knee replacements should also be discussed with the patient and documented in the medical record.
- If medical records indicate that possibly either a TKA or a UKA will be performed, based on the findings at the time of surgery, separate requests are to be submitted.
- All requests for TKA, UKA, or revision TKA are to have documentation in the medical record pertaining to the potential risks, benefits, and complications specific to these procedures.

Absolute Contraindication:

- Active infection (local or remote). If a local or remote infection is documented in the patient’s history, records should clearly demonstrate that the previous infection has been treated and symptoms have resolved or that the patient has no clinical signs or symptoms of the previous infection at the time of the operation.
- Any corticosteroid injection into the joint within 12 weeks of surgery (Bedard, 2017; Cancienne, 2015)

Relative Contraindication:

- Prior infection at site (unless aspiration with cultures and serology [CBC with differential, ESR, CRP] demonstrates no infection). If prior infection at site, tissue biopsies should be sent intraoperatively to exclude latent/dormant infection.
- BMI > 40 (D’Apuzzo, 2014)
- Severe peripheral vascular disease
- Compromised soft tissue envelope
- Uncontrolled comorbidities (Clement, 2013)
UNICOMPARTMENTAL KNEE ARTHROPLASTY (UKA) / PARTIAL KNEE REPLACEMENT (PKA)

Medial or Lateral UKA/PKA may be medically necessary when **ALL** of the following criteria are met:

- At least 3 months of pain localized to the medial or lateral compartment (Hoorntje, 2018);
- Failure of at least 3 months of non-operative treatment, including **at least two** of the following (Van Manen, 2012; AAOS, 2012; Felson, 1987; Hochberg, 2012):
  - Rest or activity modifications/limitations
  - Weight reduction for patient with elevated BMI (AAOS, 2012)
  - Protected weight-bearing with cane, walker or crutches
  - Brace/orthosis
  - Physical therapy modalities
  - Physician-supervised exercise program (including home exercise program)
  - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, or analgesics (AAOS, 2012)
  - Injections: corticosteroid or viscosupplementation
- Total arc of motion (goniometer) > 90 degrees;
- Normal ACL or stable reconstructed ACL per physical exam test (Tinius, 2012);
- Standing, weight-bearing radiographs demonstrate only unicompartmental disease (with or without patellofemoral involvement), described as Kellgren-Lawrence grade 3 or grade 4 degeneration.

**NOTE:** MRI should not be the primary radiographic test used to determine the presence or severity of arthritic changes in the joint;

- Contracture < 5-10 degrees upon physical exam (goniometer) (Purcell, 2018)
- Angular deformity < 10 degrees, passively correctable to neutral upon physical exam (goniometer) (Becker, 2013);
- BMI < 40 (Bonutti, 2011);
- No corticosteroid injection into the joint within 12 weeks of surgery (Bedard, 2017; Cancienne, 2015).

All requests for UKA in patients with chronic, *painless* effusion and extensive radiographic arthritis will be evaluated on a case-by-case basis.

**Contraindications for Medial or Lateral UKA/PKA:**

- Any corticosteroid injection into the joint within 12 weeks of surgery
- Local or systemic active infection
- Inflammatory arthritis
• Angular deformity or contracture greater than indicated range
• Significant arthritic involvement of opposite compartment
• ACL instability
• Poor bone quality or significant osteoporosis or osteopenia
• Meniscectomy of the opposite compartment
• Stiffness greater than indicated range of motion

PATELLOFEMORAL UKA/PKA may be medically necessary when **ALL** of the criteria are met within one of the following two subsections:

- **Failure of prior patellofemoral unloading procedures (i.e., Maquet or Fulkerson);**
- **Failure of at least 3 months of non-operative treatment, including at least two of the following:**
  - Rest or activity modifications/limitations
  - Weight reduction for patient with elevated BMI
  - Protected weight-bearing with cane, walker or crutches
  - Brace/orthosis
  - Physical therapy modalities
  - Physician-supervised exercise program (including home exercise program)
  - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, or analgesics
  - Injections: corticosteroid or viscosupplementation

• **Standing, AP or PA weight-bearing x-rays demonstrate only unicompartmental disease of the patellofemoral joint, described as Kellgren-Lawrence grade 3 or grade 4 degeneration (joint space narrowing, osteophyte formation, sclerosis and/or subchondral cystic changes), with no evidence of medial or lateral compartment arthritis.**

OR

- **At least 6 months of isolated patellar/anterior knee pain;**
- **Patellar/anterior knee pain that is exacerbated by stairs, inclines, transfers or prolonged sitting;**
- **Reproducible patellofemoral pain upon physical exam;**
- **No ligamentous instability upon physical exam;**
- **Failure of at least 3 months of non-operative treatment, including at least two of the following:**
  - Rest or activity modifications/limitations
  - Weight reduction for patient with elevated BMI
  - Protected weight-bearing with cane, walker or crutches
  - Brace/orthosis
  - Physical therapy modalities
  - Physician-supervised exercise program (including home exercise program)
  - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, or analgesics
o Injections: corticosteroid or viscosupplementation

- Standing, AP or PA weight-bearing radiographs demonstrate only unicompartmental disease of the patellofemoral joint, described as Kellgren-Lawrence grade 3 or grade 4 degeneration, with no evidence of medial or lateral compartment arthritis.

- No cortisone injection into the joint within 12 weeks of surgery (Bedard, 2017; Cancienne, 2015)

**NOTE:** MRI should not be the primary radiographic test used to determine the presence or severity of arthritic changes in the joint.

**Contraindications for Patellofemoral UKA/PKA:**

- Any corticosteroid injection into the joint within 12 weeks of surgery (Bedard, 2017; Cancienne, 2015)
- Local or systemic active infection
- Inflammatory arthritis
- Angular deformity or contracture greater than indicated range
- Significant arthritic involvement of the medial or lateral knee compartment(s)
- Ligament instability
- Poor bone quality or significant osteoporosis or osteopenia
- Stiffness greater than indicated range of motion

**REVISION ARTHROPLASTY**

Revision TKA may be considered medically necessary when the following criteria are met:

- Previous removal of infected knee prosthesis AND no evidence of current, ongoing, or inadequately treated knee infection (documented with a normal erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP). **NOTE:** *** If these inflammatory markers are elevated, further evaluation is required, including an aspiration with synovial fluid WBC count, gram stain and cultures, or an intraoperative frozen biopsy (Della Valle, 2010);

- The patient should be off of antibiotics at the time of re-implantation;

  OR

- When ALL of the following criteria are met (Goyal, 2012; Motififard, 2015):
  o Symptomatic UKA/PKA or TKA as evidenced by persistent, severe, disabling pain, complaints of instability, mechanical abnormalities (“clunking” or audible crepitus), any of which result in a loss of function;
  o Any of the following findings upon physical exam: tenderness to palpation objectively attributable to the implant, swelling or effusion, pain on weight-bearing or motion,
instability on stress-testing, abnormal or limited motion (compared to usual function), palpable or audible crepitus or “clunking” associated with reproducible pain;

- Aseptic loosening, instability, osteolysis, progressive bone loss, or mechanical failure confirmed on radiographic or advanced imaging (bone scan, CT scan, or MRI);
- No evidence of current, ongoing, or inadequately treated knee infection (ruled out by normal inflammatory markers (ESR and CRP)) (Lee, 2015)
- Cases that do not demonstrate any radiographic abnormalities yet show findings of gross instability on physical examination will be evaluated on a case-by-case basis

- No corticosteroid injection into the joint within 12 weeks of surgery (Bedard, 2017; Cancienne, 2015)

**NOTE:** Removal of infected knee prosthesis and subsequent insertion of antibiotic spacer is not considered a revision knee arthroplasty.

**Absolute Contraindication:**

- Active infection (local or remote). If a local or remote infection is documented in the patient’s history, records should clearly demonstrate that the previous infection has been treated and symptoms have resolved or that the patient has no clinical signs or symptoms of the previous infection at the time of the operation.
- Any corticosteroid injection into the joint within 12 weeks of surgery (Bedard, 2017; Cancienne, 2015)

**Relative Contraindication:**

- Unstable or poorly controlled comorbidities
- Severe peripheral vascular disease
- Compromised soft-tissue envelope (revision may be performed in conjunction with plastic surgical consultation for soft tissue coverage via pedicle flaps or other acceptable procedure)
GRADING APPENDIX

Kellgren-Lawrence Grading System:

MRI should not be the primary tool used to determine the presence or severity of arthritic changes in the joint.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No radiographic features of osteoarthritis</td>
</tr>
<tr>
<td>1</td>
<td>Possible joint space narrowing and osteophyte formation</td>
</tr>
<tr>
<td>2</td>
<td>Definite osteophyte formation with possible joint space narrowing</td>
</tr>
<tr>
<td>3</td>
<td>Moderate multiple osteophytes, definite narrowing of joint space, some sclerosis and possible deformity of bone contour (some sclerosis and cyst formation)</td>
</tr>
<tr>
<td>4</td>
<td>Large osteophytes, marked narrowing of joint space, severe sclerosis and definite deformity of bone contour.</td>
</tr>
</tbody>
</table>

Other Notes:
Manipulation following total knee arthroplasty: SEE KNEE ARTHROSCOPY & OTHER OPEN PROCEDURES Guideline for specific Manipulation indications.

BACKGROUND:

KNEE ARTHROPLASTY - Total, Partial & Revision Knee Replacement

This guideline addresses elective, non-emergent knee arthroplasty (knee replacement) procedures, including total knee arthroplasty (TKA), unicompartamental/unicondylar knee arthroplasty (UKA) or hemiarthroplasty (partial knee replacement), and revision arthroplasty procedures.

Arthroplasty describes the surgical replacement and reconstruction of a joint with implanted devices when the joint has been damaged by an arthritic or traumatic process. A normal knee functions as a
hinge joint between the femur and the tibia. The surfaces where these bones meet can become worn out over time, due to arthritis or other conditions, which can cause pain and swelling.

TKA replaces and reconstructs all articular joint surfaces. In some cases, only one surface within the knee develops arthritis and associated pain and functional loss. In these cases, a partial knee replacement may be necessary to remove and reconstruct only the damaged region of the knee.

In some cases, the knee prosthesis may wear out or loosen. If loosening is painful, a revision surgery may be necessary. In this procedure some or all of the components of the original replacement prosthesis are removed and replaced with new ones.

Overview:

UNICOMPARTMENTAL KNEE ARTHROPLASTY (UKA) / PARTIAL KNEE REPLACEMENT (PKA):

Unicompartmental knee arthroplasty (UKA) is also called partial replacement, hemiarthroplasty, unicondylar knee, or bicondylar knee arthroplasty. This procedure involves reconstruction of either the medial or lateral weight bearing compartment of the knee and/or patellofemoral joint. Medial UKA is performed more frequently than lateral procedures.

REVISION ARTHROPLASTY:
Revision describes surgical reconstruction due to failure or complication of a previous arthroplasty.

POLICY HISTORY:

Review Date: November 2018

Review Summary:

- Total Knee Arthroplasty (TKA): TKA may be considered medically necessary when the following criteria are met: Added ‘post-traumatic arthritis (i.e., previous proximal tibia or distal femur fracture causing subsequent arthritis)’ to separate the general fracture term into old post traumatic arthritis versus new fracture
- Additional Information: Added: 1- ‘If medical records indicate that possibly either a TKA or a UKA will be performed, based on the findings at the time of surgery, separate requests are to be submitted’; 2- ‘All requests for TKA, UKA, or revision TKA are to have documentation in the medical record pertaining to the potential risks, benefits, and complications specific to these procedures’
- Absolute Contraindication: changed ‘Any injection into the joint within 3 months of surgery’ to ‘Any corticosteroid injection into the joint within 3 months of surgery’
- Patellofemoral UKA/PKA: Modified language to include: ‘Standing, AP or PA weight-bearing x-rays (this used to say ‘radiographs’) demonstrate only unicompartmental disease of the patellofemoral joint, described as Kellgren-Lawrence grade 3 or grade 4 degeneration (joint space narrowing,
osteophyte formation, sclerosis and/or subchondral cystic changes), with no evidence of medial or lateral compartment arthritis’

- Revision TKA: Added content “… if ESR and CRP are elevated, ‘further evaluation is required, including an aspiration with synovial fluid WBC count, gram stain and cultures, or an intraoperative frozen biopsy’

- Revision TKA criteria: Added a physical exam to the criteria, see italicized ‘Symptomatic UKA/PKA or TKA as evidenced by persistent, severe, disabling pain, complaints of instability, mechanical abnormalities (“clunking” or audible crepitus’; also added clarification ‘Cases that do not demonstrate any radiographic abnormalities yet show findings of gross instability on physical examination will be evaluated on a case by case basis’

- Added and updated references

Review Date: August 2019

Review Summary:

- Added CPT code 27438 for Partial-Unicompartmental Knee Arthroplasty (UKA)

Review Date: October 2019

Review Summary:

- Updated/revised in-text references and bibliography
- Added new a statement that if “bone on bone” arthritis is documented, conservative treatment requirements are not necessary for approval.
- Deleted age limit for UKA (previous age criteria: over 50)
- Added:” No evidence of current, ongoing, or inadequately treated knee infection (ruled out by normal inflammatory markers (ESR and CRP))
- Removed Outerbridge Classification (this is an arthroscopic grading system)
- Removed Non-covered section
REFERENCES:


CPT CODES:
Knee Manipulation Under Anesthesia (MUA): 27570, 29884
Knee Ligament Reconstruction/Repair: 27405, 27407, 27409, 27427, 27428, 27429, 29877, 29888, 29889
Knee Meniscectomy/Meniscal Repair/Meniscal Transplant: 27332, 27333, 27403, 29868, 29880, 29881, 29882, 29883
Knee Surgery – Other: 27412, 27415, 27416, 27418, 27420, 27422, 27424, 27425, 29866, 29867, 29870, 29873, 29874, 29875, 29876, 29877, 29879, G0289

General Requirements
Elective arthroscopic surgery of the knee may be considered if the following general criteria are met:

- There is clinical correlation of patient’s subjective complaints with objective exam findings and/or imaging (when applicable);
- Knee pain with documented loss of function: Deviation from normal knee function which may include painful weight bearing and/or inadequate range of motion (> 10 degrees flexion contracture or < 110 degrees flexion or both) to accomplish age-appropriate activities of daily living (ADLs) or occupational or athletic requirements);
- Patient is medically stable with no uncontrolled comorbidities;
- Patient does not have an active local or systemic infection;
- Patient does not have active, untreated drug dependency (including but not limited to narcotics, opioids or muscle relaxants) unless engaged in treatment program

Clinical notes should address:

- Symptom onset, duration, and severity;
- Loss of function and/or limitations;
- Type and duration of non-operative management modalities (where applicable).

Unless otherwise stated in the subsections below, non-operative management must include at least two or more of the following, unless otherwise specified:

- Rest or activity modifications/limitations;
- Ice/heat;
- Protected weight bearing;
• Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol;
• Brace/orthosis;
• Physical therapy modalities;
• Supervised home exercise;
• Weight optimization;
• Injections: corticosteroid or viscosupplementation

INDICATIONS:

DIAGNOSTIC KNEE ARTHROSCOPY

Diagnostic knee arthroscopy may be medically necessary when **ALL** of the following criteria are met:

• At least 3 months of knee pain with documented loss of function;
• Failure of at least 12 weeks of non-operative treatment, including **at least two** of the following:
  o Rest or activity modifications/limitations
  o Ice/heat
  o Protected weight bearing
  o Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol
  o Brace/orthosis
  o Physical therapy modalities
  o Supervised home exercise
  o Weight optimization
  o Corticosteroid injection
• Clinical documentation of painful weight bearing, joint line tenderness, effusion and/or limited motion compared to pre-symptomatic joint range;
• Indeterminate radiographs **AND** MRI findings.

**NOTE:** Radiographs and/or MRI should not demonstrate any of the following: Kellgren-Lawrence Grade 3-4 changes (based on standing or weight-bearing radiographs), meniscus tears, loose bodies, stress fractures (including insufficiency fractures) or patellofemoral instability (lateral patellar tilt).

DEBRIDEMENT CHONDROPLASTY

Debridement for **non-patellofemoral (femoral condyle and tibial plateau) articular cartilage** may be medically necessary when **ALL** of the following criteria are met (Anderson, 2017; Montgomery, 2013; Scillia, 2015):

• Knee pain with documented loss of function;
• Failure of **at least 12 weeks** of non-operative treatment, including **at least two** of the following:
  o Rest or activity modifications/limitations
o Ice/heat
o Protected weight bearing
o Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol
o Brace/orthosis
o Physical therapy modalities
o Supervised home exercise
o Weight optimization
o Corticosteroid injection

- MRI results demonstrate evidence of unstable chondral flap;
- Two or more or persistent effusion(s)

Debridement chondroplasty for **patellofemoral chondrosis** when **ALL** of the following criteria are met:

- Anterior knee pain with documented loss of function;
- Other extra-articular or intra-articular sources of pain or dysfunction have been excluded (referred pain, radicular pain, tendinitis, bursitis, neuroma);
- Physical exam localizes tenderness to the patellofemoral joint with pain aggravated by activities that load the joint (single leg squat, ascending >descending stairs, and being in seated position for extended periods of time with knee flexed);
- Failure of **at least 12 weeks** of non-operative treatment, including **at least two** of the following:
  o Rest or activity modifications/limitations
  o Ice/heat
  o Protected weight bearing
  o Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol
  o Brace/orthosis
  o Physical therapy modalities
  o Supervised home exercise
  o Weight optimization
  o Corticosteroid injection
- No evidence of moderate to severe osteoarthritis (Kellgren-Lawrence Grade 3-4 based on standing or weight-bearing radiographs and patellofemoral views [see grading appendix])

Debridement for **arthrofibrosis** may be medically necessary when **ALL** of the following criteria are met:

- Arthrofibrosis as evidenced by physical exam findings of painful stiffness and loss of motion due to proliferation of scar tissue in and around the joint.

**NOTE:** Imaging is not necessary, however historically has been used to help determine the diagnosis;
• Failure of at least 6 weeks of supervised or self-directed physical therapy;

Arthroscopic debridement with or without chondroplasty for the treatment of osteoarthritis of the knee is considered **NOT MEDICALLY NECESSARY** (Katz, 2014; Mayr, 2013).

**MENISCECTOMY / MENISCAL REPAIR / MENISCAL TRANSPLANT**

**MENISCECTOMY / MENISCAL REPAIR:**

**NOTE:** There is a high incidence of incidental meniscal findings on knee MRI in middle-aged and elderly patients (Englund, 2008, 2012) and several studies have indicated that there is no difference in outcome between operative and non-operative treatment of patients with degenerative meniscus tears, especially when associated with an arthritic knee: (Englund, 2012; Herrlin, 2013; Hohmann, 2018; Jevsevar, 2013, 2015; Katz, 2013; Kise, 2016; Leopold, 2017; Liebs, 2018; MacDonald, 2013; Sihvonen, 2013; Yim, 2013).

Meniscectomy and/or meniscal repair may be medically necessary when **ALL** of the following criteria in any of the following subsections are met:

- Symptomatic meniscal tear confirmed by MRI results that demonstrate a peripheral tear in the vascular zone, root tear or other tear that the requesting physician considers repairable and is associated with pain localized to the corresponding compartment upon physical exam;

  **OR**

- MRI results demonstrate a meniscus tear in a pediatric or adolescent patient who has pain and mechanical symptoms upon physical exam.

  **OR**

- History of acute injury/onset of symptoms with a locked knee and/or mechanical symptoms of locking;
- Physical examination demonstrates 2 of the following: joint line TTP, positive McMurray’s test localized to the correct compartment, pain with full flexion or pain with full extension; evidence of a locked knee (loss of terminal extension);
- MRI demonstrates a bucket-handle tear of the meniscus. (Does not include an extruded meniscus or flap tears);

  **OR**

  - When **at least two** of the following 5 criteria are met:
    - History of “catching” or “locking” as reported by the patient;
    - Knee joint line pain with forced hyperextension upon physical exam;
    - Knee joint line pain with maximum flexion upon physical exam;
- Knee pain, crepitus, or an audible or palpable click with the McMurray’s test or Apley grind test;
- Joint line tenderness to palpation upon physical exam

AND

- Failure of at least 6 weeks of non-operative treatment, including at least two of the following:
  - Rest or activity modifications/limitations
  - Ice/heat
  - Protected weight bearing
  - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol
  - Brace/orthosis
  - Physical therapy modalities
  - Supervised home exercise
  - Weight optimization
  - Corticosteroid injection

AND

- **ONE** of the following:
  - Weight-bearing X-ray(s) that demonstrate no moderate or severe osteoarthritic changes (Kellgren-Lawrence Grade 3-4 [see grading appendix]); X-rays should be described as showing minimal or mild arthritis only;

OR

- MRI results confirm a frank meniscal tear (not simply degenerative changes, i.e., fraying) and the MRI does not demonstrate any of the following: moderate or severe articular cartilage thinning, full-thickness articular cartilage loss or defects, extrusion of the meniscus, subchondral edema, more than mild osteophytes, subchondral cysts or an impression of “moderate” or “advanced/severe” arthritis (see absolute and relative contraindications). If the MRI demonstrates any of the above-described findings of more than mild arthritis, weight-bearing X-rays are required to confirm no moderate or severe articular cartilage loss.*

*NOTE: Arthroscopic meniscus requests and MRI/X-rays of the knee - Although most patients that have a request for arthroscopic meniscectomy will have had both an MRI and X-rays of the knee, not every patient with an MRI requires a standing X-ray. Only one of these tests is required for approval, provided all other criteria for meniscectomy have been met. For example, if there has been a failure to improve with 6 weeks of non-operative treatment and there are physical examination findings of a meniscus tear, an MRI is not required, only weight-bearing X-rays that demonstrate no more than mild arthritis. Likewise, if an MRI describes a meniscus tear and does not describe any associated arthritis, weight-bearing X-rays are not required.
Absolute Contraindications: Meniscectomy / Meniscal Repair

- Arthroscopic meniscectomy or meniscal repair is never medically necessary in the presence of Kellgren-Lawrence Grade 4 osteoarthritis [see grading appendix].

Relative Contraindications: Meniscectomy / Meniscal Repair

- Meniscectomy or repair is considered NOT MEDICALLY NECESSARY in the presence of Kellgren-Lawrence Grade 3 osteoarthritis [see grading appendix], Unless:
  - There has been an acute onset with an effusion and locking (not include catching, popping, cracking, etc.); AND
  - There is MRI evidence of a bucket-handle or displaced meniscal fragment that correlates with the correct compartment (i.e. medial tenderness and locking for a medial tear).
- If grade 3 changes are present, only a meniscectomy may be indicated, not a repair. If there is evidence of meniscal extrusion on coronal MRI, with/without subchondral edema, arthroscopy is relatively contraindicated, even if a tear is present.

MENISCAL TRANSPLANT:

Meniscal Transplants may be medically necessary when ALL of the following criteria are met (Hannon, 2015; Noyes, 2015; Samitier, 2015):

- Patient is < 40 years old;
- Patient has no evidence of arthritic changes;
- Symptomatic meniscal deficiency confirmed by MRI results that show a meniscal deficient compartment, OR previous arthroscopy photographs or video showing subtotal or total meniscectomy;
- Failure of at least 6 weeks of non-operative treatment, including at least two of the following:
  - Rest or activity modifications/limitations
  - Ice/heat
  - Protected weight bearing
  - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol
  - Brace/orthosis
  - Physical therapy modalities
  - Supervised home exercise
  - Weight optimization
  - Corticosteroid injection

Absolute Contraindications: Meniscal Transplant

- Uncorrected (staged or simultaneous) ligamentous insufficiency (ACL, PCL, MCL, LCL, PMC, PLC)
• Uncorrected (staged or simultaneous) malalignment greater than 5 degrees varus or 5 degrees valgus
• Uncorrected (staged or simultaneous) full-thickness articular cartilage isolated defects (International Cartilage Research Society Grade 3 or 4; Outerbridge Grade IV [see grading appendix])
• Kellgren-Lawrence Grade 3 or 4 osteoarthritis [see grading appendix]

LIGAMENT RECONSTRUCTION / REPAIR

ANTERIOR CRUCIATE LIGAMENT (ACL) RECONSTRUCTION WITH ALLOGRAFT OR AUTOGRAFT:

ACL reconstruction or repair may be medically necessary when ALL of the following criteria in any of the following subsections are met (Dejour, 2013; Hoher, 2014; Pujol, 2012):

• Knee instability (as defined subjectively as "giving way", "giving out", "buckling", two-fist sign) with clinical findings of instability: Lachman’s 1A, 1B, 2A, 2B, 3A, 3B, Anterior Drawer, Pivot Shift test, or instrumented (KT-1000 or KT-2000) laxity of greater than 3 mm side-side difference;
• MRI results confirm complete ACL tear;
• **Patient has no evidence of severe arthritis (Kellgren-Lawrence** Grade 3 or 4 [see grading appendix]);

OR

• At least ONE of the following criteria are met:
  o MRI results confirm ACL tear associated with other ligamentous instability or repairable meniscus;
  o MRI results confirm partial or complete ACL tear AND patient has persistent symptoms despite at least 12 weeks of non-operative treatment;
  o Acute ACL tear confirmed by MRI in high demand occupation or competitive athlete (as quantified by Marx activity score for athletics (any score greater than 4) and Tegner activity score for athletics and/or occupation (score greater than 2)) [see grading appendix]);
• **Patient has no evidence of severe arthritis (Kellgren-Lawrence** Grade 3 or 4 [see grading appendix]);

** If MRI results demonstrate an ACL tear, especially in the younger patient, and there is no mention of significant arthritis, X-rays are not required.

NOTE: ACL tears in patients less than age 13 will be reviewed on a case by case basis.

POSTERIOR CRUCIATE LIGAMENT (PCL) RECONSTRUCTION:

PCL reconstruction or repair may be medically necessary when the following criteria are met (Bedi, 2016; Laprade, 2015):

• Knee instability (as defined subjectively as "giving way", "giving out" or "buckling") with clinical findings of any of the following signs/tests: positive posterior drawer, posterior sag, quadriceps active, dial test at 90 degrees knee flexion or reverse pivot shift test;
• MRI results confirm complete PCL tear;
• Failure of at least 12 weeks of non-operative treatment, including bracing and physical therapy emphasizing quadriceps strengthening);
• Absence of medial and patellofemoral K-L grade 3-4 changes in chronic tears [see grading appendix];

The following clinical scenarios will be considered and decided on a case-by-case basis:
• Pediatric and adolescent tears in patients with open physes or open growth plates;
• Symptomatic partial tears with persistent instability despite non-operative treatment;
• Incidental Kellgren-Lawrence grade 2-3 osteoarthritis [see grading appendix] in acute/subacute tears with unstable joint;
• Acute PCL repair or reconstruction when surgery is also required for the ACL, MCL or LCL.
• Tears in patients less than age 13

**COLLATERAL LIGAMENT REPAIR OR RECONSTRUCTION:**
Collateral ligament repair or reconstruction should rarely occur independent of additional ligament repair or reconstruction surgery (ACL, MCL, LCL).
All non-traumatic collateral ligament repair/reconstruction requests will be reviewed on a case by case basis.

**ARTICULAR CARTILAGE RESTORATION / REPAIR**

**SKELETALLY IMMATURE INDICATIONS:**
Articular cartilage restoration / repair may be medically necessary when ALL of the following criteria in any of the following subsections are met (Chawla, 2015; Macmull, 2010; Murphy, 2014; Salzmann, 2012, 2018; Steadman, 2015):

- Skeletally immature patient;
- Patient is symptomatic (pain, swelling, mechanical symptoms of popping, locking, catching, or limited range of motion);
- Radiographic findings (any radiograph and MRI) of a displaced lesion; OR
- Skeletally immature patient;
• Patient is symptomatic (pain, swelling, mechanical symptoms of popping, locking, catching, or limited range of motion);

• Failure of at least 12 weeks of non-operative treatment, including at least two of the following:
  o Rest or activity modifications/limitations
  o Ice/heat
  o Protected weight bearing
  o Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol
  o Brace/orthosis
  o Physical therapy modalities
  o Supervised home exercise
  o Weight optimization
  o Corticosteroid injection

• Radiographic findings (radiograph and MRI) findings of a stable osteochondral lesion; OR

• When ALL of the following criteria are met:
  o Skeletally immature;
  o Asymptomatic;
  o Failure of at least 12 weeks of non-operative treatment, including at least two of the following, to improve lesion stability or size;
    ▪ Rest or activity modifications/limitations
    ▪ Ice/heat
    ▪ Protected weight bearing
    ▪ Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol
    ▪ Brace/orthosis
    ▪ Physical therapy modalities
    ▪ Supervised home exercise
    ▪ Weight optimization
    ▪ Corticosteroid injection
  o Radiographic findings (radiograph and MRI) findings of an unstable osteochondral lesion

Exclusion (applies to all criteria above):
Exclude patients with evidence of meniscal deficiency and/or malalignment IF these are not being addressed (meniscal transplant and/or lateral release/patellar realignment procedure) at the same time as the cartilage restoration procedure.

SKELETALLY MATURE INDICATIONS
Reparative Marrow Stimulation:
Reparative marrow stimulation techniques such as microfracture & drilling (NOTE- abrasion arthroplasty is including in coding but is not indicated) may be medically necessary when **ALL** of the following criteria are met (Bae, 2013; Bark, 2014; Goyal, 2013; Mall, 2015; Sommerfeldt, 2016):

- Skeletally mature adult;
- MRI confirms a full-thickness weight-bearing lesion that is < 2.5cm²;
- Patient is symptomatic (pain, swelling, mechanical symptoms of popping, locking, catching, or limited range of motion);
- Patient is < 50 years of age;
- BMI < 35 (optimal outcomes if patient BMI < 30);
- Physical exam findings and/or (imaging) results confirm knee has stable ligaments;
- No evidence of prior meniscectomy in same compartment (medial femoral condyle full thickness lesion and prior medial meniscectomy) unless concurrent meniscal transplant performed.

**Restorative Marrow Techniques:**

Restorative techniques such as, osteoarticular transfer system or osteochondral autograft transfer system (OATS), mosaicplasty, matrix autologous chondrocyte implantation (MACI), osteochondral allograft implantation, minced articular cartilage allograft transplantation (DeNovo natural tissue NT) may be medically necessary when **ALL** of the following criteria are met (Fu, 2016; Knutsen, 2016; Mall, 2015; Minas, 2014; Sherman, 2014; Zouzias, 2016):

- Skeletally mature adult;
- MRI results confirm a full thickness chondral or osteochondral lesion of the femoral condyles or trochlea > 2.5 cm²;
- Patient is < 50 years of age;
- BMI < 35 (optimal outcomes if patient BMI < 30);
- Patient has been symptomatic (pain, swelling, mechanical symptoms of popping, locking, catching, or limited range of motion) for at least 6 months;
- Failure of **at least 6 months** of non-operative treatment, including **at least two** of the following;
  - Rest or activity modifications/limitations
  - Ice/heat
  - Protected weight bearing
  - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol
  - Brace/orthosis
  - Physical therapy modalities
  - Supervised home exercise
  - Weight optimization
o Corticosteroid injection

- MRI and/or physical findings confirm knee has normal alignment as defined as +/- 3 degrees from neutral on full-length mechanical axis long-leg x-ray (unless concurrent or staged tibial or femoral osteotomy performed) and stability (unless concurrent ligamentous repair or reconstruction performed);
- MRI shows no evidence of osteoarthritis (greater than Kellgren-Lawrence Grade 2 [see grading appendix]);
- No prior meniscectomy in same compartment (unless concurrent or staged meniscal transplant performed)

**Patellofemoral Chondrosis:**

Surgical intervention for the treatment of patellofemoral chondrosis (osteochondral autograft transfer or transplantation (OATS), microfracture, autologous chondrocyte implantation (ACI), osteochondral allograft implantation, minced articular cartilage allograft transplantation (DeNovo NT), tibial tubercle osteotomy) may be medically necessary when **ALL** of the following criteria are met (Biant, 2014; Gomoll, 2014; Von Keudell, 2017):

- Anterior knee pain and loss of function;
- Other extra-articular or intra-articular sources of pain or dysfunction have been excluded (referred pain, radicular pain, tendinitis, bursitis, neuroma);
- Physical exam localizes tenderness to the patellofemoral joint with pain aggravated by activities that load the joint (single leg squat, descending > ascending stairs or stair climbing, and being in seated position for extended periods of time with knee flexed);
- Radiologic imaging shows grade 3 or 4 patellofemoral chondrosis (International Cartilage Research Society classification*) or grade III or IV articular cartilage changes, documented by prior arthroscopic evaluation (Outerbridge Classification*) (*see grading appendix)
- Failure of **at least 6 months** of non-operative treatment, including **at least two** of the following:
  o Rest or activity modifications/limitations
  o Ice/heat
  o Protected weight bearing
  o Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol
  o Brace/orthosis
  o Physical therapy modalities
  o Supervised home exercise
  o Weight optimization
  o Corticosteroid injection
- No evidence of osteoarthritis (Kellgren-Lawrence Grade 3-4 based on standing or weight-bearing radiographs) in the medial/lateral compartments [see grading appendix].
Synovectomy (major [2+ compartments], minor [1 compartment]):
Synovectomy may be medically necessary when **ALL** of the following criteria in **any** of the following subsections are met (Auregan, 2014; Lipina, 2018; Willimon, 2018):

- Proliferative rheumatoid synovium (in patients with established rheumatoid arthritis according to the American College of Rheumatology Guidelines [see grading appendix]);
- Not responsive to disease modifying drug (DMARD) therapy for at least 6 months and failure of at least 6 weeks of non-operative treatment;
- At least one instance of aspiration of joint effusion and corticosteroid injection (if no evidence of infection); **OR**
- Hemarthrosis from injury, coagulopathy or bleeding disorder confirmed by physical exam, joint aspiration, and/or MRI; **OR**
- Proliferative pigmented villonodular synovitis, synovial chondromatosis, sarcoid synovitis, or similar proliferative synovial disease, traumatic hypertrophic synovitis confirmed by history, MRI or biopsy;
- Failure of **at least 6 weeks** of non-operative treatment, including **at least two** of the following:
  - Rest or activity modifications/limitations
  - Ice/heat
  - Protected weight bearing
  - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol
  - Brace/orthosis
  - Physical therapy modalities
  - Supervised home exercise
  - Weight optimization
  - Corticosteroid injection
- At least one instance of aspiration of joint effusion and injection of corticosteroid (if no evidence of infection); **OR**
- Detection of painful plica confirmed by physical exam and MRI findings;
- Failure of at least 12 weeks of non-operative treatment (see above for criteria);
- At least one instance of aspiration of joint effusion **OR** single injection of corticosteroid (effusion may not be present with symptomatic plica);

Loose Body Removal:
Loose body removal may be medically necessary when the following criteria are met:
• Documentation of mechanical symptoms the cause limitation or loss of function
• X-ray or MRI documentation of a loose body

**Lateral Release/Patellar Realignment:**
This guideline describes indications for surgical procedures to address patellofemoral pain disorders and abnormal alignment of the extensor mechanism of the knee by arthroscopic and/or open surgical techniques.

**Lateral Patellar Compression Syndrome:**
Surgical intervention for the treatment of lateral patellar compression syndrome is indicated when **ALL** the following criteria are met (Clifton, 2010; Fonseca, 2017; Pagenstert, 2012; Petersen, 2014; Saper, 2014):

- Evidence of lateral patellar tilt from radiologic images (patellofemoral view: Merchant (45 degrees flexion; and/or skyline (60-90 degrees flexion); and/or sunrise (60-90 degrees flexion);
- Associated lateral patella facet Kellgren-Lawrence changes grade 1, 2, or 3 [see grading appendix];
- Reproducible isolated lateral patellofemoral pain with patellar tilt test;
- Failure of **at least 6 months** of non-operative treatment, including quadriceps strengthening and appropriate hamstring/IT band stretching and patellar mobilization techniques, and **at least one** of the following:
  - Rest or activity modifications/limitations
  - Ice/heat
  - Protected weight bearing
  - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol
  - Brace/orthosis
  - Physical therapy modalities
  - Supervised home exercise
  - Weight optimization
  - Corticosteroid injection
- No evidence of patellar dislocation.
- No evidence of medial patellofemoral changes (Kellgren-Lawrence Grade 2 osteoarthritis or higher [see grading appendix]);

**Patellar Malalignment and/or Patellar Instability:**
Surgical intervention for the treatment of patellar malalignment and/or patellar instability is indicated when **ALL** of the following criteria in any of the following subsections are met (Allen, 2018; Arshi, 2016; Koh, 2015; Steensen, 2015):

- Acute traumatic patellar dislocation is associated with an osteochondral fracture, loose body, vastus medialis obliquus/medial patellofemoral ligament muscle avulsion, or other intra-articular injury that requires urgent operative management;

**OR**

- Repeat (2 or more) patellar dislocations or subluxations have occurred despite 6 months of non-operative treatment with radiologic confirmation of MPFL (medial patellofemoral ligament) deficiency (including evidence of acute or remote injury, scarring, incomplete healing, etc.) or physical examination demonstrates evidence of patellar instability (positive apprehension test).

**OR**

- When all the following criteria have been met:
  - Physical exam has patellofemoral tenderness and abnormal articulation of the patella in the femoral trochlear groove (patellar apprehension with or positive J sign);
  - CT scan or MRI rules out other abnormality to malalignment (tibial tubercle trochlear groove (TT-TG) distance > 20 millimeters);
  - Radiologic and advanced images (CT or MRI) rule out fracture or loose body, and show abnormal articulation, trochlear dysplasia, or other abnormality related to malalignment;
  - Failure of at least 6 months of non-operative treatment, including at least 3 months of physical therapy, and **ONE** of the following:
    - Rest or activity modifications/limitations
    - Ice/heat
    - Protected weight bearing
    - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol
    - Brace/orthosis
    - Supervised home exercise
    - Weight optimization
    - Corticosteroid injection

**Manipulation under Anesthesia (MUA):**

Manipulation under anesthesia (MUA) may be indicated when **ALL** of the following criteria are met (Baydoun, 2013; Evans, 2012; Gu, 2018; Issa, 2014):

- Physical exam findings demonstrate inadequate range of motion of the knee defined as less than 110 degrees of flexion;
- Failure to improve range of motion of the knee despite 6 weeks (12 visits) of documented physical therapy;
• Patient is less than 12 weeks after ligamentous or joint reconstruction

**Lysis of Adhesions for Arthrofibrosis of the knee:**
Surgical indications are based on relevant clinical symptoms, physical exam, radiologic findings, time from primary surgery, and response to conservative management when medically appropriate. Improved range of motion may be accomplished through arthroscopically-assisted or open lysis of adhesions with general anesthesia, regional anesthesia, or sedation (Chen, 2011; Schwarzkopf, 2013).

Lysis of Adhesions for Arthrofibrosis of the knee may be indicated when **ALL** of the following criteria in any of the following subsections are met:

- Physical exam findings demonstrate inadequate range of motion of the knee, defined as less than 110 degrees of flexion;
- Failure to improve range of motion of the knee despite 6 weeks (12 visits) of documented physical therapy;
- Patient is more than 12 weeks after ligamentous or joint reconstruction, or resolved infection;

**OR**

- Patient is more than 12 weeks after trauma, or resolved infection;
- Patient has native knee;
- Manipulation under anesthesia is also performed.

**GRADING APPENDIX:**
- Kellgren-Lawrence Grading System
- Outerbridge Arthroscopic Grading System
- Marx Scale
- Tegner Activity Score
- The International Cartilage Research Society (ICRS)
- American College of Rheumatology Guidelines

**Kellgren-Lawrence Grading System (Standing/weight-bearing X-rays):**
*MRI should not be the primary tool used to determine the presence or severity of arthritic changes in the joint.*

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No radiographic features of osteoarthritis</td>
</tr>
<tr>
<td>1</td>
<td>Possible joint space narrowing and osteophyte formation</td>
</tr>
<tr>
<td>2</td>
<td>Definite osteophyte formation with possible joint space narrowing</td>
</tr>
</tbody>
</table>
Moderate multiple osteophytes, definite narrowing of joint space, some sclerosis and possible deformity of bone contour

Large osteophytes, marked narrowing of joint space, severe sclerosis and definite deformity of bone contour

### Outerbridge Arthroscopic Grading System

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Normal cartilage</td>
</tr>
<tr>
<td>I</td>
<td>Softening and swelling/blistering</td>
</tr>
<tr>
<td>II</td>
<td>Partial thickness defect, fissures &lt; 1.5cm diameter/wide</td>
</tr>
<tr>
<td>III</td>
<td>Fissures /defects down to subchondral bone with intact calcified cartilage layer, diameter &gt; 1.5cm</td>
</tr>
<tr>
<td>IV</td>
<td>Exposed subchondral bone</td>
</tr>
</tbody>
</table>

### MARX SCALE (For determination of activity level in acute ACL tears)

Indicate how often you performed each activity in your healthiest and most active state, in the past year.

<table>
<thead>
<tr>
<th>Activity/Movement</th>
<th>Less than one time in a month</th>
<th>One time in a month</th>
<th>One time in a week</th>
<th>2 or 3 times in a week</th>
<th>4 or more times in a week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Running: running while playing a sport or jogging</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Cutting: changing directions while running</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Deceleration: coming to a quick stop while running</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Pivoting: turning your body with your foot planted while playing sport; For example: skiing, skating, kicking, throwing, hitting a ball (golf, tennis, squash), etc.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
**TEGNER SCORES**  (For determination of activity level in acute ACL tears)

Indicate in the spaces below the HIGHEST level of activity that you participated in BEFORE YOUR INJURY and the highest level you are able to participate in CURRENTLY.

<table>
<thead>
<tr>
<th>Level</th>
<th>Activity Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 10</td>
<td>Competitive sports- soccer, football, rugby (national elite)</td>
</tr>
<tr>
<td>Level 9</td>
<td>Competitive sports- soccer, football, rugby (lower divisions), ice hockey, wrestling, gymnastics, basketball</td>
</tr>
<tr>
<td>Level 8</td>
<td>Competitive sports- racquetball or bandy, squash or badminton, track and field athletics (jumping, etc.), down-hill skiing</td>
</tr>
<tr>
<td>Level 7</td>
<td>Competitive sports- tennis, running, motorcars speedway, handball</td>
</tr>
<tr>
<td></td>
<td>Recreational sports- soccer, football, rugby, bandy, ice hockey, basketball, squash, racquetball, running</td>
</tr>
<tr>
<td>Level 6</td>
<td>Recreational sports- tennis and badminton, handball, racquetball, down-hill skiing, jogging at least 5 times per week</td>
</tr>
<tr>
<td>Level 5</td>
<td>Work- heavy labor (construction, etc.)</td>
</tr>
<tr>
<td></td>
<td>Competitive sports- cycling, cross-country skiing; Recreational sports- jogging on uneven ground at least twice weekly</td>
</tr>
<tr>
<td>Level 4</td>
<td>Work- moderately heavy labor (e.g. truck driving, etc.)</td>
</tr>
<tr>
<td>Level 3</td>
<td>Work- light labor (nursing, etc.)</td>
</tr>
<tr>
<td>Level 2</td>
<td>Work- light labor</td>
</tr>
<tr>
<td></td>
<td>Walking on uneven ground possible, but impossible to back pack or hike</td>
</tr>
<tr>
<td>Level 1</td>
<td>Work- sedentary (secretarial, etc.)</td>
</tr>
<tr>
<td>Level 0</td>
<td>Sick leave or disability pension because of knee problems</td>
</tr>
</tbody>
</table>

**The International Cartilage Research Society (ICRS)**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Normal cartilage</td>
</tr>
</tbody>
</table>
| 1     | Nearly normal cartilage  
*Superficial lesions. Soft indentation and/or superficial fissures and cracks.*  
| 2     | Abnormal cartilage  
*Lesions extending down to <50% of cartilage depth.*  
| 3     | Severely abnormal cartilage  
*Cartilage defects extending down >50% of cartilage depth as well as down to calcified layer and down to but not through the subchondral bone. Blisters are included in this Grade.*  
| 4     | Severely abnormal cartilage (through the subchondral bone)  
*Penetration of subchondral bone that may or may not be across the full diameter of defect*  
|
American College of Rheumatology Guidelines

2010 ACR/EULAR: Classification Criteria for RA

<table>
<thead>
<tr>
<th>JOINT DISTRIBUTION (0-5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 large joint</td>
</tr>
<tr>
<td>2-10 large joints</td>
</tr>
<tr>
<td>1-3 small joints (large joints not counted)</td>
</tr>
<tr>
<td>4-10 small joints (large joints not counted)</td>
</tr>
<tr>
<td>&gt;10 joints (at least one small joint)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SEROLOGY (0-3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative RF AND negative ACPA</td>
</tr>
<tr>
<td>Low positive RF OR low positive ACPA</td>
</tr>
<tr>
<td>High positive RF OR high positive ACPA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SYMPTOM DURATION (0-1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;6 weeks</td>
</tr>
<tr>
<td>≥6 weeks</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACUTE PHASE REACTANTS (0-1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal CRP AND normal ESR</td>
</tr>
<tr>
<td>Abnormal CRP OR abnormal ESR</td>
</tr>
</tbody>
</table>

≥6 = definite RA

BACKGROUND:

KNEE ARTHROSCOPY - Knee Arthroscopy & Open, Non-Arthroplasty

This guideline addresses the following elective, non-emergent, arthroscopic knee repair procedures:

- Diagnostic knee arthroscopy
- Debridement with or without chondroplasty
- Meniscectomy/meniscal repair/meniscal transplant
- Ligament reconstruction/repair
- Articular cartilage restoration/repair (marrow stimulating and restorative techniques)
- Synovectomy (major [2+ compartments], minor [1 compartment])
- Loose body removal
- Lateral release/patellar realignment
- Manipulation under anesthesia (MUA)
- Lysis of adhesions for arthrofibrosis of the knee
Arthroscopy introduces a fiber-optic camera into the knee joint through a small incision for diagnostic visualization purposes. Other instruments may then be introduced to remove, repair, or reconstruct intra- and extra-articular joint pathology. Surgical indications are based on relevant subjective clinical symptoms, objective physical exam and radiologic findings, and response to previous non-operative treatments when medically appropriate.

Open, non-arthroplasty knee surgeries are performed instead of an arthroscopy as dictated by the type and severity of injury and/or disease.

**POLICY HISTORY:**

**Review Date:** November 2018

**Review Summary:**

- General Requirements for Elective Arthroscopic Surgery: Removed comorbidity example of diabetes
- Diagnostic Knee Arthroscopy: Added section ‘Note’ to clarify the indications for a diagnostic arthroscopy to be approved: “**Note:** Radiographs and/or MRI should not demonstrate any of the following: Kellgren-Lawrence Grade 3-4 changes (based on standing or weight-bearing radiographs), meniscus tears, loose bodies, stress fractures (including insufficiency fractures) or patellofemoral instability (lateral patellar tilt)”
- Meniscectomy/Meniscal Repair: Added indication for locked knee with an MRI that shows a bucket-handle tear of the meniscus: “History of acute injury/onset of symptoms with a locked knee and/or mechanical symptoms of locking; Physical examination demonstrates 2 of the following: joint line TTP, positive McMurray’s test localized to the correct compartment, pain with full flexion or pain with full extension; MRI demonstrates a bucket-handle tear of the meniscus (Does not include an extruded meniscus or flap tears)”
- Added a statement pertaining to arthroscopic meniscectomy in association with degenerative arthritis of the knee “**Note:** There is a high incidence of incidental meniscal findings on knee MRI in middle aged and elderly patients and several studies indicating that there is no difference in outcome between operative and non-operative treatment of patients with degenerative meniscus tears, especially when associated with an arthritic knee”
- Added and updated references

**Review Date:** October 2019

**Review Summary:**

- Updated in-text references and bibliography
- Platelet rich plasma (PRP) deleted from non-operative treatment options
- Added section for root tear or other possible repairable meniscus:
“Symptomatic meniscal tear confirmed by MRI results that demonstrate a peripheral tear in the vascular zone, root tear or other tear that the requesting physician considers repairable and is associated with pain localized to the corresponding compartment upon physical exam;”

- Revised radiographic indications for arthroscopic meniscectomy: “Weight-bearing X-ray(s) that demonstrate no moderate or severe osteoarthritic changes (Kellgren-Lawrence Grade 3-4 [see grading appendix]); X-rays should be described as showing minimal or mild arthritis only; OR
- MRI results confirm a frank meniscal tear (not simply degenerative changes, i.e., fraying) and the MRI does not demonstrate any of the following: moderate or severe articular cartilage thinning, full-thickness articular cartilage loss or defects, extrusion of the meniscus, subchondral edema, more than mild osteophytes, subchondral cysts or an impression of “moderate” or “advanced/severe” arthritis (see absolute and relative contraindications). If the MRI demonstrates any of the above-described findings of more than mild arthritis, weight-bearing X-rays are required to confirm no moderate or severe articular cartilage loss.
- Added: Additional note for radiographic criteria for meniscectomy:” Although most patients that have a request for arthroscopic meniscectomy will have had both an MRI and X-rays of the knee, not every patient with an MRI requires a standing X-ray. Only one of these tests is required for approval, provided all other criteria for meniscectomy have been met. For example, if there has been a failure to improve with 6 weeks of non-operative treatment and there are physical examination findings of a meniscus tear, an MRI is not required, only weight-bearing X-rays that demonstrate no more than mild arthritis. Likewise, if an MRI describes a meniscus tear and does not describe any associated arthritis, weight-bearing X-rays are not required.
- Patellar instability change:” Repeat (greater than 2) Repeat (two or more) patellar dislocations or subluxations have occurred despite 6 months of non-operative treatment with radiologic confirmation of MPFL (medial patellofemoral ligament) deficiency; (including evidence of acute or remote injury, scarring, incomplete healing, etc.); OR physical examination demonstrates patellar instability (positive apprehension test).
REFERENCES:


Jazrawi L, Gold HT, Zuckerman JD. Physical therapy or arthroscopic surgery for treatment of meniscal tears is noninferiority enough? JAMA. 2018 Oct 2; 320(13).


MacDonald PB. Arthroscopic partial meniscectomy was not more effective than physical therapy for meniscal tear and knee osteoarthritis. *J Bone Joint Surg*. 2013; 95(22):2058.


Shoulder Arthroplasty

CPT Codes:
Revision Shoulder Arthroplasty: 23473, 23474
Total/Reverse Shoulder Arthroplasty or Resurfacing: 23472
Partial Shoulder Arthroplasty/Hemiarthroplasty: 23470

General Requirements:
Elective surgery of the shoulder may be considered if the following general criteria are met:

- There is clinical correlation of patient’s subjective complaints with objective exam findings and/or imaging (when applicable);
- Patient has limited function (age-appropriate activities of daily living (ADLs), occupational, athletic);
- Patient is medically stable with no uncontrolled comorbidities (such as diabetes);
- Patient does not have an active local or systemic infection;
- Patient does not have active, untreated drug dependency (including but not limited to narcotics, opioids, muscle relaxants) unless engaged in treatment program;
- Patient has good oral hygiene and does not have major dental work scheduled or anticipated (ideally within one year of joint replacement), due to increased post-surgical infection risk.

Clinical notes should address:

- Symptom onset, duration, and severity;
- Loss of function and/or limitations;
- Type and duration of non-operative management modalities

Non-operative management, when required, will be specified within the clinical indications below and may include one or more of the following:

- Physical therapy or properly instructed home exercise program
- Rest or activity modification
- Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics;
- Corticosteroid injections
INDICATIONS:

TOTAL SHOULDER ARTHROPLASTY (TSA)

Total Shoulder Arthroplasty may be necessary when **ALL** of the following criteria are met (Bhat, 2016; Izquierdo, 2010; Tashjian, 2016):

- Evidence of painful osteoarthritis or inflammatory, non-infectious arthritis (e.g. rheumatoid) with functional limitations (such as activities of daily living or employment or simple recreation);
- Complete or near-complete loss of joint space on axillary or AP x-rays (internal rotation and/or external rotation) - **NOTE**: MRI should not be the primary imaging study to determine the extent of disease;
- Failure of **at least 12** weeks of non-operative treatment that includes **at least ONE** of the following:
  - Physical therapy or properly instructed home exercise program;
  - Rest or activity modification;
  - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics;
  - Corticosteroid injections;
- Functional and intact rotator cuff and deltoid (adequate abduction strength); confirmed by physical examination and/or MRI or CT scan.
- No injection into the joint within 12 weeks of surgery (Werner, 2016).

NOTES:

In general, the more severe the disease, the more loss of motion and glenoid erosion will exist and the more likely a TSA will be required, regardless of age. However, if surgery is delayed too long, it can be exceedingly difficult to insert the glenoid component for a TSA due to posterior glenoid erosion. For optimal TSA success, only one replacement should be attempted during a patient’s lifetime.

Additional research is necessary to support an accurate age range for each type of shoulder arthroplasty. At this time, patient age is a **relative indication** for surgery and ultimately relies on surgeon’s judgment and patient presentation (Bhat, 2016).

TSA can be done at any age, but in general, to minimize complications, consideration should be given to the following (Roberson, 2017):

- **Age < 55**: Hemiarthroplasty can be considered due to the likelihood that these patients will need the joint converted to a total shoulder arthroplasty. However, primary TSA outperforms HA for implant survival and patient satisfaction at short term follow up for patients younger than 50 (Eichinger, 2016).
- **Age 55-65**: Depending on patient anatomy and desired activity level, TSA, resurfacing (HHR), or reverse total shoulder arthroplasty (RTSA) may be indicated. Overall low revision rates and high implant survivorship are reported in the current literature in patients under age 65 undergoing...
TSA. Results of HA have been shown to be inferior to TSA, and conversion of HA to TSA yields less optimal result than a primary TSA (Roberson, 2017).

- Age > 65: TSA or RTSA is typically the best surgical option for patients over the age of 65.

Contraindications:

- Neurological disease resulting in chronic pain syndrome (CRPS or its variants), Charcot arthropathy or loss of deltoid or rotator cuff function.
- Active infection or any infection within 3 months of surgery:
  - History of prior shoulder joint infection without proof that indolent infection has been eliminated (patient has been off antibiotics for a minimum of 6 weeks). Evidence of resolved infection should include laboratory work (serologies, including CBC with differential, ESR (erythrocyte sedimentation rate), CRP (C-reactive protein), with or without blood cultures, soft tissue biopsy cultures, or synovial fluid aspiration (cultures, gram stain, cell count, differential, crystals). Cultures should be for aerobic and anaerobic bacteria (AFB, fungal). Cultures should be held for a minimum of 21 days (especially to rule out Cutibacterium acnes (C. acnes) formerly prionobacterium acnes (P. acnes).
  - Poor dental hygiene (e.g. tooth extraction should be performed prior to arthroplasty). Major dental work within 2 years after a joint replacement MAY lead to seeding of the implant and possible revision surgery. If possible, all dental work must be completed prior to shoulder arthroplasty as these procedures increase risk for infection. Following surgery, patients should receive antibiotics for routine dental check-ups for a minimum of two years.
- Any injection into the joint within 12 weeks of surgery (Werner, 2016).

HEMIARTHROPLASTY

Hemiarthroplasty may be necessary when ALL of the following criteria are met (Lervick, 2016):

- Patient meets all of the criteria for a Total Shoulder Arthroplasty, as detailed above, OR patient with avascular necrosis or osteonecrosis of the humeral head without advanced glenoid disease;
- Acute 3 or 4-part fracture of the proximal humerus (Shukla, 2016);
- No injection into the joint within 12 weeks of surgery (Somerson, 2016; Werner, 2016).

Contraindications:

- Any injection into the joint within 12 weeks of surgery (Werner, 2016).
- Neurologic disease resulting in CRPS or Charcot shoulder.
- Active infection within 3 months of surgery.
REVERSE TOTAL SHOULDER ARTHROPLASTY (RTSA) for the treatment of arthritis, irreparable rotator cuff tears or proximal humeral fractures:

Arthritis

RTSA may be indicated for the treatment of arthritis when ALL of the following criteria are met (Somerson, 2016):

- Evidence of painful osteoarthrosis or inflammatory, non-infectious arthritis (e.g. rheumatoid) with functional limitations (such as activities of daily living or employment or simple recreation);
- Complete or near-complete loss of joint space on axillary or AP x-rays (internal rotation and/or external rotation) OR radiographic evidence of advanced glenoid bone loss or excessive retroversion (Hyun, 2013).

**NOTE**: MRI should not be the primary imaging study to determine the extent of disease

- Non-repairable massive (> 2 tendons) rotator cuff tear, substantial partial, OR focal full thickness rotator cuff tear with significant rotator cuff dysfunction (weakness, impingement signs on exam) AND intact deltoid.

- Failure of at least 12 weeks of non-operative treatment that includes at least ONE of the following:
  - Physical therapy or properly instructed home exercise program;
  - Rest or activity modification;
  - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics;
  - Corticosteroid injections;
- Age > 60; requests for RTSA in patients < 60 will be reviewed on a case-by-case basis.
- No injection into the joint within 12 weeks of surgery (Werner, 2016)

Note: RTSA has been found to be a reliable operation in younger patients with improvement in pain, range of motion and strength, without a large number of early failures (Otto, 2017; Samuelsen, 2017).

Contraindications:

- Any injection into the joint within 12 weeks of surgery (Werner, 2016).
- Active infection within 3 months of surgery.
- Neurologic disease resulting in CRPS or Charcot shoulder

Proximal Humeral Fractures

RTSA may be indicated for the treatment of fractures when ALL of the following criteria are met:
• Acute 2, 3, or 4-part fractures of proximal humerus with or without concomitant tuberosity as evidence by radiographic findings OR painful malunion of proximal humerus fracture with rotator cuff dysfunction (weakness, impingement signs on exam); (Hyun, 2013).

• Age > 60; requests for RTSA in patients < 60 will be reviewed on a case-by-case basis.

Rotator Cuff Tears

RTSA may be indicated for the treatment of irreparable rotator cuff tears in the absence of arthritis when ALL of the following criteria are met:

• Non-repairable massive rotator cuff tear AND intact deltoid AND inability to actively elevate the arm above the level of the shoulder (90 degrees) (i.e. pseudoparalysis); OR
  
  history of previous failed rotator cuff repair with severe pain and functional disability (Virk, 2016; Weber, 2019)

• Age > 60; requests for RTSA in patients < 60 will be reviewed on a case-by-case basis.

NOTE: RTSA is a reasonable surgical option for irreparable rotator cuff repair without arthritis. However, caution should be exercised when offering RTSA to patients without pseudoparalysis because they can have a higher complication and dissatisfaction rate (Virk, 2016).

REVISION ARTHROPLASTY

Conversion of a Hemiarthroplasty to a Total Shoulder Arthroplasty may be necessary when ALL of the following criteria are met:

• Evidence of a prior hemiarthroplasty;

• Persistent pain and functional loss;

• Negative infection evaluation (including CRP, ESR, CBC, with or without negative aspiration) OR documentation of mechanical failure, or component failure/malposition

• Clinical and radiographic evidence of intact rotator cuff (or repairable rotator cuff tear), including ONE of the following two options:
  
  o Radiographic evidence of failed humeral component, including aseptic loosening or periprosthetic fracture. Documentation should include radiolucencies around cemented or uncemented components; OR

  o Clinical and radiographic evidence of glenoid articular cartilage disease (including progressive arthritis).
Conversion of a **Hemiarthroplasty to a Reverse Shoulder Arthroplasty** may be necessary when **ALL** of the following criteria are met:

- Evidence of a prior hemiarthroplasty;
- Persistent pain and functional loss;
- Negative infection evaluation (including CRP, ESR, CBC, with or without negative aspiration) OR documentation of mechanical failure, or component failure/malposition
- Intact deltoid and intact axillary nerve;
- Age > 65; requests for patients < 60 will be reviewed on a case-by-case basis.
- Evidence of pseudoparalysis (inability to elevate arm) OR severe pain with elevation

Revision of a **Total Shoulder Arthroplasty to Another Total Shoulder Arthroplasty** may be necessary when **ALL** of the following criteria are met (Izquierdo, 2010):

- Evidence of prior total shoulder arthroplasty;
- Persistent pain and functional loss;
- Negative infection evaluation (including CRP, ESR, CBC, with or without negative aspiration) OR documentation of mechanical failure, or component failure/malposition
- Clinical and radiographic evidence of intact rotator cuff (or repairable rotator cuff tear);
- Radiographic evidence of failed humeral and/or glenoid component, including aseptic loosening or periprosthetic fracture (Mallo, 2015).

Revision of a **Total Shoulder Arthroplasty to a Reverse Shoulder Arthroplasty** may be necessary when **ALL** of the following criteria are met:

- Evidence of prior total shoulder arthroplasty;
- Persistent pain and functional loss;
- Negative infection evaluation (including CRP, ESR, CBC, with or without negative aspiration) OR documentation of mechanical failure, or component failure/malposition
- Intact deltoid function;
- Age > 65; requests in patients age less than 65 will be reviewed on a case by case basis.
- Evidence of pseudoparalysis (inability to elevate arm) OR severe pain with elevation

Revision of a **Reverse Shoulder Arthroplasty to Another Reverse Shoulder Arthroplasty** may be necessary when **ALL** of the following criteria are met (Cheung, 2011):

- Evidence of a prior reverse shoulder arthroplasty;
- Persistent pain and functional loss;
- Negative infection evaluation (including CRP, ESR, CBC, with or without negative aspiration) OR documentation of mechanical failure, or component failure/malposition
- Intact deltoid function;
- Age > 65; requests in patients age less than 65 will be reviewed on a case by case basis.
All cases should be reviewed on a case-by-case basis and include the following:

- Evidence of prior reverse shoulder arthroplasty;
- Persistent pain and functional loss;
- Negative infection evaluation (including CRP, ESR, CBC, with or without negative aspiration)
  OR documentation of mechanical failure, or component failure/malposition
- Radiographic evidence of failed humeral and/or glenoid component, including aseptic loosening or periprosthetic fracture.
- Intact deltoid;

Revision of a Total Shoulder or Reverse Shoulder Arthroplasty to a Hemiarthroplasty may be necessary when ALL of the following criteria are met (Gamradt, 2012):

- Evidence of prior total shoulder or reverse shoulder arthroplasty;
- Persistent pain and functional loss;
- Negative infection evaluation (including CRP, ESR, CBC, with or without negative aspiration);
  OR documentation of mechanical failure (anterior or superior migration), or component failure;
- Radiographic evidence of failed humeral and/or glenoid component, including aseptic loosening or periprosthetic fracture.
- Intact deltoid and intact axillary nerve;
- Insufficient glenoid bone to support a revision glenoid component

Contraindications for revision arthroplasty:

- Active or recent history of infection
- Neurogenic pain syndrome
- Acromial fracture OR overly thin acromion from prior subacromial decompression
- Severe osteoporosis as evidenced by radiographic osteopenia, osteomalacia or severe osteoporosis on Dxa scan
- Non-functioning deltoid or axillary nerve injury / palsy.
BACKGROUND:

SHOULDER ARTHROPLASTY - Total, Partial & Revision Shoulder Replacement

This guideline addresses elective, non-emergent shoulder arthroplasty (shoulder replacement) procedures, including total shoulder arthroplasty, reverse shoulder arthroplasty, resurfacing arthroplasty, partial shoulder replacement or hemiarthroplasty, and revision arthroplasty procedures.

Arthroplasty describes the surgical replacement and reconstruction of a joint with implanted devices when the joint has been damaged by an arthritic or traumatic process.

In both a total shoulder replacement and a reverse shoulder replacement, the damaged joint surfaces (humeral head and glenoid) are removed and replaced with prosthetic components, with the goal of reducing pain and improving joint function. In a reverse shoulder procedure, the ball and socket feature of the joint is reversed, allowing for added rotator cuff support.

In the event the shoulder joint cannot support a glenoid prosthesis, a hemiarthroplasty, or partial joint replacement may be performed to replace the humeral head with a prosthesis.

In some cases, the shoulder prosthesis may wear out or loosen. If loosening is painful, a second surgery, such as a revision may be necessary. In this procedure some or all of the components of the original replacement prosthesis are removed and replaced with new ones.

Overview:

Total Shoulder Arthroplasty (TSA)

The replacement of the glenohumeral joint is called a shoulder arthroplasty. It can be either a total shoulder arthroplasty (TSA), where both the glenoid and humerus are replaced, a partial arthroplasty of the humerus only (hemiarthroplasty, HA), or a partial resurfacing of the humerus (humeral head resurfacing, HHR, HR). In general, these arthroplasty procedures are reserved for end stage arthritis of the shoulder joint, including functional loss of motion, pain and disability. The choice of arthroplasty is dependent upon surgeon philosophy, experience and skill. Successful outcome, regardless of procedure, is more likely with high volume (> 20 per year) shoulder specialists. Revision shoulder arthroplasty is most commonly required because of technical problems encountered at the time of surgery, such as insertion of the wrong size components, improper technique, and poor surgical exposure.
Reverse Total Shoulder Arthroplasty (RTSA)

This shoulder surgery involves placing the ball on the glenoid side (glenosphere and baseplate) of the joint and the socket on the humeral side. It works by moving the center of joint rotation medial and downward and increasing deltoid tension to facilitate active abduction and elevation of the arm (Lorenzetti, 2016).

The original purpose of a RTSA was to allow basic function of a pseudoparalytic shoulder from a non-repairable chronic rotator cuff tear with arthropathy (or arthritis) in an inactive person over age 65. Complication rates have steadily decreased as surgeons become more familiar with this procedure and technical advances have been made. Indications have expanded to include younger patients, malunions, nonunions, failed arthroplasty, and irreparable cuff tears.

Revision Arthroplasty

There are six primary indications for revision shoulder arthroplasty: (1) conversion of a hemiarthroplasty to a total shoulder arthroplasty, (2) conversion of a hemiarthroplasty to a reverse shoulder arthroplasty, (3) revision of a total shoulder arthroplasty to another total shoulder arthroplasty, (4) revision of a total shoulder arthroplasty to a reverse shoulder arthroplasty, (5) revision of a reverse total shoulder arthroplasty to another reverse shoulder arthroplasty and (6) revision of a total shoulder or reverse shoulder arthroplasty to a hemiarthroplasty.

Note: Historically this procedure was coded as the removal of hardware and total shoulder arthroplasty. CPT introduced shoulder revision procedure codes in January 2013.

POLICY HISTORY:

Review Date: November 2018

Review Summary: Added and updated references

Review Date: October 2019

Review Summary:

- Updated references
- Deleted requirement for documentation of adequate glenoid bone stock for TSA
- Deleted requirement for a cortisone injection and deltoid retraining for reverse TSA
- Expanded indications for RSTA (reverse total shoulder arthroplasty)
- Added new indication for revision surgery: Revision of a Total Shoulder or Reverse Shoulder Arthroplasty to a Hemiarthroplasty
REFERENCES:


CPT CODES:
Shoulder Rotator Cuff Repair: 23410, 23412, 23420, 29827
Shoulder Labral Repair: 23450, 23455, 23460, 23462, 23465, 23466, 29806, 29807
Frozen Shoulder Repair/Adhesive Capsulitis: 29825, 23700
Shoulder Surgery Other: 23120, 23125, 23130, 23430, 23415, 23430, 23700, 29805, 29819, 29820, 29821, 29822, 29823, 29824, 29825 +29826, 29828

General Requirements for Elective Surgery of the Shoulder:

Elective surgery of the shoulder may be considered if the following general criteria are met:

- There is clinical correlation of patient’s subjective complaints with objective exam findings and/or imaging (when applicable);
- Patient has limited function (age-appropriate activities of daily living (ADLs), occupational, athletic);
- Patient is medically stable with no uncontrolled comorbidities (such as diabetes);
- Patient does not have an active local or systemic infection;
- Patient does not have active, untreated drug dependency (including but not limited to narcotics, opioids, muscle relaxants) unless engaged in treatment program
- A smoking cessation program is highly recommended and should be instituted pre-operatively for all actively smoking patients (Bishop, 2015; Santiago-Torres, 2015).

Clinical notes should address:

- Symptom onset, duration, and severity;
- Loss of function and/or limitations;
- Type and duration of non-operative management modalities (where applicable).

Non-operative management, when required, will be specified within the clinical indications below and may include one or more of the following:

- Physical therapy or properly instructed home exercise program;
- Rest or activity modification;
- Minimum of 4 weeks of oral NSAIDs (if not medically contraindicated);
- Single injection of corticosteroid and local anesthetic into subacromial or intra-articular space, or bicipital groove;
INDICATIONS:

DIAGNOSTIC SHOULDER ARTHROSCOPY

Diagnostic arthroscopy is considered medically necessary when All of the following criteria have been met:

- Severe, disabling pain and/or a documented loss of shoulder function which interferes with the ability to carry out age appropriate activities of daily living and/or demands of employment;
- Individual demonstrates any of the following abnormal, shoulder physical examination findings, as compared to the non-involved side:
  - Functionally limited range of motion (active or passive);
  - Measurable loss in strength;
  - Positive impingement signs;
- Failure of non-surgical management for at least three (3) months duration to include TWO of the following:
  - Rest or activity modifications/limitations;
  - Ice/heat;
  - Use of a sling/immobilizer/brace;
  - Pharmacologic treatment: oral/topical NSAIDS, acetaminophen, analgesics, tramadol;
  - Physical therapy modalities;
  - Supervised home exercise;
  - Corticosteroid injection;
- Individual has undergone an appropriate radiographic work-up that includes routine X-rays and an MRI evaluation which are determined to be inconclusive for internal derangement/pathology;
- Other potential diagnostic conditions have been excluded, including, but not limited to fracture, Thoracic Outlet Syndrome, Brachial Plexus disorders, referred neck pain and arthritis.

ROTATOR CUFF REPAIR (RCR)

Surgical treatment of rotator cuff tear (RCT) should only be performed when there is a clinical correlation of patient symptoms, clinical exam findings, imaging, and failed non-operative management (where required) (Harris, 2012; Okoroha, 2017).

Partial-Thickness Rotator Cuff Tear or Calcific Tendinitis

Surgical repair of a Partially Torn Rotator Cuff may be necessary when ALL of the following criteria are met:
- Reproducible rotator cuff pain patterns (lateral arm, deltoid pain rarely radiating past the elbow, night pain, or pain with overhead motions);
- Positive impingement signs and/or tests on exam (reproducible pain when arm is positioned overhead (above plane of shoulder) with relief of pain when arm is repositioned below the plane of the shoulder) (Hedegus, 2012);
- Functional loss (age-appropriate activities of daily living (ADLs), occupational, athletic);
- MRI or Ultrasound (Apostolopoulos, 2019; Kruse 2019) that demonstrates a partial thickness tear (articular-sided, concealed, or bursal-sided) or evidence of calcific tendinitis*
- Failure of at least 12 weeks of non-operative treatment, including **at least three** of the following criteria (Pedowitz, 2011):
  - Physical therapy or properly instructed home exercise program;
  - Rest or activity modification;
  - Minimum of 4 weeks of oral NSAIDs (if not medically contraindicated);
  - Single injection of corticosteroid and local anesthetic into subacromial or intra-articular space
    - *For surgical excision of calcific tendinopathy, at least one prior cortisone injection is required

**Small (< 1cm), Full-Thickness Rotator Cuff Tear**

Surgical repair of a **small full-thickness rotator cuff tear** may be necessary when **ALL** of the following criteria are met:

- Reproducible rotator cuff pain patterns (lateral arm, deltoid pain not radiating past the elbow, night pain, or pain with overhead motions);
- Positive impingement signs and/or tests on exam (reproducible pain when arm is positioned overhead (above plane of shoulder) with relief of pain when arm is repositioned below the plane of the shoulder);
- Functional loss (age-appropriate activities of daily living (ADLs), occupational, athletic);
- Rotator cuff weakness or severe pain with rotator cuff testing on physical exam;
- MRI or Ultrasound (Apostolopoulos, 2019; Kruse 2019) that demonstrates a small, full thickness tear (< 1 cm);
- Failure of at least 6 weeks of non-operative treatment*, including physical therapy or a properly instructed home exercise program (that includes exercises for scapular dyskinesis when present) **AND** at least **ONE** of the following:
  - Rest or activity modification
  - Minimum of 4 weeks of oral NSAIDs (if not medically contraindicated)
Single injection of corticosteroid and local anesthetic into subacromial or intra-articular space

*NOTE*: The requirement for conservative, non-operative treatment is waived in a patient less than age 55 with an acute traumatic tear (onset of shoulder pain attributed to a specific traumatic event with no prior history of significant shoulder pain). For ages > 55, non-op treatment may be waived on a case by case basis.

Surgical Management Moderate evidence supports that healed rotator cuff repairs show improved patient-reported and functional outcomes compared with physical therapy and unhealed rotator cuff repairs (Weber, 2019)

**Medium (1-3cm) or Large (3-5cm), Full-Thickness Rotator Cuff Tear**

Surgical repair of a **medium or large full-thickness rotator cuff tear** may be necessary when the following criteria are met:

- Significant progression of a full-thickness tear on serial imaging performed at least 3 months apart (at least 50% increase in tear size); **OR**
- When **ALL** of the following criteria are met:
  - Reproducible rotator cuff pain patterns (lateral arm, deltoid pain rarely not radiating past the elbow, night pain, or pain with overhead motions);
  - Positive impingement signs and/or tests on exam (reproducible pain when arm is positioned overhead (above plane of shoulder) with relief of pain when arm is repositioned below the plane of the shoulder)
  - Rotator cuff weakness or severe pain with rotator cuff testing on physical exam;
  - Functional loss (age-appropriate activities of daily living (ADLs), occupational, athletic);
  - MRI or Ultrasound (Apostolopoulos, 2019; Kruse 2019) results support a Medium (1-3cm) or Large (3-5cm), full-thickness tear (tear must be a complete single tendon or greater)

**Massive (> 5 cm and least 2 tendons involved), Full-Thickness Rotator Cuff Tear**

Surgical repair of a **massive torn rotator cuff including partial repair and Superior Capsular Reconstruction** may be necessary when **ALL** of the following criteria are met (Denard, 2018; Henry, 2015; Shon, 2015; Weber, 2019):

- MRI demonstrates Goutallier stage 0 (normal muscle), 1 (some fatty streaks), or 2 (less than 50% fatty degeneration or infiltration) (Khair, 2016);
• No x-ray evidence of chronic subacromial articulation of humeral head, distance between acromion and humeral head (acromiohumeral interval) ≤ 5mm (ie. Hamada Grade 1 or 2) (Denard, 2018).

• MRI or Ultrasound (Apostolopoulos, 2019; Kruse 2019) showing massive (> 5cm), full-thickness tear (with intact or reparable subscapularis for superior capsular reconstruction)

• No severe glenohumeral arthritis on X-ray

• Failure of at least 6 weeks of non-operative treatment, including physical therapy or a properly instructed home exercise program (that includes exercises for scapular dyskinesis when present) AND at least ONE of the following:
  o Rest or activity modification
  o Minimum of 4 weeks of oral NSAIDs (if not medically contraindicated)
  o Single injection of corticosteroid and local anesthetic into subacromial or intra-articular space

AAOS consensus guidelines state that partial repair and superior capsular reconstruction, can improve patient reported outcomes (Weber, 2019).

Revision Rotator Cuff Repair

Surgical revision within 1 year of a previously repaired small, medium, large or massive torn rotator cuff will be reviewed on a case-by-case basis and must include an MRI (with or without arthrogram) or CT arthrogram that demonstrate failure of healing (Sugaya type 4-5) or recurrent tear > 3 months after index surgery (Strauss, 2012).

All RCR revision cases greater than 1 year following an initial repair must again meet indications as specified by tear size listed in Background section.

Contraindications (applies to all Rotator Cuff Repair):

• Active infection (local or remote)
• Treatment of asymptomatic, full thickness rotator cuff tear
• Active systemic bacteremia
• Deltoid or rotator cuff paralysis
• Advanced or severe arthritis (severe narrowing of glenohumeral space or bone-on-bone articulation, large osteophytes, subchondral sclerosis or cysts, etc.)
LABRAL REPAIRS

Superior Labral Anterior-Posterior (SLAP) Tear

Surgical indications should be focused on clinical symptoms and failure to respond to non-operative treatments, rather than imaging (due to a higher percentage of tears being missed on images AND significant over-diagnosing of tears based on imaging-alone).

Repair (not debridement of a SLAP lesion) may be necessary when ALL of the following criteria are met:

- History compatible with tear (acute onset in thrower or overhead athlete, fall, traction injury, shear injury (MVA), lifting injury);
- Pain localized to the glenohumeral joint (often only associated with certain reaching or lifting activities and at night) or painful catching/popping/locking sensations;
- Inability to perform desired tasks without pain (age-appropriate ADLs, sports, occupation);
- Age < 40; requests for SLAP repair in patient age >40 will be reviewed on a case-by-case basis.
- MRI demonstrating superior labral tear;
- Type 2 or 4 SLAP tear (not type 1 or 3);
  - I - Labral and biceps fraying, anchor intact
  - II - Labral fraying with detached biceps tendon anchor
  - III - Bucket handle tear, intact biceps tendon anchor (biceps separates from bucket handle tear)
  - IV - Bucket handle tear with detached biceps tendon anchor (remains attached to bucket handle tear)
- Failure of at least 12 weeks of non-operative treatment, including activity modification/avoidance of painful activities AND at least ONE of the following:
  - Minimum of 4 weeks of oral NSAIDs (if not medically contraindicated)
  - Physical therapy or a properly instructed home exercise program
  - Intra-articular injection

Contraindications:

- ANY evidence of degenerative disease upon imaging
- Smoker and age > 40
- Diabetics with poor control HgBA1c > 7
- MRI findings not attributable to normal common variants (for example, labral overhang)

*NOTE: In cases where a true SLAP tear exists, but the patient has one or more contraindications, or findings at the time of surgery indicate that a repair is not feasible, a SLAP debridement (limited,
extensive debridement), biceps tenotomy or tenodesis may be an alternative (McCormick, 2014). See Tenotomy and Tenodesis Indications.

**Anterior-Inferior Labral-Tear (Bankart lesion)** (Harris, 2013c)

Bankart repair of an acute labral tear may be necessary when ALL of the following criteria are met:

- History of an acute event of instability (subluxation or dislocation) or acute onset of pain following activity;
- Acute labral tear on MRI or CT imaging;
- Age < 30;
- Range of motion is not limited by stiffness upon physical exam;
- Clinical exam findings demonstrate positive apprehension test, positive relocation test, positive labral grind test, or objective laxity with pain.

Bankart repair of a recurrent (two or more dislocations) labral tear may be necessary when ALL of the following criteria are met (Harris, 2013):

- Recurrent instability (subluxation or dislocation);
- Evidence of a labral tear with or without bony Bankart fracture of the glenoid upon imaging;
- Range of motion is not limited by stiffness upon physical exam;
- Clinical exam findings demonstrate positive apprehension test, positive relocation test, positive labral grind test, or objective laxity with pain.

**Contraindications:**

- Pain only (no documented recurrent instability events) in patients over 40;
- X-ray, MRI or CT documentation of degenerative arthritis of the glenohumeral joint;
- Radiographic findings of a Hill Sachs humeral head defect (if surgery only includes Bankart repair);
- Cases demonstrating X-ray, MRI or CT documentation of greater than 20% glenoid bone loss require review on a case by case basis. These cases indicate that a Latarjet reconstruction or bone graft [autograft or allograft] repair may be required

**Posterior Labral Tear**

Surgical repair of a posterior labral tear may be necessary when ALL of the following criteria are met:

- Symptoms of pain OR painful catching/popping OR instability;
- MRI findings of posterior labral tear;
- Exam findings demonstrate positive load-shift test, jerk test, glenohumeral grind test, or objective laxity with pain or profound weakness (Kibler, 2015);
- Failure of at least 12 weeks of non-operative treatment (unless presenting as a traumatic tear in a competitive athlete at any level) that includes any two of the following:
  - Physical therapy or a properly instructed home exercise program;
  - Rest or activity modification;
  - Minimum of 4 weeks of oral NSAIDs (if not medically contraindicated);
- Age < 40;
- No radiographic evidence of degenerative disease (e.g. posterior glenoid cartilage loss, subchondral glenoid cysts, mucoid degeneration of labrum, narrowing of joint space with posterior humeral head subluxation on axillary x-ray or axial MRI images)

**Combined Labral Tears (e.g. Anterior / Posterior, SLAP / Anterior, SLAP / Posterior, SLAP / Ant. / Post.)** (Forsythe, 2015)

Surgical repair of an **acute combination tear** may be necessary when ALL of the following criteria are met:

- History of an acute event of instability (subluxation or dislocation);
- Acute labral tear on MRI/CT imaging with/without bony Bankart fracture not > 25% of glenoid width upon imaging;
- Age < 30;
- Range of motion not limited by stiffness upon physical exam;
- Clinical exam findings demonstrate positive apprehension test and positive relocation test, OR positive labral grind test OR objective laxity with pain;
- Minimal to no evidence of degenerative changes on imaging

Surgical repair of **recurrent combination tear** may be necessary when ALL of the following criteria are met:

- Recurrent instability (subluxation or dislocation) with at least 2 instability events;
- Labral tear on MRI or CT, with/without bony Bankart fracture not > 25% of glenoid width upon imaging;
- Range of motion not limited by stiffness upon physical exam;
- Clinical exam findings demonstrate positive apprehension test and positive relocation test, or positive labral grind test, or objective laxity with pain;
• Minimal to no evidence of degenerative changes on imaging

Open or Arthroscopic Capsulorrhapy for Multidirectional Instability of the Shoulder (MDI)

Surgical repair for MDI may be necessary when ALL of the following criteria are met:

• Patient has pain and limited function (age-appropriate ADLs, occupation, or sports);
• Patient has recurrent instability due to hyperlaxity or mobility and no traumatic dislocation;
• Physical exam supports repeatable increased glenohumeral joint translation (greater than 1cm of movement during the sulcus test);
• Imaging (x-ray and MRI) rules out fracture and/or other soft-tissue injury;
• Failure of at least 6 months of formal physical therapy and activity modification

Adhesive Capsulitis (Lysis of Adhesions, Capsulotomy/Capsular Release or Manipulation under Anesthesia)

Surgery for adhesive capsulitis may be necessary when ALL of the following criteria are met:

• Patient has pain, loss of motion, and limited function (age-appropriate ADLs, occupation, or sports);
• Physical exam demonstrates loss of motion (use contralateral shoulder for comparison);
• Co-morbidities (such as diabetes, lung disease) and other causes of loss of shoulder motion have been ruled out. Imaging (x-ray and/or MRI) may be used to identify other underlying problems;
• Failure of at least 12 weeks of non-operative treatment that includes physical therapy or a properly instructed home exercise program and documentation of any one of the following:
  o Minimum of 4 weeks of oral or topical NSAIDs (if not medically contraindicated);
  o Rest or activity modification;
  o Heat/Ice;
  o Corticosteroid injection

Distal Clavicle Excision (DCE)

Distal Clavicle Excision may be necessary when ALL of the following criteria are met (Pensak, 2010):

• Positive clinical exam findings as evidenced by pain upon palpation over AC joint and/or pain with cross-body adduction test;
• Positive findings on X-Ray or MRI (Singh, 2018):
• Radiographic (x-ray) demonstrates narrowed joint space, distal clavicle or medial acromial sclerosis, and/or osteophytes or cystic degeneration of distal clavicle or medial acromion correlating with the clinical findings, patient symptoms and diagnosis; OR
• MRI findings with edema in the distal clavicle and/or inflammatory change within the joint space correlating with the clinical findings, patient symptoms and diagnosis;

• Failure of at least 12 weeks of non-operative treatment that includes at least two of the following:
  o Minimum of 4 weeks of oral or topical NSAIDs (if not medically contraindicated);
  o Rest or activity modification;
  o AC joint corticosteroid injection (if DCE is to be performed as a standalone procedure, AC injection must be performed*);
  o Physical therapy or a properly instructed home exercise program;

*NOTE: If DCE is to be performed in isolation of other shoulder procedures, an AC joint injection is required for diagnostic purposes and documentation should support pain relief from injection. If no response to injection, this is a strong negative predictor to surgical outcome for isolated DCE.

Long Head Biceps (LHB) Tenotomy/Tenodesis

Tenotomy or Tenodesis may be necessary when ALL of the following criteria are met (Chalmers 2016; Creech, 2016; Erickson, 2015):

• Any of the following:
  o Age > 50 with SLAP tear;
  o Smoker with SLAP labral tear (regardless of age, more significant with increasing age);
  o Failed SLAP repair;
  o SLAP tear in diabetic or patient with loss of motion or predisposition to stiff shoulder;
  o LHB hypertrophy/tearing/subluxation in association with RCR;
  o Diagnosis of chronic LHB groove pain from tenosynovitis; AND

• Failure of at least 12 weeks of non-operative treatment to include TWO of the following:
  o Minimum of 4 weeks of oral or topical NSAIDs (if not medically contraindicated);
  o Rest or activity modification;
  o Bicipital groove or IA joint corticosteroid injection;
  o Physical therapy or a properly instructed home exercise program

NOTE: The indications for tenodesis and tenotomy are the same with the exception that tenodesis is typically better for more active, muscular individuals that are performing higher-demand activities for work or sport. Tenotomy is often preferred in patients that smoke (this is a relative indication of tenotomy over tenodesis) due to healing problems in tenodesis.
**Synovectomy**

Synovectomy as an isolated procedure is usually reserved for primary synovial disease or in cases where secondary hypertrophic synovitis is documented during arthroscopy (these include adhesive capsulitis, osteoarthritis, chronic rotator cuff tear). These should be evident on arthroscopic photographs taken at surgery but may be missed on preoperative images (Kanbe, 2015).

**Subacromial Decompression (SAD)**

Subacromial decompression may be necessary in conjunction with other shoulder procedures (listed below) if there is radiographic (x-ray) evidence of mechanical outlet impingement as evidenced by a Bigliani type 3 morphology. Subacromial decompression should not be performed in isolation (Familiari, 2015; Frank, 2014).

- Rotator cuff repair
- Labral repair
- Capsulorrhaphy
- Loose body removal
- Synovectomy
- Debridement
- Distal clavicle excision
- Lysis of adhesions
- Biceps tenodesis/tenotomy

**Contraindications:**

- Type 1 or Type 2 or a thinned acromion. Subacromial bursectomy may be a reasonable option.
- If patient has received an injection in the subacromial space and there is failure to adequately respond—significant relief (>50%) for minimum of 1 week—to injection in the subacromial space (pain should respond temporarily if impingement)
- Prior subacromial decompression with either a Type 1 or a thinned acromion or no evidence of overhang on x-ray (unnecessary revision can thin the acromion and lead to deltoid avulsion and/or acromial fracture)
- Open SAD procedures should rarely be performed given the increased morbidity due to deltoid disruption.

**BACKGROUND:**

This guideline addresses the following elective, non-emergent, arthroscopic shoulder repair procedures:
• Rotator Cuff Repair
• Labral Repairs
• Lysis of Adhesions (Capsulotomy)
• Distal Clavicle Excision (DCE)
• Long Head Biceps (LHB) Tenotomy or Tenodesis
• Synovectomy
• Subacromial Decompression (SAD)

Arthroscopy introduces a fiber-optic camera into the shoulder joint through a small incision for diagnostic visualization purposes. Other instruments may then be introduced to remove, repair, or reconstruct joint pathology.

Surgical indications are based on relevant subjective clinical symptoms, objective physical exam & radiologic findings, and response to previous non-operative treatments when medically appropriate.

Open, non-arthroplasty shoulder repair surgeries are performed as dictated by the type and severity of injury and/or disease.

**Rotator Cuff Repair (RCR)**

Traditional open rotator cuff repair (RCR) with deltoid take-down should be rare given increased morbidity when compared to arthroscopic or mini-open surgery.

**Revision Rotator Cuff Repair**

The Sugaya classification for evaluation in revision rotator cuff repair is as follows:

**Sugaya Classification**

- Type I - Sufficient thickness, homogeneous tendon (low signal on T2 images)
- Type II - Sufficient thickness, partial high-intensity from within the tendon
- Type III - Insufficient thickness without discontinuity
- Type IV - Minor discontinuity on more than one slice, suggesting a small tear
- Type V - Major discontinuity suggesting a moderate or large tear

**Labral Repairs**

There is a tendency to misinterpret normal degenerative labral changes and variations as “tears” which may lead to over-utilization of surgery if decisions are made upon imaging reports alone. In addition, the anterior-superior labrum (from 12 to 3 o’clock for a right shoulder) has many normal variations that can be misinterpreted as a tear, including sublabral hole/foramen, Buford complex, and a labral overhang with an intact biceps anchor. In general, true labral tears lead to pain, catching, popping, functional limitations (including age-appropriate activities of daily living (ADLs), occupational and athletic), micro-instability, and gross instability. Labral repairs are most-frequently associated with a specific traumatic event.
Anterior-Inferior Labral-Tear (Bankart lesion)

A Bankart tear of the glenoid labrum is located at the 3-6 o’clock position of a right shoulder. It is typically caused by a traumatic instability event (dislocation or subluxation). It can involve the labrum, the capsular ligaments (IGHL [inferior glenohumeral ligamentous complex]) and/or the bone (bony Bankart fracture). If symptomatic, bankart tears typically require surgical repair as patients less than 30 have a high recurrence rate of instability.

Posterior Labral Tear

Similar to Bankart tears, posterior labral tears are often associated with a paralabral cyst that grows large enough to compress the suprascapular nerve (isolated to infraspinatus). Posterior labral tears are frequently associated with contact sports or a patient history of a traumatic fall/posterior loading of the joint. They are often observed in athletes performing repetitive posterior loading of the joint (offensive linemen in football, weight-lifting: push-ups and bench press). These tears are more likely to result in pain and weakness rather than recurrent dislocations/instability. Posterior labral changes are often misinterpreted on MRI as a “tear” in age >40 years old, when changes due to early glenohumeral degeneration begin to appear.

Combined Labral Tears (e.g. Anterior / Posterior, SLAP / Anterior, SLAP / Posterior, SLAP / Ant. / Post.)

Combined tears that require repair are almost always associated with significant recurrent instability. Often tears begin within one area and overtime the failure to repair the original injury causes the tear to extend.

Adhesive Capsulitis (Lysis of Adhesions; Capsulotomy / Capsular Release)

Adhesive capsulitis is a thickening and tightening of the soft tissue capsule that surrounds the glenohumeral joint. Adhesive capsulitis usually begins with the gradual onset of pain and limitation of shoulder motion, with a progression to interference of activities of daily living. Primary adhesive capsulitis is the subject of much debate as the specific causes of this condition are not fully understood. Patients with uncontrolled diabetes have a significantly higher risk of developing adhesive capsulitis than the general population. Secondary (acquired) adhesive capsulitis develops from a known cause, such as stiffness following a shoulder injury, surgery, or a prolonged period of immobilization. Adhesive capsulitis may last from one to three years, despite active treatment, and is more common in women.

Distal Clavicle Excision (DCE)

The AC joint (acromioclavicular joint) can develop degenerative disease in those over 30 years of age, those with a history of a prior grade I or II AC sprain/separation, those with a history of heavy lifting
(labor occupation or strength training), or those with evidence of remote trauma. It can occur in isolated form in younger patients (distal clavicle osteolysis) but is more commonly observed concomitantly with rotator cuff disease in those over age 40 years of age.

**Long Head Biceps (LHB) Tenotomy / Tenodesis**

Pain in the area of the long head of the biceps tendon is common, especially in overhead sports and in the presence of rotator cuff tears (especially subscapularis). It can be an isolated source of pain in chronic tenosynovitis, SLAP tears, or small tears of the biceps sling, resulting in dynamic or static subluxation or dislocation of the tendon. LHB problems are frequently missed on MRI (especially using contrast which can mask the pathology). The choice of tenodesis versus tenotomy is controversial. Typically, tenodesis is better for more active, muscular individuals performing higher demand activity (labor, sports). Tenotomy is generally a better option for older, less active patients with poor muscle definition, as it generally leaves the patient with a "popeye" deformity and the possibility of biceps cramping or anterior shoulder pain with activity. The choice of tenotomy vs. tenodesis is generally left up to the surgeon/patient.

**Synovectomy**

Synovitis is common in many shoulder conditions and typically resolves when the primary pathology is treated. Most commonly, this includes loose bodies, inflammatory arthritis or degenerative arthritis, labral tears and adhesive capsulitis. Primary synovial diseases include pigmented villonodular synovitis, synovial chondromatosis, rheumatoid arthritis, other inflammatory arthritides, traumatic synovial hypertrophy or metaplasia.

**Subacromial Decompression (SAD)**

There are 3 types of acromion anatomy according to Bigliani classification: type 1, flat (20%), type 2, curved (40%) and type 3, hooked, (40%). Acromioplasty involves removing bone from the undersurface of the acromion to change a type 3 (hooked) acromion to a type 1 (flat) acromion. Although debated for decades, current evidence concludes that there is no role for isolated acromioplasty (subacromial decompression), which prompted conversion of CPT code 29826 (acromioplasty, subacromial decompression) from an index, primary, "stand-alone" code to an "add-on" code only (Chahal, 2012).
POLICY HISTORY:

Review Date: November 2018

Review Summary:

November 2018

- Added new section: ‘Diagnostic Shoulder Arthroscopy’
- Added and updated references

Review Date: October 2019

Review Summary:

- Updated references
- Added US (ultrasound) as acceptable diagnostic test for rotator cuff tears
- Addition Superior Capsular Reconstruction to rotator cuff repair section
- Added manipulation under anesthesia (MUA) to adhesive capsulitis section

Review Date: July 2020

Review Summary:

- Removed CPT code S2300

Review Date: November 2020

Review Summary:

- Added CPT code 29825 to Shoulder Surgery – Other
REFERENCES:


INDICATIONS:
All requests for thoracic spine surgery will be reviewed on a case-by-case basis. The following criteria must be met for consideration.

**DECOMPRESSION SURGERY ONLY**

- Positive Clinical Findings of Myelopathy with evidence of progressive neurologic deficits consistent with worsening spinal cord compression – immediate surgical evaluation is indicated (Frymoyer, 2004; Garfin, 2017). Symptoms may include any of the following:
  - Lower extremity weakness;
  - Unsteady gait related to myelopathy/balance or generalized lower extremity weakness;
  - Disturbance with coordination;
  - Hyperreflexia;
  - Positive Babinski sign;
  - Clonus; **OR**

- Progressive neurological deficit (motor deficit, bowel or bladder dysfunction) or lower extremity weakness or paralysis with corresponding evidence of spinal cord compression on an MRI or CT scan images – immediate surgical evaluation is indicated; **OR**

- When **All** of the following criteria are met:
  - Persistent or recurrent symptoms/pain with functional limitations that are unresponsive to at least 6 consecutive weeks in the last 6 months of documented, physician directed appropriate conservative treatment to include at least 2 of the following:
    - Analgesics, steroids, and/or NSAIDs
    - Structured program of physical therapy
    - Structured home exercise program prescribed by a physical therapist, chiropractic provider or physician
    - Epidural steroid injections and or selective nerve root block; **AND**
  - Imaging studies confirm the presence of spinal cord or spinal nerve root compression at the level corresponding with the clinical findings (MRI or CT)

**THORACIC DECOMPRESSION WITH FUSION SURGERY**

- Deformity Cases – please refer to our Deformity Spine Surgery (Adult) Guideline; **OR**
For Myelopathy or radiculopathy secondary to cord or root compression (see criteria described above) satisfying the indications for decompressive surgery requiring extensive decompression that results in destabilization of the thoracic spine (Frymoyer, 2004; Garfin, 2017).

**NOTE:** There is no current evidence base to support fusion in the thoracic spine for degenerative disease without significant neurological compression or significant deformity as outlined above.

### RELATIVE CONTRAINDICATIONS FOR SPINE SURGERY

- **Medical contraindications to surgery**, e.g., severe osteoporosis; infection of soft tissue adjacent to the spine, whether or not it has spread to the spine; severe cardiopulmonary disease; anemia; malnutrition and systemic infection (Puvanesarajah, 2016).

- **Psychosocial risk factors**. It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions mimicking radiculopathy or instability (e.g., peripheral neuropathy, piriformis syndrome, myofascial pain, sympathetically mediated pain syndromes, sacroiliac dysfunction, psychological conditions, etc.) prior to consideration of elective surgical intervention (Kreiner, 2014).

- **Active nicotine use prior to fusion surgery**. The patient must refrain from nicotine use for at least six weeks prior to surgery and during the period of fusion healing (Andersen, 2001; Glassman, 2000; Patel, 2013).

- **Morbid Obesity**. Contraindication to surgery in cases where there is significant risk and concern for improper post-operative healing, post-operative complications related to morbid obesity, and/or an inability to participate in post-operative rehabilitation (Epstein, 2017).

**NOTE:** Cases of severe myelopathy and progressive neurological dysfunction may require surgery despite these general contraindications.

### BACKGROUND:

**Thoracic Decompression with or without fusion:**

Thoracic disc herniation with or without nerve root compression is usually treated conservatively (non-surgically). A back brace may be worn to provide support and limit back motion. Injection of local
anesthetic and steroids around the spinal nerve (spinal nerve blocks) may be effective in relieving radicular pain. As symptoms subside, activity is gradually increased. This may include physical therapy and/or a home exercise program. Preventive and maintenance measures (e.g., exercise, proper body mechanics) should be continued indefinitely. Job modification may be necessary to avoid aggravating activities.

Simple laminectomy is rarely used in the treatment of thoracic disc herniation because of the high risk of neurologic deterioration and paralysis. Excision of the disc (discectomy) may be performed via several different surgical approaches—anteriort, laterally, or transpedicularly. Fusion should be performed only if surgery causes instability in the spinal column. Many newer techniques do not usually destabilize the thoracic spine.

**POLICY HISTORY:**

**Review Date:** November 2018

**Review Summary:**

- Added and updated references

**Review Date:** October 2019

**Review Summary:**

- Conservative care requirement further defined
- Modified contraindication section to include ‘relative’
REFERENCES:


CPT Codes: 22800, 22802, 22804, 22808, 22810, 22830, 22630, 22632, 22206, 22207, 22208, 22210, 22212, 22214, 22216, 22220, 22222, 22224, 22226

INDICATIONS:

All surgery requests to treat adult deformity will be reviewed on a case-by-case basis. The most common type of surgery in adults is a posterior spinal fusion with instrumentation. Occasionally anterior fusion is performed for severe curves. The following criteria must be met prior to reconstructive adult deformity surgery:

THORACIC DEFORMITY (MINIMAL / SECONDARY / FLEXIBLE LUMBAR INVOLVEMENT) IN ADULTS

- Progressive neurological deficit (motor deficit, bowel or bladder dysfunction) or lower extremity weakness (0-3/5 on the strength scale) or paralysis with corresponding evidence of spinal cord or nerve root compression on an MRI or CT scan images — immediate surgical evaluation is indicated (Truumees, 2017); OR

- When ALL of the following criteria are met:
  - Patient has significant pain or symptoms that impairs daily activities for > 6 months; AND
  - Failure of symptom or pain improvement upon completion of at least 12 weeks of focused non-operative* therapy/rehabilitation in the past year (NASS, 2015); AND
  - Imaging studies confirm spinal curvature and demonstrate at least one of the following (Frymoyer, 2004):
    - Spinal curvature > 50 degrees (scoliosis); OR
    - Spinal curvature > 75 degrees (kyphosis); OR
    - Severe kyphosis (chin-brow vertical angle greater than 35 degrees).

LUMBAR DEFORMITY (WITH OR WITHOUT SECONDARY THORACIC INVOLVEMENT) IN ADULTS:

- Progressive neurological deficit (motor deficit, bowel or bladder dysfunction) or lower extremity weakness (0-3/5 on the strength scale) or paralysis with corresponding evidence of spinal cord or nerve root compression on an MRI or CT scan images — immediate surgical evaluation is indicated (Kreiner, 2014); OR
• When **ALL of the following** criteria are met:
  o Lumbar back pain, neurogenic claudication, and/or radicular leg pain without significant motor deficit (0-3/5) that impairs daily activities for **at least 6 months**; **AND**
  o Failure of symptom or pain improvement upon completion of at least 12 weeks of focused non-operative therapy/rehabilitation* in the past year (NASS, 2015); **AND**
  o Imaging studies that correspond to clinical findings and show at least one of the following (Chen, 2016; Garfin, 2017):
    ▪ Sagittal or coronal imbalance of at least 5 cm measured on long plate standing x-rays of the entire spine; **OR**
    ▪ Documented progression of 10 degrees in one year in the coronal plane on x-ray (scoliosis); **OR**
    ▪ A fixed scoliosis of at least 40 degrees.

*Non-Operative Care

• Documented failure of **at least twelve (12)** consecutive weeks in the past year of **any 2** of the following physician-directed conservative treatments (NASS, 2015):
  o Analgesics, steroids, and/or NSAIDs
  o Structured program of physical therapy aimed at increasing core muscle strength
  o Structured home exercise program prescribed by a physical therapist, chiropractic provider or physician
  o Epidural steroid injections and or facet injections /selective nerve root block

**RELATIVE CONTRAINDICATIONS FOR SPINE SURGERY:**

• **Medical contraindications** to surgery, e.g., severe osteoporosis; infection of soft tissue adjacent to the spine, whether or not it has spread to the spine; severe cardiopulmonary disease; anemia; malnutrition and systemic infection (Fu, 2011; Smith, 2011).

• **Psychosocial risk factors.** It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions mimicking radiculopathy or instability (e.g., peripheral neuropathy, piriformis syndrome, myofascial pain, sympathetically mediated pain syndromes, sacroiliac dysfunction, psychological conditions, etc.) prior to consideration of elective surgical intervention (Graham, 2016; Smith, 2015).

• **Active Nicotine Use** prior to fusion surgery. The patient must refrain from nicotine use for at least six weeks prior to surgery and during the period of fusion healing (Graham, 2016).
• **Morbid Obesity.** Contraindication to surgery in cases where there is significant risk and concern for improper post-operative healing, post-operative complications related to morbid obesity, and/or an inability to participate in post-operative rehabilitation (Graham, 2016; Smith, 2015).

---

**BACKGROUND:**

This guideline covers the surgical indications for adult spinal deformity. The criteria for spine surgery for deformity are organized by the involved region of the spine. Whenever possible, spinal deformity in adults is treated non-operatively. Patients often experience significant pain relief from non-operative measures including:

- Pain medication such as non-steroidal anti-inflammatory drugs or mild narcotic medications
- Physical therapy aimed at increasing core muscle strength
- Postural training
- Ideal weight maintenance or appropriate weight loss
- Activity modification
- Braces can provide symptomatic relief
- Patients who fail initial conservative therapy may benefit from steroidal epidural injections, facet joint blocks.

All operative interventions must be based on a positive correlation with clinical findings, the natural history of the disease, the clinical course, and diagnostic tests or imaging results.

**POLICY HISTORY:**

**Review Date:** November 2018

**Review Summary:**

- Removed worsening lung function and exercise tolerance criteria from thoracic deformity indications
- Changed spinal curvature to >75 degrees kyphosis
- Added and updated references

**Review Date:** October 2019

**Review Summary:**

- “in the past year” added to further define the conservative care requirement.
- Modified contraindication section to specify ‘relative’
REFERENCES:


**Disclaimer:** Magellan Healthcare service authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. These policies are not meant to supplant your normal procedures, evaluation, diagnosis, treatment and/or care plans for your patients. Your professional judgement must be exercised and followed in all respects with regard to the treatment and care of your patients. These policies apply to all Magellan Healthcare subsidiaries including, but not limited to, National Imaging Associates ("Magellan"). The policies constitute only the reimbursement and coverage guidelines of Magellan. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies. Magellan reserves the right to review and update the guidelines at its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.