

Document ID#: 2111963
Subject: Spinal Procedures, Certain Elective
Effective Date: January 1, 2010

Clinical Documentation and Prior Authorization Required	√	Type of Review - Case Management	
Not Covered		Type of Review – Precertification Department	√
		Administrative Process (Internal Use Only)	RN

Note: Background, product, and disclaimer information is located at the end of this document.

In order to obtain prior authorization for certain elective spinal procedures, InterQual® SmartSheets™ must be completed and faxed to the Tufts Health Plan Precertification Department at 617-972-9409.

InterQual® Clinical Evidence Summary Sheets and InterQual® SmartSheets™ for these procedures are available by logging on to our web site and accessing the Prior Authorization InterQual® Criteria Link under the Clinical Resources section. If you are not a Tufts Health Plan Registered Provider, please click the Provider Log-in and follow the instructions. For a list of the specific CPT procedure codes requiring prior authorization, [click here](#).

Effective January 1, 2010, Tufts Health Plan will use Coverage Guidelines for the diagnoses, listed below, which are not addressed by InterQual® SmartSheets™. Reference the [Spinal Procedures for Diagnoses Not Available from InterQual® Medical Necessity Guidelines](#) for additional information.

Please Note: The CPT procedure codes are the same as those listed in the link above.

- Lumbar Fusion for Diagnoses not Available from InterQual®
 - Isthmic Spondylolisthesis (any grade)
 - Degenerative Spondylolisthesis with or without Spinal Stenosis
 - Internal Lumbar Disc Disruption including Anterior Lumbar Interbody Fusion (ALIF)
 - Re-do Lumbar Fusion
 - Posterior Lumbar Decompression with Lumbar Spinal Fusion for Lumbar Spinal Stenosis
- Posterior Decompression without Spinal Fusion for Spinal Stenosis
- Hemilaminectomy, lumbar with or without discectomy/foraminotomy

Approval History

Original effective date: August 16, 2005.

Subsequent Endorsement Date(s) and Changes Made:

- April 25, 2007: Reviewed and renewed.
- January 8, 2007: A completed InterQual® SmartSheet™ is required. The requirement of additional information for the authorization of a spinal procedure removed from guideline.
- March 10, 2008: CPT codes 62263 and 62264 were removed from the prior authorization program and moved to Statement of Non Coverage. Effective date July 1, 2008.
- March 10, 2008: The use of recombinant bone morphogenic protein approved for use with CPT code 22558 **ONLY**. Please see specific CPT code list for details. Effective date July 1, 2008.

- March 24, 2009: Reviewed by Medical Affairs Medical Policy: no changes.
- August 8, 2009 for an effective date of January 1, 2010: A new coverage criteria was linked to this MNG for diagnoses not available from InterQual[®], including Lumbar Fusion for Diagnoses not Available from InterQual[®] (Isthmic Spondylolisthesis (any grade), Degenerative Spondylolisthesis with or without Spinal Stenosis, Internal Lumbar Disc Disruption including Anterior Lumbar Interbody Fusion (ALIF), Re-do Lumbar Fusion, Posterior Lumbar Decompression with Lumbar Spinal Fusion for Lumbar Spinal Stenosis/Posterior Decompression without Spinal Fusion for Spinal Stenosis) and Hemilaminectomy, lumbar with or without discectomy/foraminotomy

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for Tufts Health Plan benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. Tufts Health Plan makes coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the Tufts Health Plan service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan revises and updates Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to all fully insured Tufts Health Plan products unless otherwise noted in this guideline or the Member's benefit document. This guideline does not apply to Tufts Health Plan Medicare Preferred or to certain delegated service arrangements. For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLinkSM.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.