Local Coverage Determination (LCD): Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions (L33382)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

Contractor Information

<table>
<thead>
<tr>
<th>CONTRACTOR NAME</th>
<th>CONTRACT TYPE</th>
<th>CONTRACT NUMBER</th>
<th>JURISDICTION</th>
<th>STATE(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Coast Service Options, Inc.</td>
<td>A and B MAC</td>
<td>09101 - MAC A</td>
<td>J - N</td>
<td>Florida</td>
</tr>
<tr>
<td>First Coast Service Options, Inc.</td>
<td>A and B MAC</td>
<td>09102 - MAC B</td>
<td>J - N</td>
<td>Florida</td>
</tr>
<tr>
<td>First Coast Service Options, Inc.</td>
<td>A and B MAC</td>
<td>09201 - MAC A</td>
<td>J - N</td>
<td>Puerto Rico</td>
</tr>
<tr>
<td>First Coast Service Options, Inc.</td>
<td>A and B MAC</td>
<td>09202 - MAC B</td>
<td>J - N</td>
<td>Puerto Rico</td>
</tr>
<tr>
<td>First Coast Service Options, Inc.</td>
<td>A and B MAC</td>
<td>09302 - MAC B</td>
<td>J - N</td>
<td>Virgin Islands</td>
</tr>
</tbody>
</table>

LCD Information

Document Information

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>Original Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>L33382</td>
<td>For services performed on or after 10/01/2015</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Original ICD-9 LCD ID</th>
<th>Revised Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>L32074</td>
<td>For services performed on or after 10/23/2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LCD Title</th>
<th>Revision Ending Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proposed LCD in Comment Period</th>
<th>Retirement Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Source Proposed LCD</th>
<th>Notice Period Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AMA CPT / ADA CDT / AHA NUBC Copyright Statement</th>
<th>Notice Period End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT codes, descriptions and other data only are copyright 2018 American Medical Association. All Rights Reserved. Applicable FARS/HHSARS apply.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
CMS National Coverage Policy

Language quoted from CMS National Coverage Determination (NCDs) and coverage provisions in interpretive manuals are italicized throughout the Local Coverage Determination (LCD). NCDs and coverage provisions in interpretive manuals are not subject to the LCD Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, italicized text represents quotation from one or more of the following CMS sources:

CMS Online Manual, Pub. 100-08, Chapter 6, Section 6.5.2

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Low back pain is a common disorder affecting 80% of people at some point in their lives. Causes stem from a wide variety of conditions, although in some cases no specific etiology is identified. Age-related intervertebral disc degeneration, typically resulting in degeneration of the discs themselves, facet joint arthrosis and segmental instability are causative factors. Initial management can include rest, exercise program, avoidance of activities that aggravate pain, application of heat/cold modalities, pharmacotherapy, local injections, lumbar bracing, chiropractic manipulation, and physical therapy. When conservative therapy (non-surgical medical management) is unsuccessful after at least 3 to 12 months, depending on the diagnosis, lumbar spinal fusion may be considered for certain
The goal of lumbar spinal fusion, also referred to as lumbar arthrodesis, is to permanently immobilize the spinal column vertebrae surrounding the disc(s) that are causing the discogenic low back pain. Surgical techniques to achieve lumbar spinal fusion are numerous, and include different surgical approaches (anterior, posterior, lateral) to the spine, different areas of fusion (intervertebral body (interbody), transverse process (posterolateral), different fusion materials (bone graft and/or metal instrumentation), and a variety of ancillary techniques to augment fusion. The presacral interbody technique (CPT codes 0195T, 0196T, and 22586) (e.g., AxiaLIF) is noted in a separate LCD, titled Noncovered Services, and, therefore, is not a covered service. However, this LCD does not address lumbar spinal fusion techniques, devices, instrumentation, or bone graft substitutes. Some of the emerging techniques and associated tools (devices, spinal instrumentation, bone graft substitutes, etc.) are investigational, and this LCD does not endorse such procedures. The scope of this LCD is the indications and medical need of Lumbar Spinal Fusion for instability and degenerative disc conditions.

Arthrodesis is usually performed for conditions that involve only one vertebral segment, however, it is necessary to fuse two segments in order to stop movement, which is referred to as a single level fusion. Lumbar fusion of more than a single level is not typically recommended except in some situations such as trauma, deformity, or for neoplasm. For the majority of the population age 65 or older, pure degenerative disc disease (DDD) without co-morbidities/co-diagnoses is rare and multilevel lumbar fusion in this population is not well studied.

Prior to elective fusions, co-morbidities to be considered include 1) the patient is a nonsmoker, or has refrained from smoking for at least 6 weeks prior to planned surgery, or has received counseling on the effects of smoking on surgical outcomes and treatment for smoking cessation if accepted; 2) cognitive, behavioral, or addiction issues are identified; 3) documentation should support assessment and treatment prior to surgical management; and 4) weight reduction as appropriate.

The hospital records are the primary source of information for the audit of hospital/procedure services. Therefore, any historical data supporting the medical necessity for the fusion (for example, duration and outcomes of physiotherapy, injection therapy, anatomic factors influencing the decision for surgery, etc.) must be included in the inpatient medical record as noted in the history and physical examination, operative note and/or copies of office notes. For example, fusion of iatrogenic instability (i.e., surgical resection of facet as essential portion of the required decompression rendering an unstable segment) should be documented in a pre-operative note and/or an operative note.

Any major procedure has significant benefit and risk (injury or death) that the treating physician discusses with the patient. To meet the reasonable and necessary (R&N) threshold for coverage of a procedure, the physician’s documentation for the case should clearly support both the diagnostic criteria for the indication (standard test results and/or clinical findings as applicable) and the medical need (the procedure does not exceed the medical need and is at least as beneficial as existing alternatives & the procedure is furnished with accepted standards of medical practice in a setting appropriate for the patient’s medical needs and condition). **Lacking compelling arguments for an exception in the supporting documentation, the hospital (FISS claim) and physician services (MCS claim) can be denied.** If in certain circumstances the patient does not meet all of the required criteria outlined in the local coverage determination (LCD) for a procedure, but the treating physician feels that the procedure is a covered procedure given the current standards of care, then the documentation must clearly outline the patient’s episode of care that supports the major procedure and must clearly address the reason(s) for coverage. For example, if clinical findings (or lack of) for an indication are not consistent with the LCD criteria, it should be directly addressed in the pre-procedure documentation. For example, if certain conservative therapies are not necessary for a given patient, it should be directly noted in the pre-procedure documentation. For example, if lumbar fusion for multiple levels for pure DDD is the planned intervention, the pre-procedure documentation should address this debated indication. The clinical judgment of the treating physician is always a consideration if clearly addressed in the pre-procedure record and if consistent with the episode of care for the patient as documented in patient records and claim history.
When reviewing claims for procedures with DRGs, the CMS Online Manual, Pub. 100-08, Chapter 6, Section 6.5.2 states the following:

*Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay. The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.*

**Indications:**

Spinal fusion should only be considered as a last step in the treatment of chronic back pain and is not indicated for most persons suffering from back pain. Lumbar spinal fusion surgery may be considered medically necessary and covered for the following indications:

I. Lumbar spinal instability for ANY of the following indications when confirmed by appropriate diagnostic testing (e.g., radiographic imaging, biopsy, bone aspirate, bone scan and gallium scan):

- Acute spinal fracture
- Progressive or significant acute neurological impairment (e.g., increased weakness or bladder instability)
- Neural compression after spinal fracture
- Epidural compression or vertebral destruction from tumor or abscess
- Spinal tuberculosis
- Spinal debridement for infection (e.g., osteomyelitis)
- Spinal deformity (examples include but not limited to idiopathic scoliosis over 40°, progressive degenerative scoliosis [including spinal levels from the cranial to caudal ends of the deformity and the adjacent normal segment], and sagittal plane deformity + sagittal balance over 10cm)

II. Spinal stenosis for a single level (for example, L4-L5) with associated spondylolisthesis (see classifications below in section III) or other documented evidence of instability (for example, facet joint instability [iatrogenic] related to decompression), AND symptoms of spinal claudication and radicular pain. The pain must represent a significant functional impairment despite a history of 3 months of conservative therapy (non-surgical medical management) as clinically appropriate addressing the following:

- Activity lifestyle modification
- Daily exercise
- Supervised physical therapy (PT) (activities of daily living [ADLs] diminished despite completing a plan of care)
- Anti-inflammatory medications, oral or injection therapy as appropriate, and analgesics

III. Spondylolisthesis manifested by back pain WITH OR WITHOUT spinal claudication, radicular pain, motor deficit when ANY of the following criteria are met:

- Confirmed progressive deformity usually Grade II or higher
- Multilevel spondylolysis
- Symptomatic low-grade spondylolisthesis associated with back pain and significant functional impairment despite a history of 3 months of conservative therapy (non-surgical medical management) as clinically appropriate addressing the following: activity lifestyle modification; daily exercise; supervised PT (ADLs diminished despite completing a plan of care); and anti-inflammatory medications, oral or injection therapy as appropriate, and analgesics
IV. Degenerative disc disease (DDD) in the absence of instability when all of the following criteria have been met as clinically appropriate for the patient’s current episode of care:

- Single level DDD demonstrated on imaging studies (e.g., CT scan, MRI, or discography) as the likely cause of pain. The case specific indications for two level or the rare three or more level planned fusion procedure must be directly addressed in the pre procedure record with clinical correlation to diagnostic testing results (such as disk-space narrowing, end plate changes, annular changes, etc.).
- Pain and significant functional impairment despite a history of at least 6 months of conservative therapy (non-surgical medical management) as clinically appropriate addressing the following:
  - Anti-inflammatory medications, oral or injection therapy as appropriate, and analgesics
  - Daily exercise
  - Activity lifestyle modification
  - Weight reduction as appropriate
  - Supervised PT [ADLs diminished despite completing a plan of care]

OR

- Unsuccessful improvement after completion of intense multidisciplinary rehabilitation (IMR). IMR is defined as onsite program that includes supervised PT, cognitive behavior component, and other coordinated interventions by health care professionals.

V. Lumbar fusion following prior spinal surgery for the following:

- Recurrent disc herniation despite clinically appropriate post operative nonsurgical medical management (post-operative case specific conservative therapy is prescribed as clinically appropriate in addition to documentation of pain and functional impairment).
- Adjacent segment degeneration or disc herniation despite clinically appropriate post-operative nonsurgical medical management (post-operative case specific conservative therapy is prescribed as clinically appropriate in addition to documentation of pain and functional impairment).
- Associated spondylolisthesis (for example anterolisthesis) after prior spinal surgery with ALL the following as clinically appropriate:
  - Recurrent symptoms consistent with neurological compromise
  - Significant functional impairment
  - Neural compression is documented by recent post-operative imaging
  - Unsuccessful improvement despite 3 months of clinically appropriate post-operative nonsurgical medical management (post-operative case specific conservative therapy is prescribed as clinically appropriate in addition to documentation of pain and functional impairment)
  - Instability is documented by appropriate imaging
  - Patient had some relief of pain symptoms following the prior spinal surgery

VI. Treatment of pseudoarthrosis (i.e., nonunion of prior fusion) at the same level after 12 months from prior
surgery and ALL of the following are met (unless imaging demonstrates failed spinal instrumentation [for example, fractured rod or loosened screw]):

- Imaging studies confirm evidence of pseudoarthrosis (e.g., radiographs, CT)
- Unsuccessful improvement despite 3 months of clinically appropriate post-operative nonsurgical medical management (post-operative case specific conservative therapy is prescribed as clinically appropriate in addition to documentation of pain and functional impairment)
- Patient had some relief of pain symptoms following the prior spinal surgery

Limitations:

Lumbar spinal fusion for the following conditions is not considered medically necessary and is noncovered:

1. When performed with initial primary laminectomy/discectomy for nerve root decompression or spinal stenosis, without documented spondylolisthesis or documentation of instability (e.g., documented intraoperative iatrogenic instability).
2. Lumbar fusion at multi-levels (2 or more) for pure DDD unless case specific indications for two level or the rare three or more level planned fusion procedure is directly addressed in the pre-procedure record.

Summary of Evidence

N/A

Analysis of Evidence
(Rationale for Determination)

N/A

Coding Information

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>011x</td>
<td>Hospital Inpatient (Including Medicare Part A)</td>
</tr>
<tr>
<td>012x</td>
<td>Hospital Inpatient (Medicare Part B only)</td>
</tr>
</tbody>
</table>

Created on 08/07/2019. Page 6 of 16
Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0360</td>
<td>Operating Room Services - General Classification</td>
</tr>
<tr>
<td>0960</td>
<td>Professional Fees - General Classification</td>
</tr>
</tbody>
</table>

CPT/HCPCS Codes

Group 1 Paragraph:

N/A

Group 1 Codes:

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>22533</td>
<td>ARTHRODESIS, LATERAL EXTRACAVITARY TECHNIQUE, INCLUDING MINIMAL DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); LUMBAR</td>
</tr>
<tr>
<td>22534</td>
<td>ARTHRODESIS, LATERAL EXTRACAVITARY TECHNIQUE, INCLUDING MINIMAL DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); THORACIC OR LUMBAR, EACH ADDITIONAL VERTEBRAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td>
</tr>
<tr>
<td>22558</td>
<td>ARTHRODESIS, ANTERIOR INTERBODY TECHNIQUE, INCLUDING MINIMAL DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); LUMBAR</td>
</tr>
<tr>
<td>22585</td>
<td>ARTHRODESIS, ANTERIOR INTERBODY TECHNIQUE, INCLUDING MINIMAL DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); EACH ADDITIONAL INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td>
</tr>
<tr>
<td>22612</td>
<td>ARTHRODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE, SINGLE LEVEL; LUMBAR (WITH LATERAL TRANSVERSE TECHNIQUE, WHEN PERFORMED)</td>
</tr>
<tr>
<td>22614</td>
<td>ARTHRODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE, SINGLE LEVEL; EACH ADDITIONAL VERTEBRAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td>
</tr>
<tr>
<td>22630</td>
<td>ARTHRODESIS, POSTERIOR INTERBODY TECHNIQUE, INCLUDING LAMINECTOMY AND/OR DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE; LUMBAR</td>
</tr>
<tr>
<td>22632</td>
<td>ARTHRODESIS, POSTERIOR INTERBODY TECHNIQUE, INCLUDING LAMINECTOMY</td>
</tr>
<tr>
<td>CODE</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>22633</td>
<td>ARTHRODESIS, COMBINED POSTERIOR OR POSTEROLATERAL TECHNIQUE WITH POSTERIOR INTERBODY TECHNIQUE INCLUDING LAMINECTOMY AND/OR DISCECTOMY SUFFICIENT TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE AND SEGMENT; LUMBAR</td>
</tr>
<tr>
<td>22634</td>
<td>ARTHRODESIS, COMBINED POSTERIOR OR POSTEROLATERAL TECHNIQUE WITH POSTERIOR INTERBODY TECHNIQUE INCLUDING LAMINECTOMY AND/OR DISCECTOMY SUFFICIENT TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE AND SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td>
</tr>
<tr>
<td>22800</td>
<td>ARTHRODESIS, POSTERIOR, FOR SPINAL DEFORMITY, WITH OR WITHOUT CAST; UP TO 6 VERTEBRAL SEGMENTS</td>
</tr>
<tr>
<td>22802</td>
<td>ARTHRODESIS, POSTERIOR, FOR SPINAL DEFORMITY, WITH OR WITHOUT CAST; 7 TO 12 VERTEBRAL SEGMENTS</td>
</tr>
<tr>
<td>22804</td>
<td>ARTHRODESIS, POSTERIOR, FOR SPINAL DEFORMITY, WITH OR WITHOUT CAST; 13 OR MORE VERTEBRAL SEGMENTS</td>
</tr>
<tr>
<td>22808</td>
<td>ARTHRODESIS, ANTERIOR, FOR SPINAL DEFORMITY, WITH OR WITHOUT CAST; 2 TO 3 VERTEBRAL SEGMENTS</td>
</tr>
<tr>
<td>22810</td>
<td>ARTHRODESIS, ANTERIOR, FOR SPINAL DEFORMITY, WITH OR WITHOUT CAST; 4 TO 7 VERTEBRAL SEGMENTS</td>
</tr>
<tr>
<td>22812</td>
<td>ARTHRODESIS, ANTERIOR, FOR SPINAL DEFORMITY, WITH OR WITHOUT CAST; 8 OR MORE VERTEBRAL SEGMENTS</td>
</tr>
<tr>
<td>22853</td>
<td>INSERTION OF INTERBODY BIOMECHANICAL DEVICE(S) (EG, SYNTHETIC CAGE, MESH) WITH INTEGRAL ANTERIOR INSTRUMENTATION FOR DEVICE ANCHORING (EG, SCREWS, FLANGES), WHEN PERFORMED, TO INTERVERTEBRAL DISC SPACE IN CONJUNCTION WITH INTERBODY ARTHRODESIS, EACH INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td>
</tr>
<tr>
<td>22854</td>
<td>INSERTION OF INTERVERTEBRAL BIOMECHANICAL DEVICE(S) (EG, SYNTHETIC CAGE, MESH) WITH INTEGRAL ANTERIOR INSTRUMENTATION FOR DEVICE ANCHORING (EG, SCREWS, FLANGES), WHEN PERFORMED, TO VERTEBRAL CORPECTOMY(IES) (VERTEBRAL BODY RESECTION, PARTIAL OR COMPLETE) DEFECT, IN CONJUNCTION WITH INTERBODY ARTHRODESIS, EACH CONTIGUOUS DEFECT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td>
</tr>
<tr>
<td>22859</td>
<td>INSERTION OF INTERVERTEBRAL BIOMECHANICAL DEVICE(S) (EG, SYNTHETIC CAGE, MESH, METHYLMETHACRYLATE) TO INTERVERTEBRAL DISC SPACE OR VERTEBRAL BODY DEFECT WITHOUT INTERBODY ARTHRODESIS, EACH CONTIGUOUS DEFECT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</td>
</tr>
</tbody>
</table>
ICD-10 Codes that Support Medical Necessity

**Group 1 Paragraph:**

Inpatient only ICD-10 CM Procedure Codes

0RGA0A0 Fusion of thoracolumbar vertebral joint with interbody fusion device, anterior approach, anterior column, open approach

0RGA0AJ Fusion of thoracolumbar vertebral joint with interbody fusion device, posterior approach, anterior column, open approach

0SG0070 Fusion of lumbar vertebral joint with autologous tissue substitute, anterior approach, anterior column, open approach

0SG0071 Fusion of lumbar vertebral joint with autologous tissue substitute, posterior approach, posterior column, open approach

0SG007J Fusion of lumbar vertebral joint with autologous tissue substitute, posterior approach, anterior column, open approach

0SG00AJ Fusion of lumbar vertebral joint with interbody fusion device, posterior approach, anterior column, open approach

0SG00A0 Fusion of lumbar vertebral joint with interbody fusion device, anterior approach, anterior column, open approach

0SG00J0 Fusion of lumbar vertebral joint with synthetic substitute, anterior approach, anterior column, open approach

0SG00J1 Fusion of lumbar vertebral joint with synthetic substitute, posterior approach, posterior column, open approach

0SG00JJ Fusion of lumbar vertebral joint with synthetic substitute, posterior approach, anterior column, open approach

0SG00K0 Fusion of lumbar vertebral joint with nonautologous tissue substitute, anterior approach, anterior column, open approach

0SG00K1 Fusion of lumbar vertebral joint with nonautologous tissue substitute, posterior approach, posterior column, open approach

0SG00KJ Fusion of lumbar vertebral joint with nonautologous tissue substitute, posterior approach, anterior column, open approach

0SG1070 Fusion of 2 or more lumbar vertebral joints with autologous tissue substitute, anterior approach, anterior column, open approach
0SG1071 Fusion of 2 or more lumbar vertebral joints with autologous tissue substitute, posterior approach, posterior column, open approach

0SG107J Fusion of 2 or more lumbar vertebral joints with autologous tissue substitute, posterior approach, anterior column, open approach

0SG10A0 Fusion of 2 or more lumbar vertebral joints with interbody fusion device, anterior approach, anterior column, open approach

0SG10AJ Fusion of 2 or more lumbar vertebral joints with interbody fusion device, posterior approach, anterior column, open approach

0SG10J0 Fusion of 2 or more lumbar vertebral joints with synthetic substitute, anterior approach, anterior column, open approach

0SG10J1 Fusion of 2 or more lumbar vertebral joints with synthetic substitute, posterior approach, posterior column, open approach

0SG10JJ Fusion of 2 or more lumbar vertebral joints with synthetic substitute, posterior approach, anterior column, open approach

0SG10K0 Fusion of 2 or more lumbar vertebral joints with nonautologous tissue substitute, anterior approach, anterior column, open approach

0SG10K1 Fusion of 2 or more lumbar vertebral joints with nonautologous tissue substitute, posterior approach, posterior column, open approach

0SG10KJ Fusion of 2 or more lumbar vertebral joints with nonautologous tissue substitute, posterior approach, anterior column, open approach

0SG3070 Fusion of lumbosacral joint with autologous tissue substitute, anterior approach, anterior column, open approach

0SG3071 Fusion of lumbosacral joint with autologous tissue substitute, posterior approach, posterior column, open approach

0SG307J Fusion of lumbosacral joint with autologous tissue substitute, posterior approach, anterior column, open approach

0SG30A0 Fusion of lumbosacral joint with interbody fusion device, anterior approach, anterior column, open approach

0SG30AJ Fusion of lumbosacral joint with interbody fusion device, posterior approach, anterior column, open approach

0SG30J0 Fusion of lumbosacral joint with synthetic substitute, anterior approach, anterior column, open approach

0SG30J1 Fusion of lumbosacral joint with synthetic substitute, posterior approach, posterior column, open approach
0SG30JJ Fusion of lumbosacral joint with synthetic substitute, posterior approach, anterior column, open approach

0SG30K0 Fusion of lumbosacral joint with nonautologous tissue substitute, anterior approach, anterior column, open approach

0SG30K1 Fusion of lumbosacral joint with nonautologous tissue substitute, posterior approach, posterior column, open approach

0SG30KJ Fusion of lumbosacral joint with nonautologous tissue substitute, posterior approach, anterior column, open approach

0SG504Z Fusion of sacrococcygeal joint with internal fixation device, open approach

0SG507Z Fusion of sacrococcygeal joint with autologous tissue substitute, open approach

0SG501Z Fusion of sacrococcygeal joint with synthetic substitute, open approach

0SG50KZ Fusion of sacrococcygeal joint with nonautologous tissue substitute, open approach

0SG604Z Fusion of coccygeal joint with internal fixation device, open approach

0SG607Z Fusion of coccygeal joint with autologous tissue substitute, open approach

0SG60JZ Fusion of coccygeal joint with synthetic substitute, open approach

0SG60KZ Fusion of coccygeal joint with nonautologous tissue substitute, open approach

**Group 1 Codes:**

<table>
<thead>
<tr>
<th>ICD-10 CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>XX000</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

**ICD-10 Codes that DO NOT Support Medical Necessity**

N/A

**Additional ICD-10 Information**

N/A

**General Information**

**Associated Information**

**Documentation Requirements**

Medical record documentation maintained by the physician must substantiate the medical need for lumbar spinal fusion surgery and must include the following:
• Office notes/hospital record, including history and physical by the attending/treating physician.
• Documentation of the history and duration of unsuccessful conservative therapy (non-surgical medical management) when applicable. Failure of non-surgical medical management can be historical and does not have to be under the direction of the operating surgeon.
• Interpretation and reports for X-rays, MRI’s, CT’s, etc.
• Medical clearance reports (as applicable).
• Documentation of smoking history, and that the patient has received counseling on the effects of smoking on surgical outcomes and treatment for smoking cessation if accepted (if applicable).
• Complete operative report outlining operative approach used and all the components of the spine surgery.

Medical record documentation must be made available upon request. When the documentation does not meet the criteria for the service(s) rendered or the documentation does not establish the medical necessity for the service(s), such service(s) will be denied as not reasonable and necessary under Section 1862(a)(1)(A) of the Social Security Act.

Utilization Guidelines

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

Sources of Information

First Coast Service Options, Inc. reference LCD number(s) – L32076


Cigna Medical Coverage Policy. Lumbar fusion for spinal instability and degenerative disc conditions, # 0303. (2011)

CPT® Changes Archives: An Insider's View 2000-2011


InterQual®2011 Procedures Adult Criteria, Lumbar spine fusion.


Milliman Care Guidelines®, Lumbar fusion. 2010.


Wellmark Blue Cross and Blue Shield. (2010). Spinal Fusion, Medical Policy 07.01.49.

**Bibliography**

N/A

---

**Revision History Information**

Created on 08/07/2019. Page 13 of 16
<table>
<thead>
<tr>
<th>REVISION HISTORY DATE</th>
<th>REVISION HISTORY NUMBER</th>
<th>REVISION HISTORY EXPLANATION</th>
<th>REASON(S) FOR CHANGE</th>
</tr>
</thead>
</table>
| 10/23/2018            | R7                      | Revision Number: 5  
Publication: November 2018 Connection  
LCR A/B2018-080  
Explanation of Revision: Based on a review, the LCD was revised to include the descriptors for the ICD-10-PCS codes listed in the “ICD-10 Codes that Support Medical Necessity/Group 1 Paragraph:/Inpatient only ICD-10 CM Procedure Codes” section of the LCD. Also, the inactive links were removed from the “Sources of Information” section of the LCD. The effective date of this revision is based on process date.  
10/23/2018: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this LCD. | Other |
| 10/01/2018            | R6                      | Revision Number: 4  
Publication: September 2018 Connection  
LCR A/B2018-074  
Explanation of Revision: Based on CR 10847 (Annual 2019 ICD-10-CM Update) the LCD was revised. Deleted ICD-10-PCS codes 0SG00Z0, 0SG00Z1, 0SG00ZJ, 0SG10Z0, 0SG10Z1, 0SG10ZJ, 0SG30Z0, 0SG30Z1, 0SG30ZJ, 0SG50ZZ, and 0SG60ZZ in the "ICD-10 Codes that Support Medical Necessity “Inpatient only ICD-10 CM Procedure Codes” section of the LCD. In addition, the sources of information section of the LCD was revised to complete a partial citation of a reference listed the bibliography section. The effective date of this revision is based on date of service.  
10/01/2018: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this LCD. | Revisions Due To ICD-10-CM Code Changes |
<p>| 01/01/2018            | R5                      | Revision Number: 3                                                                                                                                                                                                                                                                                                                                 | Revisions Due To CPT/HCPCS Code Changes |</p>
<table>
<thead>
<tr>
<th>REVISION HISTORY DATE</th>
<th>REVISION NUMBER</th>
<th>REVISION HISTORY EXPLANATION</th>
<th>REASON(S) FOR CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/01/2017</td>
<td>R4</td>
<td><strong>Revision Number: 2</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Publication: September 2017 Connection</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>LCR A/B2017-038</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Explanation of Revision:</strong> Based on CR 10153 (Annual 2018 ICD-10-CM Update) the LCD was revised. Deleted ICD-10-PCS codes 0RGA0A1, 0SG00A1, 0SG10A1, 0SG30A1. The effective date of this revision is based on date of service.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10/01/2017: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this policy.</td>
<td></td>
</tr>
<tr>
<td>01/01/2017</td>
<td>R3</td>
<td>Revision Number: 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Publication: December 2016 Connection</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>LCR A/B2017-001</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Explanation of Revision:</strong> Annual 2017 HCPCS Update. Revised to add CPT and/or HCPCS code(s) 22853, 22854 and 22859. The effective date of this revision is based on date of service.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10/01/2017: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this policy.</td>
<td></td>
</tr>
<tr>
<td>10/01/2015</td>
<td>R2</td>
<td>Explanation of revision:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>12/29/15 Corrected beginning alpha character in the following</td>
<td></td>
</tr>
</tbody>
</table>

**Explanation of Revision:** Annual 2018 HCPCS Update. CPT code 0309T was deleted from the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD. The effective date of this revision is based on date of service.

01/01/2018: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this policy.
## Associated Documents

### Attachments
N/A

### Related Local Coverage Documents
**Article(s)**
A56176 - Lumbar spinal fusion for instability and degenerative disc conditions revision to the Part A and Part B LCD

### Related National Coverage Documents
N/A

### Public Version(s)
Updated on 10/24/2018 with effective dates 10/23/2018 - N/A
Updated on 10/05/2018 with effective dates 10/01/2018 - 10/22/2018
Updated on 01/05/2018 with effective dates 01/01/2018 - 09/30/2018
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.

### Keywords
N/A

---

<table>
<thead>
<tr>
<th>REVISION HISTORY DATE</th>
<th>REVISION HISTORY NUMBER</th>
<th>REVISION HISTORY EXPLANATION</th>
<th>REASON(S) FOR CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/01/2015</td>
<td>R1</td>
<td>PCS codes to numeric character &quot;0&quot; ORGA0A0, ORGA0A1, ORGA0AJ and 0SG30A1</td>
<td>12/15/2015 Association to Part B contractor numbers (09102, 09202 and 09302). • Revisions Due To ICD-10-CM Code Changes</td>
</tr>
</tbody>
</table>