Spine Surgery

Policy

Mass General Brigham Health Plan will reimburse contracted providers for medically necessary emergency and elective spinal surgery for the treatment of musculoskeletal conditions.

Mass General Brigham Health Plan consults with FOCUS Health Services for evidence based clinical information and to support a spinal surgery decision. Separate authorization numbers are required for the facility and the professional services if billed under distinct group NPIs. An authorization request can be submitted by either entity for both authorizations, given that both the billing facility's and billing physician's NPIs are included in the original request. In addition, authorizations for both facility and physician are required for the procedure codes contained herein, please see Procedure Codes Applicable to Guideline section for reference. Verification of an authorization should be made by both the facility and physician prior to surgery.

Prerequisites

For elective spinal surgery, a prior authorization request must be submitted to Mass General Brigham Health Plan at least five (5) business days prior to the service date and may take up to 14 calendar days to reach a decision. All authorization decisions are made, and members and providers are notified as expeditiously as the member's health condition requires. Requests submitted without adequate clinical documentation to support medical necessity or require physician review may take up to the full 14 calendar days to reach a decision. Elective surgery performed before an authorization has been provided may not be reimbursed.

Authorization, Notification and Referral

Service	Requirement	
	Facility	Professional
Emergency Spinal Surgery	Prior authorization is **NOT** required • Notification of emergency hospital admissions must be made within 24 hours as a condition for reimbursement.	Prior authorization is **NOT** required • Notification of emergency hospital admissions must be made within 24 hours as a condition for reimbursement.
Elective Spinal Surgery	Prior authorization **IS** required for the facility and surgeon. Prior authorization requests must be submitted to Mass General Brigham Health Plan at least 5 business days prior to the service date and may take up to 14 days to reach a decision.	Prior authorization **IS** required for the facility and the surgeon. Prior authorization requests must be submitted to Mass General Brigham Health Plan at least 5 business days prior to the service date and may take up to 14 days to reach a decision.

Limitations

Reimbursement of these procedures is subject to benefit coverage and compliance with the requirements contained within this policy.

Exceptions to Policy Criteria

- Fracture of the vertebral column with or without mention of spinal cord injury does not require prior authorization for spine surgery.
- Cauda equina syndrome does not require medical necessity review prior to spine surgery.

Member Cost-Sharing

The provider is responsible for verifying at each encounter and when applicable for each day of care when the patient is hospitalized, coverage, available benefits, and member out-of-pocket costs;

copayments, coinsurance, and deductible required, if any.

Procedure Codes Applicable to Guideline

Please note: Advanced notification, full medical necessity review, and prior authorization required for each code listed in the table below.

Note: This list of codes may not be all-inclusive.

Code Ranges	Descriptor
22510-22515	Vertebral Body, Embolization or Injection
22532-22548	Arthrodesis Spine (Vertebral Column)
22554-22634	Arthrodesis Spine (Vertebral Column)
22836-22838	Vertebral body tethering
62324-62325	Spine and spinal cord injection
62350-62351	Catheter implantation
62360-62362	Reservoir/pump implantation
63001-63051	Posterior epidural laminotomy or laminectomy for exploration/decompression of neural elements or excision of herniated intervertebral discs
63055-63066	Transpedicular or Costovertebral approach for posterolateral extradural exploration/decompression
63075-63086	Anterior or anterolateral approach for extradural exploration/ decompression
63101-63103	Lateral extracavitary approach for extradural exploration/decompression
63170-63200	Incision (spine and spinal cord)
63250-62395	Excision by Laminectomy of lesion other than herniated disc
63300-63308	Excision, anterior or anterolateral approach, intraspinal lesion
63650-63688	Neurostimulators (spinal)
E0782-E0786	Infusion Pumps

Medical Necessity Review Guidelines and Documentation

Requirements for a full medical necessity review include but are not limited to:

Clinical information, including clinical notes and all clinical data that may include any or all of the following components, as appropriate and related to the spine service requested:

- Member history including baseline, current clinical exam and presenting problems, prior treatments and response to treatment;
- Treatment plan and progress notes;
- Office and hospital records;
- Lab, radiology and/or other diagnostic results;
- Consultation and specialty reports;
- Evaluations from other health care practitioners and providers;
- Photographs;
- Operative and pathological reports;
- Rehabilitation evaluations;
- Dates of admission, discharge and/or outpatient treatments;
- Psychosocial history issues and/or needs;
- Member and/or family expectations and concerns;
- Growth charts;
- Discharge information; and
- Information regarding the local delivery system.

Provider or Member Disagreement with Denial Decision

If the requesting provider or member disagrees with the decision, it may be appealed to Mass General Brigham Health Plan. A different expert will conduct the appeal review to allow for an impartial consideration of the appeal. Instructions on how to appeal the decision will be mailed to the provider with the denial letter.

References

Current year CPT, Professional Edition published by the AMA (American Medical Association)
Mass General Brigham Health Plan Provider Manual: Collection of Clinical Information for UM Decision Making:

- Section 7-14: Mass General Brigham Health Plan Commercial Provider Manual
- Section 6-12: Mass General Brigham Health Plan ACO Provider Manual
- Page 26: Mass General Brigham Health Plan Medicare Advantage Provider Manual

MassHealth Physician Manual

Publication History

Topic: Spine Surgery	Owner: Network Management
May 01, 2011	*Original documentation*
March 20, 2012	*Prerequisites updated, CPT 22633-22634 added to grid*
April 05, 2013	*PA Update and related language change to PA*
January 1, 2019	*Document restructure; codes, code descriptor and references updated*
January 1, 2023	*Document rebrand*
January 1, 2024	*Annual review, CPT 22836-22838 added to grid*
January 1, 2025	*Annual review, no policy change*

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc., and Mass General Brigham Health Plan Insurance Company.