



SPINE CENTERS OF EXCELLENCE

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I. POLICY/CRITERIA

- A. Prior authorization is required for all referrals to orthopedic or neurosurgeons for back or neck pain and other spine-related complaints.
- B. Evaluation by a Priority Spine Center of Excellence (SCOE) is required prior to referral to an orthopedic or neurosurgeon for back or neck care unless there is an acute indication for surgical evaluation (see C).
- C. Surgical evaluation of back or neck pain does not require a SCOE evaluation if any of the following “red flag” indicators is present:
 - 1. Evidence of tumor, infection or fracture.
 - 2. Acute weakness of both arms, or of both legs (paraparesis or unsteady gait) especially if associated with any of the following:
 - i. Upper motor neuron signs (Babinski or Hoffman’s signs, clonus, hyperreflexia) and/or
 - ii. Loss of bladder or bowel control and/or
 - iii. Cord compression with decreased T1 signal changes, increased T2 signal changes, or signal changes at multiple cord levels on MRI
 - 3. Cauda equina syndrome (new onset of bowel or bladder dysfunction with areflexia, asymmetric paraparesis).
- D. Prior authorization is required for follow-up to emergency or inpatient care for spine-related conditions. Authorization will be given if the patient a) was seen by a spine surgeon in the ED or inpatient setting or b) has one of the conditions outlined in IC above. Otherwise the patient will be redirected to a SCOE.
- E. The prior authorization requirement does not apply to care provided in the emergency department or inpatient setting when professional services are billed with the appropriate site of service codes.
- F. This policy applies to members ≥ 18 years of age only.

II. MEDICAL NECESSITY REVIEW

Required for outpatient services Not Required Not Applicable

III. APPLICATION TO PRODUCTS

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- ❖ **HMO/EPO:** *This policy applies to insured HMO/EPO plans.*
- ❖ **POS:** *This policy applies to insured POS plans.*
- ❖ **PPO:** *This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.*
- ❖ **ASO:** *For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.*
- ❖ **INDIVIDUAL:** *For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.*
- ❖ **MEDICARE:** *Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.*
- ❖ **MEDICAID:** *If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual and the Michigan Medicaid Fee Schedule, the Michigan Medicaid Provider Manual and the Michigan Medicaid Fee Schedule at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--00.html will govern.*
- ❖ **MICHILD:** *For MICHILD members, this policy will apply unless MICHILD certificate of coverage limits or extends coverage.*

IV. DESCRIPTION

Within the Priority Health service area and provider network, widespread variation exists in the delivery of care for members with acute and chronic back pain. This is true not only for surgical services but also for imaging, physical therapy, pain management procedures and surgical consultation. Physician networks where physiatry referral rates are higher have consistently demonstrated lower surgical rates. This is consistent with observational studies showing that frequent use of medical consultants results in lower surgical rates.

Treatment of back and neck pain is considered a preference-sensitive condition. Preference-sensitive conditions are those medical conditions for which multiple treatment options exist and for which patient values, experiences and preferences influence the chosen treatment option.

There is good evidence from clinical trials that multiple treatment options exist for acute and chronic low back pain, herniated discs, spinal stenosis, and spondylolithesis. Likewise there is good evidence that patients, when fully

informed of all their treatment options, are more satisfied with their decisions, are more knowledgeable about their treatment, and are less likely to pursue legal action for poor outcomes. Equally important, fully informed patients tend to be more conservative than their physicians.

The Spine Centers of Excellence program is intended to provide a physiatrist-led (Physical Medicine and Rehabilitation specialist) comprehensive medical evaluation including a comprehensive, patient-centered review of all the treatment options available for a patient's neck and low back pain. To be considered a Center of Excellence, specific criteria must be met. Those criteria are outlined in Appendix A. Further, this policy requires that all patients with back and neck pain, with the exception of those requiring urgent surgical evaluation, be evaluated in a Spine Center of Excellence prior to surgical evaluation.

V. CODING INFORMATION

ICD9 Diagnosis codes:

NOTE: Prior authorization of all visits, for the following diagnoses, with an orthopedic surgeon or neurosurgeon is required.

Diagnosis for which no prior consultation in a spine center of excellence is required:

- 170.2 Malignant neoplasm of vertebral column, excluding sacrum and coccyx
- 170.6 Malignant neoplasm of Pelvic bones, sacrum, and coccyx
- 192.2 Malignant neoplasm of spinal cord
- 213.2 Benign neoplasm of vertebral column, excluding sacrum and coccyx
- 213.6 Benign neoplasm of pelvic bones, sacrum, and coccyx
- 225.3 Benign neoplasm of spinal cord
- 237.5 Neoplasm of uncertain behavior of brain and spinal cord

- 336.1 Vascular myelopathies
- 336.3 Myelopathy in other diseases classified elsewhere
- 336.8 Other myelopathy
- 336.9 Unspecified diseases of the spinal cord (cord compression NOS, myelopathy NOS)

- 344.61 Cauda equina syndrome, with neurogenic bladder

- 596.54 Neurogenic bladder

- 721.1 Cervical spondylosis with myelopathy
- 721.41 Thoracic spondylosis with myelopathy
- 721.42 Lumbar spondylosis with myelopathy
- 721.7 Traumatic spondylopathy
- 721.91 Spondylosis of unspecified site with myelopathy

- 722.70 Intervertebral disc disorder with myelopathy, Unspecified region
- 722.71 Intervertebral disc disorder with myelopathy, Cervical region
- 722.72 Intervertebral disc disorder with myelopathy, Thoracic region

- 722.73 Intervertebral disc disorder with myelopathy, Lumbar region

- 730.00 Acute osteomyelitis, site unspecified
- 730.08 Acute osteomyelitis, other specified sites
- 730.10 Chronic osteomyelitis, site unspecified
- 730.18 Chronic osteomyelitis, other specified sites
- 730.20 Unspecified osteomyelitis, site unspecified
- 730.28 Unspecified osteomyelitis, other specified sites
- 730.80 Other infections involving bone in diseases classified elsewhere, site unspecified
- 730.88 Other infections involving bone in diseases classified elsewhere, other specified sites

- 733.13 Pathologic fracture of vertebrae

- 805.00 – 805.9 Fracture of vertebral column without mention of spinal cord injury
- 806.00 – 806.9 Fracture of vertebral column with spinal cord injury

- 952.2 Lumbar spinal cord injury without spinal bone injury
- 952.4 Cauda equina spinal cord injury without spinal bone injury
- 996.67 Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft

Diagnosis for which prior consultation in a spine center of excellence is required:

- 338.4 Chronic pain syndrome
- 344.60 Cauda equina syndrome, without mention of neurogenic bladder

- 353.0 Brachial plexus lesions
- 353.1 Lumbosacral plexus lesions
- 353.2 Cervical root lesions, not elsewhere classified
- 353.3 Thoracic root lesions, not elsewhere classified
- 353.4 Lumbosacral root lesions, not elsewhere classified

- 355.0 Lesion of sciatic nerve

- 720.0 Ankylosing spondylitis
- 720.1 Spinal enthesopathy
- 720.2 Sacroiliitis, not elsewhere classified

- 721.0 Cervical spondylosis without myelopathy
- 721.2 Thoracic spondylosis without myelopathy
- 721.3 Lumbosacral spondylosis without myelopathy
- 721.5 Kissing spine

- 722.0 Displacement of cervical intervertebral disc without myelopathy
- 722.10 Displacement of lumbar intervertebral disc without myelopathy
- 722.11 Displacement of thoracic intervertebral disc without myelopathy
- 722.2 Displacement of intervertebral disc, site unspecified, without myelopathy
- 722.30 Schmorl's nodes, unspecified region
- 722.31 Schmorl's nodes, thoracic region
- 722.32 Schmorl's nodes of lumbar region
- 722.39 Schmorl's nodes, other

- 722.4 Degeneration of cervical intervertebral disc
- 722.51 Degeneration of thoracic or thoracolumbar intervertebral disc
- 722.52 Degeneration of lumbar or lumbosacral intervertebral disc
- 722.6 Degeneration of intervertebral disc, site unspecified
- 722.80 Postlaminectomy syndrome, unspecified region
- 722.81 Postlaminectomy syndrome, cervical region
- 722.82 Postlaminectomy syndrome, thoracic region
- 722.83 Postlaminectomy syndrome, lumbar region

- 722.90 Other and unspecified disc disorder, unspecified region
- 722.91 Other and unspecified disc disorder of cervical region
- 722.92 Other and unspecified disc disorder, thoracic region
- 722.93 Other and unspecified disc disorder of lumbar region

- 723.0 Spinal stenosis in cervical region
- 723.1 Cervicalgia
- 723.2 Cervicocranial syndrome
- 723.3 Cervicobrachial syndrome (diffuse)
- 723.4 Brachial neuritis or radiculitis nos.
- 723.5 Torticollis, unspecified
- 723.6 Panniculitis specified as affecting neck
- 723.7 Ossification of posterior longitudinal ligament in cervical region
- 723.8 Other syndromes affecting cervical region
- 723.9 Unspecified musculoskeletal disorders and symptoms referable to neck
- 724.00 Spinal stenosis, unspecified region
- 724.01 Spinal stenosis, Thoracic region
- 724.02 Spinal stenosis, Lumbar region
- 724.03 Spinal stenosis, Lumbar region with neurogenic claudication
- 724.09 Spinal stenosis, Other
- 724.1 Pain in thoracic spine
- 724.2 Lumbago
- 724.3 Sciatica
- 724.4 Thoracic or lumbosacral neuritis or radiculitis, unspecified
- 724.5 Backache, unspecified
- 724.6 Disorders of sacrum
- 724.8 Other symptoms referable to back
- 724.9 Other unspecified back disorders
- 728.85 Spasm of muscle
- 728.89 Other disorders of muscle, ligament, and fascia

- 729.1 Myalgia and myositis, unspecified

- 738.4 Acquired spondylolithesis
- 738.5 Other acquired deformity of the back or spine
- 739.1 Nonallopathic lesions, cervical region
- 739.2 Nonallopathic lesions, Thoracic region
- 739.3 Nonallopathic lesions, Lumbar region
- 739.4 Nonallopathic lesions, Sacral region
- 739.5 Nonallopathic lesions, Pelvic region
- 739.8 Nonallopathic lesions, Rib cage

782.0 Disturbance of skin sensation

847.0 Neck sprain and strain

847.2 Lumbar sprain and strain

953.2 Injury to lumbar nerve root

953.4 Injury to Brachial plexus

CPT/HCPCS Codes:

The following services billed for specialist Neurosurgeon or Orthopedist, with any diagnosis listed above, for a member age 18 and over, requires prior authorization.

- 99201 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
- 99202 Office or other outpatient visit....new patient....expanded problem....20 minutes
- 99203 Office or other outpatient visit....new patient....30 minutes
- 99204 Office or other outpatient visit....new patient....comprehensive....45 minutes
- 99205 Office or other outpatient visit....comprehensive....high complexity.... 60 minutes
- 99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
- 99212 Office or other outpatient visit....established patient....problem focused....10 minutes.
- 99213 Office or other outpatient visit....established patient....expanded....15 minutes
- 99214 Office or other outpatient visit....established patient....detailed....25 minutes
- 99215 Office or other outpatient visit....established patient....comprehensive.... 40 minutes
- 99241 Office consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
- 99242 Office consultation for a new or established patient....expanded problem.... 30 minutes
- 99243 Office consultation for a new or established patient....detailed history....40 minutes

- 99244 Office consultation for a new or established patient....comprehensive....60 minutes
- 99245 Office consultation for a new or established patient....comprehensive.... high complexity.... 80 minutes

VI. REFERENCES

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The name "Priority Health" and the term "plan" mean Priority Health, Priority Health Managed Benefits, Inc., Priority Health Insurance Company and Priority Health Government Programs, Inc.

Appendix A Priority Health Spine Center of Excellence Requirements

1. Organizational requirements:
 - a) Sponsoring entity is a Michigan licensed hospital or a licensed Michigan physician practice with a compatible mission and vision.
 - b) Center is financially independent from surgical providers
Comment: The Medical Director will affirm by a signed affidavit that the center does not profit financially from surgical referrals. This requirement does not preclude participation of practices with surgeons and physiatrists partners.
 - c) Organizational mission statement supports multi-disciplinary approach to the management of back pain.
2. Core center staffing
 - a) Medical Director
 - (i) board certified in Physical Medicine & Rehabilitation
 - (ii) member of North American Spine Society or other organization specifically dedicated to the treatment of spinal disorders
 - (iii) annual CME in back pain management (10 hours)
 - b) Physical therapist, chiropractic consultant, or D.O., with advanced certification in the treatment of musculoskeletal conditions which includes knowledge of the McKenzie Method
 - c) Care coordinator responsible for scheduling, triage, outcomes tracking, and communications
3. Service performance expectations for new patients
 - a) Acute patients evaluated within two working days, either telephonically or in person
 - b) Non-acute patients evaluated within ten working days
 - c) Reports transmitted to referring physician within four working days
4. Use of evidence-based treatment guidelines for at least the following conditions:
 - a) Acute and chronic low back pain
 - b) Acute and chronic neck pain
 - c) Herniated disc
 - d) Spinal stenosis
 - e) SpondylolisthesisGuidelines, e.g. NASS or ICSI, must be available to the plan and providers on request.
5. Diagnostic services available within the center or from affiliated providers
 - a) Neuromuscular diagnostics (EMG, Nerve Conduction Studies)
 - b) Diagnostic nerve blocks
 - c) Behavioral screening including a biopsychosocial assessment
6. Use of shared decision making tools for patients for whom surgery is considered a reasonable management option must be provided. (Patients requesting surgery for any of the conditions below must attest that they have viewed a shared decision making tool prior to all surgery authorizations.)
 - a) Herniated disc
 - b) Spinal stenosis

- c) Acute low back pain
 - d) Chronic low back pain
7. Participation in annual half-day COE conferences sponsored by Priority Health. The intent of these sessions will be to share outcomes as well as best clinical and administrative practices.

Appendix B Primary Care Physician back and neck pain triage tools

Institute for Clinical Systems Improvement Adult Low Back Pain Guideline

http://www.icsi.org/guidelines_and_more/guidelines_order_sets_protocols/musculo-skeletal/low_back_pain/low_back_pain_adult_5.html Accessed 4 June 2007

Scope and Target Population:

Adult patients age 18 and over in primary care who have symptoms of low back pain or sciatica. The focus is on acute and chronic management, including indications for medical, non-surgical or surgical referral. For workers' compensation patients, check with state guidelines where the patient resides and where the injury took place, or in Minnesota, see the workers' compensation treatment parameters at <http://www.doli.state.mn.us/pdf/treatparam.pdf>.

Clinical Highlights and Recommendations:

1. Cauda Equina Syndrome is a condition requiring emergent evaluation and surgery. A patient should be referred immediately to the ER if any of the following emergent symptoms are present:
 - Sudden onset or otherwise unexplained loss or changes in bowel or bladder control (retention or incontinence)
 - Sudden onset or otherwise unexplained bilateral leg weakness
 - Saddle numbness
2. A patient should be offered an appointment within 24 hours if any of the following symptoms are present:
 - Fever 38°C or 100.4°F for greater than 48 hours
 - Unrelenting night pain or pain at rest
 - New onset (less than six weeks) of progressive pain with distal (below the knee) numbness or weakness of leg(s)
 - Leg weakness
 - Progressive neurological deficit
 - Patient requests for same-day appointment
3. Lumbar spine x-rays should be considered when any of the following “red flag” indicators exist:
 - Unrelenting night pain or pain at rest (increased incidence of clinically significant pathology)
 - History of or suspicion of cancer (rule out metastatic disease)
 - Fever above 38°C (100.4°F) for greater than 48 hours
 - Osteoporosis
 - Other systemic diseases
 - Neuromotor or sensory deficit if persistent for 6 weeks; or progressive despite conservative treatment
 - Chronic oral steroids
 - Immunosuppression

- Serious accident or injury (fall from heights, blunt trauma, motor vehicle accident) – this does not include twisting or lifting injury unless other risk factors are present (e.g., history of osteoporosis)
 - Clinical suspicion of ankylosing spondylitis
4. Red flag and psychosocial indicators should be reviewed and evaluated at each contact/visit. While there is no outcome data related to this, an assessment that includes a subjective pain rating, functional assessment and a clinician's objective assessment should be done at each visit.
 5. Emphasize patient education and conservative home self-care, which includes limited bed rest, early ambulation, postural advice, resumption of light-duty activities, use of ice and heat, anti-inflammatory and analgesic over-the-counter medications, and early return to work or activities.
 6. Based on history and physical, classify symptoms by duration and location into appropriate categories:
 - Acute low back pain
 - Chronic low back pain
 - Acute sciatica
 - Chronic sciatica
 7. The natural history of low back pain is that most patients will experience improvement in four to six weeks and will have a recurrence of low back pain in 12 months.

Patients with acute low back pain should be advised to stay active and continue ordinary daily activity within the limits permitted by the pain. For chronic back pain, there is evidence that exercise therapy is effective.
 8. Consideration should be given to epidural steroid injections if patient is being considered for surgical interventions. Epidural steroid injections should not be done without fluoroscopic guidance.
 9. Referrals for advanced imaging studies should be limited to patients with:
 - Progressive neurological deficits
 - Minimal to no improvement of radicular symptoms despite six weeks of conservative treatment
 - Uncontrolled pain
 - Cauda Equina Syndrome