

SPINE CENTERS OF EXCELLENCE

Effective Date: October 1, 2015

Review Dates: 6/07, 6/08, 6/09, 6/10, 6/11, 6/12, 6/13,
8/14, 8/15, 8/16, 8/17, 8/18

Date Of Origin: June 13, 2007

Status: Current

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.
- G. Patient may be required to view a shared decision making tool/information prior to surgical consultation/referral. Patient may also be required to view a pre-surgery decision making tool before surgery.

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/HEALTHY MICHIGAN PLAN:** *For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify 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

NOTE: Prior authorization is required for all office visits by neurosurgeon or orthopedic surgeon for the following diagnoses.

Diagnosis for which no consultation in a Spine Center of Excellence will be required:

ICD-10 Codes that apply to this policy:

G54.0 – G54.1	Plexus disorders
G83.4	Cauda equina syndrome
G95.20	Unspecified cord compression
G95.29	Other cord compression
G95.81	Conus medullaris syndrome
G95.89	Other specified diseases of spinal cord
G95.9	Disease of spinal cord, unspecified
G99.2	Myelopathy in diseases classified elsewhere
M47.011 – M47.16	Anterior spinal artery compression syndromes
M48.30 – M48.38	Traumatic spondylopathy
M50.00 – M50.03	Cervical disc disorder with myelopathy
M50.20 – M50.23	Other cervical disc displacement
M51.04 – M51.06	Intervertebral disc disorders with myelopathy
M99.05	Segmental and somatic dysfunction of pelvic region
M99.08	Segmental and somatic dysfunction of rib cage
N31.0	Uninhibited neuropathic bladder, not elsewhere classified
N31.1	Reflex neuropathic bladder, not elsewhere classified

N31.2	Flaccid neuropathic bladder, not elsewhere classified
N31.8	Other neuromuscular dysfunction of the bladder
N31.9	Neuromuscular dysfunction of bladder, unspecified
R20.0	Anesthesia of skin

Diagnosis for which consultation in a Spine Center of Excellence will be required:

ICD-10 Codes that apply to this policy:

G54.2	Cervical root disorders, not elsewhere classified
G54.3	Thoracic root disorders, not elsewhere classified
G54.4	Lumbosacral root disorders, not elsewhere classified
G57.00	Lesion of sciatic nerve, unspecified lower limb
G57.01	Lesion of sciatic nerve, right lower limb
G57.02	Lesion of sciatic nerve, left lower limb
G57.03	Lesion of sciatic nerve, bilateral lower limbs
G89.29	Other chronic pain
G89.4	Chronic pain syndrome
M08.1	Juvenile ankylosing spondylitis
M35.4	Diffuse (eosinophilic) fasciitis
M43.00 - M43.28	Spondylolysis/fusion of spine
M43.6	Torticollis
M43.8x9	Other specified deforming dorsopathies, site unspecified
M43.9	Deforming dorsopathy, unspecified
M45.0 - M45.9	Ankylosing spondylitis of spine
M46.00 – M46.1	Spinal enthesopathy
M46.40 - M46.49	Discitis
M47.20 – M47.28	Other spondylosis with radiculopathy
M47.811 – M47.819	Spondylosis without myelopathy or radiculopathy
M47.891 - M47.9	Other spondylosis
M48.00 – M48.08	Spinal stenosis
M48.20 – M48.27	Kissing spine
M48.8x1 - M48.8x9	Other specified spondylopathies
M50.10 – M50.13	Cervical disc disorder with radiculopathy
M50.30 - M50.93	Other cervical disc degeneration
M51.14 – M51.9	Intervertebral disc disorders with radiculopathy
M53.0 – M53.9	Other and unspecified dorsopathies, not elsewhere classified
M54.00 – M54.9	Panniculitis
M60.80	Other myositis, unspecified site
M60.88 - M60.9	Other myositis
M62.20	Nontraumatic ischemic infarction of muscle, unspecified site
M62.28	Nontraumatic ischemic infarction of muscle, other site
M62.49	Contracture of muscle, multiple sites
M62.830	Muscle spasm of back
M79.0	Rheumatism, unspecified
M79.10	Myalgia, unspecified site
M79.18	Myalgia, other site
M79.2	Neuralgia and neuritis, unspecified
M79.7	Fibromyalgia

M96.1	Postlaminectomy syndrome, not elsewhere classified
M99.00 - M99.04	Segmental and somatic dysfunction
M99.10- M99.15	Subluxation complex (vertebral)
M99.18	Subluxation complex (vertebral) of rib cage
M99.20 - M99.25	Subluxation stenosis of neural canal
M99.28	Subluxation stenosis of neural canal of rib cage
M99.30 – M99.35	Osseous stenosis of neural canal
M99.38	Osseous stenosis of neural canal of rib cage
M99.40 – M99.45	Connective tissue stenosis of neural canal
M99.48	Connective tissue stenosis of neural canal of rib cage
M99.50 – M99.55	Intervertebral disc stenosis of neural canal
M99.58	Intervertebral disc stenosis of neural canal of rib cage
M99.60 – M99.65	Osseous and subluxation stenosis of intervertebral foramina
M99.68	Osseous and subluxation stenosis of intervertebral foramina of rib cage
M99.70 – M99.75	Connective tissue and disc stenosis of intervertebral foramina
M99.78	Connective tissue and disc stenosis of intervertebral foramina of rib cage
M99.80-M99.85	Other biomechanical lesions
M99.8	Other biomechanical lesions of rib cage
M99.9	Biomechanical lesion, unspecified
R20.1 - R20.9	Disturbance of skin sensation
S13.4xxA-S13.4xxS	Sprain of ligaments of cervical spine
S13.8xxA-S13.9xxS	Sprain of joints and ligaments of other parts of neck
S16.1xxA-S16.1xxS	Strain of muscle, fascia and tendon at neck level
S33.5xxA-S33.5xxS	Sprain of ligaments of lumbar spine

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
- Consult codes not payable for Priority Health Medicare – Use 99201 – 99215.*

VI. REFERENCES

1. Hagen EM, Eriksen HR, Ursin H. Does early intervention with a light mobilization program reduce long-term sick leave for low-back pain? *Spine* 2000; 25(15):1973-6.
2. Bendix AF, Bendix T, Vaegter K, Busch E, Kirkbak S, Ostfeld S. Intensive multidisciplinary treatment of back pain—2 controlled prospective studies *Ugeskr Laeger*. 1994 156(16):2388-91, 2394-5
3. Rasmussen K, Nielsen GL, Hansen VK, Jensen OK, Schioetz-Christenson B, Rates of lumbar disc surgery before and after implementation of multidisciplinary nonsurgical spine clinics. *Spine* 30(21):2469-2473.
4. Weinstein JN, Tosteson TD, Lurie JD, Tostenson ANA, Hanscom B, Skinner JS, Abdu, WA, Hilibrand AS, Boden SD, Deyo RA. Surgical vs nonoperative treatment for lumbar disk herniation. The Spine Patient Outcomes Research Trial (SPORT): A randomized trial. *JAMA*. 2006, 296(20):
5. Deyo RA, Cherkin DC, Weinstein J, Howe J, Ciol M, Mulley AG Jr. Involving patients in clinical decisions: impact of an interactive video program on use of back surgery. *Med Care* 2000;38:959-969.
6. Lanes TC, Gauron ET, Spratt KF, Wernimont TJ, Found EM, Weinstein JN. Long-term follow-up of patients with chronic back pain treated in a multidisciplinary rehabilitation program. *Spine*. 1995 20(7):801-6.

7. Peul WC, et al. Surgery versus Prolonged Conservative Treatment for Sciatica. 2007 356(22):2245-2256
8. Weinstein JN, et al. Surgical versus Nonsurgical Treatment for Lumbar Degenerative Spondylolisthesis. 2007 356(22):2245-2256.
9. Fox J, Haig AJ, Todey B, Challa S. The effect of required physiatrist consultation on surgery rates for back pain. Spine (Phila Pa 1976). 2013 Feb 1;38(3):E178-84

AMA CPT Copyright Statement:

All Current Procedure Terminology (CPT) codes, descriptions, and other data are copyrighted by the American Medical Association.

This document is for informational purposes only. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Eligibility and benefit coverage are determined in accordance with the terms of the member's plan in effect as of the date services are rendered. Priority Health's medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion.

Priority Health's medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

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
 - d) Use of shared decision making tools for patients for whom surgery is considered a reasonable management option must be provided.
 - e) Herniated disc
 - f) Spinal stenosis
 - g) Acute low back pain
 - h) Chronic low back pain

Appendix B Primary Care Physician back and neck pain triage tools

Institute for Clinical Systems Improvement Adult Low Back Pain Guideline

https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_musculoskeletal_guidelines/low_back_pain/ Accessed 30 May 2013

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.
 8. 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.
 9. 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.
 10. 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