PriorityHealth

MEDICAL POLICY
No. 91531-R3

SPINE CENTERS OF EXCELLENCE

Effective Date: August 27, 2019
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, 8/19, 8/20
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 emergency department (ED) or inpatient setting or b) has one of the conditions outlined in I.C 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 $\geq$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) and/or the Evidence of Coverage (EOC); 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	Post laminectomy 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
M99.88	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

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3. 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
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7. Rasmussen K, Nielsen GL, Hansen VK, Jensen OK, Schioettz-Christenson B. Rates of lumbar disc surgery before and after implementation of multidisciplinary nonsurgical spine clinics. Spine 30(21):2469-2473.

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9. Weinstein JN, et al. Surgical versus Nonsurgical Treatment for Lumbar Degenerative Spondylolisthesis. 2007 356(22):2245-2256.

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) Spondylolisthesis

   Guidelines, 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 Pain Triage Tools

Institute for Clinical Systems Improvement Adult Low Back Pain, Adult Acute and Subacute Guideline (Sixteenth Edition, March 29, 2018)

https://www.icsi.org/guideline/low-back-pain/ (Accessed June 23, 2020)

Scope and Target Population:
Adult patients age 18 and over in primary care who have symptoms of low back pain or radiculopathy. The focus is on the acute (pain for up to 7 weeks) and subacute (pain for between 7 and 12 weeks) phases of low back pain. It includes the ongoing management, including indications for spine specialist referral within the first 12 weeks of onset.

Clinical Highlights and Recommendations:

Recommendation Table

Topic	Recommendation
Initial Evaluation	For patients with acute and subacute low back pain, a biopsychosocial assessment should be performed
Imaging	Clinicians should not routinely recommend imaging (x-ray, computed tomography [CT], magnetic resonance imaging [MRI] for patients with nonspecific or radicular low back pain with an absence of red flags on clinical presentation.
Education	All patients should receive appropriate education on the treatment and recovery expectations for acute and subacute low back pain.
Heat	Heat may be used for pain relief for acute and subacute low back pain
Cold	Cold therapy may be used for pain relief
Activity	Clinicians should advise patients with acute and subacute low back pain to stay active and continue activities of daily living within the limits permitted by their symptoms
Spinal Manipulation	Spinal manipulation should be considered in early intervention for acute and subacute low back pain
Acupuncture	Acupuncture should be considered for subacute low back pain.
NSAIDS	Non-steroidal anti-inflammatory medication may be used for shortterm relief in patients with acute and subacute low back pain. Patient should be counseled on potential side effects.
Acetaminophen	Acetaminophen may be used as an option for pain relief in patients with acute and subacute low back pain. Patients should be counseled on potential side effects.
Muscle Relaxants	Muscle relaxants may be used as a short-term option (< one week) in the treatment of acute low back pain. Possible side effects should be considered.
Opioids	In general, opioids are not recommended for acute and subacute low back pain.
Epidural Steroid Injections	Epidural steroid injections may be used as an adjunct treatment for acute and subacute low back pain with a radicular component to assist with pain relief.

ICSI
Institute for Clinical Systems Improvement

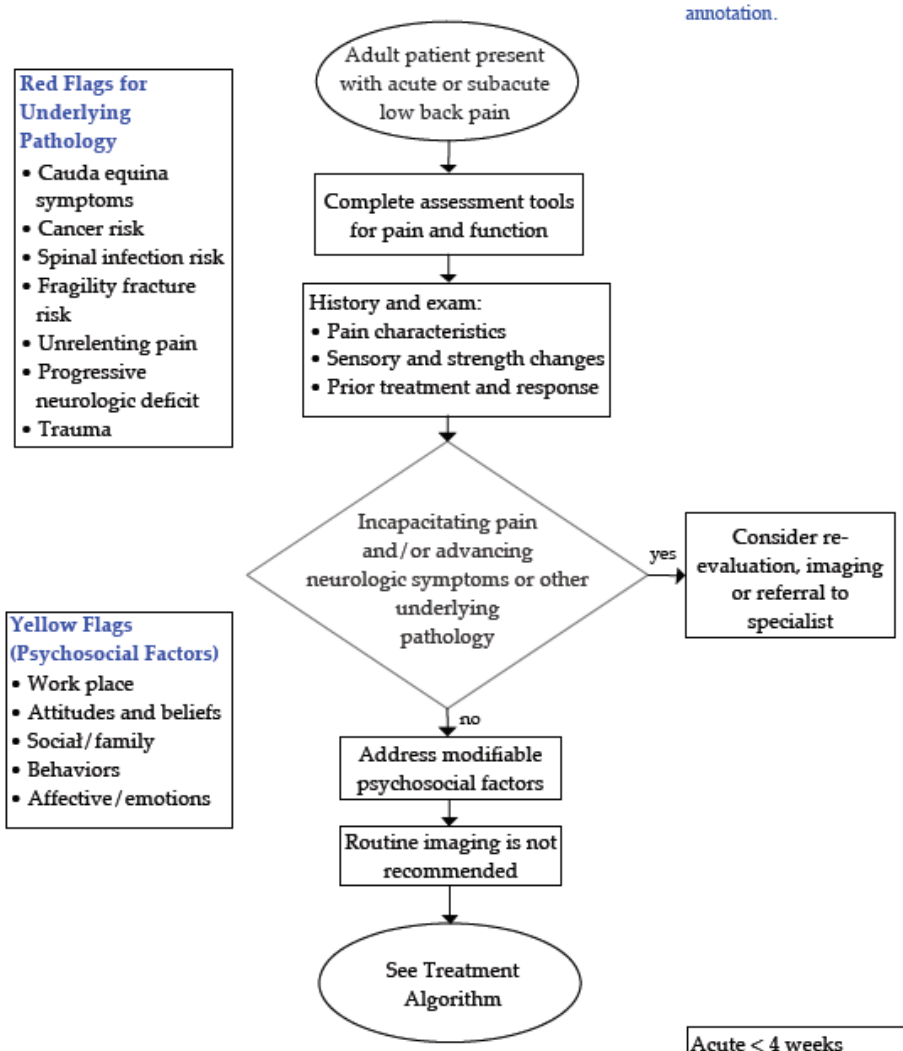
Health Care Guideline:

Adult Acute and Subacute Low Back Pain

Diagnosis Algorithm

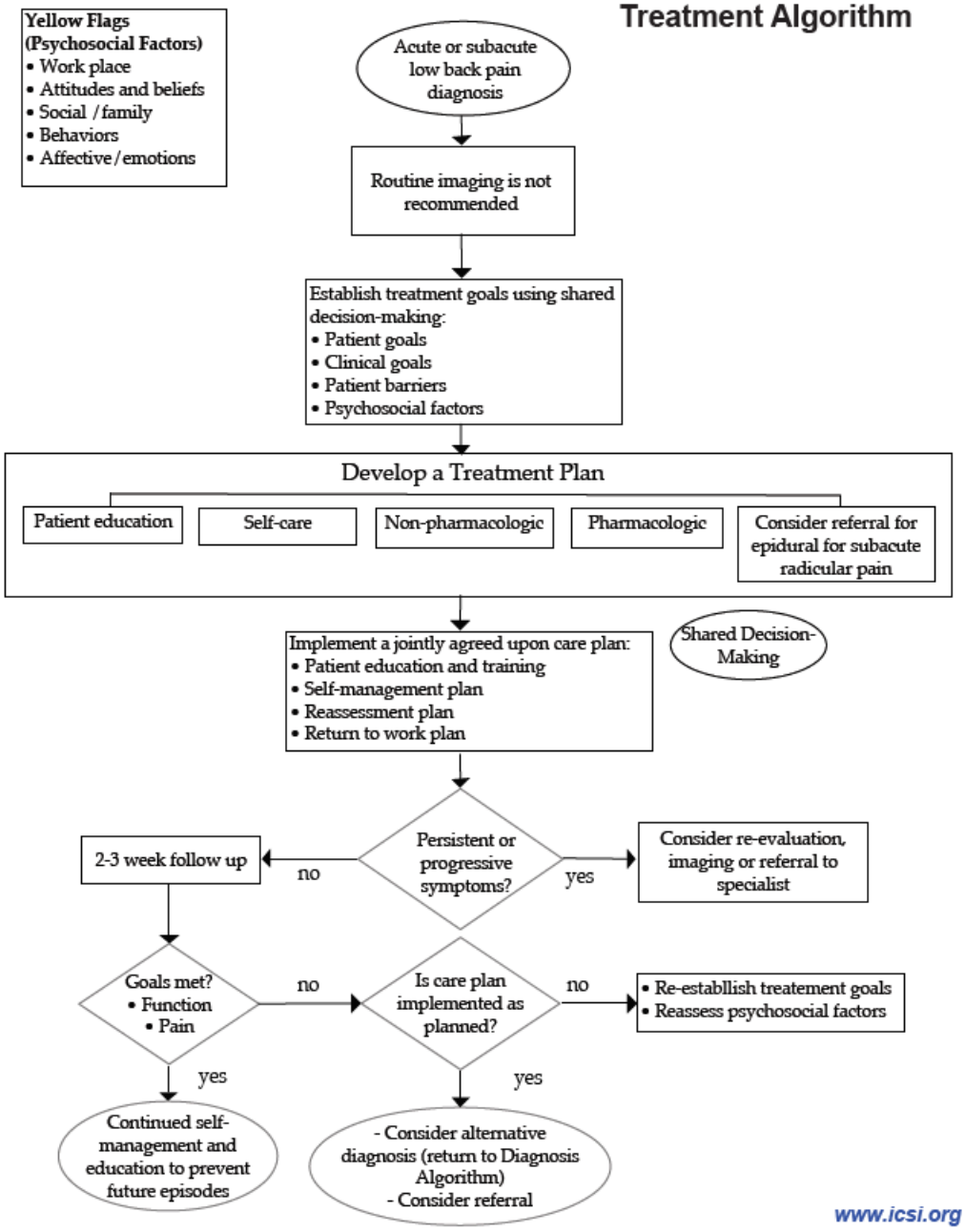
Sixteenth Edition
March 2018

Text in blue in this algorithm indicates a linked corresponding annotation.



www.icsi.org

Treatment Algorithm



Red Flags

While the presence of red flags may raise suspicion, it is important to recognize that they do not completely rule in or rule out a particular condition. Therefore, the clinician must take into consideration the full clinical picture and exercise judgment when choosing when a patient might benefit from further diagnostic workup.

The following red flags warrant consideration for **urgent** workup and/or referral:

- Bowel/bladder dysfunction (most commonly urinary retention)
- Progressive neurologic weakness
- Saddle anesthesia
- Bilateral radiculopathy
- Incapacitating pain
- Unrelenting night pain

Serious Causes of Low Back Pain

1. Cauda equina syndrome

Cauda equina syndrome is compression of the lumbrosacral nerve roots that form the cauda equina. Signs or symptoms of cauda equina syndrome, in addition to low back pain, include:

- Bladder/bowel dysfunction (most commonly urinary retention)
- Motor deficits (lower extremity weakness, depressed deep tendon reflexes)
- Sensory deficits (saddle sensory loss)

All patients with back pain should be asked about urinary retention. Those reporting this symptom should be examined for bilateral leg weakness, depressed leg deep tendon reflexes, and perineal numbness. These patients may report bowel, bladder and sexual dysfunction, and severe pain. This syndrome is rare but catastrophic and requires emergent surgical consultation.

2. Cancer Malignancy
3. Fracture
4. Infection

An uncommon but serious cause for back pain is infection. A spinal infection such as vertebral osteomyelitis or spinal epidural abscess can present as back pain with a fever.

Yellow Flags (Psychosocial Indicators)

Include a patient's attitudes, emotions, behaviors, and family and workplace factors. They may lead to an increased risk of progression to long-term distress and disability.