

## SPINE SURGERY

### Policy

NHP reimburses contracted providers for medically necessary, authorized spine surgery for the treatment of musculoskeletal conditions.

NHP has partnered with a vendor to provide expert consultation and utilization review of prior authorization requests for spine surgery. Utilizing evidence based and industry accepted guidelines, the vendor’s experts will review requests for spine surgery procedures and make appropriate recommendations. NHP will remain responsible for making the final medical necessity determination. As part of its medical necessity review approval process for spine surgery services (including those in an emergency setting), NHP may request additional supporting information from provider offices **before** the request can be finalized.

### Prerequisites

For elective spinal surgery, a prior authorization request must be submitted to NHP 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.

Prior authorization is required for all spine surgery procedures

### Authorization, Notification and Referral

| Service               | Requirement  |
|-----------------------|--|
| Facility Services     | <ul style="list-style-type: none"> <li>• Prior authorization is required</li> <li>• Separate authorization numbers required for the facility <b>and</b> the professional services if billed under distinct group NPIs. Both requests can be processed via a single submission.</li> <li>• Additional supporting documentation <u>may be</u> required <b>before</b> the authorization request can be finalized.</li> </ul>              |
| Professional Services | <ul style="list-style-type: none"> <li>• Prior authorization is required</li> <li>• Separate authorization numbers required for the professional <b>and</b> the facility professional services if billed under distinct group NPIs. Both requests can be processed via a single submission.</li> <li>• Additional supporting documentation <u>may be</u> required <b>before</b> the authorization request can be finalized.</li> </ul> |

| Service          | Requirement   |
|------------------|---|
| For HVMA Members | A referral number for most specialists is required for NHP members with a Harvard Vanguard Medical Associates PCP seeking non-emergency care outside of the Harvard Vanguard Medical Associates Network. Please verify that the member has the appropriate referral number prior to rendering care. |

The Prior Authorization Guidelines are accessible by the following link:

<http://www.nhp.org/PDFs/Providers/PriorAuthGrid.pdf>

The Procedures & Admissions Pre-certification/Pre-authorization Request Form is accessible by the following link:

<http://www.nhp.org/PDFs/Providers/PreCertAuthForm.pdf>

## Limitations

NHP's reimbursement of these procedures is subject to benefit coverage and the provider's compliance with NHP's advance notification, full medical necessity review, and prior authorization requirements.

## Spine Surgery Medical Necessity Review Program

NHP requires that providers, both the facility and the physician, obtain separate authorization prior to rendering spine surgery services. The request can be submitted by either entity, as long as it includes both the billing facility as well as the physician's billing group NPI, if applicable. This applies for each and every procedure listed within the **Procedure Codes Applicable to Guideline** section.

Rendering providers are responsible for ensuring that all spine surgery services for NHP members have the required authorization numbers for both the facility and professional components **prior** to the service being performed. Both professional and facility claims for which there are no authorization number will be denied and the member may not be billed for services associated with the denied claims. NHP Medical Directors will make a final decision on spine surgery authorization requests after a full medical necessity review and when medical necessity has been established by experts in the field.

## 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.

## Definitions

**Cauda Equina Syndrome:** An extreme version of nerve compression or inflammation.

**Interventional Pain Management:** The National Uniform Claim Committee (UB-04) defines interventional pain management as: "The discipline of medicine devoted to the diagnosis and treatment of pain and related disorders with the application of interventional techniques in

managing subacute, chronic, persistent and intractable pain, independently or in conjunction with other modalities of treatment.”

**Musculoskeletal:** Of, relating to, or involving both musculature and skeleton.

**Pain medicine:** Use of diagnostic interventions to either identify the source of pain (e.g., which nerve, if any) or to determine the cause of pain (e.g., which disease, if any). An increasing area of therapeutic interventional pain medicine is known as neuro-modulation. This involves applying electricity or administering medications directly to the nervous system to relieve pain.

### 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  |
|-------------|---|
| 22520-22527 | Vertebral Body, Embolization or Injection   |
| 22532-22548 | Arthrodesis Spine (Vertebral Column)  |
| 22554-22634 | Arthrodesis Spine (Vertebral Column)  |
| 62318-62319 | 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  |

### Provider Payment Guidelines and Documentation

Providers must comply with all CPT instructions, including but not limited to related guidelines, parenthetical instructions, and coding resources, including *CPT Assistant*, and other publications resulting from collaborative efforts of the American Medical Association with the medical specialty societies.

Professional and facility charges are processed separately by NHP. To ensure that both the facility and the physician are reimbursed for authorized surgeries, the request for authorization must provide the billing entity/pay to National Provider Identifier for both the facility and physician, when different. This information may be provided via a single authorization request form.

## 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 NHP. 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)

NHP Clinical Policy # UTM 024: Collection of Clinical Information for UM Decision Making

## Publication History

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|----------------------|------------------------------------|
| Topic: Spine Surgery | Owner: Provider Network Management |
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2011/05/01 *Original documentation*

2012/03/20 *Prerequisites updated, CPT 22633-22634 added to grid*

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. Neighborhood Health Plan utilizes McKesson's claims editing software, ClaimCheck, a clinically oriented, automated program that identifies the "appropriate set" of procedures eligible for provider reimbursement by analyzing the current and historical procedure codes billed on a single date of service and/or multiple dates of service, and also audits across dates of service to identify the unbundling of pre and post-operative care. Please refer to Neighborhood Health Plan's Provider Manual Billing Guidelines section for additional information on NHP's billing guidelines and administration policies. Questions may be directed to Provider Network Management at [prweb@nhp.org](mailto:prweb@nhp.org).