# Spine Procedures

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➲ Instructions for Use

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## Coverage Rationale

### Cervical Spine

#### *Cervical Artificial Disc Replacement*

Medicare does not have an NCD for cervical artificial disc replacement. LCDs/LCAs exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Cervical Artificial Disc Replacement.

**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Total Artificial Disc Replacement for the Spine.

#### *Cervical Spine Fusion Surgery*

Medicare does not have a National Coverage Determination (NCD) for cervical spine fusion surgery. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Cervical Spine Fusion Surgery.

#### *Cervical Spine Surgery (Other Non-Fusion Procedures)*

Medicare does not have an NCD for cervical spine surgery (other non-fusion procedures). LCDs/LCAs do not exist.

**For coverage guidelines**, refer to the UnitedHealthcare Commercial Medical Policy titled Spinal Fusion and Decompression.

### Thoracic Spine

#### *Thoracic Spine Surgery*

Medicare does not have an NCD for thoracic spine surgery. LCDs/LCAs do not exist.

**For coverage guidelines**, refer to the UnitedHealthcare Commercial Medical Policy titled Spinal Fusion and Decompression.

#### *Scoliosis or Kyphosis Surgery*

Medicare does not have an NCD for scoliosis or kyphosis surgery. LCDs/LCAs do not exist.

**For coverage guidelines**, refer to the InterQual® CP: Procedures, Scoliosis or Kyphosis Surgery.

Click here to view the InterQual® criteria.

## Lumbar Spine

### *Lumbar Spine Surgery*

Medicare does not have an NCD for lumbar spine surgery. LCDs/LCAs exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Lumbar Spine Surgery.

**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Spinal Fusion and Decompression.

### *Interlaminar Lumbar Instrumented Fusion (ILIF) Utilizing an Interspinous Process Fusion Device*

Medicare does not have an NCD for ILIF utilizing an interspinous process fusion device. LCDs/LCAs do not exist.

**For coverage guidelines**, refer to the UnitedHealthcare Commercial Medical Policy titled Interspinous Fusion and Decompression Devices.

### *Spinal Decompression and Interspinous Process Decompression Systems for the Treatment of Lumbar Spinal Stenosis [e.g., Interspinous Process Decompression (IPD)]*

Medicare does not have an NCD for spinal decompression and interspinous process decompression systems. LCDs/LCAs do not exist.

**For coverage guidelines**, refer to the UnitedHealthcare Commercial Medical Policy titled Interspinous Fusion and Decompression Devices.

### *Percutaneous Lumbar Decompression of Nucleus Pulposus*

Medicare does not have an NCD for percutaneous lumbar decompression of nucleus pulposus. LCDs/LCAs do not exist.

**For coverage guidelines**, refer to the UnitedHealthcare Commercial Medical Policy titled Minimally Invasive Spine Surgery Procedures.

## Sacral Spine

### *Percutaneous Sacral Augmentation (Sacroplasty)*

Medicare does not have an NCD for sacroplasty. LCDs/LCAs do not exist.

**For coverage guidelines**, refer to the UnitedHealthcare Commercial Medical Policy titled Minimally Invasive Spine Surgery Procedures.

### *Percutaneous Minimally Invasive Fusion/Stabilization of the Sacroiliac Joint for the Treatment of Back Pain*

Medicare does not have an NCD for percutaneous minimally invasive fusion/stabilization of the sacroiliac joint for the treatment of back pain. LCDs/LCAs exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Percutaneous Minimally Invasive Fusion/Stabilization of the Sacroiliac Joint for the Treatment of Back Pain.

**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Sacroiliac Joint Interventions.

## Annular Closure Devices (ACDs) (e.g., Barricaid Annular Closure Device)

Medicare does not have an NCD for annular closure devices. LCDs/LCAs do not exist.

**For coverage guidelines**, refer to the UnitedHealthcare Commercial Medical Policy titled Discogenic Pain Treatment.

## Spinal Fusion and Bone Healing Enhancement Products Including Allograft or Synthetic Bone Graft Materials

Medicare does not have an NCD for spinal fusion and bone healing enhancement products including allograft or synthetic bone graft materials. LCDs/LCAs do not exist.

**For coverage guidelines**, refer to the UnitedHealthcare Commercial Medical Policy titled Spinal Fusion and Bone Healing Enhancement Products.

# Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service; however, language may be included in the listing below to indicate if a code is non-covered. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other policies and guidelines may apply.

| CPT Code | Description |
|---|---|
| **Cervical Artificial Disc Replacement** | |
| 22856 | Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical |
| 22858 | Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure) |
| 22861 | Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical |
| 22899 | Unlisted procedure, spine |
| **Cervical Spine Fusion Surgery** | |
| 22548 | Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process |
| 22551 | Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2 |
| 22554 | Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2 |
| 22590 | Arthrodesis, posterior technique, craniocervical (occiput-C2) |
| 22595 | Arthrodesis, posterior technique, atlas-axis (C1-C2) |
| 22600 | Arthrodesis, posterior or posterolateral technique, single interspace; cervical below C2 segment |
| **Cervical Spine Surgery (Other Non-Fusion Procedures)** | |
| 22210 | Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical |
| 22220 | Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical |
| 22830 | Exploration of spinal fusion |
| 22849 | Reinsertion of spinal fixation device |
| 22854 | Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure) |
| 22855 | Removal of anterior instrumentation |
| 22852 | Removal of posterior segmental instrumentation |
| 63001 | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; cervical |

| CPT Code | Description |
|---|---|
| **Cervical Spine Surgery (Other Non-Fusion Procedures)** | |
| 63015 | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; cervical |
| 63020 | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical |
| 63040 | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical |
| 63045 | Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; cervical |
| 63050 | Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments |
| 63051 | Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices [e.g., wire, suture, mini plates], when performed) |
| 63075 | Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace |
| 63081 | Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment |
| **Thoracic Spine Surgery** | |
| 22206 | Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., pedicle/vertebral body subtraction); thoracic |
| 22212 | Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic |
| 22222 | Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; thoracic |
| 22532 | Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic |
| 22556 | Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic |
| 22610 | Arthrodesis, posterior or posterolateral technique, single interspace; thoracic (with lateral transverse technique, when performed) |
| 22830 | Exploration of spinal fusion |
| 22849 | Reinsertion of spinal fixation device |
| 22852 | Removal of posterior segmental instrumentation |
| 22854 | Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure) |
| 22855 | Removal of anterior instrumentation |
| 63003 | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; thoracic |
| 63016 | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; thoracic |
| 63046 | Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; thoracic |
| 63055 | Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; thoracic |

| CPT Code | Description |
|---|---|
| **Thoracic Spine Surgery** | |
| 63064 | Costovertebral approach with decompression of spinal cord or nerve root(s) (e.g., herniated intervertebral disc), thoracic; single segment |
| 63077 | Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, single interspace |
| 63085 | Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment |
| 63087 | Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment |
| 63090 | Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment |
| 63101 | Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (e.g., for tumor or retropulsed bone fragments); thoracic, single segment |
| **Scoliosis or Kyphosis Surgery** | |
| 22206 | Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., pedicle/vertebral body subtraction); thoracic |
| 22207 | Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., pedicle/vertebral body subtraction); lumbar |
| 22210 | Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical |
| 22212 | Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic |
| 22214 | Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar |
| 22220 | Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical |
| 22222 | Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; thoracic |
| 22224 | Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumbar |
| 22800 | Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments |
| 22802 | Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments |
| 22804 | Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments |
| 22808 | Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments |
| 22810 | Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments |
| 22812 | Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments |
| 22818 | Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or 2 segments |
| 22819 | Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); 3 or more segments |
| 22849 | Reinsertion of spinal fixation device |
| 22850 | Removal of posterior nonsegmental instrumentation (e.g., Harrington rod) |
| 22852 | Removal of posterior segmental instrumentation |
| 22854 | Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure) |
| 22855 | Removal of anterior instrumentation |
| **Lumbar Spine Surgery** | |
| 22207 | Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., pedicle/vertebral body subtraction); lumbar |
| 22214 | Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar |

| CPT Code | Description |
|---|---|
| **Lumbar Spine Surgery** | |
| 22224 | Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumbar |
| 22533 | Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar |
| 22558 | Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar |
| 22612 | Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed) |
| 22630 | Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar |
| 22633 | Arthrodesis, combined posterior, or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar |
| 22830 | Exploration of spinal fusion |
| 22849 | Reinsertion of spinal fixation device |
| 22852 | Removal of posterior segmental instrumentation |
| 22854 | Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure) |
| 22855 | Removal of anterior instrumentation |
| 63005 | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis |
| 63012 | Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure) |
| 63017 | Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; lumbar |
| 63030 | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar |
| 63042 | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar |
| 63047 | Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; lumbar |
| 63056 | Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (e.g., far lateral herniated intervertebral disc) |
| 63087 | Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment |
| 63090 | Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment |
| 63102 | Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (e.g., for tumor or retropulsed bone fragments); lumbar, single segment |
| **Interlaminar Lumbar Instrumented Fusion (ILIF) Utilizing an Interspinous Process Fusion Device** | |
| 22899 | Unlisted procedure, spine [when specified as insertion of a non-pedicle interspinous process fixation device] |

| CPT Code | Description |
|---|---|
| **Spinal Decompression and Interspinous Process Decompression Systems for the Treatment of Lumbar Spinal Stenosis** | |
| 22867 | Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level [Refer to the UnitedHealthcare Commercial Medical Policy titled Interspinous Fusion and Decompression Devices.] |
| 22868 | Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure) [Refer to the UnitedHealthcare Commercial Medical Policy titled Interspinous Fusion and Decompression Devices.] |
| 22869 | Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level [Refer to the UnitedHealthcare Commercial Medical Policy titled Interspinous Fusion and Decompression Devices.] |
| 22870 | Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure) [Refer to the UnitedHealthcare Commercial Medical Policy titled Interspinous Fusion and Decompression Devices.] |
| 22899 | Unlisted procedure, spine [when specified as insertion of a non-pedicle interspinous process fixation device] |
| **Percutaneous Lumbar Decompression of Nucleus Pulposus** | |
| 62287 | Decompression, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle-based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar |
| **Percutaneous Sacral Augmentation (Sacroplasty)** | |
| 0200T | Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed [Refer to the UnitedHealthcare Commercial Medical Policy titled Minimally Invasive Spine Surgery Procedures.] |
| 0201T | Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed [Refer to the UnitedHealthcare Commercial Medical Policy titled Minimally Invasive Spine Surgery Procedures.] |
| **Percutaneous Minimally Invasive Fusion/Stabilization of the Sacroiliac Joint for the Treatment of Back Pain** | |
| 27279 | Arthrodesis, sacroiliac joint, percutaneous or minimally invasive, with image guidance, includes obtaining bone graft when performed, unilateral; placement of transarticular device(s) and/or intra-articular device(s) piercing the lateral or medial cortices of the ilium and the lateral cortex of the sacrum |
| **Annular Closure Devices (ACDs)** | |
| 22899 | Unlisted procedure, spine |
| **Spinal Fusion and Bone Healing Enhancement Products Including Allograft or Synthetic Bone Graft Materials** | |
| 20930 | Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure) |
| 20931 | Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure) |
| 20939 | Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision (List separately in addition to code for primary procedure) |
| 22899 | Unlisted procedure, spine |

| Diagnosis Code | Description |
|---|---|
| **For CPT Code 27279** | |
| M43.17 | Spondylolisthesis, lumbosacral region |
| M43.18 | Spondylolisthesis, sacral and sacrococcygeal region |
| M43.27 | Fusion of spine, lumbosacral region |
| M43.28 | Fusion of spine, sacral and sacrococcygeal region |
| M46.1 | Sacroiliitis, not elsewhere classified |
| M51.17 | Intervertebral disc disorders with radiculopathy, lumbosacral region |
| M53.2X7 | Spinal instabilities, lumbosacral region |
| M53.2X8 | Spinal instabilities, sacral and sacrococcygeal region |
| M53.3 | Sacrococcygeal disorders, not elsewhere classified |
| M53.87 | Other specified dorsopathies, lumbosacral region |
| M53.88 | Other specified dorsopathies, sacral and sacrococcygeal region |
| M54.18 | Radiculopathy, sacral and sacrococcygeal region |
| M99.04 | Segmental and somatic dysfunction of sacral region |
| M99.14 | Subluxation complex (vertebral) of sacral region |
| Q74.2 | Other congenital malformations of lower limb(s), including pelvic girdle |
| S33.2XXA | Dislocation of sacroiliac and sacrococcygeal joint, initial encounter |
| S33.2XXD | Dislocation of sacroiliac and sacrococcygeal joint, subsequent encounter |
| S33.2XXS | Dislocation of sacroiliac and sacrococcygeal joint, sequela |
| S33.6XXA | Sprain of sacroiliac joint, initial encounter |
| S33.6XXD | Sprain of sacroiliac joint, subsequent encounter |
| S33.6XXS | Sprain of sacroiliac joint, sequela |
| S33.8XXA | Sprain of other parts of lumbar spine and pelvis, initial encounter |
| S33.8XXD | Sprain of other parts of lumbar spine and pelvis, subsequent encounter |
| S33.8XXS | Sprain of other parts of lumbar spine and pelvis, sequela |

## Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the Medicare Coverage Database, if no NCD, LCD, or LCA is found, refer to the criteria as noted in the Coverage Rationale section above.

| NCD | LCD | Article | Contractor Type | Contractor Name |
|---|---|---|---|---|
| **Cervical Artificial Disc Replacement** | | | | |
| N/A | L38033 Cervical Disc Replacement | A57021 Billing and Coding: Cervical Disc Replacement | A and B MAC | Palmetto** |
| **Cervical Spine Fusion Surgery** | | | | |
| N/A | L39741 Cervical Fusion | A59608 Billing and Coding: Cervical Fusion | A and B MAC | CGS |
| | L39799 Cervical Fusion | A59674 Billing and Coding: Cervical Fusion | A and B MAC | First Coast |
| | L39770 Cervical Fusion | A59632 Billing and Coding: Cervical Fusion | A and B MAC | NGS |
| | L39758 Cervical Fusion | A59624 Billing and Coding: Cervical Fusion | A and B MAC | Noridian |

| NCD | LCD | Article | Contractor Type | Contractor Name |
|---|---|---|---|---|
| **Cervical Spine Fusion Surgery** | | | | |
| N/A | L39762 Cervical Fusion **Retired 09/11/2025 (See L39758)** | A59645 Billing and Coding: Cervical Fusion **Retired 09/11/2025 (See A59624)** | A and B MAC | Noridian |
| | L39793 Cervical Fusion | A59668 Billing and Coding: Cervical Fusion | A and B MAC | Novitas** |
| | L39773 Cervical Fusion | A59634 Billing and Coding: Cervical Fusion | A and B MAC | Palmetto** |
| | L39788 Cervical Fusion | A59664 Billing and Coding: Cervical Fusion | A and B MAC | WPS* |
| **Lumbar Spine Surgery** | | | | |
| N/A | L37848 Lumbar Spinal Fusion | A56396 Billing and Coding: Lumbar Spinal Fusion | A and B MAC | Palmetto** |
| **Percutaneous Minimally Invasive Fusion/Stabilization of the Sacroiliac Joint for the Treatment of Back Pain** | | | | |
| N/A | L39802 Minimally Invasive Arthrodesis of the Sacroiliac Joint (SIJ) **Effective 04/17/2025** | A59682 Billing and Coding: Minimally Invasive Arthrodesis of the Sacroiliac Joint (SIJ) **Effective 04/17/2025** | A and B MAC | CGS |
| | L36494 Minimally-Invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint **Retired 04/16/2025** | A56535 Billing and Coding: Minimally-Invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint **Retired 04/16/2025** | | |
| | L36406 Minimally-invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint | A57431 Billing and Coding: Minimally-invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint | A and B MAC | NGS |
| | L39810 Minimally Invasive Arthrodesis of the Sacroiliac Joint (SIJ) | A59695 Billing and Coding: Minimally Invasive Arthrodesis of the Sacroiliac Joint (SIJ) | A and B MAC | Noridian |
| | L39812 Minimally Invasive Arthrodesis of the Sacroiliac Joint (SIJ) **Retired 10/23/2025 (See L39810)** | A59697 Billing and Coding: Minimally Invasive Arthrodesis of the Sacroiliac Joint (SIJ) **Retired 10/23/2025 (See A59695)** | A and B MAC | Noridian |
| | L39797 Minimally Invasive Arthrodesis of the Sacroiliac Joint (SIJ) **Effective 04/17/2025** | A59672 Billing and Coding: Minimally Invasive Arthrodesis of the Sacroiliac Joint (SIJ) **Effective 04/17/2025** | A and B MAC | Palmetto** |
| | L39025 Minimally Invasive Surgical (MIS) Fusion of the Sacroiliac Joint (SIJ) **Retired 04/16/2025** | A58739 Billing and Coding: Minimally Invasive Surgical (MIS) Fusion of the Sacroiliac Joint (SIJ) **Retired 04/16/2025** | | |

| NCD | LCD | Article | Contractor Type | Contractor Name |
|---|---|---|---|---|
| N/A | L36000 Percutaneous minimally invasive fusion/stabilization of the sacroiliac joint for the treatment of back pain | A57596 Billing and Coding: Percutaneous minimally invasive fusion/stabilization of the sacroiliac joint for the treatment of back pain | A and B MAC | WPS* |

| Medicare Administrative Contractor (MAC) With Corresponding States/Territories | |
|---|---|
| **MAC Name (Abbreviation)** | **States/Territories** |
| CGS Administrators, LLC (CGS) | KY, OH |
| First Coast Service Options, Inc. (First Coast) | FL, PR, VI |
| National Government Services, Inc. (NGS) | CT, IL, ME, MA, MN, NH, NY, RI, VT, WI |
| Noridian Healthcare Solutions, LLC (Noridian) | AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY |
| Novitas Solutions, Inc. (Novitas) | AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, VA** |
| Palmetto GBA (Palmetto) | AL, GA, NC, SC, TN, VA**, WV |
| Wisconsin Physicians Service Insurance Corporation (WPS)* | IA, IN, KS, MI, MO, NE |
| **Notes** | |
| *Wisconsin Physicians Service Insurance Corporation: Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers.<br>**For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction. | |

# Policy History/Revision Information

| Date | Summary of Changes |
|---|---|
| 06/01/2026 | **Applicable Codes**<br>• Removed CPT codes 63173, 63185, and 63190<br>**Centers for Medicare and Medicaid Services (CMS) Related Documents**<br>• Updated list of documents available in the *Medicare Coverage Database* to reflect the most current information<br>**Supporting Information**<br>• Archived previous policy version MMP089.16 |

# Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

- Medical necessity coverage guidelines; including documentation requirements, and/or
- Medicare coding or billing requirements.

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are

covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, call the customer service number on the back of the member ID card or refer to the Administrative Guide.

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

You are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate’s requirements need to be followed.