CERVICAL FUSION WITH DISC REMOVAL

This surgical procedure may relieve spinal cord or nerve root pressure and alleviate corresponding pain, weakness, numbness, and tingling. The procedure is accompanied by a fusion surgery to stabilize the spine.

Typically, there is an anterior approach to reach damaged vertebrae. An incision is made through the front of the neck; careful to avoid the esophagus, trachea, and thyroid. Retractors separate the intravertebral muscles. The disc space is cleaned out, removing the cartilaginous material above and below the vertebrae to be fused. The physician obtains and packs separately reportable graft material of iliac or other donor bone into the spaces. Traction is decreased to maintain the graft in its bed. The fascia is sutured, a drain is placed, and incision is sutured.

Coverage

Effective for dates of service July 1, 2021, and after, hospital outpatient department (HOPD) providers will need to obtain prior authorization (PA) for cervical fusion with disc removal if performed in a HOPD setting and billed with the follow CPT codes.

Table 1: CPT Codes Requiring Prior Authorization

Code	Description
22551	Fusion of spine bones with removal of disc at upper spinal column, anterior approach, complex, initial
22552	Fusion of spine bones with removal of disc in upper spinal column below second vertebra of neck, anterior approach, each additional interspace

Documentation Requirements

Documentation that is recommended for support of coverage of cervical fusion with disc removal includes but is not limited to:

- Medical imaging of the cervical spine within the last year:
  - Confirms spinal cord/nerve root compression
- Physical examination that identifies:
  - Treating diagnosis
  - Subjective and objective findings consistent with spinal cord/nerve root compression

- Pain characteristics including duration, location, and intensity
- Activity of daily living (ADLs) impairments

- Evidence of failed conservative treatment:
  - Physical therapy
  - Occupational therapy
  - Medications for a minimum of six weeks
  - Unresponsive epidural or nerve root block
  - Home exercise program
  - Use of assistive device or modification/restriction of activities

Additional Information

Include the length of time the patient trialed any conservative treatments within the clinical documentation. There may be certain conditions in which conservative treatment is not appropriate. Be sure to include the patient symptoms and all clinical findings that support foregoing conservative treatment.

In cases where conservative measures have not been completely exhausted: Situations arise where a fusion is approved without conservative treatment being documented clearly when an emergent situation is present. If an imaging report showing severe cord compression, osteophyte formation impinging on the spinal cord, loose pedicle screws affecting stability, severe fibrosis or formation of scar tissue compressing cord or nerves, and the patient's history and physical findings correlate to the imaging the surgeon should clearly document these findings and the reasons that such findings require imminent intervention.

Expedited requests are accepted if it is determined that a delay could seriously jeopardize the beneficiary's life, health, or ability to regain maximum function. The documentation must include the reason for each expedited request. Please note procedure scheduling is not a valid reason for an expedited request. If the expedited request is valid, a decision will be rendered within two business days. If it is determined that the request does not substantiate the need for an expedited review, providers will be notified, and the request will return to the standard timeframe of 10 business days.

For more information, see the OPD Operational Guide.