Kaiser Foundation Health Plan

Clinical Policy for Medical Necessity Criteria for Lumbar Spinal Fusion

Department: Orthopedic/Neurosurgery	**Effective:** 2/4/2026
Policy #: NCP 15	**Last Reviewed:** 2/4/2026

Overview/Definitions

Medical necessity criteria and policy are applied only after member eligibility and benefit coverage is determined. Questions concerning member eligibility and benefit coverage need to be directed to Membership Services.

Neurogenic claudication is bilateral or unilateral leg pain upon standing and walking that is temporarily relieved by forward flexion or sitting or lying down. The pain of lumbar stenosis is caused by relative ischemia of the lumbar nerve roots when in an upright position.

Radicular pain/suspected radiculopathy:

Leg pain is > or equal to back pain present in *nerve root distribution* (e.g., L5, S1, etc.) PLUS, 1 or more of the following:

- Positive supine straight leg raising test - radicular leg pain reproduced when the leg is extended >30 degrees (e.g., if patient reported pain down the posterior thigh and lateral calf, expectation is a positive SLR test would reproduce that pain and not cause nonspecific pain like calf tightness or low back pain) OR
- Motor weakness or sensory loss in a radicular distribution (must be in a specific radicular distribution) OR
- EMG/NCS confirms acute radiculopathy consistent with the patient's symptoms

Conservative treatment:

Patients must have 3 months of non-operative treatment as demonstrated by a trial of **1 or more** of the following medications:

- Non-steroidal anti-inflammatory drugs (oral or topical)
- Acetaminophen
- Epidural steroid injection of corticosteroids as appropriate

AND

A trial of **All** of the following physical measures:

- At least 3 visits of Physical Therapy with >50% in person (not virtual)
- Flexibility and muscle strengthening exercises

- Reasonable restriction of activities

If conservative therapy is not appropriate, the medical record must clearly document why such an approach is not reasonable.

Coverage Determinations

Line of Business	Determination Name/Number & Contractor	Revision Date
For Medicare Members		
NCD	None	
LCD	None. For Medicare lines of business, use the KP criteria below.	
For Medicaid Members		
OR Medicaid	This policy does not apply. Check Linefinder.	
WA Medicaid	This policy does not apply.	
Commercial and Self-Funded Plans		
OR Commercial	This policy applies	
WA Commercial	This policy applies	
Self-funded Plans	This policy applies	

Clinical Indications

Lumbar Spinal Fusion may be considered medically necessary when 1 or more of the following are met:

1) Spinal fracture (acute) repair indicated by **1 or more** of the following:
   - Spinal instability due to trauma; or
   - Neural compression due to trauma

2) Lumbar spinal stenosis with spondylolisthesis due to degenerative disease or congenital spondylolysis. Treatment indicated by **ALL** the following:
   - Imaging findings of lumbar spondylolisthesis defined as > 4 mm forward shift in the sagittal plane (viewed from the side) on standing flexion/extension plain x-rays **OR** Grade I or greater on the Myerding grading system (see table below)
   - Clinically important findings of spinal stenosis indicated by **1 or more** of the following:
     - Progressive or severe symptoms of neurogenic claudication or radicular pain/ suspected radiculopathy with **ALL** the following documented in notes:

        - Significant functional impairment; and
        - Central, lateral recess or foraminal stenosis demonstrated on imaging (e.g., MRI, CT myelography); and
        - Failure of at least 3 months of continuous conservative therapy within the last 12 months
    - Severe or rapidly progressive symptoms of motor loss, neurogenic claudication, or cauda equina syndrome

3) Severe degenerative scoliosis treatment with progression of deformity to greater than 30 degrees (and 40 degrees for adolescents) and having failed 3 months of conservative treatment and with **1 or more** of the following:

- Persistent significant radicular pain or weakness unresponsive to non-operative therapy
- Persistent neurogenic claudication unresponsive to non-operative therapy

4) Spinal instability due to prior surgery for neural decompression including laminectomy (must meet criteria of imaging findings of lumbar spondylolisthesis defined as > or equal to 4 mm shift in the sagittal plane (viewed from the side) on flexion/extension plain x-rays; dislocation, infection, abscess, or tumor.

5) Anticipated spinal instability (patient has not had prior fusion) due to **1 or more** of the following:

- Planned extensive surgery for dislocation, infection, abscess, or tumor
- Current plan for revision of prior decompressive surgery with anticipated instability due to wide resection needed

6) Revision fusion surgery (with history of previous fusion surgery) for adjacent segment disease as indicated by **ALL** the following:

- Radiographic evidence of adjacent segment disease (e.g., significant neural compression that correlates with symptoms)
- Persistent disabling symptoms (low back pain, radiculopathy, neurogenic claudication* (see below)
- Trial of at least 3 physical therapy visits with at least 2 in person

7) Documented pseudoarthrosis (nonunion of prior fusion) when **ALL** the following are met:

- Radiological studies showing **1 or more** of the following:
    - Lucency surrounding the hardware; or
    - Fracture of the hardware; or
    - Absence of bridging bony arthrodesis on CT imaging 12 months or more post-operative
- Previous fusion at least 12 months ago
- Persistent daily axial back pain with or without neurogenic claudication or radicular pain

- Significant functional impairment inability to perform activities of daily living, school, and work
- Trial of at least 3 physical therapy visits with at least 2 in person

8) Recurrent disc herniation in the setting of previous surgical microdiscectomy at the same level when **ALL** the following are met:

- Previous disc surgery greater than 6 months ago
- Recurrent neurogenic claudication or radicular pain unresponsive to 3 months of conservative therapy
- Neural element compression (central, lateral recess or foraminal stenosis) documented by recent imaging consistent with signs and symptoms

Patients must meet the following criteria for Lumbar Spinal Fusions:

- BMI <40 (BMI >40 is a relative contraindication to fusion in patients without progressive neurologic deficit or cord compression)

Allograft and autograft use in lumbar spinal fusion is covered if the requested procedure meets the criteria above for lumbar spinal fusion procedures.

The Myerding grading system measures the percentage of vertebral slip forward over the body beneath:

Grade	Percentage
grade 1	Up to 25 % of vertebral body has slipped forward
grade 2	25 % to 49 % of vertebral body has slipped forward
grade 3	50 % to 74 % of vertebral body has slipped forward
grade 4	75 % to 99 % of vertebral body has slipped forward
grade 5	Vertebral body has completely fallen off (i.e., spondyloptosis)

Exclusions

Spinal fusion is considered experimental or not medically necessary in these instances:

- A lumbar fusion for a spinal deformity not meeting one of above criteria performed primarily for low back pain.
- A lumbar fusion performed for any condition not listed above, including non-radicular pain with common degenerative changes (degenerative disc disease, facet joint arthrosis, etc.) or post-laminectomy low back pain.

- Minimally Invasive Lumbar Decompression (MILD): There is insufficient evidence in the published medical literature to show that this service/therapy is as safe as standard services/therapies and/or provides better long-term outcomes than current standard services/therapies.

Coding

CPT Codes	Description
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)
22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)
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 and segment; lumbar
22634	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 and segment; each additional interspace and segment (List separately in addition to code for primary procedure)
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
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)
22841	Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)
22842	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)
22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)
22846	Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)
22848	Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure)
22849	Reinsertion of spinal fixation device
22853	Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)
22854	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, 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)
22859	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)
63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)

S2348	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single or multiple levels, lumbar
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)
20936	Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from same incision (List separately in addition to code for primary procedure)
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)
20938	Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) (List separately in addition to code for primary procedure)

***Note:** Codes may not be all-inclusive. Deleted codes and codes not in effect at the time of service may not be covered.

History Details

Type	Action	Date
Review/Revised	Reviewed at UM Quality Oversight Committee	3/17/26