Cervical spine surgery

We provide coverage for this procedure for adult members who meet medical necessity criteria. Submit authorization requests through the e-referral system.

The submitter will receive a prompt to complete a questionnaire to determine the appropriateness of the requested service. The questions are listed below.

If all questions are answered, e-referral will either approve or pend the case. If the case pends and we cannot authorize it, we will contact the provider for additional clinical information. Authorization is not a guarantee of payment.

Payment is based on established claim edits. We will retrospectively monitor compliance with this authorization requirement.


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You must attach the radiology reports from the most recent imaging in the Case Communications field in the e-referral system. For requests that pend, you must also attach any clinical information from the patient’s record that you would like BCN to consider.

See below for the questions you’ll encounter in the e-referral system.

Questions:

Q Does the patient have an atlantoaxial (C1-C2) subluxation greater than 5 mm identified by imaging and ONE of the following conditions (A-C)? A. Rheumatoid arthritis. B. Os odontoideum (an abnormality of the second cervical vertebrae characterized by a separation of a portion of the odontoid process from the body of the axis.) C. Congenital abnormality of the first or second cervical vertebrae.

A Possible answers: □ Yes □ No □ N/A
## Preview questionnaire:
### Cervical spine surgery
For BCN HMO℠ (commercial) and BCN Advantage℠ members
**Effective Aug. 25, 2019**

<table>
<thead>
<tr>
<th>Question</th>
<th>Possible answers:</th>
<th>□ Yes □ No □ N/A</th>
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<tbody>
<tr>
<td>Does the patient have a primary bone or metastatic tumor of the cervical spine that was diagnosed by imaging AND BOTH of the following (A-B)? A. Confirmed by biopsy. B. Suspicion that excision of the tumor will cause instability of the cervical spine.</td>
<td>□ Yes □ No □ N/A</td>
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<tr>
<td>Does the patient have vertebral body destruction confirmed by imaging which is secondary to osteomyelitis identified by bone aspiration, biopsy or MRI AND it’s suspected that debridement will cause instability of the cervical spine?</td>
<td>□ Yes □ No □ N/A</td>
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<td>Does the patient have discitis or epidural abscess with instability identified by imaging AND at least ONE of the following (A-B)? A. Neurological deficits by physical exam. B. Continued symptoms or findings after antibiotic treatment</td>
<td>□ Yes □ No □ N/A</td>
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<tr>
<td>Does the patient have a nonunion after spinal fusion identified by imaging AND ALL of the following (A-C)? A. At least 6 months has lapsed from the previous spinal fusion surgery. B. Initial resolution of symptoms after surgery. C. Pain at the same level as prior to having the previous surgery.</td>
<td>□ Yes □ No □ N/A</td>
<td></td>
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</table>
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**Q** For neck pain NOT DUE TO ACUTE TRAUMA without neurological deficits that ALSO interferes with ADL’s (for example, ability to perform personal hygiene, work effectively, manage home), select the following X-ray results. Note: If none of the findings apply, you must select "None of the above."

**A**

**Possible answers:**
- ☐ Sagittal plane translation greater than 2mm
- ☐ Sagittal plane translation greater than 20%
- ☐ Sagittal plan angulation greater than 11 degrees
- ☐ None of the above
- ☐ N/A

**Q** Does the patient have neck pain WITH continued symptoms or findings AFTER ALL of the following (A-C)? A. Appropriate nonsteroidal anti-inflammatory drugs or acetaminophen for at least 3 weeks (unless contraindicated/not tolerated). B. Physician directed home exercise program OR physical therapy for at least 12 weeks. C. Activity modification for at least 12 weeks.

**A**

**Possible answers:** ☐ Yes ☐ No ☐ N/A

**Q** Does the patient have an ACUTE traumatic spine injury and ALL of the following (A-C)? A. Unstable vertebral fracture or dislocation on imaging that correlates with symptoms and findings. B. No neurologic deficits. C. Stabilization of the spine is not achievable by nonsurgical means (for example, closed reduction, immobilization, brace).

**A**

**Possible answers:** ☐ Yes ☐ No ☐ No imaging was performed ☐ N/A

**Q** Does the patient have nerve root compression by imaging?

**A**

**Possible answers:** ☐ Yes ☐ No ☐ No imaging was performed ☐ N/A
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### Preview questionnaire:

#### Does the patient have SEVERE symptoms and findings NOT associated with radiculopathy (no motor or sensory deficit in a specific nerve root distribution) with at least ONE of the following (A or E)?

- A. Bilateral upper or lower extremity weakness (less than 2 out of 5 muscle strength), numbness or pain.
- B. Bowel or bladder dysfunction and other etiologies excluded.
- C. Spasticity by physical exam and other etiologies are excluded.
- D. Bilateral loss of dexterity (decreased fine motor control in the hands).
- E. Gait disturbances and other etiologies are excluded.

Possible answers: □ Yes □ No □ N/A

#### Does the patient have unilateral (one sided) RADICULOPATHY AND nerve root compression by imaging that correlates with symptoms and findings?

Note: Please consider the following definitions when responding to this question:

**Radiculopathy with a Motor Deficit** refers to depressed or asymmetrical reflexes or weakness in affected muscles in a SPECIFIC NERVE ROOT DISTRIBUTION. For example, deltoids and biceps (C5), biceps and brachioradialis (C6), triceps and wrist extensors (C7), intrinsic hand muscles (C8).

**Radiculopathy with a Sensory Deficit** refers to numbness or pain in a SPECIFIC NERVE ROOT DISTRIBUTION. For example: neck, shoulder and upper arm pain (C5); neck, shoulder and radial forearm pain (C6); neck, shoulder and dorsal forearm pain (C7); neck, shoulder and ulnar forearm pain (C8).

Possible answers: □ Yes □ No □ No imaging was performed □ N/A

#### Does the patient have RADICULOPATHY WITH a sensory deficit** AND NO motor deficit** AND at least ONE of the following (A-C)?

- A. Pain.
- B. Numbness.
- C. Paresthesia (sensation of tingling, tickling, pricking, or burning) in a nerve root distribution.

Note: Please consider the following definitions when responding to this question:

**Radiculopathy with a Motor Deficit** refers to depressed or asymmetrical reflexes or weakness in affected muscles in a SPECIFIC NERVE ROOT DISTRIBUTION. For example, deltoids and biceps (C5), biceps and brachioradialis (C6), triceps and wrist extensors (C7), intrinsic hand muscles (C8).

**Radiculopathy with a Sensory Deficit** refers to numbness or pain in a SPECIFIC NERVE ROOT DISTRIBUTION. For example: neck, shoulder and upper arm pain (C5); neck, shoulder and radial forearm pain (C6); neck, shoulder and dorsal forearm pain (C7); neck, shoulder and ulnar forearm pain (C8).

Possible answers: □ Yes □ No □ N/A

#### Does the patient have RADICULOPATHY WITH a motor deficit** AND SEVERE weakness (less than 2 out of 5 muscle strength)?

Note: Please consider the following definitions when responding to this question:

**Radiculopathy with a Motor Deficit** refers to depressed or asymmetrical reflexes or weakness in affected muscles in a SPECIFIC NERVE ROOT DISTRIBUTION. For example, deltoids and biceps (C5), biceps and brachioradialis (C6), triceps and wrist extensors (C7), intrinsic hand muscles (C8).

Possible answers: □ Yes □ No □ N/A
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Does the patient have RADICULOPATHY with a motor deficit*** with MILD TO MODERATE weakness in a nerve root distribution by physical exam that is worsening? Note: Please consider the following definitions when responding to this question: ***RADICULOPATHY WITH A MOTOR DEFICIT refers to depressed or asymmetrical reflexes or weakness in affected muscles in a SPECIFIC NERVE ROOT DISTRIBUTION. For example, deltoids and biceps (C5), biceps and brachioradialis (C6), triceps and wrist extensors (C7), intrinsic hand muscles (C8).

Possible answers: □ Yes □ No □ N/A

Does the patient have neck pain WITH continued symptoms or findings AFTER ALL of the following (A-C)? A. Appropriate nonsteroidal anti-inflammatory drugs or acetaminophen for at least 3 weeks (unless contraindicated/not tolerated). B. Physician directed home exercise program OR physical therapy for at least 6 weeks. C. Activity modification for at least 6 weeks.

Possible answers: □ Yes □ No □ N/A

Does the patient have RADICULOPATHY WITH a sensory deficit** AND a motor deficit*** with MILD TO MODERATE weakness in a nerve root distribution by physical exam that continues without worsening AND ALL of the following (A-C)? A. Pain. B. Numbness. C. Parasthesia (sensation of tingling, tickling, pricking, or burning). Note: Please consider the following definitions when responding to this question: ***RADICULOPATHY WITH A MOTOR DEFICIT refers to depressed or asymmetrical reflexes or weakness in affected muscles in a SPECIFIC NERVE ROOT DISTRIBUTION. For example, deltoids and biceps (C5), biceps and brachioradialis (C6), triceps and wrist extensors (C7), intrinsic hand muscles (C8).
**RADICULOPATHY WITH A SENSORY DEFICIT refers to numbness or pain is present in a SPECIFIC NERVE ROOT DISTRIBUTION. For example: Neck, shoulder and upper arm pain (C5); neck, shoulder and radial forearm pain (C5); neck, shoulder and dorsal forearm pain (C7); neck, shoulder and ulnar forearm pain (C8).

Possible answers: □ Yes □ No □ N/A
### Does the patient's medical record show documentation that all behavioral, cognitive and substance abuse issues were addressed?

- **Possible answers:**
  - □ History of issues addressed and in full remission
  - □ Active issues; undergoing adequate active treatment currently
  - □ Active issues; not being adequately treated currently
  - □ No History of behavioral or substance abuse issues

### Is there documentation in the patient's medical record indicating that the patient was educated that cigarette smoking has been shown to adversely affect cervical spinal fusion outcomes and that smoking cessation prior to and after surgery was recommended to the patient with both pharmacologic and non-pharmacologic assistance having been offered?

- **Possible answers:** □ Yes □ No □ N/A, patient does not smoke