Spinal Fusion and Stabilization Surgery

Humana

Medicaid Medical Coverage Policy

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Scope

This policy applies to all physical and behavioral health prior authorization requests received by Humana Healthy Horizons in Ohio.

Policy

Humana Healthy Horizons in Ohio uses established criteria guidelines to make medical necessity decisions and follows the below procedure. Decisions are made on a case-by-case basis, utilizing the information provided about the member's health status and an assessment of the local delivery system. Emergent services do not require a referral or preauthorization.

The Plan covers all benefits and services required in Ohio Administrative Code (OAC) chapter 5160 in the amount, duration, and scope for the same services furnished to members under the fee-for-service (FFS) Medicaid.

When the plan receives a request for a primary code that requires prior authorization and the primary code is denied for lack of medical necessity, any related secondary codes submitted on the authorization request will be denied based on lack of medical necessity. When a primary code is approved, related secondary codes requiring prior authorization will be reviewed individually for medically necessity determinations.

Please see Ohio Medicaid Prior Authorization and Notification List for a list of CPT and HCPCS codes that require prior authorization.

Humana Healthy Horizons in Ohio will review requested non-MCO covered codes and services as required for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for medical necessity to ensure children and adolescents receive appropriate and preventative, dental, mental health, developmental and specialty services.

Humana Healthy Horizons in Ohio does not cover services, items or devices that have not been approved by the Food and Drug Administration (FDA). Other factors affecting reimbursement supersede this policy. These factors include but are not limited to Federal and/or State statutes and regulations, the State Plan, the MCE Manual, physician or other provider contracts, the beneficiaries' benefit coverage documents, and/or other reimbursement, medical or drug policies.

Providers may submit authorization request(s) through the provider portal. A provider may request an urgent prior authorization in situations where the provider considers a delay in providing services, supplies or prescription drugs requiring prior authorization to be detrimental to the health of the member. The absence of authorization and/or notification prior to the date of a service could result in financial penalties for the practice and reduced benefits for the member, based on the healthcare provider's contract and the member's Certificate of Coverage. Services or medications provided without preauthorization may be subject to retrospective medical necessity review. We recommend individual practitioners making specific requests for services or medications verify benefits and preauthorization requirements with Humana prior to providing services.

Medical necessity documentation and rationale must be submitted with the prior authorization request. Providers may access physical and behavioral clinical coverage policies and medical necessity criteria at the below links.

Physical Health:
www.humana.com/provider/medical-resources/ohio-medicaid/physical-health-clinical-coverage-policies

Behavioral Health:
www.humana.com/provider/medical-resources/ohio-medicaid/behavioral-health-clinical-coverage-policies

Members may request a copy of the medical necessity criteria by calling member services at 877-856-5702 (TTY:711), Monday-Friday, 7AM to 8PM EST.

Providers may request a copy of the medical necessity criteria by calling provider services at 877-856-5707 (TTY:711), Monday-Friday, 7AM to 8PM EST or emailing the request to ODMCDUM@humana.com.

Procedures

1. The Plan uses the following hierarchy of guidelines to review for medical necessity:
   - 1.1 Federal or state regulation, including medical criteria published in the Ohio Administrative Code, Chapter 5160.
   - 1.2 Nationally accepted evidence based clinical guidelines: MCG (formerly Milliman Care Guidelines), American Society of Addiction Medicine (ASAM) Level of Care Adolescent Guidelines and American Society of Addiction Medicine (ASAM) Patient Placement Criteria (ASAM Admission Guidelines).
   - 1.3 Humana Healthy Horizons™ in Ohio clinical policies
   - 1.4 In the case of no guidance from above, additional information that the clinical reviewer will consider, when available, includes;
     - 1.4.1 Clinical practice guidelines and reports from peer reviewed medical literature, from which a higher level of evidence and study quality is more strongly considered in determinations;
     - 1.4.2 Professional standards for safety and effectiveness recognized in the US for diagnosis, care, or treatment;
     - 1.4.3 Medical association publications;
     - 1.4.4 Government-funded or independent entities that assess and report on clinical care; Decision and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.;
     - 1.4.5 Published expert opinions;
     - 1.4.6 Opinion of health professionals in the area of specialty involved;
     - 1.4.7 Opinion of attending provider;
   - 1.5 Dental: DentaQuest coverage guidelines and policies
     Dental Coverage - Humana Healthy Horizons in Ohio | Humana
   - 1.6 Vision: EyeMed coverage guidelines and policies
     Vision Care - Humana Healthy Horizons - Ohio Medicaid | Humana

Description

Artificial Intervertebral Disc Replacement

Artificial intervertebral disc replacement is an alternative to lumbar spinal fusion surgery for an individual suffering from pain due to degenerative disc disease (DDD). The artificial disc was designed to restore normal disc height, to preserve spinal flexibility and decrease degeneration of adjacent discs, which can occur as a result of DDD.

Examples of FDA-approved devices for the lumbar spine include, but may not be limited to:

- **activL** artificial disc
- **ProDisc L** total disc replacement

Corpectomy

Corpectomy is a surgical procedure to remove the body of a vertebra, as well as the disc. This procedure is most frequently carried out in the cervical spine and is usually paired with spinal fusion. The primary purpose is to relieve pressure on the spinal cord and/or nerve roots.

Facet Joint Replacement/Implant

Facet joint replacement/implant is a relatively new procedure/device for facet joint degeneration, which has been proposed to be used in conjunction with a spinal fusion or as a stand-alone procedure. When performed as a stand-alone procedure, it is purported as a system for facet joint reconstruction, matching the joint shape and size in order to provide pain relief, normal motion and stability. Examples include, but may not be limited to, **Acadia Facet Replacement System** (which is not FDA approved) and **ION Facet Screw Spinal Fixation Implant**.

Sacroiliac Joint Fusion

Sacroiliac joint (SIJ) fusion has been suggested as a possible treatment option for an individual with low back pain due to sacroiliac joint dysfunction or syndrome. This procedure may be performed by an open surgical approach or as a minimally invasive procedure in order to place plates and/or screws to develop a bony fusion across the SIJ for stabilization.

The **iFUSE Implant System** consists of small triangular titanium implants placed *across* the sacroiliac joint (may be referred to as a lateral transiliac approach or placement of a transfixation device) to stabilize and fuse it via a percutaneous, minimally invasive approach with use of fluoroscopy to visualize placement of the implants. The triangular shape of the implants helps minimize rotation while also maximizing surface area contact across the SIJ.

Minimally invasive SIJ fusion may also be accomplished via other anatomical approaches (eg, posterior, intra-articular [within the SI joint]) or with differently designed implants (eg, cylindrical threaded implants, hollow conical shaped barrel implants). Examples of other minimally invasive systems used for SIJ fusion include, but may not be limited to:

- **Firebird SI Fusion System**
- **Genesys Sacroiliac Joint Fusion System**
- **LinQ**
- **Prolix SI Fusion System**
- **Rialto SI Fusion System**
- **Sacrofuse SIJFuse Sacroiliac Joint Fusion Device System**
- **SI-DESIS**
- **Siber Ti 3D**
- **Siconus SI Joint Fixation System**
- **SIFix**

- **SIJoin**
- **Silex Sacroiliac Joint System**
- **SILO TFX MIS Sacroiliac Joint Fixation System**
- **SImmetry Sacroiliac Joint Fusion System**
- **SIros 3D Printed SI Joint System (lateral, oblique, posterior, hybrid)**
- **TiLink-L**
- **TiLink-P**
- **TransLoc 3D**
- **Triton Sacroiliac Joint Fixation System**

Spinal Fusion Surgery

Spinal fusion, also known as spinal arthrodesis, is a surgical treatment for cervical (neck), lumbar (low back) or thoracic (mid-back) pain that fuses (unites) two or more vertebral bodies in the spinal column. The most common goal of spinal fusion surgery is to restrict spinal motion in order to relieve painful symptoms. Spinal fusion surgery is generally performed to treat DDD, scoliosis or kyphosis (abnormal spinal curvatures), spondylolisthesis, trauma resulting in spinal nerve compression and vertebral instability caused by infections or tumors.

Spinal fusion may be performed using a minimally invasive or open approach. All fusion surgeries involve the placement of a bone graft between the vertebrae. The bone graft may be either autograft (from another bone in the individual), allograft (bone from a bone bank) or a bone graft substitute product.

The spine may be approached, and the graft placed, from either an anterior (front of the body), posterior (back of the body), lateral (from the side) or by a combination anterior/posterior approach. A fusion can be performed with or without the use of supplemental hardware such as plates, screws or cages that serve as an internal splint while the bone graft heals. However, current practice most commonly employs hardware in addition to the grafts.

Spinal Osteotomy

Spinal osteotomy is a surgical procedure in which a portion of one or more vertebra is cut and removed to correct spinal deformity or to restore proper alignment of the spine. The procedure is commonly used to treat severe, rigid and fixed spinal deformities such as kyphosis and scoliosis. Typically, spinal osteotomy is one distinct portion of a larger procedure that requires the placement of hardware and/or bone graft with the intent of improving balance, relieving pain and alleviating compression of the thoracic and abdominal cavities.

Coverage Determination

Corpectomy (63081)

Humana members may be eligible under the Plan for **corpectomy** when the following criteria are met:

- Evidence of spinal cord or nerve root compression, confirmed by diagnostic imaging studies[10]; **AND ONE** of the following conditions:

- Degenerative disease due to one of the following:
  - Free disc fragment that has migrated posterior to the vertebral body[23]; **OR**
  - Large posterior osteophyte adjacent to the end plate[10]; **OR**
- Infection (osteomyelitis, discitis)[10]; **OR**
- Ossification of the posterior longitudinal ligament (if treated anteriorly)[10]; **OR**
- Trauma (vertebral fractures) in the cervical, thoracic or lumbar regions[23]; **OR**
- Tumors in the cervical, thoracic or lumbar regions[23]

Lumbar Artificial Intervertebral Disc Replacement (22857)

Humana members may be eligible under the Plan for **lumbar artificial intervertebral disc replacement** when **ALL** of the following criteria are met:

- An FDA-approved lumbar artificial intervertebral disc for replacement at ***ONE*** level, from L3 to S1[47]; **AND**
- Degenerative disc disease confirmed by a complex imaging study[66,67] (eg, CT, MRI, positive concordant discography); **AND**
- Absence of contraindications, including ANY of the following:
  - Abdominal pathology precluding an anterior retroperitoneal approach[66,67]; **OR**
  - Active or chronic infection (systemic or infection localized to the operative site)[66,67]; **OR**
  - Allergy or sensitivity to the implant materials (eg, calcium phosphate, cobalt, chromium, molybdenum, polyethylene, tantalum or titanium)[66,67]; **OR**
  - Bony lumbar stenosis[66,67]; **OR**
  - Chronic radiculopathy over a period of at least 1 year[66,67]; **OR**
  - Clinically compromised vertebral bodies at the affected level due to current or past disease (eg, ankylosing spondylitis) or trauma (eg, fracture)[66,67]; **OR**
  - Extruded disc material with sequestrum (free disc fragment)[66,67]; **OR**
  - Facet ankylosis or moderate or severe[39] facet joint degeneration[66,67]; **OR**
  - Involved vertebral endplate dimensionally smaller than 31 mm for activL or 34.5 mm for ProDisc L in the medial lateral and/or 26 mm for activL or 27 mm for ProDisc L in the anterior posterior directions[66,67]; **OR**

- Isolated lumbar radiculopathy, especially due to herniated disc[66,67]; **OR**
- Myelopathy[66,67]; **OR**
- Osteoporosis or osteopenia defined as DEXA bone mineral density T-score less than or equal to negative 1.0[66,67]; **OR**
- Pars defect[66,67]; **OR**
- Preoperative remaining disc height less than 3 mm[66,67]; **OR**
- Scoliosis[66,67]; **OR**
- Spondylolisthesis (degenerative, isthmic or lytic) greater than grade I or segmental instability[66,67]; **AND**

- Documentation of skeletal maturity***[66,67]; **AND**
- Failure of at least 6 months of conservative treatment[19,55,66,67] under the direction of a healthcare professional within the past 12 months with **ALL** of the following:
  - Epidural steroid injections if medically appropriate and not contraindicated[19]; **AND**
  - Modification of pain-inducing activities[18]; **AND**
  - Medications (eg, nonsteroidal anti-inflammatory [NSAIDs] if medically appropriate and not contraindicated[19]; **AND**
  - Physical therapy (PT) including a home exercise program (HEP)[18]; **AND**
- Implantation via an anterior or anterior retroperitoneal approach[55,66,67]; **AND**
- No more than grade I spondylolisthesis at the involved level[66,67]; **AND**
- Presurgical psychological evaluation conducted by a qualified behavioral health provider to identify surgical readiness and potential postoperative challenges that may contribute to a poor postoperative outcome[5]; **AND**
- Unremitting low back pain and functional impairment****[21]

Revision or Replacement of a Lumbar Artificial Intervertebral Disc (0165T)

Humana members may be eligible under the Plan for **revision or replacement** of a lumbar artificial intervertebral disc *at the same level as the previous surgery* when **ALL** of the following criteria are met:

- Original surgery was performed with an FDA-approved device, and in accordance with those approved indications; **AND**

- Imaging studies confirm implanted device mechanical failure (eg, dislodgement, implanted device breakage, infection, loosening, vertebral body fracture)[25]; **AND**

- Symptoms were relieved by original procedure, but reoccurred upon failure of the implanted device[25]

*****Skeletally mature refers to a system of fused skeletal bones which occur when bone growth ceases.

******Functional impairment is defined as a direct and measurable reduction in physical performance of an organ or body part limiting the ability to perform ADLs such as bathing, dressing and mobility (eg, sit, stand, walk) due to illness or pain.

Percutaneous Minimally Invasive Sacroiliac Joint Fusion (27279)

Humana members may be eligible under the Plan for **minimally invasive SIJ fusion using triangular titanium implants**, via a lateral transiliac approach (implant placement *across* the SIJ) **for chronic low back pain due to sacroiliac joint dysfunction** when the following criteria are met:

- Absence of contraindications, including ANY of the following[48,57]:

  - Acute, traumatic instability of the SIJ; **OR**
  - Fractures (including sacral insufficiency fractures); **OR**
  - Generalized pain behavior (eg, somatoform disorder); **OR**
  - Generalized pain disorder (eg, fibromyalgia); **OR**
  - Infection (localized or systemic [sepsis]); **OR**
  - Systemic arthropathy (eg, ankylosing spondylitis, rheumatoid arthritis); **OR**
  - Tumor involving the sacrum or SIJs;

AND

- Failure of 6 months of conservative treatment[48,57] including **at least 2** of the following:

  - Bracing[48,57]

  - Medications (eg, NSAIDs, non-narcotic analgesics) if medically appropriate and not contraindicated[48,57]

  - PT, including HEP and core stabilization exercises[48,57];

AND

- Imaging studies exclude the presence of other causes for SIJ dysfunction/pain including, but not limited to[48,57]:

    - Acute fracture
    - Concomitant hip osteoarthritis
    - Destructive SIJ lesions (infection, tumors)
    - Inflammatory arthropathy
    - Lumbar spine degenerative conditions or neural compression;

AND

- Positive response (reproduction of individual's typical SIJ pain) to **at least 3** of the following provocative tests/maneuvers[48,57]:

    - Compression test
    - Distraction test
    - FABER test (also referred to as Patrick test)
    - Gaenslen's test
    - Thigh thrust test (also referred to as posterior pelvic pain provocation);

AND

- Positive response to 2 diagnostic, image-guided SIJ injections, at two separate occasions (a positive response is defined as at least a 75% reduction in pain and/or symptoms)[57]

Sacroiliac Joint Fusion (Open Surgical Approach) (27280)

Humana members may be eligible under the Plan for **open sacroiliac joint fusion surgery** when the following criteria are met, as confirmed by radiographic evidence (CT or MRI):

- Fractures (eg, pelvic ring fracture, sacral fracture)[51]; **OR**

- Pelvic instability (eg, dislocation)[51]; **OR**

- Primary sacral tumors[51]; **OR**

- Sacroiliac joint infection (eg, osteomyelitis)[51]; **OR**

- When performed as part of a thoracolumbar fusion for correction of spinal deformity (eg, scoliosis, spondylolysis)[8]

Revision Sacroiliac Joint Fusion
Humana members may be eligible under the Plan for **revision sacroiliac joint fusion surgery** when **either** of the following criteria are met[51]:

- Individual is symptomatic with ongoing SI joint pain and radiographic evidence of pseudoarthrosis or nonunion with lucency, device malposition or failure of the device; **OR**

- Infection secondary to or involving the implant/device

Spinal Fusion Surgery
Humana members may be eligible under the Plan for **a bone graft utilizing an allograft or autograft** and/or **use of cages, instrumentation, plates, screws** or **wires** when a medically necessary spinal fusion is performed.

The following codes may apply: **22840, 22841, 22845, 22846, 22853**

Spinal Osteotomy (22214)
Humana members may be eligible under the Plan for **spinal osteotomy** when the following criteria are met:

- Spinal deformity confirmed by radiographic or advanced imaging for either of the following[16,18]:

    - Posterior column osteotomy (Smith-Peterson or Ponte osteotomy) when the following indications are met[16,18]:

        - Flexible coronal plane deformities (less than 30 degrees of correction required)[18]; **OR**
        - Flexible sagittal plane deformities (less than 30 degrees of correction required)[18]; **OR**
        - Scheuermann kyphosis[18]; **OR**
        - Functional limitations including any of the following, but not limited to[16]:

            - Decreased ability to perform ADLs; **OR**
            - Respiratory compromise; **OR**
            - Loss of horizontal gaze; **OR**
            - Disabling pain; **OR**

    - Three-column osteotomy (pedicle subtraction osteotomy or vertebral column resection) indications are met[16,18]:

        - Ankylosing spondylitis[18]; **OR**
        - Fixed coronal plane deformities (greater than 30 degrees of correction required)[18]; **OR**
        - Flexible sagittal plane deformities (greater than 30 degrees of correction required)[18]; **OR**
        - Flat back syndrome[18]; **OR**
        - Functional limitations including any of the following, but not limited to[16]:

- ❖ Decreased ability to perform ADLs; **OR**
- ❖ Respiratory compromise; **OR**
- ❖ Loss of horizontal gaze; **OR**
- ❖ Disabling pain; **OR**

- Sharp kyphotic deformities of the thoracic spine (greater than 50 degrees of correction)[18]

Coverage Limitations

Facet Joint Fusion (0222T)
Humana members may **NOT** be eligible under the Plan for **isolated facet joint fusion** (when performed as a stand-alone procedure [without a decompression procedure]).[26]

A review of the current medical literature shows that the **evidence is insufficient** to determine that this service is standard medical treatment for these indications. There is an absence of current, widely-used treatment guidelines or acceptable clinical literature (as defined by CMS) examining benefit and long-term clinical outcomes establishing the value of this service/in clinical management for these indications.

Lumbar Artificial Intervertebral Disc Replacement
Humana members may **NOT** be eligible under the Plan for **lumbar artificial intervertebral disc replacement** for any indications other than those listed above including, but may not be limited to:

- Multilevel lumbar disc replacement[47]; **OR**
- Planned procedure includes combined use of a lumbar artificial intervertebral disc replacement adjacent to a spinal fusion (also referred to as hybrid surgery)[41,55]; **OR**
- Prior spinal fusion surgery at the planned treatment level[66]

A review of the current medical literature shows that the **evidence is insufficient** to determine that this service is standard medical treatment. There is an absence of current, widely-used treatment guidelines or acceptable clinical literature examining benefit and long-term clinical outcomes establishing the value of this service in clinical management.

Sacroiliac Joint Fusion (Open Surgical Approach)
Humana members may **NOT** be eligible under the Plan for **open sacroiliac joint fusion surgery** for any indications other than those listed above including, but may not be limited to:

- Low back pain[58]; **OR**
- Sacroiliac joint dysfunction/syndrome[58]

A review of the current medical literature shows that the **evidence is insufficient** to determine that this service is standard medical treatment for these indications. There is an absence of current, widely-used treatment guidelines or acceptable clinical literature (as defined by CMS) examining benefit and long-term clinical outcomes establishing the value of this service/in clinical management for these indications.

Coding Information

Any codes listed on this policy are for informational purposes only. Do not rely on the accuracy and inclusion of specific codes. Inclusion of a code does not guarantee coverage and/or reimbursement for a service or procedure.

CPT® Code(s)	Description	Comments
20999	Unlisted procedure, musculoskeletal system, general	
22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar	
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)	
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)	
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)	
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar	
22899	Unlisted procedure, spine	
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	
27280	Arthrodesis, sacroiliac joint, open, includes obtaining bone graft, including instrumentation, when performed	

63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment	
CPT® Category III Code(s)	**Description**	**Comments**
0165T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)	
0222T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment (List separately in addition to code for primary procedure)	
HCPCS Code(s)	**Description**	**Comments**
No code(s) identified		

References

1. American Association American Society of Addiction Medicine. https://asam.org.

2. American Association of Neurological Surgeons (AANS). AANS/CNS position statement on arthrodesis of the spine by the non-spine surgeon. https://aans.org. Published October 14, 2021. Updated July 9, 2024.

3. American Society of Pain and Neuroscience (ASPN). Evidence-based clinical guideline of interventional treatments for low back pain. https://aspnpain.com. Published December 2022.

4. Balderston J, Gertz Z, McIntosh T, Balderston R. Long-term outcomes of 2-level total disc replacement using ProDisc-L. *Spine.* 2014;39(11):906-910.

5. ClinicalKey. Daubs F, Albanese J, Daubs M. Preoperative evaluation of psychosocial aspects and work-related issues. In: Steinmetz M, Berven S, Benzel E. *Benzel's Spine Surgery*. 5th ed. Elsevier; 2022:643-645.e2. https://clinicalkey.com.

6. ClinicalKey. Derman P, Zigler J, Guyer R, Blumenthal S, Lieberman I. Lumbar disk arthroplasty. In: Winn H. *Youmans and Winn Neurological Surgery.* 8th ed. Elsevier; 2023:2788-2793.e2. https://clinicalkey.com.

7. ClinicalKey. Devlin VJ. Pathology and pathoanatomy of degenerative disorders of the adult spine. In: Devlin VJ. *Spine Secrets*. 3rd ed. Elsevier; 2021:430-435.e1. https://clinicalkey.com.

8. ClinicalKey. Ehresman J, Pennington Z, Ahmed AK, Sciubba D. Complex lumbosacropelvic fixation techniques. In: Steinmetz M, Berven S, Benzel E. *Benzel's Spine Surgery*. 5th ed. Elsevier; 2022:1157-1164.e2. https://clinicalkey.com.

9. ClinicalKey. Gardocki RJ, Park AL. Degenerative disorders of the thoracic and lumbar spine. In: Azar FM, Beaty JH. *Campbell's Operative Orthopaedics*. 14th ed. Elsevier; 2021:1719-1801.e9. https://clinicalkey.com.

10. ClinicalKey. Hamilton K, Hurlbert J. Anterior cervical discectomy and corpectomy. In: Steinmetz M, Berven S, Benzel E. *Benzel's Spine Surgery. Techniques, Complication Avoidance, and Management.* 5th ed. Elsevier; 2022:969-979.e1. https://clinicalkey.com.

11. ClinicalKey. Heary R, Gillick J. Evaluation, indications, and techniques of revision spine surgery. In: Winn HR. *Youmans and Winn Neurological Surgery.* 8th ed. Elsevier; 2023:2853-2853.e27. https://clinicalkey.com.

12. ClinicalKey. Jack AS, Tymchak ZA, Hart RA. Surgical approaches for sacral fractures and sacropelvic injuries. In: Steinmetz M, Berven S, Benzel E. *Benzel's Spine Surgery.* 5th ed. Elsevier; 2022:1473-1479.e2. https://clinicalkey.com.

13. ClinicalKey. Jain N, Su BW, Shimer AL, Vaccaro AR. Artificial disc replacement. In: Devlin VJ. *Spine Secrets*. 3rd ed. Elsevier; 2021:314-322.e1. https://clinicalkey.com.

14. ClinicalKey. Koutsogiannis P, Khan S, Phillips F, et al. A cross-sectional analysis of 284 complications of lumbar disc replacements from medical device reports maintained by the United States Food and Drug Administration. *Spine J.* 2022;22:278-285. https://clinicalkey.com.

15. ClinicalKey. Maslak J, Casper D, Pelle D. Spine fusion: biology and biomechanics. In: Steinmetz M, Berven S, Benzel E. *Benzel's Spine Surgery.* 5th ed. Elsevier; 2022:122-129.e3. https://clinicalkey.com.

16. ClinicalKey. McGee A, Hajewski C, Boody BS, Sasso RC. Cervical osteotomy techniques. In: Vaccaro AR. *Operative Techniques: Spine Surgery.* 4th ed. Elsevier; 2025:118-128. https://clinicalkey.com.

17. ClinicalKey. Perfetti D, Galina J, Derman P, Guyer R, Ohnmeiss D, Satin A. Risk factors for reoperation for lumbar total disc replacement at short-, mid-, and long-term follow-up. *Spine J.* 2021;21:1110-1177. https://clinicalkey.com.

18. ClinicalKey. Raffa SJ, Boddu JV, Wang MY. Spinal osteotomies. In: Winn HR. *Youmans and Winn Neurological Surgery.* 8th ed. Elsevier; 2023:2848-2852.e1. https://clinicalkey.com.

19. ClinicalKey. Sack K, Rosner M. Evaluation and treatment of lumbar disk disease. In: Winn H. *Youmans and Winn Neurological Surgery.* 8th ed. Elsevier; 2023:2494-2497.e1. https://clinicalkey.com.

20. ClinicalKey. Safaee MM, Ames CP, Clark AJ. Posterior-based management of spinal deformity. In: Steinmetz M, Berven S, Benzel E. *Benzel's Spine Surgery.* 5th ed. Elsevier; 2022:1279-1282.e1. https://clinicalkey.com.

21. ClinicalKey. Satin A, Derman P, Guyer R. Lumbar total disc arthroplasty. In: Steinmetz M, Berven S, Benzel E. *Benzel's Spine Surgery*. 5th ed. Elsevier; 2022:1088-1098.e3. https://clinicalkey.com.

22. ClinicalKey. Scheer JK, Ha Y, Deviren V, Lee SH, Sears WR. Osteotomies of the cervical spine. In: Shen FH. *Textbook of the Cervical Spine*. Elsevier; 2015:337-351. https://clinicalkey.com.

23. ClinicalKey. Schmidt M, Kalra R. Thoracic corpectomy and reconstruction. In: Steinmetz M, Berven S, Benzel E. *Benzel's Spine Surgery. Techniques, Complication Avoidance, and Management.* 5th ed. Elsevier; 2022:1031-1039.e1. https://clinicalkey.com.

24. ClinicalKey. Sielatycki J, Devin C, Pennings J, et al. A novel lumbar joint replacement may be an improvement over fusion for degenerative lumbar conditions: a comparative analysis of patient-reported outcomes at one year. *Spine J.* 2021;21:829-840. https://clinicalkey.com.

25. ClinicalKey. Simpson A, Zigler J. Failed total disc arthroplasty. In: Garfin S, Eismont F, Bell G, Fischgrund J, Bono C. *Rothman-Simeone and Herkowitz's The Spine*. 7th ed. Elsevier; 2018:1889-1901. https://clinicalkey.com.

26. ClinicalKey. Warner WC, Sawyer JR. Scoliosis and kyphosis. In: Azar FM, Beaty JH. *Campbell's Operative Orthopaedics*. 14th ed. Elsevier; 2021:1998-2196.e28. https://clinicalkey.com.

27. ClinicalKey. Woodard D. Dorsal semirigid stabilization. In: Steinmetz M, Berven S, Benzel E. *Benzel's Spine Surgery.* 5th ed. Elsevier; 2022:1078-1087.e3. https://clinicalkey.com.

28. Congress of Neurological Surgeons (CNS). Guideline. Cervical surgical techniques for the treatment of cervical spondylotic myelopathy. https://cns.org. Published 2009.

29. Congress of Neurological Surgeons (CNS). Guideline update for the performance of fusion procedures for degenerative disease of the lumbar spine. Part 12: pedicle screw fixation as an adjunct to posterolateral fusion. https://cns.org. Published 2014.

30. ECRI Institute. Clinical Evidence Assessment. iFuse Implant System (SI-Bone, Inc.) for minimally invasive sacroiliac joint fusion. https://home.ecri.org. Published May 20, 2016. Updated November 4, 2022.

31. ECRI Institute. Clinical Evidence Assessment. iFuse-TORQ (SI-BONE, Inc.) for pelvic fracture fixation. https://home.ecri.org. Published August 1, 2022.

32. ECRI Institute. Clinical Evidence Assessment. LinQ (PainTeq) for sacroiliac joint fusion. https://home.ecri.org. Published February 1, 2020. Updated April 30, 2024.

33. ECRI Institute. Clinical Evidence Assessment. ProDisc-L lumbar total disc replacement system (Centinel Spine, Inc.) for treating degenerative disc disease. https://home.ecri.org. Published February 4, 2025.

34. ECRI Institute. Clinical Evidence Assessment. Rialto Sacroiliac Fusion System (Medtronic plc.) for minimally invasive spinal fusion. https://home.ecri.org. Published November 8, 2022.

35. ECRI Institute. Clinical Evidence Assessment. SI-LOK System (Globus Medical) for sacroiliac fusion. https://home.ecri.org. Published November 9, 2022.

36. ECRI Institute. Emerging Technology Evidence Report. Artificial intervertebral disc replacement (AIDR) for lumbar degenerative disc disease (DDD). https://home.ecri.org. Published March 12, 2004. Updated October 14, 2009.

37. ECRI Institute. Hotline Response. Sacroiliac joint fusion for treating chronic low-back pain. https://home.ecri.org. Published January 29, 2013. Updated May 11, 2016.

38. ECRI Institute. Product Brief. ActivL artificial disc (Aesculap, Inc.) for lumbar disc arthroplasty. https://home.ecri.org. Published August 1, 2018.

39. Eskandar T, Ahmed Z, Pan J, Agrawal D. The decline of lumbar artificial disc replacement. *J Spine Res Surg.* 2024;6(3):86-92.

40. Hayes, Inc. Evidence Analysis Research Brief. Spinal navigation systems for use in artificial disc replacement. https://evidence.hayesinc.com. Published February 28, 2024.

41. Hayes, Inc. Evolving Evidence Review. Hybrid lumbar disc arthroplasty with fusion for treatment of multilevel degenerative disc disease. https://evidence.hayesinc.com. Published April 5, 2024. Updated April 25, 2025.

42. Hayes, Inc. Evolving Evidence Review. Minimally invasive posterior sacroiliac joint fusion using a bone allograft for management of sacroiliac joint pain. https://evidence.hayesinc.com. Published March 22, 2024. Updated April 7, 2025.

43. Hayes, Inc. Evolving Evidence Review. Two-level lumbar total disk replacement for two-level degenerative disk disease. https://evidence.hayesinc.com. Published November 15, 2024. Updated November 7, 2025.

44. Hayes, Inc. Health Technology Assessment. Minimally invasive sacroiliac joint fusion using cylindrical threaded implants. https://evidence.hayesinc.com. Published September 22, 2020. Updated August 29, 2023.

45. Hayes, Inc. Health Technology Assessment. Minimally invasive sacroiliac joint fusion using triangular titanium implants (iFuse Implant System, SI-Bone Inc.). https://evidence.hayesinc.com. Published September 3, 2020. Updated August 29, 2023.

46. Hayes, Inc. Health Technology Brief. Open sacroiliac joint fusion for unspecified sacroiliac joint dysfunction. https://evidence.hayesinc.com. Published June 22, 2017. Updated July 24, 2019.

47. Hayes, Inc. Medical Technology Directory. Comparative effectiveness review of lumbar total disc replacement for degenerative disc disease. https://evidence.hayesinc.com. Published April 1, 2019. Updated March 24, 2022.

48. International Society for the Advancement of Spine Surgery (ISASS). 2020 update - minimally invasive surgical sacroiliac joint fusion (for chronic sacroiliac joint pain): coverage indications, limitations, and medical necessity. https://isass.org. Published December 2020.

49. International Society for the Advancement of Spine Surgery (ISASS). 2021 position statement from the International Society for the Advancement of Spine Surgery on cervical and lumbar disc replacement. https://isass.org. Published February 2021.

50. International Society for the Advancement of Spine Surgery (ISASS). ISASS Policy Statement. Minimally invasive sacroiliac joint fusion. https://isass.org. Published 2014. Updated July 5, 2016.

51. MCG Health. https://humana.access.mcg.com/index.

52. MCG Health. Musculoskeletal surgery or procedure GRG. https://humana.access.mcg.com/index.

53. North American Spine Society (NASS). Coverage Policy Recommendations. Cervical fusion. https://spine.org. Published July 2015. Updated May 2023.

54. North American Spine Society (NASS). Coverage Policy Recommendations. Interspinous fixation with fusion. https://spine.org. Published May 2014. Updated December 2019. Updated March 2025.

55. North American Spine Society (NASS). Coverage Policy Recommendations. Lumbar artificial disc replacement. https://spine.org. Published February 2019. Updated August 2024.

56. North American Spine Society (NASS). Coverage Policy Recommendations. Lumbar fusion. https://spine.org. Published June 2021.

57. North American Spine Society (NASS). Coverage Policy Recommendations. Minimally invasive sacroiliac joint fusion. https://spine.org. Published September 2021.

58. North American Spine Society (NASS). Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care. Diagnosis and treatment of low back pain. https://spine.org. Published 2020.

59. Ohio Administrative Code Chapter 5160 Ohio Department of Medicaid. Chapter 5160 - Ohio Administrative Code | Ohio Laws.

60. Ohio Administrative Code 5160-1-01 Medicaid medical necessity: definitions and principles. Rule 5160-1-01 - Ohio Administrative Code | Ohio Laws.

61. Ohio Administrative Code 5160-26-01 Managed care: definitions. Rule 5160-26-01 - Ohio Administrative Code | Ohio Laws.

62. Rasouli A, Cuellar J, Kanim L, Delamarter R. Multiple-level lumbar total disk replacement. A prospective clinical and radiographic analysis of motion preservation at 24-72 months. *Clin Spine Surg.* 2019;32(1):38-42.

63. UpToDate, Inc. Cervical spondylotic myelopathy. https://uptodate.com. Updated December 11, 2025.

64. UpToDate, Inc. Subacute and chronic low back pain: surgical treatment. https://uptodate.com. Updated October 3, 2025.

65. US Food & Drug Administration (FDA). 510(k) summary: iFuse Implant System. https://fda.gov. Published July 23, 2014.

66. US Food & Drug Administration (FDA). Summary of safety and effectiveness data: ActivL artificial disc. https://fda.gov. Published June 11, 2015.

67. US Food & Drug Administration (FDA). Summary of safety and effectiveness data: ProDisc-L total disc replacement. https://fda.gov. Published April 10, 2020.

68. Whang P, Darr E, Meyer SC, et al. Long-term prospective clinical and radiographic outcomes after minimally invasive lateral transiliac sacroiliac joint fusion using triangular titanium implants. *Med Devices.* 2019;12:411-422.

69. Whang P, Patel V, Duhon B, et al. Minimally invasive SI joint procedures for chronic SI joint pain: systematic review and meta-analysis of safety and efficacy. *Int J Spine Surg.* 2023;1-15.

Definitions

1. Adverse Benefit Determination – As defined in OAC rule 5160-26-01, is a managed care entity's (MCEs):
   1) Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
   2) Reduction, suspension, or termination or services prior to the member receiving the services previously authorized by the MCE;
   3) Failure to provide services in a timely manner as specified in rule 5160-26-03.1 of the Administrative Code;
   4) Failure to act within the resolution timeframes specified in rule 5160-26-08.4 of the Administrative Code;
   5) Denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities, if applicable; or

6) Denial, in whole or part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" as defined in 42 C.F.R. 447.45(b) (October 1, 2021) is not an adverse benefit determination).

2. American Society of Addiction Medicine (ASAM) – a professional medical society representing over 7,000 physicians, clinicians, and associated professionals in the field of addiction medicine. ASAM produces a comprehensive set of standards for placement, continued stay, transfer or discharge of patients with addiction and co-occurring conditions used by clinical staff to determine whether to refer a service request for physician review based upon the clinical information submitted by the requestor.
3. MCG – are nationally recognized guidelines used by clinical staff to determine whether to refer a service request for physician review based upon the clinical information submitted by the requestor.
4. Medically Necessary or Medical Necessity – Has the same meaning as OAC rule 5160-1-01:
   A. Medical necessity for individuals covered by early and periodic screening, diagnosis, and treatment (EPSDT) is criteria of coverage for procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat as adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.
   B. Medical necessity for individuals not covered by EPSDT is criteria of coverage for procedures, items, or services that prevent, diagnose, evaluate or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without which the person can be expected to suffer prolonged, increased, or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort.
   C. Conditions of medical necessity for a procedure, item, or service are met all the following apply:
      1) It meets generally accepted standards of medical practice;
      2) It is clinically appropriate in its type, frequency, extent, duration, and delivery setting;
      3) It is appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome;
      4) It is the lowest cost alternative that effectively addresses and treats the medical problem;
      5) It provides unique, essential, and appropriate information if it is used for diagnostic purposes; and
      6) It is not provided primarily for the economic benefit of the provider nor for the sole convenience of the provider or anyone else other than the recipient.
   D. The fact that a physician, dentist, or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself make the procedure, item, or service medically necessary and does not guarantee payment.
   E. The definition and conditions of medical necessity articulated in this rule apply throughout the entire medicaid program. More specific criteria regarding the conditions of medical necessity for particular categories of service may be set forth within the Ohio Department of Medicaid (ODM) coverage policies or rules.

Appendix

Appendix A
Spondylolisthesis Grades[26]
In this system the slip grade is calculated by determining the ratio between the anteroposterior diameter in the top of the first sacral vertebra and the distance the L5 has slipped anteriorly.

Grade I	25% or less displacement
Grade II	Between 25% and 50% displacement
Grade III	Between 50% and 75% displacement
Grade IV	More than 75% displacement
Grade V	L5 vertebra positioned completely below the top of the sacrum

Change Summary

03/03/2026 New Policy.