curative

TITLE:	SPINAL SURGERY - LAMINECTOMY AND FUSION POLICY
POLICY #:	MM-PNP-019
VERSION #:	02
DEPARTMENT:	MEDICAL MANAGEMENT
ORIGINAL EFFECTIVE DATE:	10/01/2023
CURRENT REVISION DATE:	10/30/2025

1. PURPOSE

Define Curative's clinical, safety, and medical-necessity criteria for spinal laminectomy and/or fusion procedures, preserving the full 2025 policy content verbatim within Curative's controlled-document structure.

2. SCOPE

Applies to Curative Medical UM operations for utilization review, pre-authorization, and clinical decision-making for spinal surgery requests.

3. DEFINITIONS

- P-SOP (Pre-Surgical Optimization Program): Multidisciplinary program required for elective fusion and for high-risk elective decompressions.
- Biologic DMARDs / JAK Inhibitors: Biologic or targeted synthetic disease-modifying antirheumatic drugs.
- High-Risk Patient: BMI ≥ 35 kg/m²; Age ≥ 65 with Frailty Score ≥ 3; Active chronic opioid use; or Moderate–severe anxiety/depression not optimally managed.

4. POLICY

4.1 Patient Safety and Pre-Operative Requirements (MANDATORY for Elective Surgery)

The successful completion of the Pre-Surgical Optimization Program (P-SOP) is a non-negotiable component of medical necessity for all elective spinal fusion procedures and any elective laminectomy/decompression surgery for High-Risk Patients.

A. Nicotine Cessation (P-SOP Component 1)

- Requirement: Abstinence from all nicotine products for a minimum of six (6) weeks prior to surgery.
- Mandatory Metric: Negative Urine Cotinine lab report (below 100 ng/mL or laboratory non-user cutoff) dated within 7 days of surgery.

  Note: If patient is using Nicotine Replacement Therapy (NRT), a negative Anabasine test or a pre-operative Exhaled CO test is the preferred alternative metric.

B. Biologic Drug Management (P-SOP Component 2)

- Withhold Biologic DMARDs and JAK inhibitors prior to surgery, with the procedure at the end of the drug's dosing cycle. Conventional DMARDs generally continued.
- Resume Biologics/JAK inhibitors after adequate wound healing (≈ 14 days) and absence of infection.
- Mandatory Metric: Joint sign-off by the surgeon and rheumatologist confirming last dose date and resumption criteria.

C. Mandatory Pre-Habilitation Program (P-SOP)

- High-Risk Patient Definition (P-SOP Required): P-SOP is mandatory for any elective spinal fusion OR elective decompression with one or more of: BMI ≥ 35; Age ≥ 65 with Frailty ≥ 3; Active chronic opioid use; Moderate–severe anxiety/depression not optimally managed.
- P-SOP Core Components (Mandatory Metrics): The P-SOP must be administered/documented by a licensed provider for ≥ 6 weeks in the 3 months leading up to surgery.

P-SOP Component	**Goal/Intervention**	**Mandatory Metric for Authorization**
Physical/Functional	Targeted core/spinal strengthening, aerobic capacity, gait training.	≥ 6 PT sessions AND pre-treatment Oswestry Disability Index (ODI) baseline.
Psychological/Behavioral	CBT or Pain Neuroscience Education to address fear-avoidance, catastrophizing, anxiety.	≥ 3 CBT/PNE sessions with licensed provider; expectation setting and coping mechanisms.
Nutritional/Metabolic	Optimize nutrition to promote wound healing.	Pre-Albumin ≥ 20 mg/dL (or other acceptable marker) and diet plan/counseling as needed.
Opioid Weaning	Cessation or aggressive tapering of chronic pre-op opioid use.	Opioid cessation or ≥ 50% reduction of baseline MME daily dose for 6 weeks.

P-SOP Compliance and Waivers: Documentation of engagement required for authorization. Waived only if underlying medical necessity is waived (emergent surgery for acute neurologic deficit, trauma, tumor).

4.2 Medical Necessity: Universal Criteria and Conservative Management

A. Diagnosis, Correlation, and Imaging Requirements

- Advanced imaging (MRI/CT/CT Myelogram) of the symptomatic region required; generally current within 6 months unless presentation unchanged.
- Formal written Radiologist report required; supersedes conflicting chart notes for medical necessity review.
- Mandatory Clinical–Radiological Correlation: symptoms/exam/functional impairment must match the anatomical pathology on imaging.
- Not Medically Necessary when imaging findings (e.g., mild stenosis, asymptomatic degeneration) do not correlate with chief complaints/deficits.
- Instability for fusion: dynamic imaging must document translational shift (≥ 3 mm) or angular deformity (≈ 11°).

B. Conservative Management (Required Duration)

- Fusion (DDD, spondylolisthesis, chronic instability): 3–6 months.
- Laminectomy/Decompression (stenosis/radiculopathy): 6–12 weeks.

Conservative components: Active PT (≥ 4–6 weeks) AND ≥ 1 complementary strategy (NSAIDs, ESI, nerve stabilizers, or physician-guided complementary therapies).

C. Exceptions to Conservative Management (Waiver)

- Acute or rapidly progressive motor deficit (e.g., severe motor weakness Grade 4− or less).
- Cauda Equina Syndrome (new bowel/bladder dysfunction, saddle anesthesia).
- Spinal Cord Compression/Myelopathy with new or rapidly worsening symptoms.
- Acute instability due to infection, fracture, or tumor.

4.3 Medical Necessity: Level-Specific & Advanced Techniques (Cervical, Thoracic, Lumbar)

Spine Segment / Procedure	**Technique**	**Specific 2025 Medical Necessity Criteria**
Cervical (C-Spine)	Fusion (ACDF/ACCF)	Instability: angulation > 11° OR translation > 3.5 mm; OR progressive myelopathy; severe stenosis; post-laminectomy kyphosis.

Cervical (C-Spine)	Disc Arthroplasty (ADR)	Medically necessary for 1–2 level DDD/radiculopathy without significant facet arthritis, bony compression, or instability requiring fusion.
Cervical (C-Spine)	Laminectomy / Laminoplasty	Required for multi-level central stenosis/myelopathy; laminoplasty preferred without major kyphotic deformity (regional kyphosis ≤ 13°).
Thoracic (T-Spine)	Fusion / Decompression	Rarely for degenerative disease; indications: myelopathy from large central disc/OLF; trauma/tumor/infection; deformity (Kyphosis ≥ 75°, Scoliosis ≥ 50°).
Lumbar (L-Spine)	Fusion (TLIF/PLIF/ALIF)	Degenerative spondylolisthesis Grade I–II with objective dynamic instability (≥ 3–4 mm shift) OR recurrent herniation/stenosis after prior decompression causing iatrogenic instability.
Lumbar (L-Spine)	Laminectomy / Decompression	Required for neurogenic claudication or radicular pain limiting ADLs correlating with imaging-confirmed stenosis.
All	MIS Endoscopic/Robotics/Navigation	Covered as a surgical approach when clinical indication is met and performed at an accredited facility.

4.4 Exclusions (Not Medically Necessary)

- Interspinous/Interlaminar stabilization or decompression devices without fusion (e.g., Coflex, X-Stop, Superion).
- Isolated facet fusion/arthroplasty (e.g., intrafacet implants) for isolated back pain.
- Lumbar Artificial Disc Replacement (ADR); Thoracic Total Disc Replacement.
- Vertebral augmentation (vertebroplasty/kyphoplasty) for chronic, non-malignant, or non-traumatic compression fractures > 3 months without non-union.
- Stem cell therapy or PRP injections for disc regeneration/pain/fusion enhancement.
- BMP (e.g., rhBMP-2/INFUSE) use inconsistent with FDA-approved labeling (e.g., most cervical fusions, lateral/multi-level).
- Laminectomy/decompression for isolated axial pain without correlative symptoms/instability/deformity.
- Surgical fusion for DDD without strict 12-month conservative treatment and functional disability criteria.

5. PROCEDURE

N/A

6. TRAINING REQUIREMENT

All Medical UM associates are responsible for reading and comprehending this policy and for contacting management or Privacy & Compliance with questions.

7. ENFORCEMENT

Violations may result in sanctions per Curative's sanctions controlled document, up to termination of employment or contractor status. Additional civil, criminal, and equitable remedies may apply.

8. DOCUMENTATION

N/A

9. REFERENCE DOCUMENTS AND MATERIALS

Regulatory Authority: N/A

Internal: N/A

External: N/A

10. COLLABORATING DEPARTMENTS

Pharmacy and Utilization Management

11. DOCUMENT CONTROL

APPROVED BY:	
Brandon Charles, MD, Chief Medical Officer	Brandon Charles
(Printed Name) (Date)	**(Signature)**

REVISION HISTORY			
Date	**Author**	**Version**	**Comments**
2023	Initial Version	01	Original policy established
10/20/2025	Carol Palackdharry MD MS	02	2025 Revision

APPENDICES

Any applicable attachments, resources or other materials should be included as appendices in this section. Label each appendix as follows:

APPENDIX A – Referenced Documents and Guideline Sources

I. Patient Safety and Pre-Operative Requirements (MANDATORY P-SOP)

Policy components and rationale from major commercial payers, NASS consensus, ACR/AAHKS 2022 guideline, and VBC models (CMS TEAM).

Selected Evidence:

1. Zheng LM, Zhang ZW, Wang W, Li Y, Wen F. Scientific Reports. 2022;12(1):9172. doi:10.1038/s41598-022-13198-x.
2. Martin CT, Gao Y, Duchman KR, Pugely AJ. Spine. 2016;41(7):577-84. doi:10.1097/BRS.0000000000001281.
3. Badiee RK, Chan AK, Rivera J, et al. Neurosurgery. 2021;88(6):1088-1094. doi:10.1093/neuros/nyaa593.
4. Li Y, Zheng LM, Zhang ZW, He CJ. World Neurosurgery. 2021;154:e222-e235. doi:10.1016/j.wneu.2021.07.011. URL: https://pubmed.ncbi.nlm.nih.gov/35654928
5. Lim S, Schultz L, Zakko P, et al. World Neurosurgery. 2023;173:e241-e249. doi:10.1016/j.wneu.2023.02.038.
6. Harrop JS, Mohamed B, Bisson EF, et al. Neurosurgery. 2021;89(Suppl 1):S9-S18. doi:10.1093/neuros/nyab316.
7. Seicean A, Seicean S, Alan N, et al. Spine. 2013;38(15):1294-302. doi:10.1097/BRS.0b013e31828e2747.

Additional supporting thresholds and payer criteria (plain text): https://pubmed.ncbi.nlm.nih.gov/36791883 ; https://pubmed.ncbi.nlm.nih.gov/34490886 ; https://pubmed.ncbi.nlm.nih.gov/23462575