Back Conditions Technical Changes

Originally posted 8/10/2015; updated 5/20/2016

This document contains changes to coverage for conditions of the back and spine for which implementation is scheduled for July 1, 2016. (Implementation had previously been delayed to assess implementation needs.)

The document reflects the creation of new lines on the treatment of conditions of the back and spine, which were approved at the March, 2015 HERC meeting, as well as revisions made at subsequent meetings through May 19, 2016. Some noteworthy changes are summarized below; for a fuller description, see the meeting materials and minutes for the meetings referenced below.

- The May 7, 2015 changes included removal of intrathecal pumps from these lines.
- The August 13, 2015 changes include revisions to Guideline Note 56.
- The January 14, 2016 changes include removal of epidural steroid injections from line 407 and reverting criteria for Guideline Note D4, Advanced Imaging for Back Pain, to their previous state as well as correction of some ICD-10-CM diagnosis codes and removal of ICD-9 diagnosis codes.
- On May 19, 2016, HERC approved additional changes to the back lines and guideline notes. All changes were approved as presented in the meeting materials and shown in the 5/2/16 version of this document, except the changes to guideline note 60 shown as revisions in this document. Changes include:
    - Removal of ICD-10-CM diagnosis code M99.12-M99.13 from line 407
    - Removal of CPT Code 62311 from line 407
    - Add Guideline Note 92 ACUPUNCTURE to line 366 SCOLIOSIS, and add references to visit limits for acupuncture for scoliosis to Guideline Note 92.
    - Proposed additional language in Guideline note 56 stating that electrical stimulation/TENS and mechanical traction are not included on the back lines.
    - Changes to Guideline note 60 OPIOID PRESCRIBING FOR CONDITIONS OF THE BACK AND SPINE related to the tapering of those currently being treated with long-term opioid therapy. These changes require development of an individualized treatment plan for tapering off opioids to be developed by 1/1/2017. The plan must include nonpharmalogic treatments to address the patient's pain and a quit date no later than 1/1/2018.
    - Additional minor wording changes showing additions/deletions for clarity and consistency.

For a narrative description of the changes and details about the process leading to the changes see the Back Policy Changes Fact Sheet.

Changes to Line Items

Line: **351**
Condition: CONDITIONS OF THE BACK AND SPINE WITH URGENT SURGICAL INDICATIONS (See Guideline Notes 37,60,64,65,100,101)
Treatment: SURGICAL THERAPY
ICD-10: G83.4,M43.10-M43.19,M47.011-M47.16,M48.00-M48.08,M50.00-M50.03,M51.04-M51.06,M53.2X1-M53.2X9, Q76.2
CPT: 20660-20665,20930-20938,21720,21725,22206-22226,22532-22865,29000-29046,29710,29720,62287,63001-63091,63170,63180-63200,63270-63273,63295-63610,63650,63655,63685,96150-96154,97001-97004,97022, 97110-97124,97140-97530,97535,98966-98969,99051,99060,99070,99078,99201-99239,99281-99285,99291-99337,99401-99404,99408-99412,99441-99449,99468-99480,99605-99607
HCPCS: G0157-G0160,G0396,G0397,G0406-G0408,G0425-G0427,G0463,G0466,G0467,S2350,S2351

Line: **366**
Condition: SCOLIOSIS (See Guideline Notes 41,56,60,64,65,92,100,101)
Treatment: MEDICAL AND SURGICAL THERAPY
ICD-10: M41.00-M41.08,M41.112-M41.9,M96.5,Q67.5,Q76.3,Z47.82
CPT: 20660-20665,20930-20938,21720,21725,22206-22226,22532-22855,29000-29046,29710,29720,62287,63001-63091,63170,63180-63200,63295-63610,63650,63655,63685,96150-96154,97001-97004,97022,97110-97124,97140-97530,97535,97760,97762,97810-98942,98966-98969,99051,99060,99070,99078,99201-99239,99281-99285,99291-99337,99401-99404,99408-99412,99441-99449,99468-99480,99605-99607
HCPCS: G0157-G0160,G0396,G0397,G0406-G0408,G0425-G0427,G0463,G0466,G0467

Line: **407**
Condition: CONDITIONS OF THE BACK AND SPINE (See Guideline Notes 56,60,64,65,92)
Treatment: RISK ASSESSMENT, PHYSICAL MODALITIES, COGNITIVE BEHAVIORAL THERAPY, MEDICAL THERAPY
ICD-10: F45.42,G83.4,G95.0,M24.08,M25.78,M40.00-M40.15,M40.202-M40.57,M42.00-M42.09,M42.11-M42.9,M43.00-M43.4,M43.5X2-M43.9,M45.0-M45.9,M46.1,M46.40-M46.99,M47.011-M47.9,M48.00-M48.38,M48.8X1-M48.9,M49.80-M49.89,M50.00-M50.93,M51.04-M51.9,M53.2X1-M53.9,M54.00-M54.9,M62.830,M96.1-M96.4,M99.00-M99.09,M99.20-M99.79,M99.81-M99.84,Q06.0-Q06.3,Q06.8-Q06.9,Q76.0-Q76.2,Q76.411-Q76.49,S13.0XXA-S13.0XXD,S13.4XXA-S13.4XXD,S13.8XXA-S13.8XXD,S13.9XXA-S13.9XXD,S16.1XXA-S16.1XXD,S23.0XXA-S23.0XXD,S23.100A-S23.100D,S23.101A-S23.101D,S23.110A-S23.110D,S23.111A-S23.111D,S23.120A-S23.120D,S23.121A-S23.121D,S23.122A-S23.122D,S23.123A-S23.123D,S23.130A-S23.130D,S23.131A-S23.131D,S23.132A-S23.132D,S23.133A-S23.133D,S23.140A-S23.140D,S23.141A-S23.141D,S23.142A-S23.142D,S23.143A-S23.143D,S23.150A-S23.150D,S23.151A-S23.151D,S23.152A-S23.152D,S23.153A-S23.153D,S23.160A-S23.160D,S23.161A-S23.161D,S23.162A-S23.162D,S23.163A-S23.163D,S23.170A-S23.170D,S23.171A-S23.171D,S23.3XXA-S23.3XXD,S23.8XXA-S23.8XXD,S23.9XXA-S23.9XXD,S33.0XXA-S33.0XXD,S33.100A-S33.100D,S33.101A-S33.101D,S33.110A-S33.110D,S33.111A-S33.111D,S33.120A-S33.120D,S33.121A-S33.121D,S33.130A-S33.130D,S33.131A-S33.131D,S33.140A-S33.140D,S33.141A-S33.141D,S33.5XXA-S33.5XXD,S33.8XXA-S33.8XXD,S33.9XXA-S33.9XXD,S34.3XXA-S34.3XXD,S39.092A-S39.092D,S39.82XA-S39.82XD,S39.92XA-S39.92XD
CPT: 90785,90832-90840,90853,96150-96154,97001-97004,97022,97110-97124,97140-97530,97535,97810-98942,98966-98969,99051,99060,99070,99078,99201-99215,99281-99285,99304-99337,99340-99359,99366-99404,99408-99412,99441-99449,99487-99490,99605-99607
HCPCS: G0157-G0160,G0396,G0397,G0425-G0427,G0463,G0466,G0467,G0469,G0470,S9451

Line: **532**
Condition: CONDITIONS OF THE BACK AND SPINE WITHOUT URGENT SURGICAL INDICATIONS (See Guideline Notes 37,60,64,65,100,101)
Treatment: SURGICAL THERAPY
ICD-10: G95.0,M40.00-M40.15,M40.202-M40.57,M42.00-M42.9,M43.00-M43.28,M43.8X1-M43.8X9,M45.0-M45.9,M46.40-M46.99,M47.20-M47.28,M47.811-M47.9,M48.00-M48.19,M48.30-M48.38,M48.8X1-M48.9,M49.80-M49.89,M50.10-M50.93,M51.14-M51.9,M53.80-M53.9,M54.10-M54.18,M96.1-M96.4,M99.20-M99.79,Q06.0-Q06.3,Q06.8-Q06.9,Q76.0-Q76.2,Q76.411-Q76.49,S13.0XXA-S13.0XXD,S23.0XXA-S23.0XXD,S23.100A-S23.100D,S23.110A-S23.110D,S23.120A-S23.120D,S23.122A-S23.122D,S23.130A-S23.130D,S23.132A-S23.132D,S23.140A-S23.140D,S23.142A-S23.142D,S23.150A-S23.150D,S23.152A-S23.152D,S23.160A-S23.160D,S23.162A-S23.162D,S23.170A-S23.170D,S33.0XXA-S33.0XXD,S33.100A-S33.100D,S33.110A-S33.110D,S33.120A-S33.120D,S33.130A-S33.130D,S33.140A-S33.140D,S34.3XXA-S34.3XXD
CPT: 20660-20665,20930-20938,21720,21725,22206-22226,22532-22865,27035,29000-29046,29710,29720,62287,63001-63091,63170,63180-63200,63270-63273,63295-63610,63650,63655,63685,96150-96154,97001-97004,97022,97110-97124,97140-97530,97535,98966-98969,99051,99060,99070,99078,99201-99239,99281-99285,99291-99337,99401-99404,99408-99412,99441-99449,99468-99480,99605-99607
HCPCS: G0157-G0160,G0396,G0397,G0406-G0408,G0425-G0427,G0463,G0466,G0467,S2350,S2351

New guideline notes

GUIDELINE NOTE 56, NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE

Lines 366,407

Patients seeking care for back pain should be assessed for potentially serious conditions ("red flag") symptoms requiring immediate diagnostic testing, as defined in Diagnostic Guideline D4. Patients lacking red flag symptoms should be assessed using a validated assessment tool (e.g. STarT Back Assessment Tool) in order to determine their risk level for poor functional prognosis based on psychosocial indicators.
For patients who are determined to be low risk on the assessment tool, the following services are included on these lines:

- Office evaluation and education,
- Up to 4 total visits, consisting of the following treatments: OMT/CMT, acupuncture, and PT/OT. Massage, if available, may be considered.
- First line medications: NSAIDs, acetaminophen, and/or muscle relaxers. Opioids may be considered as a second line treatment, subject to the limitations on coverage of opioids in Guideline Note 60 OPIOID PRESCRIBING FOR CONDITIONS OF THE BACK AND SPINE. See evidence table.

For patients who are determined to be medium- or high risk on the validated assessment tool, the following treatments are included on these lines:

- Office evaluation, consultation and education
- Cognitive behavioral therapy. The necessity for cognitive behavioral therapy should be re-evaluated every 90 days and coverage will only be continued if there is documented evidence of decreasing depression or anxiety symptomatology, improved ability to work/function, increased self-efficacy, or other clinically significant, objective improvement.
- Prescription and over-the-counter medications; opioid medications subject to the limitations on coverage of opioids in Guideline Note 60 OPIOID PRESCRIBING FOR CONDITIONS OF THE BACK AND SPINE. See evidence table.
- The following evidence-based therapies, when available, are encouraged: yoga, massage, supervised exercise therapy, intensive interdisciplinary rehabilitation. HCPCS S9451 is only included on line 407 for the provision of yoga or supervised exercise therapy.
- A total of 30 visits per year of any combination of the following evidence-based therapies when available and medically appropriate. These therapies are only included on these lines if provided by a provider licensed to provide the therapy and when there is documentation of measurable clinically significant progress toward the therapy plan of care goals and objectives using evidence based objective tools (e.g. Oswestry, Neck Disability Index, SF-MPQ, and MSPQ).
    1) Rehabilitative therapy (physical and/or occupational therapy), if provided according to Guideline Note 6 REHABILITATIVE THERAPIES. Rehabilitation services provided under this guideline also count towards visit totals in Guideline Note 6
    2) Chiropractic or osteopathic manipulation
    3) Acupuncture

Mechanical traction (CPT 97012) is not included on these lines, due to evidence of lack of effectiveness for treatment of back and neck conditions. Transcutaneous electrical nerve stimulation (TENS; CPT 64550, 97014 and 97032) is not included on the Prioritized List for any condition due to lack of evidence of effectiveness.

The development of this guideline note was informed by a HERC coverage guidance. See http://www.oregon.gov/oha/herc/Pages/blog-low-back-non-pharmacologic-intervention.aspx.

Back Conditions Technical Changes

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Evidence Table of Effective Treatments for the Management of Low Back Pain

Intervention Category*	Intervention	Acute < 4 Weeks	Subacute & Chronic > 4 Weeks
Self-care	Advice to remain active	•	•
	Books, handout	•	•
	Application of superficial heat	•	
Nonpharmacologic therapy	Spinal manipulation	•	•
	Exercise therapy		•
	Massage		•
	Acupuncture		•
	Yoga		•
	Cognitive-behavioral therapy		•
	Progressive relaxation		•
Pharmacologic therapy (Carefully consider risks/harms)	Acetaminophen	•	•
	NSAIDs	•(▲)	•(▲)
	Skeletal muscle relaxants	•	
	Antidepressants (TCA)		•
	*Benzodiazepines***	•(▲)	•(▲)
	*Tramadol, opioids***	•(▲)	•(▲)
Interdisciplinary therapy	Intensive interdisciplinary rehabilitation		•

• Interventions supported by grade B evidence (at least fair-quality evidence of moderate benefit, or small benefit but no significant harms, costs, or burdens). No intervention was supported by grade "A" evidence (good-quality evidence of substantial benefit).

▲ *Carries greater risk of harms than other agents in table.*

NSAIDs = nonsteroidal anti-inflammatory drugs; TCA = tricyclic antidepressants.

*These are general categories only. Individual care plans need to be developed on a case by case basis. For more detailed information please see: http://www.annals.org/content/147/7/478.full.pdf

**Associated with significant risks related to potential for abuse, addiction and tolerance. This evidence evaluates effectiveness of these agents with relatively short term use studies. Chronic use of these agents may result in significant harms.

GUIDELINE NOTE 60, OPIOID PRESCRIBING FOR CONDITIONS OF THE BACK AND SPINE

Lines 351,366,407,532

The following restrictions on opioid treatment apply to all diagnoses included on these lines.

For acute injury, acute flare of chronic pain, or after surgery:

1) During the first 6 weeks after the acute injury, flare or surgery, opioid treatment is included on these lines ONLY
   a) When each prescription is limited to 7 days of treatment, AND
   b) For short acting opioids only, AND
   c) When one or more alternative first line pharmacologic therapies such as NSAIDs, acetaminophen, and muscle relaxers have been tried and found not effective or are contraindicated, AND
   d) When prescribed with a plan to keep active (home or prescribed exercise regime) and with consideration of additional therapies such as spinal manipulation, physical therapy, yoga, or acupuncture, AND
   e) There is documented lack of current or prior opioid misuse or abuse.
2) Treatment with opioids after 6 weeks, up to 90 days, requires the following
   a) Documented evidence of improvement of function of at least thirty percent as compared to baseline based on a validated tools. (e.g. Oswestry, Neck Disability Index, SF-MPQ, and MSPQ).
   b) Must be prescribed in conjunction with therapies such as spinal manipulation, physical therapy, yoga, or acupuncture.
   c) Verification that the patient is not high risk for opioid misuse or abuse. Such verification may involve

i) Documented verification from the state's prescription monitoring program database that the controlled substance history is consistent with the prescribing record
ii) Use of a validated screening instrument to verify the absence of a current substance use disorder (excluding nicotine) or a history of prior opioid misuse or abuse
iii) Administration of a baseline urine drug test to verify the absence of illicit drugs and non-prescribed opioids.

d) Each prescription must be limited to 7 days of treatment and for short acting opioids only

3) Further opioid treatment after 90 days may be considered ONLY when there is a significant change in status, such as a clinically significant verifiable new injury or surgery. In such cases, use of opioids is limited to a maximum of an additional 7 days. In exceptional cases, use up to 28 days may be covered, subject to the criteria in #2 above.

For patients with chronic pain from diagnoses on these lines currently treated with long term opioid therapy, opioids must be tapered off using an individualized treatment plan developed by January 1, 2017 with a quit date no later than January 1, 2018~~, with a taper of about 10% per week recommended~~. Taper plans must include nonpharmacological treatment strategies for managing the patient's pain based on Guideline note 56. ~~By the end of 2016, all patients currently treated with long term opioid therapy must be tapered off of long term opioids for diagnoses on these lines.~~ If a patient has developed dependence and/or addiction related to their opioids, treatment is available on Line 4 SUBSTANCE USE DISORDER**.**

GUIDELINE NOTE 37, SURGICAL INTERVENTIONS FOR CONDITIONS OF THE BACK AND SPINE OTHER THAN SCOLIOSIS

Lines 351,532

Surgical consultation/consideration for surgical intervention are included on these lines only for patients with neurological complications, defined as showing objective evidence of one or more of the following:

A. Markedly abnormal reflexes
B. Segmental muscle weakness
C. Segmental sensory loss
D. EMG or NCV evidence of nerve root impingement
E. Cauda equina syndrome
F. Neurogenic bowel or bladder
G. Long tract abnormalities

Spondylolisthesis (ICD-10-CM M43.1, Q76.2) is included on Line 351 only when it results in spinal stenosis with signs and symptoms of neurogenic claudication. Otherwise, these diagnoses are included on Line 532.

Surgical correction of spinal stenosis (ICD-10-CM M48.0) is only included on Line 351 for patients with:

1) MRI evidence of moderate to severe central or foraminal spinal stenosis AND
2) A history of neurogenic claudication, or objective evidence of neurologic impairment consistent with MRI findings.

Otherwise, these diagnoses are included on Line 532. Only decompression surgery is included on these lines for spinal stenosis; spinal fusion procedures are not included on either line for this diagnosis.

The following interventions are not included on these lines due to lack of evidence of effectiveness for the treatment of conditions on these lines, including cervical, thoracic, lumbar, and sacral conditions:

- facet joint corticosteroid injection
- prolotherapy
- intradiscal corticosteroid injection
- local injections
- botulinum toxin injection
- intradiscal electrothermal therapy
- therapeutic medial branch block
- sacroiliac joint steroid injection
- coblation nucleoplasty
- percutaneous intradiscal radiofrequency thermocoagulation
- radiofrequency denervation
- epidural steroid injections

GUIDELINE NOTE 41, SCOLIOSIS

Line 366

Non-surgical treatments of scoliosis (ICD-10-CM M41) are included on Line 366 when

1) the scoliosis is considered clinically significant, defined as curvature greater than or equal to 25 degrees, or
2) there is curvature with a documented rapid progression.

Surgical treatments of scoliosis are included on Line 366

1) only for children and adolescents (age 20 and younger) with
2) a spinal curvature of greater than 45 degrees

Revised guideline notes

DIAGNOSTIC GUIDELINE D4, ADVANCED IMAGING FOR LOW BACK PAIN

In patients with non-specific low back pain and no “red flag” conditions [see Table D4], imaging is not a covered service; otherwise work up is covered as shown in the table. Repeat imaging is only covered when there is a substantial clinical change (e.g. progressive neurological deficit) or new clinical indication for imaging (i.e. development of a new red flag condition). Repeat imaging for acute exacerbations of chronic radiculopathic pain is not covered.

Electromyelography (CPT 96002-4) is not covered for non-specific low back pain.

Table D4
Low Back Pain - Potentially Serious Conditions (“Red Flags”) and Recommendations for Initial Diagnostic Work-up

Possible cause	Key features on history or physical examination	Imaging[1]	Additional studies[1]
Cancer	• History of cancer with new onset of LBP	MRI	
	• Unexplained weight loss • Failure to improve after 1 month • Age >50 years • Symptoms such as painless neurologic deficit, night pain or pain increased in supine position	Lumbosacral plain radiography	ESR
	• Multiple risk factors for cancer present	Plain radiography or MRI	
Spinal column infection	• Fever • Intravenous drug use • Recent infection	MRI	ESR and/or CRP
Cauda equina syndrome	• Urinary retention • Motor deficits at multiple levels • Fecal incontinence • Saddle anesthesia	MRI	None
Vertebral compression fracture	• History of osteoporosis • Use of corticosteroids • Older age	Lumbosacral plain radiography	None
Ankylosing spondylitis	• Morning stiffness • Improvement with exercise • Alternating buttock pain • Awakening due to back pain during the second part of the night • Younger age	Anterior-posterior pelvis plain radiography	ESR and/or CRP, HLA-B27
Nerve compression/ disorders (e.g. herniated disc with radiculopathy)	• Back pain with leg pain in an L4, L5, or S1 nerve root distribution present < 1 month • Positive straight-leg-raise test or crossed straight-leg-raise test	None	None
	• Radiculopathic signs[2] present >1 month • Severe/progressive neurologic deficits (such as foot drop), progressive motor weakness	MRI[3]	Consider EMG/NCV
Spinal stenosis	• Radiating leg pain • Older age • Pain usually relieved with sitting (Pseudoclaudication a weak predictor)	None	None

Possible cause	Key features on history or physical examination	Imaging[1]	Additional studies[1]
	• Spinal stenosis symptoms present >1 month	MRI[3]	Consider EMG/NCV

[1]Level of evidence for diagnostic evaluation is variable
[2]Radiculopathic signs are defined for the purposes of this guideline as the presence of any of the following:

A. Markedly abnormal reflexes
B. Segmental muscle weakness
C. Segmental sensory loss
D. EMG or NCV evidence of nerve root impingement
E. Cauda equina syndrome,
F. Neurogenic bowel or bladder
G. Long tract abnormalities

[3]Only if patient is a potential candidate for surgery

Red Flag: Red flags are findings from the history and physical examination that may be associated with a higher risk of serious disorders.

CRP = C-reactive protein; EMG = electromyography; ESR = erythrocyte sedimentation rate; MRI = magnetic resonance imaging; NCV = nerve conduction velocity.

Extracted and modified from Chou R, Qaseem A, Snow V, et al: Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society. Ann Intern Med. 2007; 147:478-491.

The development of this guideline note was informed by a HERC coverage guidance. See http://www.oregon.gov/oha/herc/Pages/blog-adv-imaging-low-back.aspx

GUIDELINE NOTE 92, ACUPUNCTURE

Lines 1,208,366,407,415,467,543

Inclusion of acupuncture (CPT 97810-97814) on the Prioritized List has the following limitations:

Line 1 PREGNANCY
Acupuncture pairs on Line 1 for the following conditions and codes.

Hyperemesis gravidarum

ICD-10-CM: O21.0, O21.1
Acupuncture pairs with hyperemesis gravidarum when a diagnosis is made by the maternity care provider and referred for acupuncture treatment for up to 12 sessions of acupressure/acupuncture.

Breech presentation

ICD-10-CM: O32.1
Acupuncture (and moxibustion) is paired with breech presentation when a referral with a diagnosis of breech presentation is made by the maternity care provider, the patient is between 33 and 38 weeks gestation, for up to 6 visits.

Back and pelvic pain of pregnancy

ICD-10-CM: O99.89
Acupuncture is paired with back and pelvic pain of pregnancy when referred by maternity care provider/primary care provider for up to 12 sessions.

Line 208 DEPRESSION AND OTHER MOOD DISORDERS, MILD OR MODERATE
Acupuncture is paired with the treatment of post-stroke depression only. Treatments may be billed to a maximum of 30 minutes face-to-face time and limited to 12 total sessions, with documentation of meaningful improvement.

Line 366 SCOLIOSIS
Acupuncture is included on line 366 for pairing with visit limitations as in GUIDELINE NOTE 56 Non-interventional treatments for Conditions of the back and spine

Line 407 CONDITIONS OF THE BACK AND SPINE
Acupuncture is included on this line with visit limitations as in Guideline Note 56 NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE.

Line 415 MIGRAINE HEADACHES
Acupuncture pairs on Line 415 for migraine (ICD-10-CM G43.0, G43.1, G43.5, G43.7, G43.8, G43.9), for up to 12 sessions.

Line 467 OSTEOARTHRITIS AND ALLIED DISORDERS
Acupuncture pairs on Line 467 for osteoarthritis of the knee only (ICD-10-CM M17), for up to 12 sessions.

*Line 543 TENSION HEADACHES
Acupuncture is included on Line 543 for treatment of tension headaches (ICD-10-CM G44.2), for up to 12 sessions.

The development of this guideline note was informed by a HERC coverage guidance. See http://www.oregon.gov/oha/herc/Pages/blog-low-back-non-pharmacologic-intervention.aspx

*Below the current funding line.

Deleted guideline notes

GUIDELINE NOTE 37, DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT (FROM THE OCT. 1, 2015 PRIORITIZED LIST†)

Lines 351 and 532 (Lines 374 and 545 from the Oct. 1, 2015 Prioritized List†)

Diagnoses are included on Line 351 (Line 374 from the Oct. 1, 2015 Prioritized List†) when objective evidence of neurologic impairment or radiculopathy is present, as defined as:

A) Markedly abnormal reflexes
B) Segmental muscle weakness
C) Segmental sensory loss
D) EMG or NCV evidence of nerve root impingement
E) Cauda equina syndrome,
F) Neurogenic bowel or bladder
G) Long tract abnormalities

Otherwise, disorders of spine not meeting these criteria (e.g. pain alone) fall on Line 532 (Line 545 from the Oct. 1, 2015 Prioritized List†).

GUIDELINE NOTE 41, SPINAL DEFORMITY, CLINICALLY SIGNIFICANT (FROM THE OCT. 1, 2015 PRIORITIZED LIST†)

Line 366 (Line 412 from the Oct. 1, 2015 Prioritized List†)

Clinically significant scoliosis is defined as curvature greater than or equal to 25 degrees or curvature with a documented rapid progression. Clinically significant spinal stenosis is defined as having MRI evidence of moderate to severe central or foraminal spinal stenosis in addition to a history of neurogenic claudication, or objective evidence of neurologic impairment consistent with MRI findings (see Guideline Note 37).

GUIDELINE NOTE 56, ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT (FROM THE OCT. 1, 2015 PRIORITIZED LIST†)

Line 532 (Line 545 from the Oct. 1, 2015 Prioritized List†)

Disorders of spine without neurologic impairment include any conditions represented on this line for which objective evidence of one or more of the criteria stated in Guideline Note 37 is not available.

GUIDELINE NOTE 60, SPINAL DEFORMITY, NOT CLINICALLY SIGNIFICANT (FROM THE OCT. 1, 2015 PRIORITIZED LIST†)

Line 666 (Line 588 from the Oct. 1, 2015 Prioritized List†)

Scoliosis not defined as clinically significant including curvature less than 25 degrees that does not have a documented progression of at least 10 degrees.

GUIDELINE NOTE 72, ELECTRONIC ANALYSIS OF INTRATHECAL PUMPS

Lines 351,532,607 (Lines 351 and 532 represent lines 374 and 545 from the Oct. 1, 2015 Prioritized List†)

Electronic analysis of intrathecal pumps, with or without programming (CPT codes 62367-62370), is included on these lines only for pumps implanted prior to April 1, 2009.

GUIDELINE NOTE 105, EPIDURAL STEROID INJECTIONS, OTHER PERCUTANEOUS INTERVENTIONS FOR LOW BACK PAIN (FROM THE OCT. 1, 2015 PRIORITIZED LIST†)

Lines 351, 366, 532 and 666 (Lines 374, 412, 545 and 588 from the Oct. 1, 2015 Prioritized List†)

Epidural steroid injections (CPT 62311, 64483, 64484) are covered for patients with persistent radiculopathy due to herniated disc, where radiculopathy is as defined in Guideline Note 37 as showing evidence of one or more of the following:

A) Markedly abnormal reflexes
B) Segmental muscle weakness
C) Segmental sensory loss
D) EMG or NCV evidence of nerve root impingement
E) Cauda equina syndrome
F) Neurogenic bowel or bladder
G) Long tract abnormalities

It is recommended that shared decision-making regarding epidural steroid injection include a specific discussion about inconsistent evidence showing moderate short-term benefits, and lack of long-term benefits. If an epidural steroid injection does not offer benefit, repeated injections should not be covered. Epidural steroid injections are not covered for spinal stenosis or for patients with low back pain without radiculopathy.

The following interventions are not covered for low back pain, with or without radiculopathy:

- facet joint corticosteroid injection
- prolotherapy
- intradiscal corticosteroid injection
- local injections
- botulinum toxin injection
- intradiscal electrothermal therapy
- therapeutic medial branch block
- radiofrequency denervation
- sacroiliac joint steroid injection
- coblation nucleoplasty
- percutaneous intradiscal radiofrequency thermocoagulation
- radiofrequency denervation

The development of this guideline note was informed by a HERC coverage guidance. See http://www.oregon.gov/oha/herc/Pages/blog-percutaneous-low-back.aspx