Priority Health	BILLING POLICY No. 148
CERVICAL FUSION	
Date of origin: 08/2025	**Review dates: None Yet Recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

Cervical fusion is a surgical procedure that joins two vertebral bones in the cervical spine. The procedure is performed to treat severe neck pain and disability, or instability of the cervical spine, and involves the use of bone graft materials and various types of instrumentation to join the vertebrae together. The cervical spine may be approached anteriorly or posteriorly or use a combination of anterior-posterior approaches. In some instances, cervical fusion may be considered an alternative to cervical disc arthroplasty.

MEDICAL POLICY

MEDICAL POLICY No. 91581-R22

BILLING POLICY No. 043

For Medicare

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Documentation requirements (while not an all-inclusive listing) the medical record should clearly document:

- Location: cervical
- The approach: anterior, posterior, or lateral extra cavity or percutaneous

- What was done and medical indication (decompression, disc-ectomy, corpectomy, arthrodesis)
- Type of bone graft: allograft or autograft
- Type of Instrumentation: rods, screws or cages

CODING GUIDELINES

Anterior cervical interbody fusion and an anterior cervical discectomy are done on the same date of service by different providers. CPT® Professional Edition states, Do not report 22554 in conjunction with 63075, even if performed by a separate individual. To report anterior cervical discectomy and interbody fusion at the same level during the same session, use 22551.

MODIFIERS

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

CPT/HCPCS Modifiers

If implants were used the following modifiers are appropriate:

- 59: Distinct procedural service
- XS: Separate structure, a service that is distinct because it was performed on a separate organ/structure
- 62: Co-surgeon (Note: Don't report modifier 62 on add codes.

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

REFERENCES

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been

performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Aug. 2025	New policy – effective Nov. 17, 2025