Priority Health	BILLING POLICY No. 043
MUSCULOSKELETAL (MSK) SPINE	
Date of origin: Oct. 8, 2024	**Review dates: 2/2025, 2/2026**

DEFINITION

There are multiple procedures that could be done on the spine. This policy addresses bundling, when/how to report add on codes and documentation guidelines for spine procedures.

MEDICAL POLICY

- Spine Procedures (#91581)

POLICY SPECIFIC INFORMATION

Bundling guidelines

The following CPT codes are bundled into the main spine procedure:

- Bone marrow aspiration procedures (38220,38230,38232) are always included and not paid separately when done with a spinal osteotomy, vertebral fracture repair, spinal arthrodesis, spinal fusion, laminectomy, spinal decompression, vertebral corpectomy
- Spinal exploration (22830) when done in the same anatomic area as another spinal procedure
- Intraoperative neurophysiology testing (95940,95941, G0453) when done by the same physician during the spinal procedure
- Neurophysiology testing (95822,95960,95868,95870,99507-95913,92925-95937)
- Manipulation of the spine under anesthesia (22505)
- Anterior instrumentation (22845-22847) when used to anchor an interbody biomechanical device (22853-22854) to the intervertebral disc space. (However, these codes can be reported if the instrumentation (plate or rod etc.) is unrelated to anchoring the device.)
- Removing instrumentation (22850, 22852) at the same site of reinserting instrumentation

Co-surgeon services must be documented according to guidelines outlined in our modifier 62 guidelines.

- Documentation may be required when co-surgeon service CPT has a status indicator to indicate co-surgeon is payable only with supporting documentation. We align to CMS status indicator for co-surgeon so please refer to CMS PFS to confirm if medical records may be required.

Add on codes

Spinal CPT codes are grouped by “families” of codes, the families are based on the level of the spine (i.e., cervical, thoracic and lumbar). Each family has its own group of CPT codes. One code is a primary code, and each additional level is reported with an add on code.

- When one skin incision is made and the surgery is done on multiple spinal levels, the primary CPT code of the level that started the procedure should be reported. For each additional level, the add on code should be reported regardless of family of codes.
- When more than one skin incision is made and the surgery is done at multiple spinal levels, the primary procedure for that family is reported. For each additional level, the add on code for that family is reported.

Bone grafts (20930, 20931, 20936, 20937, 20938) are add on codes. Note that placing the bone graft is included in the arthrodesis/fusion codes.

Documentation requirements
While not an all-inclusive listing, the medical record should clearly document:

- Location: cervical, thoracic, lumbar or sacral
- The approach, anterior, posterior, or lateral extracavity 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
- If implants were used and the type

Modifiers

- **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.)

RESOURCES

- Medicare NCCI Policy Manual – Chapter IV – Surgery: Musculoskeletal System (CMS)

DISCLAIMER
CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. 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
Feb. 13, 2025	Added “Disclaimer” section
Feb 17, 2026	Reviewed, no updates