



UM-CDG-022 Lumbar Spinal Fusion

Approved By:  
Director, Health Services

Effective Date:  
10/22/2025

***This Policy applies to all SECUR affiliates, associates, and subsidiaries.***

Approved by Courtney Gonzales, Director of Health Services on behalf of the Utilization Management Committee.

## PURPOSE

This coverage determination guideline serves to address lumbar spinal fusion, also referred to as lumbar arthrodesis, a procedure to permanently immobilize the spinal column vertebrae surrounding the disc(s) that are causing discogenic low back pain. Surgical techniques to achieve this are numerous and include a variety of surgical approaches. This procedure is typically performed for conditions that involve a singular vertebral segment, but it is necessary to fuse two segments in order to prevent movement, which is referred to as a single level fusion. Lumbar fusion of more than a single level is typically not recommended except in situations such as trauma, deformity, or neoplasm.

For SECUR Health Plan members, National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) will be applied to requests when applicable. SECUR Health Plan Coverage Determination Guidelines (CDG) will be utilized in the absence of an appropriate NCD and/or LCD.

## DEFINITIONS

None

## POLICY

SECUR Health Plan considers lumbar spinal fusion medically necessary when the member meets one or more of the following:

1. Radiographic or clinical evidence of instability due to any one of the following:
  - Congenital deformity
  - Trauma
  - Fracture
  - Chronic degenerative condition
  - Tumor
  - Infection
  - Erosive condition
  - Space occupying lesion
  - Iatrogenic causes including expected instability because of another medically necessary spinal procedure
2. Symptomatic spinal deformity in the absence of instability or neural compression that meets all the following:
  - Functional limitation in daily activities due to back pain or discomfort, and
  - Nonresponsive to at least one (1) year of nonoperative treatment

Additionally, any one of the following must be met:

- Sagittal or coronal imbalance by at least 5 cm as measured on radiographic imaging of the entire spine, or
  - Progression of deformity by at least 10 degrees, or
  - Scoliotic curvature of greater than 30 degrees
3. Revision surgery for pseudarthrosis following an initial spinal surgery if the following are all met:
    - Member had a period of reduced pain initially following surgery, and
    - The time since the prior procedure has been at least one (1) year, and
    - There is clear radiologic evidence of pseudarthrosis, and
    - Member has exhausted all available conservative treatment measures. Supporting documentation submitted must indicate which conservative treatments were deployed and/or which conservative treatments the member is not a candidate for and why.
  4. Symptomatic compression of neural elements for which disc excision is necessary for decompression.

Outcomes for fusion revision surgery do not usually lead to pain relief and such fusion is considered as a last resort treatment option only when all other treatment options have been unsuccessful. This information must be communicated to the member prior to surgery to allow for appropriate shared decision making with a well-informed member. The documentation submitted must reflect this counseling has occurred and indicate the member's desire to undergo surgery with appropriately informed consent.

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