5221.6500 PARAMETERS FOR SURGICAL PROCEDURES.

Subpart 1. **General.**

A. The health care provider must provide prior notification according to part 5221.6050, subpart 9, before proceeding with any elective inpatient surgery.

B. Emergency surgery may proceed without prior notification. The reasonableness and necessity for the emergency surgery is subject to retrospective review based on the information available at the time of the emergency surgery.

C. For treatment on or after October 1, 2015, an ICD-10-CM code that is equivalent to an applicable ICD-9-CM code listed in this part must be used instead of the ICD-9-CM code. The General Equivalence Mappings tool established by the Centers for Medicare and Medicaid Services must be used to determine the equivalent ICD-10-CM code or codes.

Subp. 2. **Spinal surgery.** Initial nonsurgical, surgical, and chronic management parameters are also included in parts 5221.6200, low back pain; 5221.6205, neck pain; and 5221.6210, thoracic back pain.

A. Surgical decompression of a lumbar nerve root or roots includes, but is not limited to, the following lumbar procedures: laminectomy, laminotomy, discectomy, microdiscectomy, percutaneous discectomy, or foraminotomy. When providing prior notification for decompression of multiple nerve roots, the procedure at each nerve root is subject independently to the requirements of subitems (1) to (3).

(1) Diagnoses: surgical decompression of a lumbar nerve root may be performed for the following diagnoses:

(a) intractable and incapacitating regional low back pain with positive nerve root tension signs and an imaging study showing displacement of lumbar intervertebral disc which impinges significantly on a nerve root or the thecal sac, ICD-9-CM code 722.10;

(b) sciatica, ICD-9-CM code 724.3; or

(c) lumbosacral radiculopathy or radiculitis, ICD-9-CM code 724.4.

(2) Indications: both of the following conditions in units (a) and (b) must be satisfied to indicate that the surgery is reasonably required.

(a) Response to nonsurgical care: the employee's condition includes one of the following:

i. failure to improve with a minimum of eight weeks of initial nonsurgical care; or

ii. cauda equina syndrome, ICD-9-CM code 344.6, 344.60, or 344.61; or

iii. progressive neurological deficits.

(b) Clinical findings: the employee exhibits one of the findings of subunit i in combination with the test results of subunit ii or, in the case of diagnosis in subitem (1), unit (a), a second opinion confirms that decompression of the lumbar nerve root is the appropriate treatment for the patient's condition:

i. subjective sensory symptoms in a dermatomal distribution which may include radiating pain, burning, numbness, tingling, or paresthesia, or objective clinical findings of nerve root specific motor deficit, including, but not limited to, foot drop or quadriceps weakness, reflex changes, or positive EMG; and

ii. medical imaging test results that correlate with the level of nerve root involvement consistent with both the subjective and objective findings.

(3) Repeat surgical decompression of a lumbar nerve root is not indicated at the same nerve root unless a second opinion, if requested by the insurer, confirms that surgery is indicated.

B. Surgical decompression of a cervical nerve root. Surgical decompression of a cervical nerve root or roots includes, but is not limited to, the following cervical procedures: laminectomy, laminotomy, discectomy, foraminotomy with or without fusion. When providing prior notification for decompression of multiple nerve roots, the procedure at each nerve root is subject independently to the requirements of subitems (1) to (3).

(1) Diagnoses: surgical decompression of a cervical nerve root may be performed for the following diagnoses:

(a) displacement of cervical intervertebral disc, ICD-9-CM code 722.0, excluding fracture; or

(b) cervical radiculopathy or radiculitis, ICD-9-CM code 723.4, excluding fracture.

(2) Indications: the requirements in units (a) and (b) must be satisfied to indicate that surgery is reasonably required:

(a) response to nonsurgical care, the employee's condition includes one of the following:

i. failure to improve with a minimum of eight weeks of initial nonsurgical care;

ii. cervical compressive myelopathy; or

iii. progressive neurologic deficits;

(b) clinical findings: the employee exhibits one of the findings of subunit i, in combination with the test results of subunit ii:

i. subjective sensory symptoms in a dermatomal distribution which may include radiating pain, burning, numbness, tingling, or paresthesia, or objective clinical findings of nerve root specific motor deficit, reflex changes, or positive EMG; and

ii. medical imaging test results that correlate with the level of nerve root involvement consistent with both the subjective and objective findings.

(3) Second opinions: surgical decompression of a cervical nerve root is not indicated for the following conditions, unless a second opinion, if requested by the insurer, confirms that the surgery is indicated:

(a) repeat surgery at same level; or

(b) request for surgery at the C3-4 level.

C. Lumbar arthrodesis with or without instrumentation.

(1) Indications: one of the following conditions must be satisfied to indicate that the surgery is reasonably required:

(a) unstable lumbar vertebral fracture, ICD-9-CM codes 805.4, 805.5, 806.4, and 806.5; or

(b) for a second or third surgery only, documented reextrusion or redisplacement of lumbar intervertebral disc, ICD-9-CM code 722.10, after previous successful disc surgery at the same level and new lumbar radiculopathy with or without incapacitating back pain, ICD-9-CM code 724.4. Documentation under this item must include an MRI or CT scan or a myelogram; or

(c) traumatic spinal deformity including a history of compression (wedge) fracture or fractures, ICD-9-CM code 733.1, and demonstrated acquired kyphosis or scoliosis, ICD-9-CM codes 737.1, 737.10, 737.30, 737.41, and 737.43; or

(d) incapacitating low back pain, ICD-9-CM code 724.2, for longer than three months, and one of the following conditions involving lumbar segments L-3 and below is present:

i. for the first surgery only, degenerative disc disease, ICD-9-CM code 722.4, 722.5, 722.6, or 722.7, with postoperative documentation of instability created or found at the time of surgery, or positive discogram at one or two levels; or

ii. pseudoarthrosis, ICD-9-CM code 733.82;

iii. for the second or third surgery only, previously operated disc; or

iv. spondylolisthesis.

(2) Contraindications: lumbar arthrodesis is not indicated as the first primary surgical procedure for a new, acute lumbosacral disc herniation with unilateral radiating leg pain in a radicular pattern with or without neurological deficit.

(3) Retrospective review: when lumbar arthrodesis is performed to correct instability created during a decompression, laminectomy, or discectomy, approval for the arthrodesis will be based on a retrospective review of the operative report.

Subp. 3. **Upper extremity surgery.** Initial nonsurgical, surgical, and chronic management parameters for upper extremity disorders are found in part 5221.6300, subparts 1 to 16.

A. Rotator cuff repair:

(1) Diagnoses: rotator cuff surgery may be performed for the following diagnoses:

(a) rotator cuff syndrome of the shoulder, ICD-9-CM code 726.1, and allied disorders: unspecified disorders of shoulder bursae and tendons, ICD-9-CM code 726.10, calcifying tendinitis of shoulder, ICD-9-CM code 726.11, bicipital tenosynovitis, ICD-9-CM code 726.12, and other specified disorders, ICD-9-CM code 726.19; or

(b) tear of rotator cuff, ICD-9-CM code 727.61.

(2) Criteria and indications: in addition to one of the diagnoses in subitem (1), both of the following conditions must be satisfied to indicate that surgery is reasonably required:

(a) response to nonsurgical care: the employee's condition has failed to improve with adequate initial nonsurgical treatment; and

(b) clinical findings: the employee exhibits:

i. severe shoulder pain and inability to elevate the shoulder; or

ii. weak or absent abduction and tenderness over rotator cuff, or pain relief obtained with an injection of anesthetic for diagnostic or therapeutic trial; and

iii. positive findings in arthrogram, MRI, or ultrasound, or positive findings on previous arthroscopy, if performed.

B. Acromioplasty:

(1) Diagnosis: acromioplasty may be performed for acromial impingement syndrome, ICD-9-CM codes 726.0 to 726.2.

(2) Criteria and indications: in addition to the diagnosis in subitem (1), both of the following conditions must be satisfied for acromioplasty:

(a) response to nonsurgical care: the employee's condition has failed to improve after adequate initial nonsurgical care; and

(b) clinical findings: the employee exhibits pain with active elevation from 90 to 130 degrees and pain at night, and a positive impingement test.

C. Repair of acromioclavicular or costoclavicular ligaments:

(1) Diagnosis: surgical repair of acromioclavicular or costoclavicular ligaments may be performed for acromioclavicular separation, ICD-9-CM codes 831.04 to 831.14.

(2) Criteria and indications: in addition to the diagnosis in subitem (1), the requirements of units (a) and (b) must be satisfied for repair of acromioclavicular or costoclavicular ligaments:

(a) response to nonsurgical care: the employee's condition includes:

i. failure to improve after at least a one-week trial period in a support brace; or

ii. separation cannot be reduced and held in a brace; or

iii. grade III separation has occurred; and

(b) clinical findings: the employee exhibits localized pain at the acromioclavicular joint and prominent distal clavicle and radiographic evidence of separation at the acromioclavicular joint.

D. Excision of distal clavicle:

(1) Diagnosis: excision of the distal clavicle may be performed for the following conditions:

(a) acromioclavicular separation, ICD-9-CM codes 831.01 to 831.14;

(b) osteoarthrosis of the acromioclavicular joint, ICD-9-CM codes 715.11, 715.21, and 715.31; or

(c) shoulder impingement syndrome.

(2) Criteria and indications: in addition to one of the diagnosis in subitem (1), the following conditions must be satisfied for excision of distal clavicle:

(a) response to nonsurgical care: the employee's condition fails to improve with adequate initial nonsurgical care; and

(b) clinical findings: the employee exhibits:

i. pain at the acromioclavicular joint, with aggravation of pain with motion of shoulder or carrying weight;

ii. confirmation that separation of AC joint is unresolved and prominent distal clavicle, or pain relief obtained with an injection of anesthetic for diagnostic/therapeutic trial; and

iii. separation at the acromioclavicular joint with weight-bearing films, or severe degenerative joint disease at the acromioclavicular joint noted on X-rays.

E. Repair of shoulder dislocation or subluxation (any procedure):

(1) Diagnosis: surgical repair of a shoulder dislocation may be performed for the following diagnoses:

(a) recurrent dislocations, ICD-9-CM code 718.31;

(b) recurrent subluxations; or

(c) persistent instability following traumatic dislocation.

(2) Criteria and indications: in addition to one of the diagnoses in subitem (1), the following clinical findings must exist for repair of a shoulder dislocation:

(a) the employee exhibits a history of multiple dislocations or subluxations that inhibit activities of daily living; and

(b) X-ray findings are consistent with multiple dislocations or subluxations.

F. Repair of proximal biceps tendon:

(1) Diagnosis: surgical repair of a proximal biceps tendon may be performed for proximal rupture of the biceps, ICD-9-CM code 727.62 or 840.8.

(2) Criteria and indications: in addition to the diagnosis in subitem (1), both of the following conditions must be satisfied for repair of proximal biceps tendon:

(a) the procedure may be done alone or in conjunction with another indicated repair of the rotator cuff; and

(b) clinical findings: the employee exhibits:

i. complaint of pain that does not resolve with attempt to use arm; and

ii. palpation of "bulge" in upper aspect of arm.

G. Epicondylitis. Specific requirements for surgery for epicondylitis are included in part 5221.6300, subpart 11.

H. Tendinitis. Specific requirements for surgery for tendinitis are included in part 5221.6300, subpart 12.

I. Nerve entrapment syndromes. Specific requirements for nerve entrapment syndromes are included in part 5221.6300, subpart 13.

J. Muscle pain syndromes. Surgery is not indicated for muscle pain syndromes.

K. Traumatic sprains and strains. Surgery is not indicated for the treatment of traumatic sprains and strains, unless there is clinical evidence of complete tissue disruption. Patients with complete tissue disruption may need immediate surgery.

Subp. 4. **Lower extremity surgery.**

A. Anterior cruciate ligament (ACL) reconstruction:

(1) Diagnoses: surgical repair of the anterior cruciate ligament, including arthroscopic repair, may be performed for the following diagnoses:

(a) old disruption of anterior cruciate ligament, ICD-9-CM code 717.83; or

(b) sprain of cruciate ligament of knee, ICD-9-CM code 844.2.

(2) Criteria and indications: in addition to one of the diagnoses in subitem (1) the conditions in units (a) to (c) must be satisfied for anterior cruciate ligament reconstruction. Pain alone is not an indication:

(a) the employee gives a history of instability of the knee described as "buckling or giving way" with significant effusion at time of injury, or description of injury indicates a rotary twisting or hyperextension occurred;

(b) there are objective clinical findings of positive Lachman's sign, positive pivot shift, and/or positive anterior drawer; and

(c) there are positive diagnostic findings with arthrogram, MRI, or arthroscopy and there is no evidence of severe compartmental arthritis.

B. Patella tendon realignment or Maquet procedure:

(1) Diagnosis: patella tendon realignment may be performed for dislocation of patella, open, ICD-9-CM code 836.3, or closed, ICD-9-CM code 836.4, or chronic residuals of dislocation.

(2) Criteria and indications: in addition to the diagnosis in subitem (1), all of the following conditions must be satisfied for a patella tendon realignment:

(a) the employee gives a history of rest pain as well as pain with patellofemoral movement, and recurrent effusion, or recurrent dislocation; and

(b) there are objective clinical findings of patellar apprehension, synovitis, lateral tracking, or Q angle greater than 15 degrees.

C. Knee joint replacement:

(1) Diagnoses: knee joint replacement may be performed for degeneration of articular cartilage or meniscus of knee, ICD-9-CM codes 717.1 to 717.4.

(2) Criteria and indications: in addition to the diagnosis in subitem (1), the following conditions must be satisfied for a knee joint replacement:

(a) clinical findings: the employee exhibits limited range of motion, night pain in the joint or pain with weight-bearing, and no significant relief of pain with an adequate course of initial nonsurgical care; and

(b) diagnostic findings: there is significant loss or erosion of cartilage to the bone, and positive findings of advanced arthritis and joint destruction with standing films, MRI, or arthroscopy.

D. Fusion; ankle, tarsal, metatarsal:

(1) Diagnoses: fusion may be performed for the following conditions:

(a) malunion or nonunion of fracture of ankle, tarsal, or metatarsal, ICD-9-CM code 733.81 or 733.82; or

(b) traumatic arthritis (arthropathy), ICD-9-CM code 716.17.

(2) Criteria and indications: in addition to one of the diagnoses in subitem (1), the following conditions must be satisfied for an ankle, tarsal, or metatarsal fusion:

(a) initial nonsurgical care: the employee must have failed to improve with an adequate course of initial nonsurgical care which included:

i. immobilization which may include casting, bracing, shoe modification, or other orthotics; and

ii. anti-inflammatory medications;

(b) clinical findings:

i. the employee gives a history of pain which is aggravated by activity and weight-bearing, and relieved by xylocaine injection; and

ii. there are objective findings on physical examination of malalignment or specific joint line tenderness, and decreased range of motion; and

(c) diagnostic findings: there are medical imaging studies confirming the presence of:

i. loss of articular cartilage and joint space narrowing;

ii. bone deformity with hypertrophic spurring and sclerosis; or

iii. nonunion or malunion of a fracture.

E. Lateral ligament ankle reconstruction:

(1) Diagnoses: ankle reconstruction surgery involving the lateral ligaments may be performed for the following conditions:

(a) chronic ankle instability, ICD-9-CM code 718.87; or

(b) grade III sprain, ICD-9-CM codes 845.0 to 845.09.

(2) Criteria and indications: in addition to one of the diagnoses in subitem (1), the following conditions must be satisfied for a lateral ligament ankle reconstruction:

(a) initial nonsurgical care: the employee must have received an adequate course of initial nonsurgical care including, at least:

i. immobilization with support, cast, or ankle brace, followed by

ii. a physical rehabilitation program; and

(b) clinical findings:

i. the employee gives a history of ankle instability and swelling; and

ii. there is a positive anterior drawer sign on examination; or

iii. there are positive stress X-rays identifying motion at ankle or subtalar joint with at least a 15 degree lateral opening at the ankle joint, or demonstrable subtalar movement, and negative to minimal arthritic joint changes on X-ray, or ligamentous injury is shown on MRI scan.

(3) Prosthetic ligaments: prosthetic ligaments are not indicated.

(4) Implants: requests for any plastic implant must be confirmed by a second opinion.

(5) Calcaneus osteotomy: requests for calcaneus osteotomies must be confirmed by a second opinion.

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