

MEDICAL POLICY – 7.01.560

Cervical Spine Surgeries: Discectomy, Laminectomy, and Fusion in Adults

Effective Date: Feb. 1, 2019
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 (renumbered)

RELATED MEDICAL POLICIES:

- 7.01.18 Automated Percutaneous and Percutaneous Endoscopic Discectomy
- 7.01.87 Artificial Intervertebral Disc: Lumbar Spine
- 7.01.93 Decompression of the Intervertebral Disc Using Laser Energy (Laser Discectomy) or Radiofrequency Coblation (Nucleoplasty)
- 7.01.108 Artificial Intervertebral Disc: Cervical Spine
- 7.01.551 Lumbar Spine Decompression Surgery: Discectomy, Foraminotomy, Laminotomy, Laminectomy

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Introduction

There are several different types of neck (cervical) surgeries that can relieve pain that is caused by pressure on the spinal cord or nerves. Cervical fusion joins or fuses bones (vertebrae) in the neck. It is done through an incision either on the front or back of the neck. Laminectomy and laminotomy are two different surgeries that can be done on the lamina, which is the protective, bony covering that’s at the back of the spinal canal. A laminectomy is the full removal of the lamina. A laminotomy, which is also called a hemilaminectomy, is partial removal of the lamina. Sometimes the pain is caused by a disc that’s pressing on a nerve. In this case, surgery on the disc, called a discectomy, may be needed. This policy describes when cervical fusion, laminectomy, laminotomy, and discectomy may be considered medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

This policy only applies to the adult population age 19 and older.

Note: Requests for fusions of more than 2 levels must be reviewed by a medical director.

Indications	Medical Necessity
Anterior Cervical Fusion	
<ul style="list-style-type: none"> • Degenerative cervical spondylosis • Infection of cervical spine • Ossification of posterior longitudinal ligament (OPLL) • Posttraumatic cervical instability • Tumor of cervical spine 	<p>Anterior cervical fusion may be considered medically necessary in the following situations:</p> <ul style="list-style-type: none"> • Degenerative cervical spondylosis with kyphosis causing cord compression • Infection of cervical spine requiring decompression or debridement • Ossification of posterior longitudinal ligament (OPLL) at 1 to 3 levels associated with myelopathy • Posttraumatic cervical instability (eg, unstable anterior column fracture) • Tumor of cervical spine causing pathologic fracture, cord compression, or instability
<p>Cervical radiculopathy</p>	<p>Anterior cervical fusion may be considered medically necessary for cervical radiculopathy and ALL of the following:</p> <ul style="list-style-type: none"> • Patient has unremitting radicular pain or progressive weakness secondary to nerve root compression. <p>AND</p> <ul style="list-style-type: none"> • Non-operative therapy for at least 6 weeks has failed, including Physical Therapy (or chiropractic care) AND 1 or more of the following: <ul style="list-style-type: none"> ○ Medical treatment with NSAIDs, or other analgesics (non-narcotic or narcotic) ○ Cervical collar ○ Exercise program ○ Oral corticosteroids ○ Acupuncture <p>AND</p> <ul style="list-style-type: none"> • A cervical spine MRI or CT scan with myelogram within the past 12 months demonstrates spinal stenosis or nerve root compression at the same level as the symptoms and physical exam findings

Indications	Medical Necessity
<p>Spondylotic myelopathy</p>	<p>Anterior cervical fusion may be considered medically necessary for spondylotic myelopathy treatment indicated by ALL of the following:</p> <ul style="list-style-type: none"> • Signs or symptoms of myelopathy are present as indicated by 1 or more of the following: <ul style="list-style-type: none"> ○ Upper limb weakness in more than a single nerve root distribution ○ Lower limb weakness ○ Loss of dexterity (eg, clumsiness of hands) ○ Bowel or bladder incontinence ○ Frequent falls ○ Hyperreflexia ○ Hoffmann sign ○ Increased extremity muscle tone or spasticity ○ Gait abnormality ○ Positive Babinski sign <p>AND</p> <ul style="list-style-type: none"> • A cervical spine MRI or CT scan with myelogram within the past 12 months which demonstrates spinal cord compression corresponding to symptoms and physical exam findings due to 1 or more of the following: <ul style="list-style-type: none"> ○ Herniated disk ○ Osteophyte ○ Ossification of the posterior longitudinal ligament
<p>Cervical pseudarthrosis</p>	<p>Anterior cervical fusion may be considered medically necessary for cervical pseudarthrosis (failed union) and ALL of the following:</p> <ul style="list-style-type: none"> • Neck pain is unresponsive to non-operative therapy of at least 6 weeks, including Physical Therapy (or chiropractic care) AND 1 or more of the following: <ul style="list-style-type: none"> ○ Medical treatment with NSAIDs or other analgesics (non-narcotic or narcotic) ○ Cervical collar ○ Exercise program ○ Oral corticosteroids ○ Acupuncture <p>AND</p> <ul style="list-style-type: none"> • Alternative etiologies of symptoms have been ruled out

Indications	Medical Necessity
	<p>AND</p> <ul style="list-style-type: none"> A cervical spine MRI or CT scan with myelogram within the past 12 months demonstrates spinal stenosis or nerve root compression at the same level as the symptoms and physical exam findings
<p>Degenerative spinal segment</p>	<p>Anterior cervical fusion may be considered medically necessary for a degenerative spinal segment adjacent to a prior decompressive or fusion procedure with 1 or more of the following:</p> <ul style="list-style-type: none"> Symptomatic myelopathy corresponding clinically to an adjacent level <p>OR</p> <ul style="list-style-type: none"> Symptomatic radiculopathy corresponding clinically to an adjacent level and unresponsive to non-operative therapy of at least 6 weeks, including Physical Therapy (or chiropractic care) AND 1 or more of the following: <ul style="list-style-type: none"> Medical treatment with NSAIDs or other analgesics (non-narcotic or narcotic) Cervical collar Exercise program Oral corticosteroids Acupuncture <p>AND</p> <ul style="list-style-type: none"> A cervical spine MRI or CT scan with myelogram within the past 12 months demonstrates spinal stenosis or nerve root compression at the same level as the symptoms and physical exam findings
<p>Cervical spine injury</p>	<p>Anterior cervical fusion may be considered medically necessary for treatment of a cervical spine injury (eg, trauma), as indicated by ALL of the following:</p> <ul style="list-style-type: none"> Acutely symptomatic cervical radiculopathy or myelopathy MRI or other neuroimaging finding (eg, cord compression, root compression) done within the past 12 months demonstrates pathologic anatomy corresponding to symptoms
<p>Posterior Cervical Fusion</p>	
<p>As listed</p>	<p>Posterior cervical fusion may be considered medically necessary in the following situations:</p>

Indications	Medical Necessity
	<ul style="list-style-type: none"> • Atlas and axis fractures • Bilateral locked facets • Cervical instability in Down syndrome • Cervical instability in skeletal dysplasia or connective tissue disorders • Disruption of posterior ligamentous structures • Facet fractures with dislocation • Infection of cervical spine requiring decompression or debridement • Klippel-Feil syndrome • Ossification of posterior longitudinal ligament without kyphosis with associated myelopathy • Part of stabilization procedure with corpectomy, laminectomy, or other procedure at cervicothoracic junction (eg, C7 and T1) • Part of stabilization procedure with laminectomy (eg, at C2) • Posttraumatic cervical instability • Subluxation and cord compression in rheumatoid arthritis • Tumor of cervical spine causing pathologic fracture, cord compression, or instability • Posttraumatic cervical instability
<p>Multilevel spondylotic myelopathy</p>	<p>Posterior cervical fusion may be considered medically necessary for the treatment of multilevel spondylotic myelopathy without kyphosis as indicated by ALL of the following:</p> <ul style="list-style-type: none"> • Signs or symptoms of myelopathy are present as indicated by 1 or more of the following: <ul style="list-style-type: none"> ○ Upper limb weakness in more than single nerve root distribution ○ Lower limb weakness ○ Loss of dexterity (eg, clumsiness of hands) ○ Bowel or bladder incontinence ○ Frequent falls ○ Hyperreflexia ○ Hoffman sign ○ Increased muscle tone or spasticity ○ Gait abnormality ○ Positive Babinski sign <p>AND</p>

Indications	Medical Necessity
	<ul style="list-style-type: none"> • MRI or other neuroimaging finding done within the past 12 months correlates with clinical signs and symptoms and demonstrates cord compression due to 1 or more of the following: <ul style="list-style-type: none"> ○ Herniated disk ○ Osteophyte
Symptomatic unstable cervical spondylosis	<p>Posterior cervical fusion may be considered medically necessary for symptomatic unstable cervical spondylosis with radiographic findings that include 1 or more of the following:</p> <ul style="list-style-type: none"> • Subluxation of more than 3.5 mm on static lateral views • Sagittal plane angulation of more than 11 degrees between adjacent segments • More than 4 mm of motion (subluxation) on dynamic views
Cervical pseudarthrosis	<p>Posterior cervical fusion may be considered medically necessary for cervical pseudoarthrosis and ALL of the following:</p> <ul style="list-style-type: none"> • Neck pain is unresponsive to non-operative therapy of at least 6 weeks, including Physical Therapy (or chiropractic care) and 1 or more of the following: <ul style="list-style-type: none"> ○ Medical treatment with NSAIDs or other analgesics (non-narcotic or narcotic) ○ Cervical collar ○ Exercise program ○ Oral corticosteroids ○ Acupuncture <p>AND</p> <ul style="list-style-type: none"> • Alternative etiologies of symptoms have been ruled out
Cervical spine injury	<p>Posterior cervical fusion may be considered medically necessary for treatment of a cervical spine injury (eg, trauma), as indicated by ALL of the following:</p> <ul style="list-style-type: none"> • Acutely symptomatic cervical radiculopathy or myelopathy • MRI or other neuroimaging finding (eg, cord compression, root compression) done within the past 12 months demonstrates pathologic anatomy corresponding to symptoms
Cervical Discectomy	
Cervical discectomy	Cervical discectomy* may be considered medically necessary for the treatment of a cervical herniated disc when All of the

Indications	Medical Necessity
	<p>following criteria are met:</p> <ul style="list-style-type: none"> • Signs and symptoms of radiculopathy and/or myelopathy are present, such as 1 or more of the following: <ul style="list-style-type: none"> ○ Pain that radiates into the shoulder, down the arms to the hands ○ Numbness and tingling in a dermatomal distribution ○ Muscular weakness in a pattern associated with spinal nerve root compression ○ Increased or abnormal reflexes corresponding to affected nerve root level ○ Loss of sensation in a dermatomal pattern <p>AND</p> <ul style="list-style-type: none"> • One of the following clinical presentations is present: <ul style="list-style-type: none"> ○ Rapidly progressing neurologic deficits OR ○ Persistent debilitating neck, back, or arm pain OR ○ Persistent or progressive symptoms of myelopathy are unresponsive to non-operative therapy of at least 6 weeks, including Physical Therapy (or chiropractic care) AND 1 or more of the following: <ul style="list-style-type: none"> ▪ Medical treatment with NSAIDs or other analgesics (non-narcotic or narcotic) ▪ Cervical Collar ▪ Exercise Program ▪ Epidural steroid injections ▪ Acupuncture <p>AND</p> <ul style="list-style-type: none"> • Documentation of nerve root compression on imaging (MRI or CT) at a level that corresponds with the individual's symptoms. <p>Cervical discectomy is considered not medically necessary for the treatment of a cervical herniated disc when the above criteria are not met.</p> <p>Note: *Cervical discectomy refers to open anterior cervical discectomy (with or without fusion) or minimally invasive posterior cervical discectomy/foraminotomy</p>
Cervical Laminectomy	

Indications	Medical Necessity
As listed	<p>Cervical laminectomy may be considered medically necessary for ANY of the following:</p> <ul style="list-style-type: none"> • Spinal fracture, dislocation, locked facets, or displaced fracture fragment confirmed by imaging studies (eg, CT or MRI) • Spinal infection confirmed by imaging studies (eg, CT or MRI) • Spinal tumor confirmed by imaging studies (eg, CT or MRI)
Cervical laminectomy	<p>Cervical laminectomy may be considered medically necessary for the treatment of herniated discs, or other causes of spinal cord or nerve root compression (such as osteophytic spurring or ligamentum flavum hypertrophy) when ALL of the following criteria are met:</p> <ul style="list-style-type: none"> • Signs and symptoms of radiculopathy and/or myelopathy are present, such as 1 or more of the following: <ul style="list-style-type: none"> ○ Pain that radiates into the shoulder, down the arms to the hands ○ Numbness and tingling in a dermatomal distribution ○ Muscular weakness in a pattern associated with spinal nerve root compression ○ Increased or abnormal reflexes corresponding to affected nerve root level ○ Loss of sensation in a dermatomal pattern <p>AND</p> <ul style="list-style-type: none"> • Rapidly progressing neurologic deficits OR • Persistent debilitating neck, back, or arm pain OR • Persistent or progressive symptoms of myelopathy that are unresponsive to non-operative therapy of at least 6 weeks, including Physical Therapy and 1 or more of the following: <ul style="list-style-type: none"> ○ Medical treatment with NSAIDs or other analgesics (non-narcotic or narcotic) ○ Cervical Collar ○ Exercise Program ○ Epidural steroid injections ○ Acupuncture <p>AND</p> <ul style="list-style-type: none"> • Alternative etiologies of symptoms have been ruled out <p>AND</p> <ul style="list-style-type: none"> • MRI or other neuroimaging finding (eg, cord compression, root compression) done within the past 12 months demonstrates

Indications	Medical Necessity
	pathologic anatomy corresponding to symptoms

Documentation Requirements
<p>The following information must be submitted to ensure an accurate, expeditious, and complete review for cervical spinal fusion surgery:</p> <ul style="list-style-type: none"> • Specific procedures requested with related procedure/diagnosis codes and identification of disc level(s) for surgery • Office notes that include a current history and physical exam • Clinical notes document the individual has been evaluated at least twice by a physician(s) before submitting a request for surgery (except in cases of malignancy, trauma, infection or rapidly progressive neurologic symptoms) • Detailed documentation of extent and response to conservative therapy, if applicable, including outcomes of any procedural interventions, medication use and physical therapy/physiatrist notes • Copy of radiologist’s report(s) for diagnostic imaging (MRIs, CTs, etc.) completed within the past 12 months. Imaging must be performed and read by an independent radiologist. If discrepancies should arise in the interpretation of the imaging, the radiologist report will supersede

Coding

Code	Description
CPT	
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical below C2
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2
22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)

Code	Description
22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical
63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Related Information

Definition of Terms

American Society of Anesthesiologists (ASA) Score:

- ASA 1** A normal healthy patient.
- ASA 2** A patient with mild systemic disease.
- ASA 3** A patient with severe systemic disease.
- ASA 4** A patient with severe systemic disease that is a constant threat to life.
- ASA 5** A moribund patient who is not expected to survive

Positive Babinski sign: A reflex response consisting of extension of the big toe when the sole of the foot is stroked.

Cervical myelopathy: The loss of function in the upper and lower extremities due to compression of the spinal cord within the neck.

Cervical radiculopathy: Persistent neck pain that radiates into the shoulder/arm in a dermatomal/single nerve pattern, or progressive weakness caused by irritation or injury near the root of a spinal nerve in the neck. The North American Spine Society (NASS) describes the most common clinical findings as arm pain, neck pain, scapular or periscapular pain, paresthesias, numbness and sensory changes, weakness, or abnormal deep tendon reflexes in the arm.

Cervical spondylosis: Abnormal wear of the cartilage and bones in the cervical vertebrae. This includes the discs or cushions between the neck vertebrae and the joints between the bones of the cervical spine. May result in bone spurs.

Dermatome/dermatomal: Each area of skin (dermis) has sensory nerve fibers coming from a single spinal nerve root (see [Appendix](#)).

Hoffman's sign/Finger Flexor reflex: Holding the patient's middle finger loosely and flicking the fingernail downward, causing the finger to rebound slightly into extension. If the thumb flexes and adducts in response, Hoffmann's sign is present.

Myotome: A muscle of the back supplied by a nerve of the spine.

New York Heart Association (NYHA) Classification:

Class I No symptoms and no limitation in ordinary physical activity, eg, shortness of breath when walking, climbing stairs etc.

Class II Mild symptoms (mild shortness of breath and/or angina) and slight limitation during ordinary activity.

Class III Marked limitation in activity due to symptoms, even during less-than-ordinary activity, eg, walking short distances (20–100 m). Comfortable only at rest.

Class IV Severe limitations. Experiences symptoms even while at rest. Mostly bedbound patients

Ossification of the posterior longitudinal ligament: A ligament in the spine that travels from the neck to the sacrum. It may become thickened and cause pressure on the spinal cord and lead to nerve damage.

Place of Service (Professional Claims Codes):

Off-Campus-Outpatient Hospital A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Code 19)

Inpatient Hospital A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions. (Code 21)

On Campus-Outpatient Hospital A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Code 22)

Ambulatory Surgical Center A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis. (Code 24)

Pseudarthrosis: When bones fail to fuse with one another after spinal fusion surgery. Lack of union at the fused location.

Benefit Application

Prior authorization review and approval is required on all indications with submission of clinical information that supports the medical necessity for cervical spine surgery such as cervical discectomy, laminectomy, or fusion.

Consideration of Age

This policy is intended for use in the adult population and is based on utilization in this population. Cervical spine surgeries are often performed when the cervical vertebrae become damaged due to injury or chronic degenerative changes. Degenerative disc changes are an age-related condition.

Evidence Review

Description

Cervical fusion is a surgery that joins or fuses selected bones in the neck. It is performed through an incision on the front (anterior) or back (posterior) of the neck. Cervical fusion is often performed when the cervical vertebrae become damaged due to injury or chronic degenerative changes, leading to compression of the spinal cord or the cervical nerve root. The expected outcome from cervical fusion is stabilization of the vertebrae and alleviation of pain and/or weakness resulting from vertebral instability.

Bone grafts are often used, taken from elsewhere in the body or received from a bone bank. Metal implants can be used to hold the vertebrae together until new bone grows between them. Metal plates can be screwed into adjacent vertebrae to join them. An entire vertebra can be removed, and the spine then fused. A spinal disc can be removed and the adjacent vertebrae fused.

Clinical complications of cervical fusion surgery include: infection; injury to the nerves; misplaced, broken, or loosened plates, screws or implants; injury to the spinal cord; possible need for additional surgery in the future due to adjacent segment breakdown; and/or increased pain.

An adequate course of conservative treatment may avert the need for surgical intervention.

Cervical discectomy is a surgical procedure in which one or more intervertebral discs are removed. Extrusion of an intervertebral disc beyond the intervertebral space can compress the spinal nerves and result in pain, numbness, and weakness. Discectomy is intended to treat symptoms by relieving pressure on the affected nerve root(s). Discectomy can be performed by a variety of surgical approaches, with either open surgery or minimally invasive techniques.

Background

Disc Herniation

Extrusion of an intervertebral disc beyond the intervertebral space can compress the spinal nerves and result in symptoms of pain, numbness, and weakness.

The natural history of untreated disc herniations is not well-characterized, but most herniations will decrease in size over time due to shrinking and/or regression of the disc.¹ Clinical symptoms will also tend to improve over time in conjunction with shrinkage or regression of the herniation.

Treatment

Because most disc herniations improve over time, initial care is conservative, consisting of analgesics and a prescribed activity program tailored to patient considerations. Other potential nonsurgical interventions include opioid analgesics and chiropractic manipulation. Epidural steroid injections can also be used as a second-line intervention and are associated with short-term relief of symptoms.²

However, some disc herniations will not improve over time with conservative care. A small proportion of patients will have rapidly progressive signs and symptoms, thus putting them at risk for irreversible neurologic deficits. These patients are considered to be surgical emergencies, and expedient surgery is intended to prevent further neurologic deterioration and allow for nerve recovery.

Other patients will not progress but will have the persistence of symptoms that require further intervention. It is estimated that up to 30% of patients with sciatica will continue to have pain for more than 1 year.³ For these patients, there is a high degree of morbidity and functional disability associated with chronic back pain, and there is a tendency for recurrent pain despite treatment. Therefore, treatments that have more uniform efficacy for patients with a herniated disc and chronic back pain are needed. In particular, decreased chronic pain and decreased disability are the goals of treatment of chronic low back pain due to a herniated disc.

Cervical Discectomy

The most common procedure for cervical discectomy is anterior cervical discectomy. This is an open procedure in which the cervical spine is approached through an incision in the anterior neck. Soft tissues and muscles are separated to expose the spine. The disc is removed using direct visualization. This procedure can be done with or without spinal fusion, but most commonly it is performed with fusion.

A less invasive procedure for cervical discectomy is posterior cervical discectomy and foraminotomy. They are performed through a small incision in the back of the neck. The nerves and muscles are separated using a small retractor. The spine is visualized with microscopic guidance, and a portion of the spine—the foramen—is removed to expose the spinal canal. Special instruments are used to remove a portion of the disc or the entire disc.

Adverse Events

Complications of discectomy generally include bleeding, infections, and inadvertent nerve injuries. Dural puncture occurs in a small percentage of patients, leading to leakage of cerebrospinal fluid that can be accompanied by headaches and/or neck stiffness. In a small percentage of cases, worsening of neurologic symptoms can occur postsurgery.

Summary of Evidence

Literature suggests that spinal fusion appears to provide faster relief of pain and symptoms than conservative management (ie, physical therapy or cervical collar immobilization) in the first several months after the surgery. Over time, however, these differences diminished and clinical outcomes of cervical fusion and conservative treatment were comparable at 12 months after the intervention. Additionally, spinal fusion may cause relatively rare but significant complications. Therefore, the first line of treatment for chronic cervical pain should be a comprehensive non-operative approach. A non-emergent cervical spine fusion may be a consideration only after conservative therapy has failed and a physical examination and diagnostic imaging findings indicate neural compression at the appropriate level.

For individuals who have cervical herniated disc(s) and symptoms of radiculopathy rapidly progressing or refractory to conservative care who receive cervical discectomy, the evidence includes RCTs, nonrandomized comparative studies, and systematic reviews. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, and treatment-

related mortality and morbidity. Two small RCTs were identified for inclusion in this evidence review. Although there is less evidence for this indication, it does not differ substantially from lumbar herniated disc, showing that patient-reported symptoms and disability favor surgery in the short-term, and that long-term outcomes do not differ. Because cervical discectomy closely parallels lumbar discectomy, with close similarities in anatomy and surgical procedure, it can be inferred that the benefit reported for lumbar discectomy supports a benefit for cervical discectomy. Based on the available evidence and extrapolation from studies of lumbar herniated disc, it is likely that use of discectomy for cervical herniated disc improves short-term symptoms and disability. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

Practice Guidelines and Position Statements

American Association of Neurologic Surgeons (AANS) Guideline – 2009

The AANS published guidelines in 2009 that used a systematic review of the National Library of Medicine and Cochrane database, regarding indications for anterior cervical decompression for the treatment of cervical degenerative radiculopathy. They state: “In the acute phase, non-operative management is the mainstay, with success rates averaging 90%.” The AANS further states: “When clinical cervical radiculopathy is present with active nerve root compression visible on diagnostic imaging, the clinician often recommends surgical decompression if nonoperative measures have failed.” While they state that anterior nerve root decompression via anterior nerve root discectomy with or without fusion for radiculopathy is associated with rapid relief (3-4 months) compared with physical therapy, they acknowledge that at the 12-month point, comparable clinical improvements with PT or cervical immobilization are also present. They also acknowledge that there is insufficient data to factor in the cost of complications and any undesirable long-term effect related to the specific surgical intervention, such as adjacent segment disease.

North American Spine Society (NASS) Guideline – 2011

The NASS published evidence-based clinical guidelines (2011) on the diagnosis and treatment of cervical radiculopathy from degenerative disorders.² The guidelines included evaluations of anterior cervical discectomy (ACD), ACD with fusion, ACD with instrumented fusion, ACD with fusion plus plate, and posterior laminoforaminotomy. Recommendations are listed in [Table 1](#).

Table 1. Recommendations Treating Cervical Radiculopathy From Degenerative Disorders

Recommendations	GORa
Surgical intervention is suggested for the rapid relief of symptoms when compared to medical/interventional treatment.	B
Surgery is an option to produce and maintain favorable long-term (>4 years) outcomes.	C
Both ACD and ACDF are suggested as comparable treatment strategies, producing similar clinical outcomes.	B
ACDF and total disc arthroplasty are suggested as comparable treatments, resulting in similarly successful short-term outcomes.	B
Both ACDF with and without a plate are suggested as comparable treatments, resulting in similar clinical outcomes and fusion rates.	B
Either ACDF or PLF are suggested for treatment of single level degenerative cervical radiculopathy secondary to foraminal soft disc herniation to achieve comparably successful clinical outcomes.	B

ACD: anterior cervical discectomy; ACDF: anterior cervical discectomy with fusion; GOR: grade of recommendation; PLF: posterior laminoforaminotomy.

^a Grade B: fair evidence (level II or III studies with consistent findings); grade C: poor quality evidence (level IV or V studies).

American College of Occupational and Environmental Medicine (ACOEM) Guideline – 2011

In 2011, the ACOEM issued guidelines on the diagnostic testing and management of cervical and thoracic spine disorders.

MRI received the strongest ACOEM testing recommendation for patients with:

- Acute cervical pain with progressive neurologic deficit
- Significant trauma with no improvement in significantly painful or debilitating symptoms
- A history of neoplasia (cancer)
- Multiple neurological abnormalities that span more than one neurological root level
- Previous neck surgery with increasing neurologic symptoms
- Fever with severe cervical pain
- Symptoms or signs of myelopathy

- Subacute or chronic radicular pain syndromes lasting at least 4 to 6 weeks in whom dermatomal and myotomal symptoms are not trending towards improvement if either injection is being considered or both the patient and surgeon are considering early surgical treatment if supportive findings on MRI are found

For acute, subacute and chronic cervicothoracic pain, ACOEM "A" (strong) or "B" (moderate) recommendations included strengthening, endurance and aerobic exercises, proton pump inhibitors, sucralfate, acetaminophen/aspirin, and manipulation/mobilization.

Institute for Clinical and Economic Review (ICER) Evaluation – 2013

In 2013, Washington State Health Care Authority commissioned the ICER to evaluate the comparative clinical effectiveness and comparative value of spinal fusion and its alternatives in patients with cervical degenerative disc disease (DDD).

The focus of this appraisal was on adults (>17 years of age) with cervical DDD symptoms, including neck pain, arm pain, and/or radiculopathic symptoms (eg, numbness, tingling); these symptoms could occur with or without the presence of spondylosis. In all cases, the target population was focused on patients whose symptoms have persisted despite an initial short course (ie, 4-6 weeks) of self-care and conservative management.

Evidence was sought to answer several key questions, including:

What is the comparative clinical effectiveness of cervical fusion for DDD relative to that of conservative management approaches, minimally-invasive procedures, and other forms of surgery?

ICER conferred a "Comparable" rating for spinal fusion vs. conservative management for radiculopathic symptoms. They stated: "For patients with clinical symptoms of radiculopathy and radiographic evidence of nerve root compression there is not a large evidence base comparing outcomes between spinal fusion and conservative management. We identified only 1 RCT and 1 comparative cohort study, neither of which stood out for their methodologic rigor, size, or generalizability. Despite variability in study design, entry criteria, and outcomes measured, findings were reasonably consistent. Specifically, spinal fusion appeared to provide faster relief of pain and symptoms than conservative management (ie, physical therapy or cervical collar immobilization) in the short term. Over time, however, these differences diminished and no material differences in outcome were observed by 12 months after intervention. ICER cited a Cochrane review by Nikolaidis and colleagues to determine whether surgical treatment of cervical radiculopathy or myelopathy was associated with improved outcome compared with conservative management. Two trials (N = 149) were included. In both trials, allocation

concealment was inadequate and arrangements for blinding of outcome assessment were unclear. One trial (81 patients with cervical radiculopathy) found that surgical decompression was superior to physiotherapy or cervical collar immobilization in the short-term for pain, weakness or sensory loss; at one year, there were no significant differences between groups. One trial (68 patients with mild functional deficit associated with cervical myelopathy) found no significant differences between surgery and conservative treatment in three years following treatment. A substantial proportion of cases were lost to follow-up. The authors concluded that it was unclear whether the short-term risks of surgery are offset by long-term benefits. There was low quality evidence that surgery may provide pain relief faster than physiotherapy or hard collar immobilization in patients with cervical radiculopathy; but there is little or no difference in the long-term. There was very low quality evidence that patients with mild myelopathy felt subjectively better shortly after surgery, but there was little or no difference in the long-term.

Because of this, and because spinal fusion may cause relatively rare but significant complications, we deemed the overall comparative clinical effectiveness of fusion to conservative management “Comparable”. In some patients, however, neck pain and related symptoms may be so severe and disabling that the faster relief potentially afforded by fusion surgery would also allow a quicker return to work and other normal activities. For such patients, fusion might in fact be considered “Incremental” in comparison to ongoing conservative management.

Another key question concerned potential harms associated with cervical fusion compared to conservative management:

What are the adverse events and other potential harms associated with cervical fusion compared to conservative management approaches, minimally-invasive procedures, and other forms of surgery?

In analyzing data from randomized controlled trials (RCTs) and comparative cohorts, ICER found that the rate of harm and complications from cervical fusion were significantly greater than those from conservative treatment. Some of the highest rates of potential harm from fusion were events of infection (0-13%), adjacent segment disease (7-16%), paresthesia (14%), dysphagia (3-17%), pseudoarthrosis (8%), and neurological decline (3-23%). Conservative treatment harms were relatively minor, with the exception of neurological decline (14.2%) and paresthesia (8%).

2015 Update

A literature search through July 2015 was performed and there were no studies which would alter the policy statement.

In a meta-analysis, Wu et al stated that the traditional surgical method of ACDF carries with it the disadvantages of motion loss at the operative level and accelerated adjacent level disc degeneration. They performed a meta-analysis comparing the long-term outcomes of cervical total disc arthroplasty (TDA) versus fusion. This review was prepared following the standard procedures set forth by the Cochrane Collaboration organization, and preferred reporting items for systematic reviews and meta-analyses (PRISMA). The only studies included were randomized controlled trials with a minimum of 4 years of follow-up data. The meta-analysis included the neck disability index (NDI), visual analog scale (VAS) of neck and arm pain, SF-36 physical component scores (SF-36 PCS), over success, neurological success, work status, implant-related complications, and secondary surgery events. Four randomized controlled trials met the inclusion criteria. The long-term improvement of NDI, VAS of neck and arm pain, SF-36 PCS, over success, and neurological success favored the TDA group. The TDA group also had a lower incidence of secondary surgery for both the index level and adjacent level. In this meta-analysis of 4 including RCTs with a minimum 4 years of follow-ups, total disc arthroplasty showed improvements over ACDF as measured by the NDI, VAS of neck and arm pain, and SF-36 PCS.

2016 Update

A literature search through February 2016 was performed and there were no studies which would alter the policy statement.

Adjacent segment disease (ASD) development is known to occur after anterior cervical discectomy and fusion. Bydon and colleagues (2014) retrospectively evaluated 888 individuals treated at a single institution over a 20-year period who underwent ACDF for cervical spondylosis. Of these individuals, 108 had re-do surgery as a result of symptomatic adjacent segment disease (ASD). Individuals were followed for an average of 92.4 ± 52.6 months after the index ACDF. Individuals were more likely to develop ASD, known to occur after ACDF, above the index level of fusion. In agreement with previous ACDF case series, they found the highest rate of cervical spinal degenerative disease requiring surgery was at C5/C6, followed by C6/C7. However, neither the inherent location of the index ACDF nor the length of instrumented arthrodesis appeared to correlate with the propensity to develop ASD.

2017 Update

No literature to change the policy statement.

2018 Update

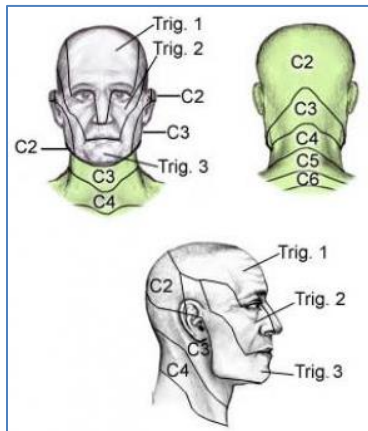
References 10-15 added. Posterior cervical fusion, cervical discectomy, and cervical laminectomy medical necessity criteria added to the policy.

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Appendix

Image 1



Appendix Table 1. Dermatomes of the Head and Neck

Spinal Component	Skin Distribution
Divisions of the trigeminal nerve (cranial nerve [CN] V1, V2, and V3)	Most of the skin of the face, including anterior aspect of lower jaw (CN V3); the area of skin in front of both ears; superior part of the lateral aspect of the auricle (CN V3)
Cervical plexus (ventral rami of C2-C4)	Skin over the angle of the mandible, anterior to and behind the ear, the anterior neck and back of the head and neck; inferior part of the lateral aspect of the auricle and skin on medial aspect of the auricle; the lateral and anterior aspects of the neck
Greater occipital nerve (dorsal ramus of C2), third occipital nerve (dorsal ramus of C3), and the posterior divisions of C4-C6	The posterior aspect of the head (C2) and neck (C3) with C4-C6 innervating the back of the neck

Image 2

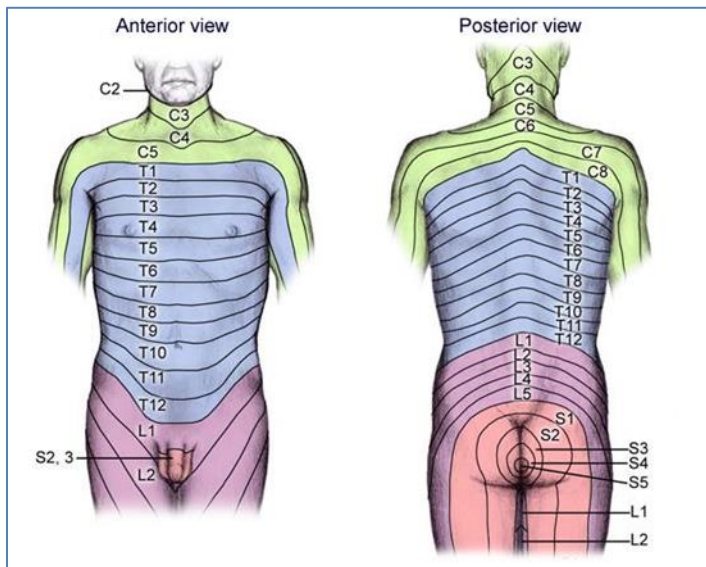
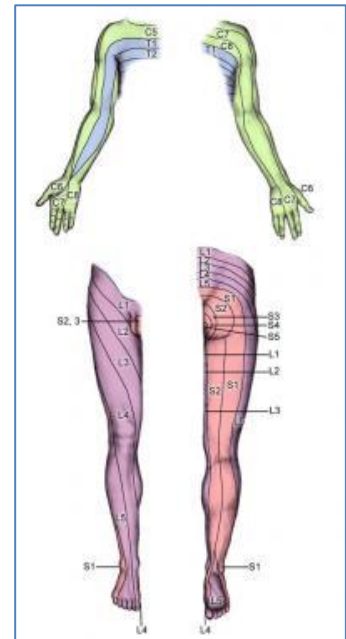


Image 3



Appendix Table 2. Dermatomes of the Upper Extremity

Spinal Component	Skin Distribution
Third and fourth cervical nerves	Limited area of skin over the root of the neck, upper aspect of the pectoral region, and shoulder
C5 dermatome	Lateral aspect of the upper extremities at and above the elbow
C6 dermatome	The forearm and the radial side of the hand
C7 dermatome	The middle finger
C8 dermatome	The skin over the small finger and the medial aspect of each hand
T1 dermatome	The medial side of the forearm
T2 dermatome	The medial and upper aspect of the arm and the axillary region

History

Date	Comments
9/08/14	New Policy. Added to UM section. May be considered medically necessary when criteria are met. Policy approved with a hold for provider notification and will be effective December 15, 2014.

Date	Comments
11/04/14	Minor update. Policy title updated; order change in words only for improved clarification.
12/22/14	Interim Review. Policy renumbered; moved from UM section (11.01.505) to Surgery section (7.01.560). Reference #4 removed.
02/10/15	Interim Review. All information specific to posterior cervical removed from policy statement. Title revised to note that criteria apply to anterior cervical decompression and fusion only and to adults only. Definition of corpectomy in Policy Guidelines deleted and definition of cervical radiculopathy expanded. Codes for posterior (22600/22614) deleted.
05/12/15	Minor update. "With or Without Fusion" removed from title for purposes of clarification. Additional clarifications: the word "cervical" added to multi-level fusion statement and note added that decompression as a stand-alone procedure is not subject to medical review.
09/08/15	Annual Review. Abbreviation "OPLL" added to policy statement for ossification of posterior longitudinal ligament. Dermatome graphics added to Appendix. Rationale updated and reference added. Policy statement revised as noted.
11/10/15	Interim Review. Added Documentation section to Policy Guidelines stating medical necessity is established by submitting documentation of medical history, physical findings, and diagnostic imaging results that demonstrate need for cervical spine surgery. (No documentation guidance was in the policy previously). Policy statements unchanged.
05/01/16	Annual Review, approved April 12, 2016. Policy statement revised: Timeframe for completion of diagnostic imaging changed from 6 months to 12 months, consistent with documentation requirements in Policy Guidelines. Rationale updated and reference added.
05/24/16	Update Related Policies. Removed 7.01.146 as it was added in error. Replaced with 7.01.551.
11/01/16	Interim review, approved October 11, 2016. Clarified cervical radiculopathy statement to show that imaging needs to show spinal stenosis and nerve root compression, and added herniated disk and osteophytes to physical findings. Clarified spondylotic myelopathy policy statement that imaging needs to show spinal cord compression and added ossification of posterior longitudinal ligament to list of physical findings. Policy moved into new format.
01/01/17	Interim Review, approved December 13, 2016. Policy statement revised: Requests for fusions of more than 2 levels must be reviewed by a medical director.
10/01/17	Annual Review, approved September 5, 2017. No changes to policy statement, no new references.
03/01/18	Note added that this policy has been revised. Added link to revised policy that will become effective June 1, 2018.
04/15/18	Minor update, removed 11.01.524 from Related Policies as Anterior Cervical Spine

Date	Comments
	Decompression and Fusion in Adults was removed from the Site of Service program. Removed link to revised policy.
06/08/18	Minor edit. Policy criteria bullets changed from "spinal stenosis <u>and</u> nerve root compression" to "spinal stenosis <u>or</u> nerve root compression".
09/21/18	Minor update. Added Consideration of Age statement.
11/01/18	Annual Review, approved October 9, 2018, effective February 1, 2019. Literature review through September 2018. References 10-15 added. Title changed from "Anterior Cervical Spine Decompression and Fusion in Adults" to "Cervical Spine Surgeries: Discectomy, Laminectomy, and Fusion in Adults". Policy statements added for posterior cervical fusion, cervical discectomy, and cervical laminectomy. Chiropractic care added as a nonoperative therapy. Added codes 22600, 63020 & 63045.

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200 Independence Avenue SW, Room 509F, HHH Building
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본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 귀하의 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하의 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-722-1471 (TTY: 800-842-5357) 로 전화하십시오.

ລາວ (Lao):

ແຈງການນີ້ມີຂໍ້ມູນສໍາຄັນ. ແຈງການນີ້ອາດຈະມີຂໍ້ມູນສໍາຄັນກ່ຽວກັບຄໍາອ້ອງສະໝັກ ຫຼື ຄວາມຄົມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross. ອາດຈະມີວັນທີ່ສໍາຄັນໃນແຈງການນີ້. ທ່ານອາດຈະຈໍາເປັນຕ້ອງດໍາເນີນການຕາມກຳນົດ ເວລາສະເພາະເພື່ອຮັກສາຄວາມຄົມຄອງປະກັນສະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອເວັ້ນເວີ້ ຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄດ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໃບທາ 800-722-1471 (TTY: 800-842-5357).

ភាសាខ្មែរ (Khmer):

សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។ សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការរៀបចំរបស់អ្នកកាមរយ: Premera Blue Cross ។ ប្រហែលជាមាន កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ជាក់សមត្ថភាព ដល់កិច្ចការច្នៃផ្ទះធានា ដើម្បីនឹងរក្សាទុកការធានារ៉ាប់រងអនាគតរបស់អ្នក ឬប្រាក់ដុល្លារចេញផ្លូវ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងដុល្លារនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 800-722-1471 (TTY: 800-842-5357)។

ਪੰਜਾਬੀ (Punjabi):

ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਵਿਚ Premera Blue Cross ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਟਿਸ ਨਵ ਖਾਸ ਤਾਰੀਖਾਂ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀਂ ਜਸਰਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾਂ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ ਤੋਂ ਪਹਿਲਾਂ ਢੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ ,ਤੁਹਾਨੂੰ ਮੁਫਤ ਵਿੱਚ ਤੋਂ ਅਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ ,ਕਾਲ 800-722-1471 (TTY: 800-842-5357).

فارسی (Farsi):

این اعلامیه حاوی اطلاعات مهم میباشد. این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریق Premera Blue Cross باشد. به تاریخ های مهم در این اعلامیه توجه نمایید. شما ممکن است برای حفظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید. شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-722-1471 (کلیران TTY تماس باشماره 800-842-5357) تماس برقرار نمایید.

Polskie (Polish):

To ogłoszenie może zawierać ważne informacje. To ogłoszenie może zawierać ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Premera Blue Cross. Prosimy zwrócić uwagę na kluczowe daty, które mogą być zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-722-1471 (TTY: 800-842-5357).

Português (Portuguese):

Este aviso contém informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-722-1471 (TTY: 800-842-5357).

Română (Romanian):

Prezenta notificare conține informații importante privind cererea sau acoperirea asigurării dumneavoastră de sănătate prin Premera Blue Cross. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența provizorie la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 800-722-1471 (TTY: 800-842-5357).

Русский (Russian):

Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-722-1471 (TTY: 800-842-5357).

Fa'asamoa (Samoan):

Atonu ua iai i lenei fa'asilasilaga ni fa'amatalaga e sili ona taua e tatau ona e malamalama i ai. O lenei fa'asilasilaga o se fesoasoani e fa'amatala atili i ai i le tulaga o le polokalame, Premera Blue Cross, ua e tau fia maua atu i ai. Fa'amolemole, ia e iloilo fa'alelei i aso fa'apitoa olo'o iai i lenei fa'asilasilaga taua. Masalo o le'a iai ni feau e tatau ona e faia ao le'i aulia le aso ua ta'ua i lenei fa'asilasilaga ina ia e iai pea ma maua fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe le aia tatau e maua atu i lenei fa'asilasilaga ma lenei fa'matalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 800-722-1471 (TTY: 800-842-5357).

Español (Spanish):

Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).

Tagalog (Tagalog):

Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganiitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-722-1471 (TTY: 800-842-5357).

ไทย (Thai):

ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับกาการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-722-1471 (TTY: 800-842-5357)

Український (Ukrainian):

Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страховального покриття через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 800-722-1471 (TTY: 800-842-5357).

Tiếng Việt (Vietnamese):

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-722-1471 (TTY: 800-842-5357).