Spine Surgery
Clinical Coverage Criteria

Description

Spine surgery is a specialized medical procedure aimed at treating conditions that affect the spinal column and its surrounding structures, such as herniated discs, spinal stenosis, scoliosis, fractures, or tumors. Its primary goals are to relieve pain, restore function, and improve spinal stability when conservative treatments like physical therapy or medication fail. Common techniques include spinal fusion, which joins two or more vertebrae to reduce motion and pain; laminectomy, which removes part of the vertebra to relieve nerve pressure; and discectomy, which removes damaged disc material. Advances in minimally invasive approaches have made these surgeries safer, reducing recovery time and complications compared to traditional open procedures. Spine surgery, like any surgical procedure, carries risks that patients should fully understand before proceeding.

Policy

This Policy applies to the following Fallon Health products:
☒ Medicare Advantage (Fallon Medicare Plus, Fallon Medicare Plus Central)
☒ MassHealth ACO
☒ NaviCare (NaviCare HMO SNP, NaviCare SCO)
☒ PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
☒ Community Care

Spine surgery requires prior authorization.

Fallon Health Clinical Coverage Criteria

Fallon Health Clinical Coverage Criteria for the spine surgeries include below may apply to one or more Fallon Health products.

Artificial Disc Replacement, Cervical

Fallon Health Clinical Coverage Criteria for cervical artificial disc replacement apply to all plan members.

Effective for dates of service on or after December 1, 2023, Fallon Health will use InterQual® Criteria when making medical necessity determinations for cervical artificial disc replacement for plan members 18 years of age and older.

For coverage criteria, refer to the InterQual® Criteria in effect on the date of service:
- InterQual® CP:Procedures, Artificial Disc Replacement, Cervical

For cervical artificial disc implant failure without request for removal or removal and replacement of another implant, see the “Decompression +/- Fusion, Cervical” or "Fusion, Cervical Spine" criteria subset.

Fallon Health makes InterQual® criteria available through the Transparency Tool on our website, effective January 1, 2024.

Requests for cervical artificial disc replacement for plan members < 18 years of age will be reviewed by a Plan Medical Director on an individual case-by-case basis.

Artificial Disc Replacement, Lumbar

Fallon Health Clinical Coverage Criteria for lumbar artificial disc replacement apply to all plan members, with the exception of Fallon Medicare Plus members > 60 years of age, for whom for the Medicare NCD Lumbar Artificial Disc Replacement (LADR) (150.15) applies. See Medicare Variation section below for additional information.

Effective for dates of service on or after December 1, 2023, Fallon Health will use InterQual® Criteria when making medical necessity determinations for lumbar artificial disc replacement for plan members 18 years of age and older.

For coverage criteria lumbar artificial disc replacement, refer to the InterQual® Criteria in effect on the date of service:
- InterQual® CP:Procedures, Artificial Disc Replacement, Lumbar

Note: Medical Director review is required for this procedure.

For lumbar artificial disc implant failure, see the “Decompression +/ Fusion, Lumbar” criteria subset.

Fallon Health makes InterQual® criteria available through the Transparency Tool on our website, effective January 1, 2024.

Requests for lumbar artificial disc replacement for plan members < 18 years of age will be reviewed by a Plan Medical Director on an individual case-by-case basis.

Fusion, Cervical Spine

Fallon Health Clinical Coverage Criteria for cervical spine fusion apply to MassHealth ACO and Community Care members.

Effective for dates of service on or after December 1, 2023, Fallon Health will use InterQual® Criteria when making medical necessity determinations for cervical spine fusion for plan members 18 years of age and older.

For coverage criteria, refer to the InterQual® Criteria in effect on the date of service:
- InterQual® CP:Procedures, Fusion, Cervical

These criteria address anterior and posterior spinal fusion performed for cervical instability and do not cover fusion accompanying decompressive surgery. For fusion performed with decompressive surgery, see the "Decompression +/- Fusion, Cervical" criteria subset.

Fallon Health makes InterQual® criteria available through the Transparency Tool on our website, effective January 1, 2024.

Requests for cervical spine fusion for plan members < 18 years of age will be reviewed by a Plan Medical Director on an individual case-by-case basis.

Fusion, Lumbar Spine

Fallon Health Clinical Coverage Criteria for lumbar spine fusion apply to all plan members.

Effective for dates of service on or after December 1, 2023, Fallon Health will use InterQual® Criteria when making medical necessity determinations for lumbar spine fusion for plan members 18 years of age and older.

For coverage criteria, refer to the InterQual® criteria in effect on the date of service:
- InterQual® CP:Procedures, Fusion, Lumbar

These criteria address anterior, posterior, and lateral spinal fusion performed for instability and do not cover fusion accompanying decompressive surgery for neurocompression. For fusion performed with decompressive surgery, see the "Decompression +/- Fusion, Lumbar" criteria subset.

Fallon Health makes InterQual® criteria available through the Transparency Tool on our website, effective January 1, 2024.

Requests for lumbar spine fusion for plan members < 18 years of age will be reviewed by a Plan Medical Director on an individual case-by-case basis.

Fusion, Thoracic Spine

Fallon Health Clinical Coverage Criteria for thoracic spine fusion apply to all plan members. Effective for dates of service on or after December 1, 2023, Fallon Health will use InterQual® Criteria when making medical necessity determinations for thoracic spine fusion for plan members 18 years of age and older.

For coverage criteria, refer to the InterQual® criteria in effect on the date of service:
- InterQual® CP:Procedures, Fusion, Thoracic

These criteria address anterior (thoracotomy, thoracolumbar) and posterior (transpedicular, posteriolateral) spinal fusion performed for instability and do not cover fusion accompanying decompressive surgery for neurocompression. For fusion performed with decompressive surgery, see the "Decompression +/- Fusion, Thoracic" criteria subset.

Fallon Health makes InterQual® criteria available through the Transparency Tool on our website, effective January 1, 2024.

Requests for thoracic spine fusion for plan members < 18 years of age will be reviewed by a Plan Medical Director on an individual case-by-case basis.

Decompression +/- Fusion, Cervical

Fallon Health Clinical Coverage Criteria for cervical decompression +/- fusion apply to MassHealth ACO and Community Care members.

Effective for dates of service on or after December 1, 2023, Fallon Health will use InterQual® Criteria when making medical necessity determinations for cervical decompression +/- fusion for plan members 18 years of age and older.

For coverage criteria, refer to the InterQual® criteria in effect on the date of service:
- InterQual® CP:Procedures, Decompression +/- Fusion, Cervical

These criteria address decompressive surgery for neurocompression; decompressive surgery may be accompanied by a spinal fusion when the decompression causes instability or there is documentation of instability preoperatively. For fusion performed for instability without the need for decompressive surgery, see the "Fusion, Cervical Spine" criteria subset.

Fallon Health makes InterQual® criteria available through the Transparency Tool on our website, effective January 1, 2024.

Requests for cervical decompression +/- fusion for plan members < 18 years of age will be reviewed by a Plan Medical Director on an individual case-by-case basis.

Decompression +/- Fusion, Lumbar

Fallon Health Clinical Coverage Criteria for lumbar decompression +/- fusion apply to all plan members.

Effective for dates of service on or after December 1, 2023, Fallon Health will use InterQual® Criteria when making medical necessity determinations for lumbar decompression +/- fusion for plan members 18 years of age and older.

For coverage criteria, refer to the InterQual® criteria in effect on the date of service:
- InterQual® CP:Procedures, Decompression +/- Fusion, Lumbar.

These criteria address decompressive surgery for neurocompression; decompressive surgery may be accompanied by a spinal fusion when the decompression causes instability or there is evidence of instability preoperatively. For fusion performed for instability without the need for decompressive surgery, see the "Fusion, Lumbar Spine" criteria subset.
Fallon Health makes InterQual® criteria available through the Transparency Tool on our website, effective January 1, 2024.

These criteria do not cover percutaneous image-guided lumbar decompression (PILD). Medicare Advantage members have coverage for PILD for lumbar spinal stenosis under NCD 150.13 when enrolled in a Medicare-approved clinical trial listed on the CMS Coverage with Evidence Development website at: https://www.cms.gov/medicare/coverage/evidence/lumbar-spinal-stenosis.

Requests for lumbar decompression +/- fusion for plan members < 18 years of age will be reviewed by a Plan Medical Director on an individual case-by-case basis.

Decompression +/- Fusion, Thoracic

Fallon Health Clinical Coverage Criteria for thoracic decompression +/- fusion apply to all plan members.

Effective for dates of service on or after December 1, 2023, Fallon Health will use InterQual® Criteria when making medical necessity determinations for thoracic decompression +/- fusion for plan members 18 years of age and older.

For coverage criteria, refer to the InterQual® criteria in effect on the date of service:
- InterQual® CP:Procedures, Decompression +/- Fusion, thoracic

These criteria address decompressive surgery for neurocompression. The inherent stability provided by the thoracic rib cage makes fusion for thoracic disc disease unnecessary for most patients. However, when decompressive surgery causes instability, fusion may accompany the surgery and does not require separate authorization. For fusion performed for instability without decompressive surgery, see the "Fusion, Thoracic Spine" criteria subset.

Fallon Health makes InterQual® criteria available through the Transparency Tool on our website, effective January 1, 2024.

Requests for thoracic decompression +/- fusion for plan members < 18 years of age will be reviewed by a Plan Medical Director on an individual case-by-case basis.

Scoliosis or Kyphosis Surgery

Fallon Health Clinical Coverage Criteria for scoliosis or kyphosis surgery apply to all plan members.

Effective for dates of service on or after December 1, 2023, Fallon Health will use InterQual® Criteria when making medical necessity determinations for scoliosis or kyphosis surgery for plan members 18 years of age and older.

For coverage criteria, refer to the InterQual criteria in effect on the date of service:
- InterQual® CP:Procedures, Scoliosis or Kyphosis Surgery (Pediatric)

Fallon Health makes InterQual® criteria available through the Transparency Tool on our website, effective January 1, 2024.

Scoliosis or Kyphosis Surgery (Pediatric)

Medicare statutes and regulations do not have coverage criteria for pediatric scoliosis or kyphosis surgery. Medicare does not have a National Coverage Determination (NCD) for pediatric scoliosis or kyphosis surgery. National Government Services, Inc., the Part A/B Medicare Administrative Contractor (MAC) with jurisdiction in the Plan's service area does not have an LCD for pediatric scoliosis or kyphosis surgery (Medicare Coverage Database search 10/28/2024). Coverage criteria for pediatric scoliosis or kyphosis surgery are not fully established by Medicare; therefore, the Plan's coverage criteria are applicable.

MassHealth does not have Guidelines for Medical Necessity Determination for pediatric scoliosis or kyphosis surgery (MassHealth website search 10/28/2024).

Fallon Health Clinical Coverage Criteria for pediatric scoliosis or kyphosis surgery apply to all plan members.

Effective for dates of service on or after December 1, 2023, Fallon Health will use InterQual® Criteria when making medical necessity determinations for scoliosis or kyphosis surgery for plan members less than 18 years of age.

For coverage criteria, refer to the InterQual® criteria in effect on the date of service:
- InterQual® CP:Procedures, Scoliosis or Kyphosis Surgery (Pediatric)

Fallon Health makes InterQual® criteria available through the Transparency Tool on our website, effective January 1, 2024.

Vertebroplasty or Kyphoplasty

Fallon Health Clinical Coverage Criteria for vertebroplasty and kyphoplasty apply to MassHealth ACO and Community Care members, and to Medicare Advantage members for indications other than osteoporotic vertebral compression fracture.

Effective for dates of service on or after December 1, 2023, Fallon Health will use InterQual® Criteria when making medical necessity determinations for vertebroplasty or kyphoplasty for plan members less than 18 years of age.

For coverage criteria, refer to the InterQual® criteria in effect on the date of service:
- InterQual® CP:Procedures, Vertebroplasty or Kyphoplasty

Fallon Health makes InterQual® criteria available through the Transparency Tool on our website, effective January 1, 2024.

Requests for vertebroplasty or kyphoplasty for plan members < 18 years of age will be reviewed by a Plan Medical Director on an individual case-by-case basis.

Medicare Variation

Artificial Disc Replacement, Cervical - Medicare statutes and regulations do not have coverage criteria for cervical artificial disc replacement. Medicare does not have a National Coverage

Determination (NCD) for cervical artificial disc replacement. National Government Services, Inc., the Part A/B Medicare Administrative Contractor (MAC) with jurisdiction in the Plan's service area does not have a Local Coverage Determination (LCD) for cervical artificial disc replacement (Medicare Coverage Database search 10/26/2025). Coverage criteria for cervical artificial disc replacement are not fully established by Medicare; therefore, the Plan's coverage criteria are applicable.

Artificial Disc Replacement, Lumbar - Medicare statutes and regulations do not have coverage criteria for lumbar artificial disc replacement. Medicare has a National Coverage Determination (NCD) for Lumbar Artificial Disc Replacement (LADR) (150.10) (Version 2, effective 08/14/2007). Effective for services performed on or after August 14, 2007, LADR is non-covered for Medicare beneficiaries over 60 years of age. Medicare does not have an NCD for beneficiaries 60 years of age and younger; coverage determination is to be made by the local contractor. National Government Services, Inc., the Part A/B Medicare Administrative Contractor (MAC) with jurisdiction in the Plan's service area does not have an LCD for lumbar artificial disc replacement (Medicare Coverage Database search 10/26/2025). Coverage criteria for lumbar artificial disc replacement are fully established by Medicare for Fallon Medicare Plus and Fallon Medicare Plus Central members > 60 years of age for whom NCD 150.15 applies. Clinical coverage criteria for LADR for Medicare Advantage members 60 years of age and younger are not fully established by Medicare, therefore, the Plan's clinical coverage criteria are applicable.

Link: NCD Lumbar Artificial Disc Replacement (LADR) (150.15)

Fusion, Cervical Spine - Medicare statutes and regulations do not have coverage criteria for cervical spine fusion. Medicare does not have a National Coverage Determination (NCD) for cervical spine fusion. National Government Services, Inc., the Part A/B Medicare Administrative Contractor (MAC) with jurisdiction in the Plan's service area has an LCD for Cervical Fusion (L39770) (Original Effective Date For services performed on or after 08/01/2024) (Medicare Coverage Database search 10/26/2025). Coverage criteria for cervical fusion are fully established in LCD L39770 effective for dates of service on or after 08/01/2024; therefore, the Plan's coverage criteria are not applicable.

Link: National Government Services, Inc. LCD Cervical Fusion (L39770)

Fusion, Lumbar Spine - Medicare statutes and regulations do not have coverage criteria for lumbar spine fusion. Medicare statutes and regulations do not have coverage criteria for lumbar spine fusion. Medicare does not have a National Coverage Determination (NCD) for lumbar spine fusion. National Government Services, Inc. the Part A/B Medicare Administrative Contractor with jurisdiction in the Plan's service area does not have an LCD for lumbar spine fusion (Medicare Coverage Database search 10/26/2025). Coverage criteria for lumbar spine fusion are not fully established by Medicare; therefore, the Plan's coverage criteria are applicable.

Fusion, Thoracic Spine - Medicare statutes and regulations do not have coverage criteria for thoracic spine fusion. Medicare does not have a National Coverage Determination (NCD) for thoracic spine fusion. National Government Services, Inc. is the Medicare Administrative Contractor with jurisdiction over Part A and Part B services in the Plan's service area. National Government Services, Inc. does not have an LCD for cervical spine fusion (Medicare Coverage Database search 10/28/2024). Coverage criteria for thoracic spine fusion are not fully established by Medicare; therefore, the Plan's coverage criteria are applicable.

Decompression +/- Fusion, Cervical - Medicare statutes and regulations do not have coverage criteria for cervical decompression +/- fusion. Medicare does not have a National Coverage Determination (NCD) for cervical decompression +/- fusion. National Government Services, Inc., the Part A/B Medicare Administrative Contractor (MAC) with jurisdiction in the Plan's service area has an LCD for Cervical Fusion L39770 effective for dates of service on or after 08/01/2024 (Medicare Coverage Database search 10/26/2025).

- Coverage criteria for cervical decompression with fusion are fully established in LCD L39770, therefore, the Plan's coverage criteria for cervical decompression with fusion are not applicable.
- Coverage criteria for cervical decompression without fusion are not fully established by Medicare; therefore, the Plan's coverage criteria for cervical decompression are applicable.

Link: National Government Services, Inc. LCD Cervical Fusion (L39770)

Decompression +/- Fusion, Lumbar - Medicare statutes and regulations do not have coverage criteria for lumbar decompression +/- fusion. Medicare does not have a National Coverage Determination (NCD) for lumbar decompression +/- fusion. National Government Services, Inc., the Part A/B Medicare Administrative Contractor (MAC) with jurisdiction in the Plan's service area does not have an LCD for lumbar decompression +/- fusion (Medicare Coverage Database search 10/26/2025). Coverage criteria for lumbar decompression +/- fusion are not fully established by Medicare; therefore, the Plan's coverage criteria are applicable.

Decompression +/- Fusion, Thoracic - Medicare statutes and regulations do not have coverage criteria for thoracic decompression +/- fusion. Medicare does not have a National Coverage Determination (NCD) for thoracic decompression +/- fusion. National Government Services, Inc., the Part A/B Medicare Administrative Contractor (MAC) in the Plan's service area does not have an LCD for thoracic decompression +/- fusion (Medicare Coverage Database search 10/26/2025). Coverage criteria for thoracic decompression +/- fusion are not fully established by Medicare; therefore; the Plan's coverage criteria are applicable.

Scoliosis or Kyphosis Surgery - Medicare statutes and regulations do not have coverage criteria for scoliosis or kyphosis surgery. Medicare does not have a National Coverage Determination (NCD) for scoliosis or kyphosis surgery. National Government Services, Inc., the Part A/B Medicare Administrative Contractor (MAC) with jurisdiction in the Plan's service area does not have an LCD for scoliosis or kyphosis surgery (Medicare Coverage Database search 10/26/2025). Coverage criteria for scoliosis or kyphosis surgery are not fully established by Medicare; therefore, the Plan's coverage criteria are applicable.

Scoliosis or Kyphosis Surgery (Pediatric) - Medicare statutes and regulations do not have coverage criteria for pediatric scoliosis or kyphosis surgery. Medicare does not have a National Coverage Determination (NCD) for pediatric scoliosis or kyphosis surgery. National Government Services, Inc., the Part A/B Medicare Administrative Contractor (MAC) with jurisdiction in the Plan's service area does not have an LCD for pediatric scoliosis or kyphosis surgery (Medicare Coverage Database search 10/26/2025). Coverage criteria for pediatric scoliosis or kyphosis surgery are not fully established by Medicare; therefore, the Plan's coverage criteria are applicable.

Vertebroplasty or Kyphoplasty - Medicare statutes and regulations do not have coverage criteria for vertebroplasty or kyphoplasty. Medicare does not have a National Coverage Determination (NCD) for vertebroplasty or kyphoplasty. National Government Services, Inc., the Part A/B Medicare Administrative Contractor with jurisdiction in the Plan's service area has an LCD Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF) (L33569) (Revision Effective Date 12/01/2020). The National Government Services, Inc. LCD only addresses vertebral augmentation for osteoporotic vertebral compression fracture; therefore, coverage remains available for medically necessary procedures for indications not included in this LCD (Medicare Coverage Database search 10/26/2025). Coverage criteria are fully established by Medicare for PVA for osteoporotic vertebral compression fracture. Coverage criteria for PVA for other indications not included in L33569 are not fully established by Medicare; therefore, Plan's coverage criteria are applicable.

Link: National Government Services, Inc. LCD Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF) (L33569)

MassHealth Variation

Artificial Disc Replacement, Cervical - MassHealth does not have Guidelines for Medical Necessity Determination for cervical artificial disc replacement (10/26/2025).

Artificial Disc Replacement, Lumbar - MassHealth does not have Guidelines for Medical Necessity Determination for lumbar artificial disc replacement (MassHealth website search 10/26/2025).

Fusion. Cervical Spine - MassHealth does not have Guidelines for Medical Necessity Determination for cervical spine fusion (MassHealth website search 10/26/2025).

Fusion, Lumbar Spine - MassHealth does not have Guidelines for Medical Necessity Determination for lumbar spine fusion (MassHealth website search 10/26/2025).

Fusion, Thoracic Spine - MassHealth does not have Guidelines for Medical Necessity Determination for thoracic spine fusion (MassHealth website search 10/26/2025).

Decompression +/- Fusion, Cervical - MassHealth does not have Guidelines for Medical Necessity Determination for cervical decompression +/- fusion (MassHealth website search 10/26/2025).

Decompression +/- Fusion, Lumbar - MassHealth does not have Guidelines for Medical Necessity Determination for lumbar decompression +/- fusion (MassHealth website search 10/26/2025).

Decompression +/- Fusion, Thoracic - MassHealth does not have Guidelines for Medical Necessity Determination for thoracic decompression +/- fusion (MassHealth website search 10/26/2025).

Scoliosis or Kyphosis Surgery - MassHealth does not have Guidelines for Medical Necessity Determination for scoliosis or kyphosis surgery (MassHealth website search 10/26/2025).

Scoliosis or Kyphosis Surgery (Pediatric) - MassHealth does not have Guidelines for Medical Necessity Determination for pediatric scoliosis or kyphosis surgery (MassHealth website search 10/26/2025).

Vertebroplasty or Kyphoplasty - MassHealth does not have Guidelines for Medical Necessity Determination for vertebroplasty or kyphoplasty (MassHealth website search 10/26/2025).

Exclusions

- Image guided minimally invasive spinal decompression for spinal stenosis (0274T, 0275T) is considered experimental/investigational. Medicare Advantage members have coverage for Percutaneous Image-Guided Lumbar Decompression (PILD) for lumbar spinal stenosis when enrolled in a Medicare-approved clinical trial listed on the CMS Coverage with Evidence Development website at: https://www.cms.gov/medicare/coverage/evidence/lumbar-spinal-stenosis in accordance with NCD Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis (150.13).
- Intracept Intraosseous Nerve Ablation System (CPT 64628, 64629) is considered experimental/investigational.

Coding

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage.

Code	Description

0095T	Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical
0098T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical
0164T	Removal of total disc arthroplasty, (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)
0165T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)
0274T	Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar
01941	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg, kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic
01942	Anesthesia for percutaneous image guided neuromodulation or intravertebral procedures (eg, kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)
20931	Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)
20936	Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from same incision
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision)
20938	Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision)
22206	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., pedicle/vertebral body subtraction); thoracic
22207	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., pedicle/vertebral body subtraction); lumbar
22208	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to code for primary procedure)
22210	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical
22212	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic
22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar
22216	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure)
22220	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical

22222	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; thoracic
22224	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumbar
22226	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; each additional verte3bral segment (List separately in addition to code for primary procedure)
22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic
22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral
22512	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (list separately in addition to code for primary procedure)
22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic
22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar
22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (list separately in addition to code for primary procedure)
22532	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)
22548	Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2; each additional interspace
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2
22556	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
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)

22590	Arthrodesis, posterior technique, craniocervical (occiput-C2)
22595	Arthrodesis, posterior technique, atlas-axis (C1-C2)
22600	Arthrodesis, posterior or posterolateral technique, single interspace; cervical below C2 segment
22610	Arthrodesis, posterior or posterolateral technique, single interspace; thoracic (with lateral transverse technique, when performed)
22612	Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed
22614	Arthrodesis, posterior or posterolateral technique, single interspace; each additional vertebral segment (list separately in addition to code for primary procedure)
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar;
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar; each additional interspace (List separately in addition to code for primary procedure)
22633	Arthrodesis, combined posterior, or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar;
22634	Arthrodesis, combined posterior, or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar; each additional interspace (List separately in addition to code for primary procedure)
22800	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments
22802	Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments
22804	Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments
22808	Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments
22810	Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments
22812	Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments
22818	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or 2 segments
22819	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); 3 or more segments
22830	Exploration of spinal fusion
22840	Reinsertion of spinal fixation device
22841	Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)
22842	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)
22843	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure)
22844	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (List separately in addition to code for primary procedure)

22845	Anterior instrumentation, 2 to 3 vertebral segments (List separately in addition to code for primary procedure)
22846	Anterior instrumentation, 4 to 7 vertebral segments (List separately in addition to code for primary procedure)
22847	Anterior instrumentation, 8 or more vertebral segments vertebral segments (List separately in addition to code for primary procedure)
22848	Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure)
22849	Reinsertion of spinal fixation device
22850	Removal of posterior nonsegmental instrumentation (e.g., Harrington rod)
22852	Removal of posterior segmental instrumentation
22853	Insertion of interbody biomechanical devices(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)
22854	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
22855	Removal of anterior instrumentation
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)
22859	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
22860	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar
63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; cervical
63003	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; thoracic

63005	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis
63012	Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)
63015	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; cervical
63016	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; thoracic
63017	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; lumbar
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)
63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar
63043	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure)
63044	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)
63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; cervical
63046	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; thoracic
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; lumbar
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; each additional vertebral segment, cervical, thoracic or lumbar (List separately in addition to code for primary procedure)
63050	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments

63051	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices [e.g., wire, suture, mini plates], when performed)
63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s][eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)
63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s][eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional vertebral segment (List separately in addition to code for primary procedure)
63055	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; thoracic
63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (e.g., far lateral herniated intervertebral disc)
63057	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure
63064	Costovertebral approach with decompression of spinal cord or nerve root(s) (e.g., herniated intervertebral disc), thoracic; single segment
63066	Costovertebral approach with decompression of spinal cord or nerve root(s) (e.g., herniated intervertebral disc), thoracic; each additional segment (List separately in addition to code for primary procedure)
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace
63076	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)
63077	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, single interspace
63078	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, each additional interspace (List separately in addition to code for primary procedure)
63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
63082	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure)
63085	Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment
63086	Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, each additional segment (List separately in addition to code for primary procedure)
63087	Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment

63088	Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; each additional segment (List separately in addition to code for primary procedure)
63090	Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment
63091	Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; each additional segment (List separately in addition to code for primary procedure)
63101	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (e.g., for tumor or retropulsed bone fragments); thoracic, single segment
63102	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (e.g., for tumor or retropulsed bone fragments); lumbar, single segment
63103	Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (e.g., for tumor or retropulsed bone fragments); thoracic or lumbar, each additional segment (List separately in addition to code for primary procedure)
63265	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical
63266	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic
63267	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar
63270	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical
63271	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; thoracic
63272	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar
63275	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical
63276	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, thoracic
63277	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, lumbar
63280	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, cervical
63281	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, thoracic
63282	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, lumbar
63285	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, cervical
63286	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracic
63287	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracolumbar
63290	Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level

63300	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, cervical
63301	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by transthoracic approach
63302	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by thoracolumbar approach
63303	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, lumbar or sacral by transperitoneal or retroperitoneal approach
63304	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, cervical
63305	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, thoracic by transthoracic approach
63306	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, thoracic by thoracolumbar approach
63307	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, lumbar or sacral by transperitoneal or retroperitoneal approach
63308	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; each additional segment (List separately in addition to codes for single segment)
64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral
64629	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (list separately in addition to code for primary procedure)

References

1. Medicare National Coverage Determination (NCD). NCD Lumbar Artificial Disc Replacement (LADR) (150.10). Version Number 2, Effective Date of This Version 08/14/2007. Available at: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=313. Accessed 10/28/2024.
2. National Government Services, Inc. Local Coverage Determination (LCD) Cervical Fusion (L39770). Original Effective Date For services performed on or after 08/01/2024. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=39770&ver=4. Accessed 10/28/2024.
3. National Government Services, Inc. Local Coverage Determination (LCD) Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF) (L33569). Original Effective Date For services performed on or after 10/01/2015. Revision Effective Date For services performed on or after 12/01/2020. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33569. Accessed 10/28/2024.

Policy history

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Review/Approval date(s):	Technology Assessment Committee: 09/26/2023, 10/24/2023 (policy origination), 10/29/2024 (annual review, added Coding and References sections)., 10/28/2025 (annual review, no changes to coverage criteria, added new sections for Medicare and MassHealth variation).

UM Committee: 11/19/2024 (annual review), 11/18/2025 (annual review, approved with no changes to coverage criteria).

Instructions for Use

Fallon Health complies with CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations for Medicare Advantage members. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health may create internal coverage criteria under specific circumstances described at § 422.101(b)(6)(i) and (ii).

Fallon Health generally follows Medical Necessity Guidelines published by MassHealth when making medical necessity determinations for MassHealth members. In the absence of Medical Necessity Guidelines published by MassHealth, Fallon Health may create clinical coverage criteria in accordance with the definition of Medical Necessity in 130 CMR 450.204.

For plan members enrolled in NaviCare, Fallon Health first follows CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, or if the NaviCare member does not meet coverage criteria in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health then follows Medical Necessity Guidelines published by MassHealth when making necessity determinations for NaviCare members.

Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans