



CLINICAL GUIDELINES

CMM-606: Lumbar Microdiscectomy (Laminotomy, Laminectomy, or Hemilaminectomy) Guidelines

Version 1.0.2023
Effective May 31, 2023



eviCore healthcare Clinical Decision Support Tool Diagnostic Strategies: This tool addresses common symptoms and symptom complexes. Requests for individuals with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist and/or individual's Primary Care Physician (PCP) may provide additional insight.

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Clinical guidelines for medical necessity review of Comprehensive Musculoskeletal Management Services.

CMM-606: Lumbar Microdiscectomy (Laminotomy, Laminectomy, or Hemilaminectomy)

CMM-606.1: General Guidelines

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CMM-606.1: General Guidelines

Application of Guideline

- The determination of medical necessity for the performance lumbar microdiscectomy and excision of extradural lesion other than neoplasm is always made on a case-by-case basis.
- For prior authorization requirements, see **CMM-600.1: Prior Authorization Requirements**.

Urgent/Emergent Indications/Conditions

- The presence of urgent/emergent indications/conditions warrants definitive surgical treatment. Confirmatory advanced imaging studies are required. The following criteria are **NOT** required for confirmed urgent/emergent conditions:
 - ◆ Provider-directed non-surgical management
 - ◆ Absence of unmanaged significant mental and/or behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, opioid and alcohol use disorders)
- Urgent/emergent conditions for lumbar microdiscectomy and/or excision of extradural lesion other than neoplasm include **ANY** of the following:
 - ◆ Cauda equina syndrome (CES)
 - ◆ Documentation of progressive neurological deficit on two separate physical examinations
 - ◆ **ANY** of the following due to a neurocompressive pathology
 - Motor weakness of grade 3/5 or less of specified muscle(s)
 - Rapidly progressive symptoms of motor loss
 - Bowel incontinence
 - Bladder incontinence/retention
 - ◆ Documentation of severe debilitating pain and/or dysfunction to the point of being incapacitated
 - ◆ Epidural hematoma
 - ◆ Infection (e.g. discitis, epidural abscess, osteomyelitis)
 - ◆ Primary or metastatic neoplastic disease causing pathologic fracture, cord or nerve compression, or instability

CMM-606.2: Initial Primary Lumbar Microdiscectomy (Laminotomy, Laminectomy or Hemilaminectomy)

Initial primary lumbar microdiscectomy (laminotomy, laminectomy, or hemilaminectomy) is considered **medically necessary** when performed for **ANY** of the following when **ALL** of the associated criteria are met:

Neurogenic Claudication

- Subjective symptoms including **BOTH** of the following:
 - ◆ Clinically significant function limiting pain and/or symptoms on a daily basis (e.g. inability to perform household chores, prolonged standing, or essential job functions)
 - ◆ Pain, cramping, weakness, or tingling in the lower back, buttock(s), and leg(s) brought about by walking or positions that cause thecal sac or nerve root compression (e.g. standing, extension) and **EITHER** of the following:
 - Symptoms worsen with standing and/or walking
 - Symptoms are alleviated with sitting and/or forward flexion
- Objective physical examination findings concordant with recent (within 6 months) MRI/CT
- Less than clinically meaningful improvement with at least **TWO** of the following (unless contraindicated):
 - ◆ Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
 - ◆ Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
 - ◆ Epidural steroid injection(s)/selective nerve root block(s) performed at the same level(s) as the requested surgery
- Recent (within 6 months) MRI/CT identifies nerve root impingement and/or thecal sac impingement that is concordant with patient symptoms **and** physical examination findings and is caused by **ONE OR MORE** of the following:
 - ◆ Herniated disc(s)
 - ◆ Synovial cyst or arachnoid cyst
 - ◆ Central/lateral/foraminal stenosis
- All other sources of pain have been excluded
- Absence of unmanaged significant mental and/or behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, opioid and alcohol use disorders)

Radiculopathy

- Subjective symptoms including **BOTH** of the following:
 - ◆ Significant level of pain on a daily basis defined as **EITHER** of the following:
 - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - Severe, disabling, crippling, or incapacitating pain
 - ◆ Persistent radiating pain into the buttock(s) and/or lower extremity(ies) resulting in clinically significant functional impairment (e.g. inability to perform household chores, prolonged standing, or essential job functions)
- Objective physical examination findings including **EITHER** of the following:
 - ◆ Nerve root tension sign including **ANY** of the following:
 - Positive straight leg raise
 - Crossed straight leg raise
 - Femoral stretch test
 - ◆ Neurologic deficit including **ANY** of the following:
 - Dermatomal sensory deficit
 - Functionally limiting motor weakness (e.g. foot drop, quadriceps weakness)
 - Reflex changes
- Less than clinically meaningful improvement with at least **TWO** of the following (unless contraindicated):
 - ◆ Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
 - ◆ Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
 - ◆ Epidural steroid injection(s) or selective nerve root block(s) performed at the same level(s) as the requested surgery
- Recent (within 6 months) MRI/CT identifies nerve root impingement and/or thecal sac impingement that is concordant with patient symptoms **and** physical examination findings and is caused by **ONE OR MORE** of the following:
 - ◆ Herniated disc(s)
 - ◆ Synovial cyst or arachnoid cyst
 - ◆ Central/lateral/foraminal stenosis
- All other sources of pain have been excluded
- Absence of unmanaged significant mental and/or behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, opioid and alcohol use disorders)

CMM-606.3: Repeat Lumbar Microdiscectomy (Laminotomy or Laminectomy) at the Same Level

Repeat lumbar microdiscectomy (laminotomy or laminectomy) at the same level is considered **medically necessary** when performed for **ANY** of the following **when ALL** of the associated criteria are met:

Neurogenic Claudication

- Greater than 12 weeks since initial lumbar disc decompression surgery
- Initial relief of symptoms following previous disc decompression procedure at the same level unless recent (within 6 months) post-operative imaging demonstrates persistent significant neurologic compression at the surgical level
- Subjective symptoms including **BOTH** of the following:
 - ◆ Clinically significant function limiting pain and/or symptoms on a daily basis (e.g. inability to perform household chores, prolonged standing, or essential job functions)
 - ◆ Pain, cramping, weakness, or tingling in the lower back, buttock(s), and leg(s) brought about by walking or positions that cause thecal sac or nerve root compression (e.g. standing, extension) and **EITHER** of the following:
 - Symptoms worsen with standing and/or walking
 - Symptoms are alleviated with sitting and/or forward flexion
- Objective physical examination findings concordant with recent (within 6 months) MRI/CT
- Less than clinically meaningful improvement with at least **TWO** of the following unless contraindicated:
 - ◆ Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
 - ◆ Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
 - ◆ Epidural steroid injection(s) or selective nerve root block(s) performed at the same level(s) as the requested surgery
- Recent (within 6 months) post-operative MRI /CT identifies neural structure compression at the requested level(s) that is concordant with patient symptoms **and** physical examination findings and is caused by **ONE OR MORE** of the following:
 - ◆ Herniated Disc (retained disc material or a recurrent disc herniation)
 - ◆ Synovial cyst or arachnoid cyst
 - ◆ Central/lateral/foraminal stenosis
- All other sources of pain have been excluded
- Absence of unmanaged significant mental and/or behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, opioid and alcohol use disorders)

Radiculopathy

- Greater than 12 weeks since initial lumbar disc decompression surgery
- Initial relief of symptoms following previous disc decompression procedure at the same level unless recent (within 6 months) post-operative imaging demonstrates persistent significant neurologic compression at the surgical level
- Subjective symptoms including **BOTH** of the following:
 - ◆ Significant level of pain on a daily basis defined as **EITHER** of the following:
 - Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) as ≥ 7
 - Severe, disabling, crippling, or incapacitating pain
 - ◆ Persistent radiating pain into the buttock(s) and/or lower extremity(ies) resulting in clinically significant functional impairment (e.g. inability to perform household chores, prolonged standing, or essential job functions)
- Objective physical examination findings including **EITHER** of the following:
 - ◆ Nerve root tension sign including **ANY** of the following:
 - Positive straight leg raise
 - Crossed straight leg raise
 - Femoral stretch test
 - ◆ Neurologic deficit including **ANY** of the following:
 - Dermatomal sensory deficit
 - Functionally limiting motor weakness (e.g. foot drop, quadriceps weakness)
 - Reflex changes
- Less than clinically meaningful improvement with at least **TWO** of the following (unless contraindicated):
 - ◆ Prescription strength analgesics, steroids, and/or NSAIDs for 6 weeks
 - ◆ Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks
 - ◆ Epidural steroid injection(s) or selective nerve root block(s) performed at the same level(s) as the requested surgery
- Recent (within 6 months) post-operative MRI /CT identifies neural structure compression at the requested level(s) that is concordant with patient symptoms **and** physical examination findings and is caused by **ONE OR MORE** of the following:
 - ◆ Herniated Disc (retained disc material or a recurrent disc herniation)
 - ◆ Synovial cyst or arachnoid cyst
 - ◆ Central/lateral/foraminal stenosis
- All other sources of pain have been excluded
- Absence of unmanaged significant mental and/or behavioral health disorders (e.g. major depressive disorder, chronic pain syndrome, secondary gain, opioid and alcohol use disorders)

CMM-606.4: Non-Indications

Not Medically Necessary

- Initial and repeat lumbar microdiscectomy (laminotomy, laminectomy, and hemilaminectomy) performed without meeting the requirements listed in the General Guidelines and the specific procedure sections is considered **not medically necessary**.
- Initial and repeat lumbar microdiscectomy (laminotomy, laminectomy, and hemilaminectomy) performed for **ANY** of the following sole indications is considered **not medically necessary**:
 - ◆ Subjective symptoms and objective physical examination findings that are not concordant with imaging
 - ◆ Predominate lower back pain associated with disc degeneration with or without annular tears in the absence of a disc herniation
 - ◆ Patients who are asymptomatic with a normal physical examination regardless of the size of the disc herniation
 - ◆ Disc bulge with no neural impingement or cord compression on imaging
 - ◆ Concordant discography
 - ◆ MR Spectroscopy results
 - ◆ Isolated axial lower back pain in the presence of disc herniation
- The performance of lumbar microdiscectomy (laminotomy, laminectomy, and hemilaminectomy) with laser technique is considered **not medically necessary**.

Experimental, Investigational, or Unproven (EIU)

- Percutaneous laser disc decompression of spinal cord nerve root(s) is considered **experimental, investigational, or unproven (EIU)**.

CMM-606.5: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

CPT®	Code Description/Definition
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar
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)
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar
+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)
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)
63267	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar
63272	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar
63277	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, lumbar
HCPCS Code	Code Description/Definition
C9757	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar
S2350	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; lumbar, single interspace
+S2351	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; lumbar, each additional interspace (list separately in addition to code for primary procedure)
This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.	

CMM-606.6: References

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