



CLINICAL GUIDELINES

CMM-608: Lumbar Decompression Guidelines

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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-608: Lumbar Decompression

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CMM-608.1: General Guidelines

Application of Guideline

- The determination of medical necessity for the performance of lumbar decompression 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 decompression include **ANY** of the following:
 - ◆ Acute/unstable traumatic spinal fractures or dislocations with neural compression
 - ◆ 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
 - ◆ Epidural hematoma
 - ◆ Infection (e.g. discitis, epidural abscess, osteomyelitis)
 - ◆ Primary or metastatic neoplastic disease causing pathologic fracture, cord compression or instability
 - ◆ Documentation of severe debilitating pain and/or dysfunction to the point of being incapacitated

CMM-608.2: Initial Primary Lumbar Decompression

Initial primary lumbar decompression is considered **medically necessary** when performed for **EITHER** of the following when **ALL** of the associated criteria are met:

Neurogenic Claudication

- Subjective symptoms including at least **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) 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 at least **TWO** 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) on a daily basis that has a documented negative impact on activities of daily living despite optimal conservative treatment as described below
- 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) imaging findings 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-608.3: Repeat Lumbar Decompression at the Same Level

Repeat lumbar decompression at the same level is considered **medically necessary** when performed for **EITHER** of the following **when ALL** of the associated criteria is met:

Neurogenic Claudication

- Greater than 12 weeks since last decompression surgery
- Initial relief of symptoms following previous decompression procedure at the same level(s) unless recent (within 6 months) post-operative imaging demonstrates persistent significant neurologic compression at the surgical level
- Subjective symptoms including at least **TWO** 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) post-operative 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 last decompression surgery
- Initial relief of symptoms following previous decompression procedure at the same level(s) unless recent (within 6 months) post-operative imaging demonstrates persistent significant neurologic compression at the requested level(s)
- Subjective symptoms including at least **TWO** 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) on a daily basis that has a documented negative impact on activities of daily living despite optimal conservative treatment as described below
- 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) postoperative imaging findings 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-608.4: Non-Indications

Not Medically Necessary

- Lumbar decompression/discectomy performed without meeting the requirements in the General Guidelines and the procedure specific Indications section (initial or repeat) is considered **not medically necessary**.
- Lumbar decompression/discectomy performed for **ANY** of the following sole indications is considered **not medically necessary**:
 - ◆ Signs and symptoms with no correlation to advanced imaging studies
 - ◆ Annular tears
 - ◆ Disc bulge with no neural impingement or cord compression on advanced diagnostic imaging
 - ◆ Concordant discography
 - ◆ MR Spectroscopy results
 - ◆ Degenerative disc disease

Experimental, Investigational, or Unproven (EIU)

- **ANY** of the following procedures are considered **experimental, investigational, or unproven**:
 - ◆ Percutaneous lumbar discectomy
 - ◆ Percutaneous laser discectomy
 - ◆ Laser-assisted disc decompression
 - ◆ Percutaneous laser disc decompression

- ◆ Percutaneous nucleotomy
- ◆ Vertos Medical mild® Surgical Procedure
- Interspinous/interlaminar process spacer devices (ISS) and interspinous/interlaminar stabilization/distraction devices, and interspinous process decompression (IPD) systems/devices (e.g. Coflex Interlaminar Technology Implant, Superior ISS Interspinous Spacer System, X-STOP Interspinous Process Decompression System, X-STOP PEEK Interspinous Process Decompression System, and Total Posterior Spine [TOPS™] System) are considered **experimental, investigational or unproven** for **ALL** indications including, but not limited to:
 - ◆ Lumbar interspinous/interlaminar distraction without fusion for indirect spinal decompression
 - ◆ Lumbar interspinous fixation with fusion with or without decompression for stabilization
 - ◆ Lumbar spinal stabilization with an interspinous process device/interlaminar device without fusion in conjunction with decompression laminectomy

CMM-608.5: 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/Definitions
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level
+22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level
+22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)
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
63011	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; sacral
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)
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
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 segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)
63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [e.g., 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] [e.g., spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)
0274T	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; 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
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-608.6: References

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