Cigna Medical Coverage Policies – Musculoskeletal
Lumbar Microdiscectomy Guidelines

Effective November 1, 2024

Instructions for use

The following coverage policy applies to health benefit plans administered by Cigna. Coverage policies are intended to provide guidance in interpreting certain standard Cigna benefit plans and are used by medical directors and other health care professionals in making medical necessity and other coverage determinations. Please note the terms of a customer's particular benefit plan document may differ significantly from the standard benefit plans upon which these coverage policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a coverage policy.

In the event of a conflict, a customer's benefit plan document always supersedes the information in the coverage policy. In the absence of federal or state coverage mandates, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of:

1. The terms of the applicable benefit plan document in effect on the date of service
2. Any applicable laws and regulations
3. Any relevant collateral source materials including coverage policies
4. The specific facts of the particular situation

Coverage policies relate exclusively to the administration of health benefit plans. Coverage policies are not recommendations for treatment and should never be used as treatment guidelines.

This evidence-based medical coverage policy has been developed by eviCore, Inc. Some information in this coverage policy may not apply to all benefit plans administered by Cigna.

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

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CMM-606.1: General Guidelines

Application of Guideline

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

Urgent/Emergent Indications/Conditions

- The presence of urgent/emergent indications/conditions warrants definitive surgical treatment. **Imaging findings noted in the applicable procedure section(s) 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)
    - Timeframe for repeat procedure
- 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 exams
  - **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 or nerve compression, or instability
  - A condition otherwise meeting criteria listed in the applicable procedure section(s) with documentation of severe debilitating pain and/or dysfunction to the point of being incapacitated

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Credentialed Spine Surgeon Required

- Endoscopic lumbar discectomy requires the procedure be performed by a spine surgeon with surgical privileges at a hospital, hospital outpatient department, or ambulatory surgery center to perform open surgical approach(es) for lumbar discectomy.

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 conditions when **ALL** of the associated criteria have been met:

Neurogenic Claudication

- Subjective symptoms including **BOTH** of the following:
  - Significant level of pain on a daily basis defined as clinically significant functional impairment (e.g., inability to perform household chores, prolonged standing, etc.)
  - 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 exam findings concordant with MRI/CT
- Less than clinically meaningful improvement with at least **TWO** of the following (unless contraindicated):
  - Prescription strength analgesics, steroids, gabapentinoids, 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
- MRI/CT shows neural structure compression at the requested level(s) that is concordant with the individual's symptoms **and** physical exam findings and that is caused by **ANY** of the following:
  - Herniated disc(s) (retained disc material or a recurrent disc herniation)
  - Synovial cyst or arachnoid cyst
  - Central/lateral/foraminal stenosis
  - Osteophytes
- 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)

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Radiculopathy

- Subjective symptoms include **BOTH** of the following:
  - Significant level of pain on a daily basis defined as clinically significant functional impairment (e.g., inability to perform household chores, prolonged standing, etc.)
  - Persistent radiating pain into the buttock(s) and/or lower extremity(ies)in
- Objective physical exam findings include **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, gabapentinoids, 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
- MRI/CT shows neural structure compression at the requested level(s) that is concordant with the individual's symptoms **and** physical exam findings and that is caused by **ANY** of the following:
  - Herniated disc(s) (retained disc material or a recurrent disc herniation)
  - Synovial cyst or arachnoid cyst
  - Central/lateral/foraminal stenosis
  - Osteophytes
- 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)

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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 have been met:

Neurogenic Claudication

- Greater than 12 weeks since initial lumbar disc decompression surgery
- Subjective symptoms include **BOTH** of the following:
  - Significant level of pain on a daily basis defined as clinically significant functional impairment (e.g., inability to perform household chores, prolonged standing, etc.)
  - 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 exam findings are concordant with post-operative MRI/CT
- Less than clinically meaningful improvement with at least **TWO** of the following (unless contraindicated):
  - Prescription strength analgesics, steroids, gabapentinoids, 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
- Post-operative MRI /CT shows neural structure compression at the requested level(s) that is concordant with the individual's symptoms **and** physical exam findings and that is caused by **ANY** of the following:
  - Herniated Disc(s) (retained disc material or a recurrent disc herniation)
  - Synovial cyst or arachnoid cyst
  - Central/lateral/foraminal stenosis
  - Osteophytes
- 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)

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Radiculopathy

- Greater than 12 weeks since initial lumbar disc decompression surgery
- Subjective symptoms include **BOTH** of the following:
  - Significant level of pain on a daily basis defined as clinically significant functional impairment (e.g., inability to perform household chores, prolonged standing, etc.)
  - Persistent radiating pain into the buttock(s) and/or lower extremity(ies)
- Objective physical exam findings include **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, gabapentinoids, 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
- Post-operative MRI /CT shows neural structure compression at the requested level(s) that is concordant with the individual's symptoms **and** physical exam findings and that is caused by **ANY** of the following:
  - Herniated Disc(s) (retained disc material or a recurrent disc herniation)
  - Synovial cyst or arachnoid cyst
  - Central/lateral/foraminal stenosis
  - Osteophytes
- 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)

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CMM-606.4: Non-Indications

Not Medically Necessary

- Lumbar microdiscectomy (laminotomy, laminectomy, and hemilaminectomy) performed without meeting the criteria in the **General Guidelines** (Credentialed Spine Surgeon Required; and, when applicable, Urgent/Emergent Indications/Conditions) **and** the criteria in the **applicable procedure-specific section** (initial microdiscectomy or repeat microdiscectomy) 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**:
  - Annular tears
  - Degenerative disc disease
  - Concordant discography
  - MR Spectroscopy results
- The performance of lumbar microdiscectomy (laminotomy, laminectomy, and hemilaminectomy) with laser technique is considered **not medically necessary**.

Experimental, Investigational, or Unproven (EIU)

- Percutaneous lumbar discectomy (i.e., lumbar discectomy performed with indirect visualization of the spine) is considered **experimental, investigational, or unproven (EIU)**.
- Devices for disc annular repair are considered **experimental, investigational, or unproven (EIU)**.

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Procedure (CPT®) Codes (CMM-606)

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	Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; lumbar, single interspace
+S2351	Diskectomy, 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.

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