Cigna Medical Coverage Policies – Musculoskeletal Thoracic Decompression and Discectomy 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.

CMM-613: Thoracic Decompression/Discectomy

CMM-613.1: General Guidelines

Application of Guideline

- The determination of medical necessity for the performance of thoracic decompression/discectomy 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 thoracic decompression/discectomy include **ANY** of the following:
  - Acute/unstable spinal fractures or dislocations with neural compression
  - Myelopathy or Cord signal changes on MRI due to cord compression
  - 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 findings 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
  - 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

CMM-613.2: Initial Thoracic Decompression/Discectomy

Initial primary thoracic decompression/discectomy is considered **medically necessary** when performed for **EITHER** of the following conditions when **ALL** of the associated criteria have been met:

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.)
  - Unremitting radicular pain into the chest wall or upper abdominal wall resulting in disability
- Objective physical exam findings include **ANY** of the following:
  - Dermatomal sensory deficit
  - Unremitting radicular pain into the chest wall or upper abdominal wall without concordant objective physical exam findings
- 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 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, drug and alcohol abuse)

Myelopathy

- Subjective symptoms include **ANY** of the following:
  - Lower extremity weakness, numbness, or pain
  - Gait disturbance
  - New-onset bowel or bladder dysfunction due to a neurocompressive pathology
  - Frequent falls
- Objective physical exam findings include **ANY** of the following:
  - Ataxic gait
  - Lower extremity hyperreflexia
  - Tandem walking test demonstrating ataxia
  - Increased muscle tone or spasticity
  - Clonus
  - Babinski sign
- MRI/CT shows findings that are concordant with the individual's symptoms and physical exam and that are caused by **EITHER** of the following:

- Thoracic/thoracolumbar spinal cord compression
- Thoracic/thoracolumbar spinal stenosis

CMM-613.3: Corpectomy

Thoracic corpectomy can be performed as an alternative for thoracic discectomy when **ALL** of the following criteria have been met:

- Complete corpectomy or partial corpectomy (i.e., removal of at least one-third of the vertebral body [not for resection of osteophytes alone]) is being performed for **ANY** of the following:
  - Infection
  - Trauma
  - Tumor
  - Compression at or behind the level of the vertebral body
- Thoracic corpectomy must be performed with a thoracic fusion due to the iatrogenic instability of the thoracic corpectomy procedure.
- **ALL** of the criteria for thoracic decompression have been met per the applicable procedure-specific section below:
  - **CMM-613.2: Initial Thoracic Decompression/Discectomy**
  - **CMM-613.4: Repeat Thoracic Decompression/Discectomy at the Same Level**

CMM-613.4: Repeat Thoracic Decompression/Discectomy at the Same Level

Repeat thoracic decompression/discectomy at the same level is considered **medically necessary** when performed for **EITHER** of the following conditions when **ALL** of the associated criteria have been met:

Radiculopathy

- Greater than 12 weeks since the initial primary decompression/microdiscectomy
- 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.)
  - Unremitting radicular pain into the chest wall or upper abdominal wall resulting in disability
- Objective physical exam findings include **ANY** of the following:
  - Dermatomal sensory deficit
  - Unremitting radicular pain into the chest wall or upper abdominal wall without concordant objective physical exam findings
- 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, drug and alcohol abuse)

Myelopathy

➢ Subjective symptoms include **ANY** of the following:
- Lower extremity weakness, numbness, or pain
- Gait disturbance
- New-onset bowel or bladder dysfunction due to a neurocompressive pathology
- Frequent falls

➢ Objective physical exam findings include **ANY** of the following:
- Ataxic gait
- Lower extremity hyperreflexia
- Tandem walking test demonstrating ataxia
- Increased muscle tone or spasticity
- Clonus
- Babinski sign

➢ Post-operative MRI /CT shows findings that are concordant with the individual's symptoms **and** physical exam findings and that are caused by **EITHER** of the following:
- Thoracic/thoracolumbar spinal cord compression
- Thoracic/thoracolumbar spinal stenosis

CMM-613.5: Non-Indications

Not Medically Necessary

- **Thoracic decompression/discectomy/corpectomy** performed without meeting the criteria in the **General Guidelines** (when applicable for urgent/emergent conditions) **and** the criteria in the applicable procedure-specific section(s) (initial decompression, corpectomy, or repeat decompression) is considered **not medically necessary**.
- **Thoracic decompression/discectomy/corpectomy** performed for **ANY** of the following sole indications is considered **not medically necessary**:
  - Annular tears
  - Concordant discography
  - MR Spectroscopy results
  - Degenerative disc disease
- The performance of thoracic decompression or discectomy with laser technique is considered **not medically necessary**.

Experimental, Investigational, or Unproven (EIU)

- **ANY** of the following procedures are considered **experimental, investigational, or unproven (EIU)**:
  - Percutaneous thoracic discectomy (i.e., thoracic discectomy performed with indirect visualization
  - Percutaneous thoracic decompression (i.e., thoracic decompression performed with indirect visualization)
  - Endoscopic thoracic decompression or discectomy

Procedure (CPT®) Codes (CMM-613)

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
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
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
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
+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)
63055	Transpedicular approach with decompression of spinal cord, equina and /or nerve root(s) (e.g., herniated intervertebral disc), single segment; thoracic
+ 63057	Transpedicular approach with decompression of spinal cord, equina and/or nerve(s) (e.g., herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (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)
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 equine or nerve root(s), lower thoracic or lumbar, single segment

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**
+63088	Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equine 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 equine 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 equine 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
+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)
63266	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic
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
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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