

# Cigna Medical Coverage Policies – Musculoskeletal Lumbar Microdiscectomy (Laminotomy, Laminectomy, or Hemilaminectomy)

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## 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)**

**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 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

## **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 six (6) weeks
  - ◆ Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for six (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)

## **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)
- 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 six (6) weeks
  - ◆ Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for six (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)

### **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 the prior lumbar 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.)
  - ◆ 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 six (6) weeks
  - ◆ Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for six (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)

## **Radiculopathy**

- Greater than 12 weeks since the prior lumbar 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.)
  - ◆ 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 six (6) weeks
  - ◆ Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for six (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)

## **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)**.

## Codes (CMM-606)

The inclusion of any code in this table does not imply that the code is under management or requires prior authorization. Refer to the applicable health plan for management details. Prior authorization of a code listed in this table is not a guarantee of payment. The Certificate of Coverage or Evidence of Coverage policy outlines the terms and conditions of the member's health insurance policy.

Code	Code Description/Definition
<b>62380</b>	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar
<b>63030</b>	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar
<b>+63035</b>	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)
<b>63042</b>	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar
<b>+63044</b>	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)
<b>63056</b>	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)
<b>+63057</b>	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)
<b>S2350</b>	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctectomy; lumbar, single interspace
<b>+S2351</b>	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctectomy; lumbar, each additional interspace (list separately in addition to code for primary procedure)

## **Evidence Discussion (CMM-606)**

### **Lumbar Microdiscectomy (Laminotomy, Laminectomy, or Hemilaminectomy)**

Risks of lumbar microdiscectomy surgery include, but are not limited to, the following: infection; neurovascular injury; persistent or incomplete relief of symptoms; possible need for more surgery; dural tear; deep vein thrombosis; pulmonary embolus; paralysis; and, death. Given the potential possibility for significant complications, proper surgical candidacy selection is critical to minimize the risk benefit ratio.

As recommended by the North American Spine Society (NASS) *Coverage Policy Recommendations: Lumbar Discectomy*, symptoms, physical exam findings, and imaging findings should support lumbar discectomy surgery. Subjective symptoms and examination findings need to be concordant with imaging as it is not uncommon for asymptomatic patients to have abnormalities on MRI.

Multiple studies and reports have shown most cases of acute back pain and sciatica are self-limited and typically improve within six (6) weeks with conservative care. Therefore, a six (6) week course of non-operative treatment is recommended prior to surgical intervention. However, the presence of an urgent/emergent condition (e.g., cauda equina syndrome, infection, epidural hematoma) would obviate the need for conservative treatment.

Jackson et al. (2020) noted higher rates of postoperative complications and worse functional outcomes in patients with psychological disorders undergoing spinal surgery. It was concluded that proper identification and treatment of these conditions prior to surgery may significantly improve many outcome measures in this population.

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