Cigna Medical Coverage Policies – Musculoskeletal Posterior Cervical Decompression 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-603: Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/ Laminoplasty)

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CMM-603.1: General Guidelines

Application of Guideline

- The determination of medical necessity for the performance of posterior cervical decompression 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 posterior cervical decompression include **ANY** of the following:
  - Acute/unstable traumatic spinal fractures or dislocations with neural compression
  - Central cord syndrome
  - 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 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 cord compression
  - 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
  - Vascular malformations (e.g., AVM)

CMM-603.2: Initial Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/Laminoplasty)

Initial primary posterior cervical decompression (laminectomy/hemilaminectomy/ laminoplasty) is considered **medically necessary** for **ANY** 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 to shoulder girdle and/or upper extremity resulting in disability
- Objective physical exam findings include **ANY** of the following:
  - Dermatomal sensory deficit
  - Motor deficit (e.g., biceps, triceps weakness)
  - Reflex changes
  - Shoulder abduction relief sign
  - Nerve root tension sign (e.g., Spurling's maneuver)
  - Unremitting radicular pain to shoulder girdle and/or upper extremity 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 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)

Myelopathy

- Subjective symptoms include **ANY** of the following:
  - Upper/lower extremity weakness, numbness, or pain
  - Fine motor dysfunction (buttoning, handwriting, clumsiness of hands)
  - Gait disturbance
  - New-onset bowel or bladder dysfunction
  - Frequent falls
- Objective physical exam findings include **ANY** of the following:
  - Grip and release test
  - Ataxic gait
  - Hyperreflexia
  - Hoffmann sign
  - Babinski sign
  - Tandem walking test demonstrating ataxia
  - Inverted brachial radial reflex
  - Increased muscle tone or spasticity
  - Clonus
  - Myelopathic hand
- 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:
  - Cervical spinal cord compression
  - Cervical spinal stenosis

CMM-603.3: Repeat Posterior Cervical Decompression at the Same Level

Repeat posterior cervical decompression at the same level is considered **medically necessary** for **ANY** of the following conditions when **ALL** of the associated criteria have been met:

Radiculopathy

- Greater than 12 weeks since the prior posterior cervical 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.)
  - Unremitting radicular pain to shoulder girdle and/or upper extremity resulting in disability

- Objective physical exam findings include **ANY** of the following:
  - Dermatomal sensory deficit
  - Motor deficit (e.g., biceps, triceps weakness)
  - Reflex changes
  - Shoulder abduction relief sign
  - Nerve root tension sign (e.g., Spurling's maneuver)
  - Unremitting radicular pain to shoulder girdle and/or upper extremity 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, opioid and alcohol use disorders)

Myelopathy

- Subjective symptoms include **ANY** of the following:
  - Upper/lower extremity weakness, numbness, or pain
  - Fine motor dysfunction (buttoning, handwriting, clumsiness of hands)
  - Gait disturbance
  - New-onset bowel or bladder dysfunction
  - Frequent falls

- Objective physical exam findings include **ANY** of the following:
  - Grip and release test
  - Ataxic gait
  - Hyperreflexia
  - Hoffmann sign
  - Babinski sign
  - Tandem walking test demonstrating ataxia
  - Inverted brachial radial reflex
  - Increased muscle tone or spasticity
  - Clonus
  - Myelopathic hand
- 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:
  - Cervical spinal cord compression
  - Cervical spinal stenosis

CMM-603.4: Non-Indications

Not Medically Necessary

- **Posterior cervical decompression** (laminectomy, hemilaminectomy, and laminoplasty) performed without meeting the criteria in the **General Guidelines** (when applicable for urgent/emergent conditions) **and** the criteria in the applicable procedure-specific section (initial decompression or repeat decompression) is considered **not medically necessary**.
- **Posterior cervical decompression** (laminectomy, hemilaminectomy, and laminoplasty) is considered **not medically necessary** when performed for **ANY** of the following sole indications:
  - Signs and symptoms with no correlation to imaging studies
  - Annular tears
  - Disc bulge with no neural impingement or cord compression on imaging
  - Concordant Discography
  - MR Spectroscopy results
  - Degenerative disc disease

Experimental, Investigational, or Unproven (EIU)

- Percutaneous cervical discectomy (i.e., cervical discectomy performed with indirect visualization of the spine) is considered **experimental, investigational, or unproven (EIU)**.
- Posterior endoscopic cervical disc/nerve root decompression is considered **experimental, investigational or unproven (EIU)**, including **ANY** of the following procedures:
  - Posterior endoscopic cervical discectomy
  - Posterior endoscopic cervical foraminotomy (PECF)

Procedure (CPT®) Codes (CMM-603)

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
63001	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; cervical
63015	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; cervical
63045	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; cervical
+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 vertebral segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)
63050	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments;
63051	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (e.g. wire, suture, mini-plates), when performed)
63265	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical
63270	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical
63275	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical
63280	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, cervical
63285	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, cervical
63290	Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level
+63295	Laminectomy for biopsy/excision of intraspinal neoplasm; osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (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

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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