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

Effective July 1, 2025

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)

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 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)

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 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)

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)

Codes (CMM-603)

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
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

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References (CMM-603)

1. Barton C, Kalakoti P, Bedard NA, Hendrickson NR, Saifi C, Pugely AJ. What Are the Costs of Cervical Radiculopathy Prior to Surgical Treatment? *Spine*. 2019;44(13):937-942. doi:10.1097/brs.0000000000002983.
2. Bond M, McIntosh G, Fisher C, et al. Treatment of Mild Cervical Myelopathy. *Spine* (*Phila Pa 1976*). 2019;44(22):1606-1612. doi:10.1097/brs.0000000000003124.
3. Boonstra AM, Schiphorst Preuper HR, Balk GA, Stewart RE. Cut-off points for mild, moderate, and severe pain on the visual analogue scale for pain in patients with chronic musculoskeletal pain. *Pain*. 2014;155(12):2545-2550. doi:10.1016/j.pain.2014.09.014.
4. Broekema AEH, Simões de Souza NF, Soer R, et al. Noninferiority of Posterior Cervical Foraminotomy vs Anterior Cervical Discectomy With Fusion for Procedural Success and Reduction in Arm Pain Among Patients With Cervical Radiculopathy at 1 Year. *JAMA Neurol*. 2023;80(1):40-40. doi:10.1001/jamaneurol.2022.4208.
5. Carette S, Fehlings MG. Clinical practice. Cervical radiculopathy. *NEJM*. 2005;353(4):392-399.
6. Celestre PC, Pazmiño PR, Mikhael MM, et al. Minimally invasive approaches to the cervical spine. *Orthop Clin North Am*. 2012;43(1):137-147. doi:10.1016/j.ocl.2011.08.007.
7. Chatley A, Kumar R, Jain V, Behari S, Sahu R. Effect of spinal cord signal intensity changes on clinical outcome after surgery for cervical spondylotic myelopathy. *J Neurosurg Spine*. 2009;11(5):562-567. doi:10.3171/2009.6.spine091.
8. Cohen SP, Hanling S, Bicket MC, et al. Epidural steroid injections compared with gabapentin for lumbosacral radicular pain: multicenter randomized double blind comparative efficacy study. *BMJ*. 2015;350:h1748. doi:10.1136/bmj.h1748.
9. Dvorak MF, Fisher CG, Fehlings MG, et al. The surgical approach to subaxial cervical spine injuries: an evidence-based algorithm based on the SLIC classification system. *Spine*. 2007;32(23):2620-2629. doi: 10.1097/BRS.0b013e318158ce16.
10. Farshad M, Burgstaller JM, Held U, et al. Do preoperative corticosteroid injections increase the risk for infections or wound healing problems after spine surgery? *Spine*. 2018;43(15):1089-1094.
11. Fejer R, Jordan A, Hartvigsen J. Categorising the severity of neck pain: Establishment of cut-points for use in clinical and epidemiological research. *Pain*. 2005;119(1-3):176-182. doi:10.1016/j.pain.2005.09.033.
12. Ghogawala Z, Martin B, Benzel EC, et al. Comparative effectiveness of ventral vs dorsal surgery for cervical spondylotic myelopathy. *Neurosurgery*. 2011;68(3):622-631. doi:10.1227/NEU.0b013e31820777cf.
13. Grabowski G, Cornett CA, Kang JD. Esophageal and vertebral artery injuries during complex cervical spine surgery--avoidance and management. *Orthop Clin North Am.* 2012;43(1):63-74.
14. Hilton B, Tempest-Mitchell J, Davies B, Kotter M. Assessment of degenerative cervical myelopathy differs between specialists and may influence time to diagnosis and clinical outcomes. *PLoS ONE*. 2018;13(12). doi:10.1371/journal.pone.0207709.
15. Hsu WK. Advanced techniques in cervical spine surgery. *J Bone Joint Surg Am*. 2011;93(8):780-788.
16. Jayaram RH, Joo P, Gouzoulis MJ, Ratnasamy PP, Caruana D, Moore HE. Single-level Anterior Cervical discEctomy and Fusion has Lower Five-year Revisions than Posterior Cervical Foraminotomy in a Large National Cohort. *Spine*. 2023;48(18):1266-1271.doi:10.1097/brs.0000000000004754.
17. Komotar RJ, Mocco J, Kaiser MG. Surgical management of cervical myelopathy: indications and techniques for laminectomy and fusion. *Spine J*. 2006;6(6 Suppl):252S-267S.
18. Kushchayev SV, Glushko T, Jarraya M, et al. ABCs of the degenerative spine. *Insights Imaging*. 2018;9(2):253-274. doi:10.1007/s13244-017-0584-z.
19. Lawrence BD, Brodke DS. Posterior surgery for cervical myelopathy: indications, techniques, and outcomes. *Ortho Clin North Am*. 2012;43(1):29-40.
20. Lee BS, Nault R, Grabowski M, et al. Utility of repeat magnetic resonance imaging in surgical patients with lumbar stenosis without disc herniation. *Spine J*. 2019;19(2):191-198. doi:10.1016/j.spinee.2018.06.357.
21. Machino M, Yukawa Y, Ito K, et al. Risk Factors for Poor Outcome of Cervical Laminoplasty for Cervical Spondylotic Myelopathy in Patients with Diabetes. *J Bone Joint Surg Am*. 2014:96:2049-2055.
22. Manzano GR, Casella G, Wang MY, Vanni S, Levi AD. A Prospective, Randomized Trial Comparing Expansile Cervical Laminoplasty versus Cervical Laminectomy and Fusion for Multi-level Cervical Myelopathy. *Neurosurgery*. 2012;70(2):264-277. doi:10.1227/NEU.0b013e3182305669.
23. Matz PG, Anderson PA, Groff MW, et al. Cervical laminoplasty for the treatment of cervical degenerative myelopathy. *J Neurosurg Spine*. 2009;11(2):157-169.doi:10.3171/2009.1.SPINE08726.
24. McDonald C, Hershman S, Hogan W, et al. Cervical Laminoplasty Versus Posterior Laminectomy and Fusion: Trends in Utilization and Evaluation of Complication and Revision Surgery Rates. *JAAOS*. 2022;30(17):858-866. doi:10.5435/jaaos-d-22-00106.
25. Molina CA, Gokaslan ZL, Sciubba DM. Diagnosis and management of metastatic cervical spine tumors. *Orthop Clin North Am*. 2012;43(1):75-87.
26. Mummaneni PV, Kaiser MG, Matz PG, et al. Preoperative patient selection with magnetic resonance imaging, computed tomography, and electroencephalography: does the test predict outcome after cervical surgery? *J Neurosurg*. 2009;11(2):119-129. doi:10.3171/2009.3.SPINE08717.

27. Mummaneni PV, Kaiser MG, Matz PG, et al. Cervical surgical techniques for the treatment of cervical spondylotic myelopathy. *J Neurosurg Spine*. 2009;11(2):130-141. doi:10.3171/2009.3.SPINE08728.
28. Panagopoulos J, Hush J, Steffens D, Hancock MJ. Do MRI Findings Change Over a Period of Up to 1 Year in Patients With Low Back Pain and/or Sciatica? *Spine*. 2017;42(7):504-512. doi:10.1097/brs.0000000000001790.
29. Perfetti DC, Rogers-LaVanne MP, Satin AM, et al. Learning curve for endoscopic posterior cervical foraminotomy. *Eur Spine J*. 2023;32(8):2670-2678. doi:10.1007/s00586-023-07623-6.
30. Rathmell JP, Saal JS. Discography, IDET, Percutaneous Discectomy, and Nucleoplasty: Complications and Their Preventions. *Pain Med*. 2008;9(Issue S1):S79-S8.doi:10.1111/J.1526-4637.2008.00442.X.
31. Rao RD, Gourab K, David KS. Operative treatment of cervical spondylotic myelopathy. *J Bone Joint Surg Am*. 2006;88(7):1619-1640.
32. Ries ZG, Glassman SD, Vasilyev I, Metcalfe L, Carreon LY. Updated imaging does not affect revision rates in adults undergoing spine surgery for lumbar degenerative disease. *J Neurosurg Spine*. Published online Nov 2018. 2019;30(2):228-223. doi:10.3171/2018.8.spine18586.
33. Sakaura H, Hosono N, Mukai Y, Ishii T, Iwasaki M, Yoshikawa H. Long-term outcome of laminoplasty for cervical myelopathy due to disc herniation: a comparative study of laminoplasty and anterior spinal fusion. *Spine (Phila Pa 1976)*. 2005;30(7):756-759.
34. Shafshak TS, Elnemr R. The Visual Analogue Scale Versus Numerical Rating Scale in Measuring Pain Severity and Predicting Disability in Low Back Pain. *J Clin Rheumatol*. 2020;27(7):1. doi:10.1097/rhu.0000000000001320.
35. Siemionow K, Janusz P, Phillips FM, et al. Clinical and Radiographic Results of Indirect Decompression and Posterior Cervical Fusion for Single-Level Cervical Radiculopathy Using an Expandable Implant with 2-Year Follow-Up. *J Neurol Surg A Cent Eur Neurosurg*. 2016;77(6):482-488. Epub 2016 Jun 8. doi:10.1055/s-0036-1584210.
36. Simões de Souza NF, Broekema AEH, Reneman MF, et al. Posterior Cervical Foraminotomy Compared with Anterior Cervical Discectomy with Fusion for Cervical Radiculopathy: Two-Year Results of the FACET Randomized Noninferiority Study. J Bone Joint Surg Am. 2024;106(18):1653-1663. doi:10.2106/JBJS.23.00775.
37. Sun Q, Hu A, Zhang Y, et al. Do intramedullary spinal cord changes in signal intensity on MRI affect surgical opportunity and approach for cervical myelopathy due to ossification of the posterior longitudinal ligament? *Eur Spine J*. 2011;20(9):1466-1473. doi:10.1007/s00586-011-1813-7.
38. Thayer L, Tiffany E, Carreira D. Addressing Smoking in Musculoskeletal Specialty Care. *J Bone Joint Surg Am*. 2021;103(22):2145-2152. doi: 10.2106/jbjs.21.00108.
39. Tracy JA, Bartleson JD. Cervical spondylotic myelopathy. *Neurologist*. 2010;16(3):176-187.
40. Tretreault L, Tan G, Kopjar B, et al. Clinical and surgical predictors of complications following surgery for the treatment of cervical spondylotic myelopathy: results from the multicenter, prospective AOSpine International Study of 479 patients. *Neurosurgery*. 2016;79(1):33-44. doi:10.1227/NEU.0000000000001151.
41. Turgut M. Klippel-Feil syndrome in association with posterior fossa dermoid tumour. *Acta Neurochirurgica*. 2009;151(3):269-276.
42. Wang VY, Chou D. The cervicothoracic junction. *Neurosurg Clin North Am*. 2007;18(2):365-371.
43. Weinberg D, Chugh AJ, Gebhart JJ, et al. Magnetic resonance imaging of the cervical spine under-represents sagittal plane deformity in degenerative myelopathy patients. *Int J Spine Surg*. 2016;10:32. doi:10.14444/3032.
44. Yaksi A, Özgönenel L, Özgönenel B. The Efficiency of Gabapentin Therapy in Patients With Lumbar Spinal Stenosis. *Spine*. 2007;32(9):939-942. doi:10.1097/01.brs.0000261029.29170.e6.
45. Yin L, Zhang J, Wu Y, Li J, Yang Q. Increased signal intensity of spinal cord on T2W magnetic resonance imaging for cervical spondylotic myelopathy patients. *Medicine (Baltimore)*. 2020;99(49):e23098. doi: 10.1097/md.0000000000023098.
46. Zhang C, Wu J, Zheng W, Li C, Zhou Y. Posterior Endoscopic Cervical Decompression: Review and Technical Note. *Neurospine*. 2020;17(Suppl 1):S74-S80. doi:10.14245/ns.2040166.083.