

Cigna Medical Coverage Policies – Musculoskeletal Cervical 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-605: Cervical Microdiscectomy

CMM-605.1: General Guidelines**CMM-605.2: Initial Primary Cervical Microdiscectomy****CMM-605.3: Repeat Cervical Microdiscectomy at the Same Level****CMM-605.4: Non-Indications****Procedure (CPT®) Codes (CMM-605)****References (CMM-605)**

CMM-605.1: General Guidelines

Application of Guideline

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

Urgent/Emergent Conditions/Indications

- 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 cervical microdiscectomy include **ANY** of the following:
 - ◆ 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
 - ◆ 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-605.2: Initial Primary Cervical Microdiscectomy

Initial primary cervical microdiscectomy 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.)
 - ◆ Unrelenting 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)
 - ◆ Unrelenting radicular pain to shoulder girdle and/or upper extremity without concordant objective 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 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-605.3: Repeat Cervical Microdiscectomy at the Same Level

Repeat cervical microdiscectomy 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 cervical 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.)
 - ◆ Unrelenting 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)
 - ◆ Unrelenting 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 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-605.4: Non-Indications

Not Medically Necessary

- Cervical microdiscectomy 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 microdiscectomy or repeat microdiscectomy) is considered **not medically necessary**.
- Cervical microdiscectomy performed for **ANY** of the following sole indications is considered **not medically necessary**:
 - ◆ Annular tears
 - ◆ Concordant discography
 - ◆ MR Spectroscopy results
 - ◆ Degenerative disc disease

Experimental, Investigational, or Unproven (EIU)

- Percutaneous cervical discectomy (i.e., cervical discectomy performed with indirect visualization) is considered **experimental, investigational, or unproven (EIU)**.
- Endoscopic cervical discectomy is considered **experimental, investigational, or unproven (EIU)**.

Procedure (CPT®) Codes (CMM-605)

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
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical
+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)
63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical
+63043	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical 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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