Cigna Medical Coverage Policies – Musculoskeletal Lumbar 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-608: Lumbar Decompression

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CMM-608.1: General Guidelines

Application of Guideline

- The determination of medical necessity for the performance of lumbar 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 lumbar decompression include **ANY** of the following:
  - Acute/unstable traumatic spinal fractures or dislocations with **EITHER** of the following:
    - Neural compression
    - Traumatic cerebrospinal fluid (CSF) leak
  - 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 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 decompression 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 decompression.

CMM-608.2: Initial Primary Lumbar Decompression

Initial primary lumbar decompression is considered **medically necessary** when performed for **EITHER** of the following when **ALL** of the associated criteria are met:

Neurogenic Claudication

- 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 occur:
    - Symptoms worsen with standing and/or walking
    - Symptoms are alleviated with sitting and/or forward flexion
- Objective physical exam findings are 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 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)

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) on a daily basis that has a documented negative impact on activities of daily living despite optimal conservative treatment as described below
- 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 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)

CMM-608.3: Corpectomy

Lumbar corpectomy can be performed for decompression 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
- **ALL** of the criteria have been met in the applicable procedure-specific section below:
  - **CMM-608.2: Initial Primary Lumbar Decompression**
  - **CMM-608.4: Repeat Lumbar Decompression at the Same Level**

Note: Due to iatrogenic instability of the corpectomy procedure, lumbar fusion is appropriate.

CMM-608.4: Repeat Lumbar Decompression at the Same Level

Repeat lumbar decompression at the same level is considered **medically necessary** when performed for **EITHER** of the following when **ALL** of the associated criteria is met:

Neurogenic Claudication

- Greater than 12 weeks since last 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.)
  - 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 occur:
    - 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 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)

Radiculopathy

- Greater than 12 weeks since last 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.)
  - Persistent radiating pain into the buttock(s) and/or lower extremity(ies) on a daily basis that has a documented negative impact on activities of daily living despite optimal conservative treatment as described below
- 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 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)

CMM-608.5: Non-Indications

Not Medically Necessary

- Lumbar decompression/discectomy/corpectomy 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(s) (initial decompression, corpectomy, or repeat decompression) is considered **not medically necessary**.
- Lumbar decompression/discectomy/corpectomy performed for **ANY** of the following sole indications is considered **not medically necessary**:
  - Annular tears
  - Degenerative disc disease
  - Concordant discography
  - MR Spectroscopy results

Experimental, Investigational, or Unproven (EIU)

- Percutaneous lumbar decompression (e.g., Vertos Medical mild® Surgical Procedure) is considered **experimental, investigational, or unproven (EIU).**
- Interspinous/interlaminar process spacer devices (ISS) and interspinous/interlaminar stabilization/distraction devices, and interspinous process decompression (IPD) systems/devices (e.g., Coflex Interlaminar Technology Implant, Superion ISS Interspinous Spacer System, X-STOP Interspinous Process Decompression System, X-STOP PEEK Interspinous Process Decompression System, and Total Posterior Spine [TOPS™] System) are considered **experimental, investigational, or unproven** for **ALL** indications including, but not limited to, the following:
  - Lumbar interspinous/interlaminar distraction (without fusion) for indirect spinal decompression
  - Lumbar interspinous fixation with fusion (with or without decompression) for stabilization
  - Lumbar spinal stabilization with an interspinous process device/interlaminar device (without fusion) in conjunction with decompression laminectomy

Procedure (CPT®) Codes (CMM-608)

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/Definitions
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level
+22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level
+22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar
63005	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; lumbar, except for spondylolisthesis
63011	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; sacral
63012	Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)
63017	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; lumbar
63047	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; lumbar
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)
63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [e.g., spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)

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/Definitions**
63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [e.g., spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; 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
+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)
63102	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); lumbar, 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)
0275T	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; lumbar
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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