

CIGNA MEDICAL COVERAGE POLICIES - MUSCULOSKELETAL

CMM-608: Lumbar Decompression

Effective Date: August 04, 2026



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.

These guidelines include procedures EviCore does not review for Cigna. Please refer to the [Cigna CPT code list](#) for the current list of high-tech imaging procedures that EviCore reviews for Cigna.

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Lumbar Decompression

CMM-608.1: General Guidelines

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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)
 - time frame 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
 - cerebrospinal fluid (CSF) leak
 - cauda equina syndrome (CES)
 - progressive neurological deficit documented on two separate physical exams
 - neurocompressive pathology with ANY of the following:
 - 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

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Lumbar Decompression

CMM-608.2: Initial Primary Lumbar Decompression

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

Neurogenic Claudication

- 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
- Less than clinically meaningful improvement with at least TWO of the following (unless contraindicated):
 - prescription strength analgesics, steroids, gabapentinoids, and/or nonsteroidal anti-inflammatory drugs (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

- 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)
- Physical exam findings include ANY of the following:
 - positive straight leg raise
 - positive crossed straight leg raise
 - positive femoral stretch test
 - dermatomal sensory deficit
 - functionally limiting motor weakness (e.g., foot drop, quadriceps weakness)
 - reflex changes
 - unremitting radicular pain into the lower extremity(ies) 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 nonsteroidal anti-inflammatory drugs (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)

Interlaminar Decompression Device in Open Lumbar Decompression

Use of an FDA-approved interlaminar decompression device (i.e., Coflex®) is considered **medically necessary** when used for an open lumbar decompression when ALL of the following criteria have been met:

- Meets initial lumbar decompression criteria for EITHER **Neurogenic Claudication** or **Radiculopathy**

- The interlaminar decompression device will not be used for an open lumbar decompression performed with a lumbar fusion.
- The interlaminar decompression device will only be used at one or two lumbar levels between L1-L5.
- Meyerding Grade 1 spondylolisthesis with or without anticipated iatrogenic instability (created by disruption of the posterior elements due to facet joint excision exceeding 50% bilaterally or 75% or more of a single facet during spinal decompression)

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CMM-608.3: Lumbar Corpectomy

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Lumbar corpectomy is considered **medically necessary** and can be performed as an alternative for lumbar 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 performed for ANY of the following:
 - infection
 - trauma
 - tumor
 - compression at or behind the level of the vertebral body
- Lumbar corpectomy must be performed with a lumbar fusion due to the iatrogenic instability of the corpectomy procedure.
- Lumbar decompression criteria have been met in the applicable procedure-specific section:
 - **CMM-608.2: Initial Primary Lumbar Decompression**
 - **CMM-608.4: Repeat Lumbar Decompression at the Same Level**

CMM-608.4: Repeat Lumbar Decompression at the Same Level

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CMM-608.4: Repeat Lumbar Decompression at the Same Level

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Repeat lumbar decompression 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:

Neurogenic Claudication

- Greater than 12 weeks since the prior lumbar decompression
- 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
- Less than clinically meaningful improvement with at least TWO of the following (unless contraindicated):
 - prescription strength analgesics, steroids, gabapentinoids, and/or nonsteroidal anti-inflammatory drugs (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 decompression
- 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)
- Physical exam findings include ANY of the following:
 - positive straight leg raise
 - positive crossed straight leg raise
 - positive femoral stretch test
 - dermatomal sensory deficit
 - functionally limiting motor weakness (e.g., foot drop, quadriceps weakness)
 - reflex changes
 - unremitting radicular pain into the lower extremity(ies) 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 nonsteroidal anti-inflammatory drugs (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)

Interlaminar Decompression Device in Open Lumbar Decompression

Use of an FDA-approved interlaminar decompression device (i.e., Coflex®) is considered **medically necessary** when used for an open lumbar decompression when ALL of the following criteria have been met:

- Meets repeat lumbar decompression criteria for EITHER **Neurogenic Claudication** or **Radiculopathy**
- The interlaminar decompression device will not be used for an open lumbar decompression performed with a lumbar fusion.
- The interlaminar decompression device will only be used at one or two lumbar levels between L1-L5.
- Meyerding Grade 1 spondylolisthesis with or without anticipated iatrogenic instability (created by disruption of the posterior elements due to facet joint excision exceeding 50% bilaterally or 75% or more of a single facet during spinal decompression)

CMM-608.5: Non-Indications

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CMM-608.5: Non-Indications

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Not Medically Necessary

- Lumbar decompression, lumbar discectomy, and lumbar 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, lumbar discectomy, and lumbar corpectomy is considered **not medically necessary** when performed for ANY of the following sole indications:
 - annular tears
 - degenerative disc disease
 - concordant discography
 - MR Spectroscopy results
- Coflex® is considered **not medically necessary** when used in ANY of the following scenarios:
 - used without meeting the decompression criteria in the applicable procedure-specific section(s) (**initial decompression or repeat decompression**)
 - used in the presence of Meyerding Grade 2 or higher degenerative spondylolisthesis
 - used in the presence of spondylolysis or isthmic spondylolisthesis
 - used when a lumbar fusion is also being performed at the same level
 - used when a lumbar decompression is not performed as an open procedure

Experimental, Investigational, or Unproven (EIU)

- Percutaneous lumbar decompression (i.e., performed with indirect visualization of the spine) (e.g., Vertos Medical MILD®) is considered **experimental, investigational, or unproven**.
- Interspinous/interlaminar process spacer devices (ISS), interspinous/interlaminar stabilization/distraction devices, and interspinous process decompression (IPD) systems/devices (e.g., Superior® 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

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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/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)
62330	Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (i.e., CT or fluoroscopy), bilateral; one interspace, lumbar
+62331	Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (i.e., CT or fluoroscopy), bilateral; additional interspace(s), lumbar (List separately in addition to code for primary procedure)

Lumbar Decompression

Code	Code Description/Definitions
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)

Lumbar Decompression

Code	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)

Code	Code Description/Definitions
63267	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar
63272	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar
63277	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, lumbar

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Evidence Discussion (CMM-608)

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Lumbar Decompression

Risks of lumbar decompression 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 Decompression: Laminectomy, Laminotomy, & Foraminotomy,⁶⁶ symptoms, physical exam findings, and imaging findings should support lumbar decompression surgery. Subjective symptoms and examination findings need to be concordant with imaging as is not uncommon for asymptomatic individuals to have abnormalities on MRI.⁴²

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.^{15,40} Therefore, a six (6) week course of non-operative treatment is recommended prior to surgical intervention.⁶⁶ 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 individuals with psychological disorders undergoing spinal surgery.⁴¹ 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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