

Department:	Medical Management	Original Approval:	11/13/2024
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Policy Title:	Lumbar Surgeries Clinical Coverage Criteria		
Approved By:	UM Criteria Subcommittee		
Applicable Line(s) of Business:	<input type="checkbox"/> Washington Apple Health (Medicaid) <input type="checkbox"/> Behavioral Health Services Only <input type="checkbox"/> Apple Health Expansion <input checked="" type="checkbox"/> Medicare Advantage/Special Needs Plan <input checked="" type="checkbox"/> Medicare Advantage Only <input type="checkbox"/> Cascade Select		

Required Clinical Documentation for Review

Requests for prior authorizations for the procedures covered under this policy must be submitted by the operating surgeon and accompanied by clinical documentation that supports the medical necessity for the procedures.

Documentation of medical necessity must include all of the following:

1. The primary diagnosis name(s) and the ICD-CM code(s) for the condition requiring the procedure;
2. The secondary diagnosis name(s) and ICD-CM code(s) pertinent to any co-morbid conditions, if present;
3. A description of the specific procedure and appropriate CPT code(s) for the procedure being requested;
4. The most recent medical evaluation, including a summary of the medical history and the most recent physical exam, with emphasis on the spine examination and testing specific to the patient's condition;
5. Results of any radiology studies (e.g. routine x-rays, MRI, CT, etc.) and other tests that may have been previously performed and are relevant to the condition for which the procedure is being requested;
6. An official report of all the imaging studies. If the operating surgeon disagrees with the official report, they must document the disagreement. The imaging must have been performed within the last year, or after the onset of the current symptoms or any relevant surgical procedures, whichever comes first.
7. A summary of appropriate, non-operative, conservative treatments that have been tried and have been unsuccessful in managing the patient's condition;

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8. Any risk factors and/or co-morbid conditions;
9. Pertinent labs if abnormal

Background

CHPW creates internal coverage criteria for Medicare when the coverage criteria are not fully established in CMS coverage guidelines; National Coverage Determinations (NCDs), or Local Coverage Determinations (LCDs). Criteria may be considered as not fully established when (1) there are no applicable Medicare statutes or regulations, NCD, or applicable LCD setting forth coverage criteria; (2) the NCD or applicable LCD explicitly allow for coverage in circumstances beyond the indications listed in the NCD or LCD; or (3) additional, unspecified criteria are needed to interpret or supplement general Medicare provisions in order to determine medical necessity consistently. The current CMS coverage guidelines can be found on [CMS Medicare Coverage Database](#) and in the [CMS Online Manual System \(IOMs\)](#). You can also find new or recently changed policies or procedures in [Transmittals](#). CHPW's internal clinical coverage criteria developed to assist in medical necessity determinations are based on the evidence-based guidelines and clinical studies in the peer-reviewed published medical literature as well as recommended practice guidelines. CHPW establishes internal guidelines to ensure timely decision-making for members and to assure that only services which are proven to be both safe and effective are provided. These services must demonstrate a clear benefit that outweighs any potential risks.

Per CMS, medical necessity is defined as services that are reasonable and necessary for diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member and are not excluded under another provision of the Medicare Program. For information on services that are excluded, please review <https://med.noridianmedicare.com/web/jfb/topics/non-covered-services>.

Per Medicare guidelines, the services should be medically appropriate and necessary to be covered. Investigational and Experimental services will not be covered, as Medicare does not consider them to be medically necessary. Services should be FDA approved when appropriate.

CHPW follows CMS requirements to create Clinical Coverage Policies. All the policies are reviewed and voted on by the CHPW Utilization Management Criteria Committee. Policies are reviewed at least annually to reflect the changes in CMS guidance as well as the emergence of new technologies.

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Definitions

Lumbar central canal stenosis is narrowing of the spinal canal due to degeneration and progressive hypertrophy of the surrounding osseocartilaginous and ligamentous structures. The most common symptom associated with lumbar central stenosis is neurogenic claudication, a clinical condition in which patients experience lower leg pain, cramps, and weakness after walking for a certain distance.

Lumbar neural foraminal stenosis occurs when the nerve root at the neural foramen is compromised because of a combination of degenerative changes in the lumbar spine, including decreased height of the intervertebral disc, osteoarthritis of the facet joint, associated cephalad subluxation of the superior articular process, buckling of the ligamentum flava, or protrusion of the annulus fibrosus.

Herniated disc is a condition, also known as a slipped or ruptured disc, in which the gelatinous core material of a disc bulges out of position and puts painful pressure on surrounding nerve roots.

Laminectomy involves removing the part or all of the vertebral bone (lamina), bone spurs, and ligaments that are compressing the nerves. This helps ease pressure on the spinal cord or the nerve roots that may be caused by injury, herniated disk, narrowing of the canal (spinal stenosis), or tumors. This procedure may also be called decompression. Laminectomy can be performed as open surgery, in which your doctor uses a single, larger incision to access the spine. The procedure can also be done using a minimally invasive method, where several smaller incisions are made. In most cases, a laminectomy is considered only after other nonsurgical treatments have not helped with the improvement of symptoms.

Discectomy involves removal of part or all of an intervertebral disc, performed to relieve pressure on a nerve root or the spinal cord. Spinal discs are essentially elastic rings with soft material inside that serve as cushions between the vertebral bones. If the elastic ring becomes weakened, the soft tissue inside can extrude — or herniate — outside of the elastic ring. The herniated disc material can compress the nerves passing by, thus causing the symptoms of nerve compression.

Foramen is a naturally occurring opening or passage in the vertebrae of the spine through which the spinal nerve roots travel. **Foraminotomy** is a surgical opening or enlargement of the foramen traversed by a nerve root as it leaves the spinal canal, to help increase space for that nerve.

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Lamina is the flattened or arched part of the vertebral arch, forming the roof of the spinal canal. **Laminotomy** involves creating an opening in a lamina, to relieve pressure on the nerve roots. As opposed to laminectomy (where the entire lamina is removed), a laminotomy typically involves removal of just half the lamina (the side where a patient is having symptoms).

CPT codes and descriptions

Codes listed here are for informational purposes only.

When reporting a laminotomy, you should append modifier 50 if the neurosurgeon performs the procedure bilaterally.

Each additional lumbar interspace (List separately in addition to code for primary procedure)

CPT codes	Description	Comments
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 (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic	
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 (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar	
63005	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis	
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 (eg, spinal stenosis), more than 2 vertebral segments; lumbar	

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63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	
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)	
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar	
63044	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)	
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, 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], [eg, 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)	
63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	
63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during	

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	posterior interbody arthrodesis, lumbar; each additional vertebral segment (List separately in addition to code for primary procedure)	
63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)	
63057	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)	
63200	Laminectomy, with release of tethered spinal cord, lumbar	
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	
63282	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, lumbar	
63287	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracolumbar	
63290	Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level	
	each additional lumbar interspace (List separately in addition to code for primary procedure)	

Indications/Criteria

Lumbar Spine Procedures

For clinical coverage criteria for Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis:

Please refer to NCD 150.13 [NCD - Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis \(150.13\)](#)

For clinical coverage criteria for Lumbar Spinal Fusion, CHPW has adopted Medicare guidelines from [Palmetto GBA](#)

Please refer to LCD 37848 [LCD - Lumbar Spinal Fusion \(L37848\)](#)

Following guidelines include clinical indications for Lumbar Laminectomy, Lumbar Discectomy, Foraminotomy, or Laminotomy.

Lumbar Laminectomy

Procedure is indicated for **1 or more** of the following:

1. Spinal cord compression (myelopathy), as indicated by **ALL** of the following:
 - a. Progressive or severe neurologic deficits consistent with spinal cord compression (eg, bladder or bowel incontinence)
 - b. MRI or other neuroimaging findings of lumbar cord compression that correlate with clinical findings
2. Cauda equina syndrome, as indicated by **ALL** of the following:
 - a. Progressive or severe neurologic deficits consistent with cauda equina or spinal cord compression, including **1 or more** of the following:
 - i. Bowel dysfunction
 - ii. Bladder dysfunction (eg, incontinence or urinary retention)
 - iii. Saddle anesthesia
 - iv. Bilateral lower extremity neurologic abnormalities
 - v. New decrease in rectal tone or sacral reflexes
 - b. MRI or other neuroimaging findings that correlate with clinical signs and symptoms
3. Lumbar spinal stenosis, as indicated by **1 or more** of the following:
 - a. Rapidly progressive or very severe symptoms of neurogenic claudication with imaging findings of lumbar spinal stenosis that correlate with clinical findings
 - b. Leg or buttock neurogenic claudication symptoms and **ALL** of the following:
 - i. Symptoms that are persistent and disabling

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- ii. Imaging findings of lumbar spinal stenosis that correlate with clinical findings
 - iii. Failure of 3 months of nonsurgical treatments
4. Lumbar spondylolisthesis, as indicated by **1 or more** of the following:
- a. Rapidly progressive or severe neurologic deficits (eg, bowel or bladder dysfunction)
 - b. Symptoms requiring treatment, as indicated by **ALL** of the following:
 - i. Patient has persistent disabling symptoms, including 1 or more of the following:
 - i. Low back pain
 - ii. Neurogenic claudication
 - iii. Radicular pain
 - ii. Treatment is indicated by **ALL** of the following:
 - i. Listhesis demonstrated on imaging
 - ii. Symptoms that correlate with findings on MRI or other imaging
 - iii. Failure of 3 months of nonsurgical treatments
5. Lumbar disk disease and **ALL** of the following:
- a. Patient has unremitting radicular pain or progressive weakness secondary to nerve root compression.
 - b. Imaging findings of lumbar disk disease that correlate with clinical findings
 - c. Failure of 6 weeks of 1 or more nonsurgical treatments as indicated in Appendix A
6. Dorsal rhizotomy for spasticity (eg, cerebral palsy)
7. Signs or symptoms of lumbar disease (eg, pain, motor weakness, bowel or bladder incontinence) secondary to tumor or neoplasm
8. Signs or symptoms of lumbar disease (eg, pain, motor weakness, bowel or bladder incontinence) secondary to infectious process (eg, epidural abscess)
9. Signs or symptoms of lumbar disease (eg, pain, motor weakness, bowel or bladder incontinence) secondary to acute trauma

Lumbar Discectomy, Foraminotomy, or Laminotomy

Procedure is indicated for 1 or more of the following:

- 1. Cauda equina or spinal cord compression (myelopathy), as indicated by **ALL** of the following:
 - a. Progressive or severe neurologic deficits consistent with cauda equina or spinal cord compression, including **1 or more** of the following:

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- i. Bowel dysfunction
 - ii. Bladder dysfunction (eg, incontinence or urinary retention)
 - iii. Saddle anesthesia
 - iv. Bilateral lower extremity neurologic abnormalities
 - v. New decrease in rectal tone or sacral reflexes
 - b. MRI or other neuroimaging finding correlates with clinical signs and symptoms.
2. Lumbar radiculopathy and **ALL** of the following:
- a. Patient has unremitting radicular pain or progressive weakness secondary to nerve root compression.
 - b. Failure of 6 weeks of 1 or more nonsurgical treatments
 - c. MRI or other neuroimaging findings correlate with clinical signs and symptoms.
3. Lumbar spondylolisthesis, as indicated by **1 or more** of the following:
- a. Rapidly progressive or very severe neurologic deficits (eg, bowel or bladder dysfunction)
 - b. Symptoms requiring treatment, as indicated by ALL of the following:
 - i. Patient has persistent disabling symptoms, including 1 or more of the following:
 - a. Low back pain
 - b. Neurogenic claudication
 - c. Radicular pain
 - ii. Treatment is indicated by ALL of the following:
 - d. Listhesis demonstrated on imaging
 - e. Symptoms correlate with findings on MRI or other imaging.
 - f. Failure of 3 months of nonsurgical treatments

Special Considerations

N/A

Limitations/Exclusions

Trial of nonsurgical treatments is not required in the following situations :

- 1. Spinal cord compression (this does not include nerve root compression);
- 2. Stenosis causing cauda equina syndrome;

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3. Stenosis causing severe weakness of the muscle(s) innervated by nerves at the requested surgical level(s) (graded 4 minus or less on MRC scale (see appendix) (Note: 4 minus strength describes muscle activation that is beyond antigravity (3/5) and produces motion against only slight resistance and fails against moderate resistance);
4. Progressive neurological deficit on serial examinations by the same examiner;
5. Severe stenosis associated with instability (dynamic excursion with flexion/extension or from supine to standing) when fusion is requested (not just decompression only); or
6. A discharge note from a physical therapist documents the lack of utility of further physical therapy given the member's inability to adapt to a tolerable treatment plan due to exceptional pain.

Line of Business	Link to Member Coverage Documents
Medicare Advantage Plans (Including D-SNP)	https://medicare.chpw.org/ Select the appropriate plan from the “Plans” drop down on the top navigation bar.
Apple Health	
Cascade Select	

List of Appendices

Appendix A: Nonsurgical/Conservative treatments for spine conditions

Appendix B: The Medical Research Council (MRC) Muscle Scale is used for grading muscle strength from 0 to 5:

Appendix C: Lee Grading Criteria for Lumbar Central Canal Stenosis

Appendix D: List of Sources

Citations & References

CFR	42 CFR 422.101(b)(6)	
WAC		
RCW		
LOB & Contract Citation	<input type="checkbox"/> WAHIMC	
	<input type="checkbox"/> BHSO	
	<input type="checkbox"/> Wraparound	
	<input type="checkbox"/> SMAC	
	<input type="checkbox"/> HH	
	<input type="checkbox"/> AHE	

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	<input checked="" type="checkbox"/> MA/DSNP	MMCM Ch 4, Sec. 10.16: Medical Necessity and Sec. 90: National and Local Coverage Determinations
	<input type="checkbox"/> CS	
Other Requirements		
NCQA Elements		
References		

Revision History

Revision Date	Revision Description	Revision Made By
11/08/2024	Policy drafted	Aparna Gadekar, MD
11/13/2024	Approval	UM Criteria Subcommittee

Appendix A: Nonsurgical/Conservative treatments for spine conditions

1. Modifications in activity including
 - a. Rest or activity modification or limitation
 - b. Bracing or orthosis
 - c. Protected weight bearing
 - d. Weight optimization

2. Physical therapy modalities
 - a. Ice/heat
 - b. Exercises to strengthen and improve mobility in formal physical therapy sessions
 - c. Supervised home exercise to strengthen and improve mobility

3. Medications
 - a. Oral/topical NSAIDS or other analgesics
 - b. Muscle relaxants
 - b. Epidural steroid Injections or oral corticosteroids

*Physical therapy needs to be confirmed either by the actual PT notes, or by documentation in the member records.

*Conservative treatments must be within 1 year of requested procedure.

*Intra-articular steroid injections should be avoided 1 month prior to planned interventions on the same joint.

Appendix B: The Medical Research Council (MRC) Muscle Scale is used for grading muscle strength from 0 to 5:

0: No visible contraction

1: A trace or flicker of contraction

2: Movement is possible with gravity eliminated

3: Movement is possible against gravity

4: Movement against gravity and resistance, but not quite normal

5: Normal strength

Appendix C: Lee Grading Criteria for Lumbar Central Canal Stenosis.

Grade	Severity	Description
Grade 0	Normal	No lumbar central canal stenosis. The anterior CSF space is not obliterated.
Grade 1	Mild	The anterior CSF space is mildly obliterated, but all the cauda equina can be clearly separated from each other.
Grade 2	Moderate	The anterior CSF space is moderately obliterated and some of the cauda equina is aggregated, making it impossible to visually separate them.
Grade 3	Severe	The anterior CSF space is obliterated severely as to show marked compression of the dural sac, and none of the cauda equina can be visually separated from each other, appearing as single bundle.

CSF = cerebrospinal fluid

Appendix D: List of Sources

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