

## Lumbar Laminectomy, Surgical 121

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**All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.\*.**

### Purpose:

This policy addresses Lumbar Laminectomy of the spine.

### Description & Definitions:

**Lumbar Laminectomy** is a surgery that creates space between the vertebrae by removing bone spurs and other tissues associated with arthritis of the spine. Generally, lumbar laminectomies involve removing a small piece of the lamina of the small bones of the vertebrae. Laminectomies enlarge the spinal canal, leading to pressure relief on the spinal cord or nerves. Laminectomies are often considered a part of decompression surgery.

### Criteria:

Lumbar Laminectomy is considered medically necessary for **1 or more** of the following:

- Spinal cord compression (myelopathy), as indicated by **ALL of the** following are present and will be approved as ambulatory (outpatient) unless additional criteria are met as noted by MCG's Ambulatory Surgery or Procedure criteria located at the bottom of this section:
  - Progressive or severe neurologic deficits consistent with spinal cord compression (eg, bladder or bowel incontinence)
  - Imaging findings of lumbar cord compression that correlate with clinical findings
- Cauda equina syndrome, as indicated by **1 or more** of the following are present and will be approved as ambulatory (outpatient) unless additional criteria are met as noted by MCG's Ambulatory Surgery or Procedure criteria located at the bottom of this section:
  - Bowel dysfunction
  - Bladder dysfunction
  - Saddle anesthesia
  - Bilateral lower extremity neurologic abnormalities

- Lumbar spinal stenosis, as indicated by **1 or more** of the following are present and will be approved as ambulatory (outpatient) unless additional criteria are met as noted by MCG's Ambulatory Surgery or Procedure criteria located at the bottom of this section:
  - Rapidly progressive or very severe symptoms of neurogenic claudication with imaging findings of lumbar spinal stenosis that correlate with clinical findings
  - Leg or buttock neurogenic claudication symptoms and **ALL of the** following:
    - Symptoms that are persistent and disabling
    - Imaging findings of lumbar spinal stenosis that correlate with clinical findings
    - Failure of 3 months of nonoperative therapy
- Lumbar spondylolisthesis, as indicated by **1 or more** of the following are present and will be approved as ambulatory (outpatient) unless additional criteria are met as noted by MCG's Ambulatory Surgery or Procedure criteria located at the bottom of this section:
  - Rapidly progressive or severe neurologic deficits (eg, bowel or bladder dysfunction)
  - Symptoms requiring treatment, as indicated by **ALL of the** following:
    - Individual has persistent disabling symptoms, including **1 or more** of the following:
      - Low back pain
      - Neurogenic claudication
      - Radicular pain
    - Treatment is indicated by **ALL of the** following:
      - Listhesis demonstrated on imaging
      - Symptoms that correlate with findings on MRI or other imaging
      - Failure of 3 months of nonoperative therapy
- Lumbar disk disease and **ALL of the** following are present and will be approved as ambulatory (outpatient) unless additional criteria are met as noted by MCG's Ambulatory Surgery or Procedure criteria located at the bottom of this section:
  - Individual has unremitting radicular pain or progressive weakness secondary to nerve root compression.
  - Imaging findings of lumbar disk disease that correlate with clinical findings
  - Failure of 6 weeks of nonoperative therapy that includes **1 or more** of the following:
    - Medication (eg, NSAIDs, analgesics)
    - Physical therapy
    - Epidural corticosteroid
- Dorsal rhizotomy for spasticity (eg, cerebral palsy)
- Signs or symptoms of lumbar disease (eg, pain, motor weakness, bowel or bladder incontinence) secondary to tumor or neoplasm
- Signs or symptoms of lumbar disease (eg, pain, motor weakness, bowel or bladder incontinence) secondary to infectious process (eg, epidural abscess)
- Signs or symptoms of lumbar disease (eg, pain, motor weakness, bowel or bladder incontinence) secondary to acute trauma
- Synovial facet cyst associated with **1 or more** radiculopathy or neurogenic claudication symptoms are present and will be approved as ambulatory (outpatient) unless additional criteria are met as noted by MCG's Ambulatory Surgery or Procedure criteria located at the bottom of this section:
  - Individual with symptoms of neurogenic claudication/radiculopathy that correlate with imaging
  - Individual has failed a minimum 6 weeks of conservative treatment
  - The initial 6 weeks of conservative treatment can be mitigated by **1 or more** of the following:
    - Severity of symptoms leads to forced bed rest or places the individual at significant risk for a fall
    - Stenosis results in functionally limiting motor weakness
    - Progressive neurologic deficit
    - Individual symptoms are so severe they prevent work
    - Individual not responding to initial treatment
- Spinal fracture to perform **1 or more** of the following are present and will be approved as ambulatory (outpatient) unless additional criteria are met as noted by MCG's Ambulatory Surgery or Procedure criteria located at the bottom of this section:

- Removal of fractured posterior elements causing spinal stenosis
  - Access the spinal canal to address retropulsion of the vertebral body
  - Surgery to repair a traumatic cerebrospinal fluid leak
- Evacuation of an Epidural/subdural hematoma to decompress the spinal canal

As noted in MCG's Ambulatory Surgery or Procedure GRG PG-AS (ISC GRG):

This surgery or procedure will be traditionally approved ambulatory (outpatient), but may receive initial approval for Inpatient Care when **one or more of the following** are met:

- Inpatient care needed for clinically significant disease or condition identified preoperatively, as indicated by **one or more of the following**:
  - Severe infection
  - Altered mental status
  - Dangerous arrhythmia
  - Hypotension
  - Hypoxemia
- Complex surgical approach or situation anticipated, as indicated by **1 or more** of the following:
  - Prolonged airway monitoring required (eg, severe obstructive sleep apnea, open neck procedure)
  - Other aspect or feature of procedure that indicates a likely need for prolonged postoperative care or monitoring
- High patient risk identified preoperatively, as indicated by **1 or more** of the following:
  - American Society of Anesthesiologists class IV or greater American Society of Anesthesiologists (ASA) Physical Status Classification System
  - Severe frailty
  - Severe valvular disease (eg, severe aortic stenosis)
  - Symptomatic coronary artery disease, or heart failure
  - Symptomatic chronic lung disease (eg, COPD, chronic lung disease of prematurity)
  - Severe renal disease (eg, glomerular filtration rate (GFR) less than 30 mL/min/1.73m<sup>2</sup> (0.5 mL/sec/1.73m<sup>2</sup>) or on dialysis) eGFR - Adult Calculator
  - Morbid obesity (eg, body mass index greater than 40 BMI Calculator) with hemodynamic or respiratory problems (eg, severe obstructive sleep apnea, hypoventilation)
  - Complex chronic condition in children (eg, ventilator-dependent, neuromuscular, genetic, or immunologic disease)
  - Other patient condition or finding that places patient at increased anesthetic risk such that prolonged postoperative inpatient monitoring or treatment is anticipated
- Presence of drug-related risk identified preoperatively, as indicated by **1 or more** of the following:
  - Procedure requires discontinuing medication (eg, antiarrhythmic medication, antiseizure or anticoagulant medication), which necessitates preoperative or prolonged postoperative inpatient monitoring or treatment.
  - Preoperative use of drugs that may interact with anesthetic (eg, cocaine, amphetamines, monoamine oxidase inhibitor) such that prolonged postoperative monitoring or treatment is needed

Lumbar laminectomy is NOT COVERED for ANY of the following:

- Annulus repair devices (Xclose Tissue Repair System, Barricaid, Disc Annular Repair Technology (DART) System)
- Coblation nucleoplasty
- Coblation percutaneous disc decompression
- Endoscopic epidural adhesiolysis

- Endoscopic laser foraminoplasty, endoscopic foraminotomy, laminotomy, and rhizotomy (endoscopic radiofrequency ablation)
- Endoscopic transforaminal discectomy
- Epidural fat grafting during lumbar decompression laminectomy/discectomy
- Minimally Invasive Lumbar Decompression (MILD)
- Percutaneous Laminotomy/Laminectomy

There is insufficient scientific evidence to support the medical necessity of lumbar laminectomy for uses other than those listed in the clinical indications for procedure section.

## Coding:

### Medically necessary with criteria:

Coding	Description
22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)
22846	Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)
22847	Anterior instrumentation; 8 or more vertebral segments (List separately in addition to code for primary procedure)
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
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
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)
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)
63087	Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina 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 equina 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 equina 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 equina 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) (eg, 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) (eg, for tumor or retropulsed bone fragments); thoracic or lumbar, each additional segment (List separately in addition to code for primary procedure)
63170	Laminectomy with myelotomy (eg, Bischof or DREZ type), cervical, thoracic, or thoracolumbar
63185	Laminectomy with rhizotomy; 1 or 2 segments
63190	Laminectomy with rhizotomy; more than 2 segments
63200	Laminectomy, with release of tethered spinal cord, lumbar
63252	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracolumbar
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

### Considered Not Medically Necessary:

Coding	Description
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

U.S. Food and Drug Administration (FDA) - approved only products only.

### Document History:

#### Revised Dates:

- 2024: June – added codes 22845-22847
- 2023: October

#### Reviewed Dates:

- 2024: October – no changes references updated

#### Effective Date:

- July 2023

### References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

28th Edition. (2024). Retrieved 9 2024, from MCG: <https://careweb.careguidelines.com/ed28/index.html>

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Clinical Guidelines. (2021). Retrieved 9 2024, from North American Spine Society (NASS): <https://www.spine.org/Research/Clinical-Guidelines>

Lumbar spinal stenosis: Treatment and prognosis. (2024, 2). Retrieved 9 2024, from UpToDate: [https://www.uptodate.com/contents/lumbar-spinal-stenosis-treatment-and-prognosis?search=Lumbar+decompression+&source=search\\_result&selectedTitle=1%7E150&usage\\_type=default&display\\_rank=1](https://www.uptodate.com/contents/lumbar-spinal-stenosis-treatment-and-prognosis?search=Lumbar+decompression+&source=search_result&selectedTitle=1%7E150&usage_type=default&display_rank=1)

NCD: Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis (150.13). (2017). Retrieved 9 2024, from CMS: <https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=358&ncdver=2&keyword=laminectomy&keywordType=all&areald=all&docType=NCA.CAL.NCD.MEDCAC.TA.MCD.6.3.5.1.F.P&contractOption=all&sortBy=relevance&bc=1>

Percutaneous laminotomy. (2024). Retrieved 9 2024, from Hayes:

<https://evidence.hayesinc.com/search?q=%257B%2522text%2522:%2522Percutaneous%2520laminotomy%2522,%2522title%2522:null,%2522termsource%2522:%2522searchbar%2522,%2522page%2522:%257B%2522page%2522:0,%2522size%2522:50%257D,%2522type%2522:%2522all%2522,%2522so>

Spine Surgery. (2024, 1). Retrieved 9 2024, from Carelon:

<https://guidelines.carelonmedicalbenefitsmanagement.com/spine-surgery-2024-01-01/>

### Special Notes: \*

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

### Keywords:

Lumbar Laminectomy, SHP Surgical 121, Spinal cord compression, myelopathy, neurologic deficits, Cauda equina syndrome, Lumbar spinal stenosis, Lumbar spondylolisthesis, Dorsal rhizotomy, Annulus repair devices, Xclose Tissue Repair System, Barricaid, Disc Annular Repair Technology System, DART System, Coblation nucleoplasty, Coblation percutaneous disc decompression, Endoscopic epidural adhesiolysis, Endoscopic laser foraminoplasty, endoscopic foraminotomy, laminotomy, rhizotomy, endoscopic radiofrequency ablation, Endoscopic transforaminal discectomy, Epidural fat grafting during lumbar decompression laminectomy/discectomy, Minimally Invasive Lumbar Decompression, MILD, Percutaneous Laminotomy/Laminectomy