Sentara Health Plans

Medicaid

Cervical Laminectomy, Surgical 122

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Coverage Policy	Surgical 122
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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 by 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 Cervical Laminectomy of the spine.

Description & Definitions:

Cervical Laminectomy is a surgery that creates space by removing of the lamina, the back portion of a spinal bone in the neck. The laminectomy procedure removes pressure on the spinal cord caused by stenosis, spondylosis, intervertebral disc prolapse, degenerative changes, arthritis, or trauma.

Criteria:

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

- Treatment of myelopathy secondary to cervical spondylopathy, 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:
  - Spondylopathy at 3 or more levels
  - Signs or symptoms of myelopathy, as indicated by **1 or more** of the following:
    - Upper limb weakness in more than single nerve root distribution
    - Lower limb weakness in upper motor neuron distribution
    - Loss of dexterity (eg, clumsiness of hands)
    - Bowel or bladder incontinence
    - Frequent falls
    - Hyperreflexia
    - Hoffmann sign
    - Increased extremity muscle tone or spasticity
    - Gait abnormality

        - Positive Babinski sign
        - Alternative clinical signs or symptoms of myelopathy
    - MRI or other neuroimaging finding demonstrates cord compression from spondylosis that corresponds with clinical presentation
- Ossification of posterior longitudinal ligament with associated myelopathy
- Congenital cervical stenosis or Chiari malformation with impending or actual cord compression
- Basilar impression
- Cord compression due to rheumatoid arthritis (in conjunction with posterior fusion procedure for stabilization)
- Biopsy or excision of spinal lesions (eg, neoplasm, arteriovenous malformation)
- Infection of cervical spine requiring decompression or debridement
- Cervical intradural disk herniation
- Need for procedure as part of treating cervical spine injury (eg, trauma), 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:
    - Acutely symptomatic cervical radiculopathy or myelopathy
    - MRI or other neuroimaging finding (eg, cord compression, root compression) demonstrates pathologic anatomy corresponding to symptoms.
- Spinal stenosis in the cervical spine, including recurrent spinal stenosis, congenital stenosis, or stenosis caused by cervical spondylosis or ossification of the posterior longitudinal ligament (OPLL) meeting **1 or more** of the following criteria 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:
    - Signs and symptoms of cervical myelopathy associated with diagnostic imaging.
    - Decompression of the neural elements as an addition to stabilize when mechanical spinal column instability is indicated.
    - Myelomalacia causing spinal cord in an area of spinal cord compression or instability
- Tumor or metastatic neoplasm in **1 or more** of the following cases 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:
    - Open biopsy for tissue diagnosis performed.
    - Removal of tumor to decompress the spinal canal or neural elements.
    - Intradural lesion (intradural tumor, arachnoid cyst, vascular malformation or hematoma) requiring laminectomy or laminoplasty to access the thecal sac
- 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:k

- 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^2 (0.5 mL/sec/1.73m^2) 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

Cervical laminectomy is NOT COVERED for ANY of the following:

- Minimally invasive/endoscopic cervical laminoforaminotomy for cervical radiculopathy/lateral and foraminal cervical disc herniations or other indications

There is insufficient scientific evidence to support the medical necessity of cervical 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)
63001	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; cervical
63015	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; cervical
63045	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; cervical
63050	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments
63051	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non

63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
63082	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure)
63185	Laminectomy with rhizotomy; 1 or 2 segments
63190	Laminectomy with rhizotomy; more than 2 segments
63191	Laminectomy with section of spinal accessory nerve
63250	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; cervical
63265	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical
63270	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical
63275	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical
63280	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, cervical
63285	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, cervical
63300	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, cervical
63304	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, cervical

Considered Not Medically Necessary:

Coding	Description
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

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

Document History:

Revised Dates:

- 2024: June - added coded – 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).

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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 by 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:

Cervical Laminectomy, SHP Surgical 122, myelopathy, cervical spondylopathy, Spondylopathy, Ossification, posterior longitudinal ligament, associated myelopathy, Congenital cervical stenosis, Chiari malformation, cord compression, Basilar impression, Infection of cervical spine requiring decompression or debridement, Cervical intradural disk herniation, cervical spine injury, cervical radiculopathy, cervical myelopathy