

MEDICAL POLICY

MEDICAL POLICY DETAILS	
Medical Policy Title	LUMBAR DECOMPRESSION
Policy Number	7.01.97
Category	Technology Assessment
Effective Date	06/21/18
Revised Date	12/20/18, 07/18/19, 1/16/20
Product Disclaimer	<ul style="list-style-type: none"> • If a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply. • If a commercial product (including an Essential Plan product) or a Medicaid product covers a specific service, medical policy criteria apply to the benefit. • If a Medicare product covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.

POLICY STATEMENT

- I. Based on our criteria and assessment of the peer-reviewed literature, an initial primary lumbar decompression has been medically proven to be effective and is considered **medically appropriate** for spinal stenosis/spondylolisthesis when **ALL** the following are met:
 - A. Subjective symptoms, including at least **TWO** of the following:
 1. Significant level of pain on a daily basis, defined as either of the following:
 - a. Visual Analog Scale (VAS)/Numeric Rating Scale (NRS) greater than or equal to 7; or
 - b. Severe, disabling, crippling, or incapacitating pain; and/or
 2. 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; and/or
 3. 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).
 - B. Performed for **EITHER** of the following:
 1. Neurogenic claudication secondary to central/lateral recess/foraminal stenosis when **BOTH** of the following criteria are met:
 - a. Subjective symptoms including **EITHER** of the following:
 - i. Symptoms worsen with standing and/or walking; or
 - ii. Symptoms are alleviated with sitting and/or forward flexion; and
 - b. Objective physical findings consistent with MRI/CT; OR
 2. Spondylolisthesis with neurogenic claudication symptoms or radicular pain from lateral recess or foraminal stenosis associated with listhesis demonstrated on plain x-rays and/or MRI/CT.
 - C. Less than clinically meaningful improvement with at least **TWO** of the following, unless contraindicated:
 1. Prescription strength analgesics, steroids, and/or NSAIDS for 6 weeks; and/or
 2. Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for 6 weeks; and/or
 3. Epidural steroid injection(s)/selective nerve root block(s).
 - D. MRI/CT identifies nerve root impingement and/or thecal sac impingement caused by stenosis/listhesis that correlates with patient symptoms or physical findings.
 - E. No previous surgeries at the level(s) involved.
 - F. All other sources of pain have been excluded.
 - G. Absence of unmanaged significant behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, drug and alcohol use disorders).

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- II. Based on our criteria and assessment of the peer-reviewed literature, a *repeat* lumbar decompression has been medically proven to be effective and is considered **medically appropriate** when **ALL** of the criteria noted in Policy Statement I above (with the exception of E, no previous surgeries at level(s) involved), plus **ALL** of the following, are met:
 - A. Post-operative MRI /CT confirms radiographic evidence of neural structure compression (e.g., nerve root(s) compression);
 - B. More than 12 months have elapsed since last decompression surgery; and
 - C. Patient experienced initial relief of symptoms following previous decompression procedure at same level(s), unless post-operative imaging demonstrates persistent significant neurologic compression at the surgical level.
- III. Based upon our criteria and assessment of peer-reviewed literature, the following procedures have not been medically proven effective and are, therefore, considered **investigational** or unproven:
 - A. Percutaneous lumbar discectomy;
 - B. Percutaneous laser discectomy;
 - C. Laser-assisted/percutaneous laser disc decompression; and
 - D. Percutaneous nucleotomy.

Refer to Corporate Medical Policy #7.01.16 Automated Percutaneous and Endoscopic Discectomy.

Refer to Corporate Medical Policy #7.01.62 Intervertebral Disc Decompression: Laser and Radiofrequency Coblation Techniques.

Refer to Corporate Medical Policy #7.01.75 Interspinous and Interlaminar Stabilization/Distractor Implants (Spacers).

Refer to Corporate Medical Policy #7.01.83 Minimally Invasive/Minimal Access Techniques for Lumbar Interbody Fusion.

Refer to Corporate Medical Policy #7.01.90 Lumbar Fusion for Adults.

Refer to Corporate Medical Policy #11.01.03 Experimental or Investigational Services.

POLICY GUIDELINES

- I. Acceptable imaging modalities are CT scan, MRI, and myelogram. Imaging must be performed and read by an independent radiologist. If discrepancies should arise in the interpretation of the imaging, interpretations by the radiologist will supersede. Discography results will not be used as a determining factor of medical necessity for any requested procedures. Use is not endorsed.
- II. Clinically meaningful improvement is defined as global assessment showing at least 50% improvement.
- III. The Federal Employee Health Benefit Program (FEHBP/FEP) requires that procedures, devices or laboratory tests approved by the U.S. Food and Drug Administration (FDA) may not be considered investigational and thus these procedures, devices or laboratory tests may be assessed only on the basis of their medical necessity.

DESCRIPTION

Narrowing/stenosis or spondylolisthesis that creates a narrowing of the spinal canal can cause chronic pain, numbness, and muscle weakness in an individual's arms or legs. Spinal decompression can be performed anywhere along the spine from the neck (cervical) to the lower back (lumbar). The procedure is performed through a surgical incision in the back (posterior). The lamina is the bone that forms the backside of the spinal canal and makes a roof over the spinal cord. Removing the lamina and other soft tissues gives more room for the nerves, relieves pressure and allows for removal of bone spurs. Depending on the extent of stenosis, one vertebra (single-level) or more (multi-level) may be involved. There are several types of decompression surgery:

- I. Laminectomy is the removal of the entire bony lamina, a portion of the enlarged facet joints, and the thickened ligaments overlying the spinal cord and nerves.

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- II. Laminotomy is the removal of a small portion of the lamina and ligaments, usually on one side. Using this method the natural support of the lamina is left in place, decreasing the chance of postoperative spinal instability. Sometimes an endoscope may be used, allowing for a smaller, less invasive incision.
- III. Foraminotomy is the removal of bone around the neural foramen, the space between vertebrae where the nerve root exits the spinal canal. This method is used when disc degeneration has caused the height of the foramen to collapse, resulting in a pinched nerve. It can be performed with a laminectomy or laminotomy.

RATIONALE

The Spine Patient Outcomes Research Trial (SPORT) was funded by the National Institutes of Health (NIH) to study the outcomes from surgical and nonsurgical management of three conditions: intervertebral disc herniation, degenerative spondylolisthesis, and lumbar spinal stenosis. Both surgical and nonsurgical care of intervertebral disc herniation resulted in significant improvement in symptoms of low back and leg pain. However, the treatment effect of surgery for intervertebral disc herniation was less than that seen in individuals with degenerative spondylolisthesis and lumbar spinal stenosis. The preliminary four-year outcomes data demonstrated more significant degrees of improvement in pain levels and function with surgical versus nonsurgical treatment in the chronic conditions of lumbar spinal stenosis and lumbar spinal stenosis with spondylolisthesis (Asghar, 2012; Weinstein, 2006a; Weinstein, 2006b; Weinstein, 2007; Weinstein, 2009).

According to the American Pain Society (APS), decompressive laminectomy may be an acceptable option for individuals experiencing disabling and persistent leg pain due to spinal stenosis, either with or without degenerative spondylolisthesis. The APS reports that decompressive laminectomy is associated with moderate benefits compared to nonsurgical therapy through one to two years, though the effects of the procedure appear to diminish with long-term follow-up. Although individuals on average do not worsen without surgery, improvements are less than those observed in individuals with radiculopathy due to herniated lumbar disc. Their guidelines indicate there is insufficient evidence to determine if laminectomy with fusion is more effective than laminectomy without fusion. The authors recommended that shared decision-making regarding surgery include a specific discussion about moderate/average benefits, which appear to decrease over time in affected individuals who undergo surgery (Chou, 2009).

CODES

- *Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.*
- ***CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.***
- *Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.*

CPT Codes

Code	Description
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
63011	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; 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 (eg, spinal stenosis), more than 2 vertebral segments; lumbar

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Code	Description
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 segment, cervical, thoracic, or lumbar

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HCPSC Codes

Code	Description
No codes	

ICD10 Codes

Code	Description
C72.0	Malignant neoplasm of spinal cord
C79.40	Secondary malignant neoplasm of unspecified part of nervous system
G06.1	Intraspinal abscess and granuloma
M43.15-M43.17	Spondylolisthesis, thoracolumbar, lumbar or lumbosacral region (code range)
M48.05-M48.07	Spinal stenosis, thoracolumbar, lumbar or lumbosacral region (code range)

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KEY WORDS

Lumbar foraminotomy, Lumbar decompression, Lumbar laminectomy, Spinal stenosis, Spondylolisthesis

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

Based upon review, lumbar decompression is not addressed in a National or Local Medicare coverage determination or policy