Policy: MP268
Section: Medical Benefit Policy
Subject: Elective Laminectomy

I. Policy: Elective Laminectomy

II. Purpose/Objective:
To provide a policy of coverage regarding Elective Laminectomy

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) The service or benefit will assist the Member to achieve or maintain maximum functional
capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

DESCRIPTION:
Laminectomy is a surgical procedure done to remove a portion of the lamina to relieve pressure on the spinal cord or on the nerve roots that emerge from the spinal canal.

INDICATIONS: Requires Prior Medical Director or designee Authorization (Not applicable to Medicare, Medicaid and TPA business segments with the exception of GHP)
Elective cervical, thoracic, or lumbar laminectomy is considered medically necessary for individuals with compression of the spinal cord or nerve roots when all of the following criteria are met:

1. Completed a spine evaluation and surgical intervention is recommended by the healthcare provider providing and overseeing treatment of the spine.
2. Nerve, spinal cord, or dural sac impingement on imaging studies and is consistent with clinical exam findings
3. Clinical presentation of at least 1 of the following:
   a. Motor weakness
   b. Loss of sensation
   c. Loss of lower extremity reflex
   d. Positive straight leg or cross straight leg raise test
4. Symptoms lasting at least 6 weeks and have not responded to conservative therapy such as but not limited to medication, physical therapy, assistive devices, injections.

EXCLUSIONS:
The Plan does NOT provide coverage for Laminectomy as a treatment for any other indication because it is considered experimental, investigational or unproven.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven services is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment

CODING ASSOCIATED WITH: Laminectomy
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services.

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

63030 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; 1 interspace, lumbar

63042 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; 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

63185 Laminectomy with rhizotomy; 1 or 2 segments

63190 Laminectomy with rhizotomy; more than 2 segments

63191 Laminectomy with section of spinal accessory nerve
63035 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)

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)

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; each additional segment, cervical,

63046 thoracic

63047 lumbar

63048; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)


LINE OF BUSINESS:
Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD’s and NCD’s will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:


This policy will be revised as necessary and reviewed no less than annually.

Devised: 11/12
Revised: 5/13, 11/13, 7/14
Reviewed: 7/15, 7/16, 6/17, 6/18, 6/19