ND

Medical Policies

Print

Policy Number:	S-5145		
Policy Name:	Laminectomy		
Policy Type:	Medical	**Policy Subtype:**	Surgery
Effective Date:	09-15-2025	**End Date:**	11-02-2025

Description

Laminectomy

Laminectomy is an inpatient procedure performed under general anesthesia. An incision is made in the back over the affected region, and the back muscles are dissected to expose the spinal cord. The lamina is then removed from the vertebral body, along with any inflamed or thickened ligaments that may be contributing to compression. Following resection, the muscles are reapproximated and the soft tissues sutured back into place. The extent of laminectomy varies, but most commonly extends two levels above and below the site of maximal cord compression.

Surgical Variations

Hemilaminotomy and laminotomy, sometimes called laminoforaminotomy, are less invasive than a laminectomy. These procedures focus on the interlaminar space, where most of the pathologic changes are concentrated, minimizing resection of the stabilizing posterior spine. A laminotomy typically removes the inferior aspect of the cranial lamina, the superior aspect of the subjacent lamina, the ligamentum flavum, and the medial aspect of the facet joint. Unlike laminectomy, laminotomy does not disrupt the facet joints, supra- and interspinous ligaments, a major portion of the lamina, or the muscular attachments. Muscular dissection and retraction are required to achieve adequate surgical visualization.

Summary of Evidence

For individuals who have lumbar spinal stenosis and spinal cord or nerve root compression who receive lumbar laminectomy, the evidence includes randomized controlled trials (RCTs) and a systematic review of RCTs. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. In individuals with spinal stenosis, there is sufficient evidence that laminectomy is more effective than nonoperative "usual care" in individuals with spinal stenosis who do not improve after eight (8) weeks of conservative treatment. The superiority of laminectomy is sustained through eight (8) years of

follow-up. This conclusion applies best to individuals who do not want to undergo intensive, organized conservative treatment, or who do not have access to such a program. For individuals who want to delay surgery and participate in an organized program of physical therapy and exercise, early surgery with the combination of conservative initial treatment and delayed surgery in selected individuals have similar outcomes at two (2) years. From a policy perspective, this means that immediate laminectomy and intensive conservative care are both viable options. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have cervical spinal stenosis and spinal cord or nerve root compression who receive cervical laminectomy, the evidence includes RCTs and nonrandomized comparative studies. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. There is a lack of high-quality, comparative evidence for this indication, although what evidence there is offers outcomes similar to those for lumbar spinal stenosis. Given the parallels between cervical laminectomy and lumbar laminectomy, a chain of evidence can be developed that the benefit reported for lumbar laminectomy supports a benefit for cervical laminectomy. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have space-occupying lesion(s) of the spinal canal or nerve root compression who receive cervical, thoracic, or lumbar laminectomy, the evidence includes case series. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Most case series are small and retrospective. They have reported that most patients with myelopathy experience improvements in symptoms or abatement of symptom progression after laminectomy. However, this uncontrolled evidence does not provide a basis to determine the efficacy of the procedure compared with alternatives. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Policy Application

All claims submitted for this policy will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

Criteria

Cervical laminectomy may be considered **medically necessary** when ALL of the following conditions are met:

- Spinal cord or nerve root compression due to one of the following conditions:
  - Spinal stenosis (with or without spondylolisthesis)
  - Ossification of the posterior longitudinal ligament or the yellow ligament; or hypertrophy of the ligamentumflavum.
- Signs and/or symptoms that meet at least one of the following criteria:
  - Neurologic deficits that are rapidly progressive; **or**
  - Symptoms of cervical myelopathy (see Policy Guidelines section) or cervical cord compression (with or without radiculopathy); **or**
  - Persistent debilitating pain that is refractory to at least six (6) weeks of conservative nonsurgical therapy (See Policy Guidelines section).
- Imaging studies (preferably magnetic resonance imaging) with findings of spinal cord compression, nerve root compression, and/ormyelographic changes, at a level corresponding to the indivdual's signs and

symptoms.

Lumbar laminectomy may be considered **medically necessary** when ALL of the following conditions are met:

- Spinal cord or nerve root compression due to spinal stenosis (with or without spondylolisthesis);
- Signs and/or symptoms that meet at least one of the following criteria:
  - Neurologic deficits that are rapidly progressive; **or**
  - Neurologic claudication that is persistent and refractory to at least six (6) weeks of conservative nonsurgical therapy (see Policy Guidelines section); **or**
  - Persistent debilitating pain that is refractory to at least six (6) weeks of conservative nonsurgical management (see Policy Guidelines section).
- Imaging studies (preferably magnetic resonance imaging) with findings of spinal cord or nerve root compression, at a level corresponding to the individual's signs and symptoms.

Laminectomy (cervical, thoracic, lumbar) may be considered **medically necessary** for space-occupying lesions of the spinal cord **and/or** spinal canal.

- Primary or metastatic tumors
- Abscesses or other localized infections.

Laminectomy (cervical or lumbar) is **not medically necessary** for spinal stenosis when the above criteria are not met.

Laminectomy is considered **investigational** for all other indications.

Policy Guidelines

Cervical Myelopathy And/Or Cord Compression

Signs and symptoms of cervical myelopathy and/or cord compression include the following (Epstein, 2003):

- Difficulty with fine movements of the hand and upper extremity
- Incoordination of the hand and upper extremity
- Atrophy of the thenar and hypothenar eminence
- Diffuse hyperreflexia and bilateral Babinski responses
- Decreased sensation, vibratory sense, and proprioception at a level of C5 or below
- Inability to perform tandem walk
- Bowel and bladder incontinence.

Conservative nonsurgical therapy for the duration specified should include the following:

- Use of prescription strength analgesics for several weeks at a dose sufficient to induce a therapeutic response
  - Analgesics should include anti-inflammatory medications with **or** without adjunctive medications such as nerve membrane stabilizers or muscle relaxants; **and**
- Participation in at least six (6) weeks of physical therapy (including active exercise) or documentation of why the individual could not tolerate physical therapy; **and**
- Evaluation and appropriate management of associated cognitive, behavioral, or addiction issues
- Documentation of individual compliance with the preceding criteria.

Persistent debilitating pain is defined as:

- Significant level of pain on a daily basis as measured as a visual analog scale score of four (4) or greater; and
- Pain on a daily basis that has a documented impact on activities of daily living despite optimal conservative nonsurgical therapy as outlined above and appropriate for the individual.

Laminectomy may occasionally be performed for the sole indication of radiculopathy due to herniated disc. In these cases, discectomy alone is not sufficient to relieve compression on vital structures, and laminectomy is required for adequate decompression. Compression of the spine due to herniated disc is uncommon, and there are no standardized preoperative criteria to determine which individuals may require laminectomy in addition to discectomy.

The following procedures can be considered alternatives to laminectomy for decompression of the spinal cord. The specific indications for these alternative procedures are not standardized, and the evidence is insufficient to determine the effectiveness of these procedures compared with laminectomy:

- Hemilaminectomy
- Laminotomy
- Foraminotomy.

Medical necessity is established by documentation of medical history, physical findings, and diagnostic imaging results that demonstrate spinal nerve compression and support the surgical intervention. Documentation in the medical record must clearly support the medical necessity of the surgery and include medical history, physical examination, and diagnostic testing.

Medical History

- Assessment of comorbid physical and psychological health conditions (e.g. morbid obesity, current smoking, diabetes, renal disease, osteoporosis, severe physical deconditioning)
- History of back surgery, including minimally invasive back procedures
- Prior trial, failure, or contraindication to conservative medical/nonoperative interventions that may include but are not limited to the following:
    - Activity modification for at least six (6) weeks
    - Oral analgesics and/or anti-inflammatory medications
    - Physical therapy
    - Chiropractic manipulation
    - Epidural steroid injections.

Physical Examination

- Clinical findings including the individual's stated symptoms and duration.

Diagnostic Testing

- Radiologist's report of a magnetic resonance image or computerized tomography scan with myelogram of the spine within the past six (6) months showing a spine abnormality
- Report of the selective nerve root injection results, if applicable to the individual's diagnostic workup.

Procedure Codes

63001	63005	63015	63017	63052	63053	63270
63271	63272	63275	63276	63277	63280	63281
63282	63285	63286	63287			

Professional Statements and Societal Positions Guidelines

Practice Guidelines and Position Statements

The North American Spine Society

Issued evidence-based guidelines (2011) on the diagnosis and treatment of degenerative lumbar spinal stenosis. The guidelines stated that individuals with mild symptoms of lumbar spinal stenosis are not considered surgical candidates; however, decompressive surgery was suggested to improve outcomes in individuals with moderate-to-severe symptoms of lumbar spinal stenosis (grade B recommendation). The Society also indicated that current evidence was insufficient to recommend for or against the placement of interspinous process spacing devices to treat spinal stenosis.

Excerpts from the North American Spine Society Coverage Recommendations

Laminectomy

1. Spinal Stenosis (including recurrent spinal stenosis, congenital stenosis, stenosis associated with achondroplasia) meeting the following criteria:

    a. signs and symptoms of neurogenic claudication or radiculopathy correlated with imaging:
    b. at least six (6) weeks of nonoperative treatment
    c. the following can mitigate the need for initial nonoperative trial

        i. severity of symptoms causes forced bed rest
        ii. stenosis results in functionally limiting motor weakness (e.g., foot drop)
        iii. progressive neurological deficit

Diagnosis Codes

C72.0	C79.40	G06.1	M48.00	M48.01	M48.02	M48.03
M48.04	M48.05	M48.06	M48.061	M48.062	M48.07	M48.08
M48.8X1	M48.8X2	M48.8X3	M48.8X4	M48.8X5	M48.8X6	M48.8X7
M48.8X8	M48.8X9					

CURRENT CODING

CPT:

63001	LAM W/O FACETEC FORAMOT/DSC 1/2 VRT SGM CRV	Commercial
63005	LAMINECTOMY W/O FFD 1/2 VERT SEG LUMBAR	Commercial
63015	LAMINECTOMY W/O FFD > 2 VERT SEG CERVICAL	Commercial
63017	LAMINECTOMY W/O FFD > 2 VERT SEG LUMBAR	Commercial
63052	LAM FACETEC/FORAMOT DRG ARTHRD LUMBAR 1 VRT SGM	Commercial
63053	LAM FACETEC/FORAMOT DRG ARTHRD LMBR EA ADDL SGM	Commercial
63270	LAM EXC ISPI LES OTH/THN NEO IDRL CERVICAL	Commercial
63271	LAM EXC ISPI LES OTH/THN NEO IDRL THORACIC	Commercial
63272	LAM EXC ISPI LES OTH/THN NEO IDRL LUMBAR	Commercial
63275	LAMINECTOMY BX/EXC ISPI NEO XDRL CERVICAL	Commercial
63276	LAMINECTOMY BX/EXC ISPI NEO XDRL THORACIC	Commercial
63277	LAMINECTOMY BX/EXC ISPI NEO XDRL LUMBAR	Commercial
63280	LAM BX/EXC ISPI NEO IDRL XMED CERVICAL	Commercial
63281	LAM BX/EXC ISPI NEO IDRL XMED THORACIC	Commercial
63282	LAM BX/EXC ISPI NEO IDRL XMED LUMBAR	Commercial
63285	LAM BX/EXC ISPI NEO IDRL IMED CERVICAL	Commercial
63286	LAM BX/EXC ISPI NEO IDRL IMED THORACIC	Commercial
63287	LAM BX/EXC ISPI NEO IDRL IMED THORACOLMBR	Commercial
63001	LAM W/O FACETEC FORAMOT/DSC 1/2 VRT SGM CRV	Medicaid Expansion

63005	LAMINECTOMY W/O FFD 1/2 VERT SEG LUMBAR	Medicaid Expansion
63015	LAMINECTOMY W/O FFD > 2 VERT SEG CERVICAL	Medicaid Expansion
63017	LAMINECTOMY W/O FFD > 2 VERT SEG LUMBAR	Medicaid Expansion
63052	LAM FACETEC/FORAMOT DRG ARTHRD LUMBAR 1 VRT SGM	Medicaid Expansion
63053	LAM FACETEC/FORAMOT DRG ARTHRD LMBR EA ADDL SGM	Medicaid Expansion
63270	LAM EXC ISPI LES OTH/THN NEO IDRL CERVICAL	Medicaid Expansion
63271	LAM EXC ISPI LES OTH/THN NEO IDRL THORACIC	Medicaid Expansion
63272	LAM EXC ISPI LES OTH/THN NEO IDRL LUMBAR	Medicaid Expansion
63275	LAMINECTOMY BX/EXC ISPI NEO XDRL CERVICAL	Medicaid Expansion
63276	LAMINECTOMY BX/EXC ISPI NEO XDRL THORACIC	Medicaid Expansion
63277	LAMINECTOMY BX/EXC ISPI NEO XDRL LUMBAR	Medicaid Expansion
63280	LAM BX/EXC ISPI NEO IDRL XMED CERVICAL	Medicaid Expansion
63281	LAM BX/EXC ISPI NEO IDRL XMED THORACIC	Medicaid Expansion
63282	LAM BX/EXC ISPI NEO IDRL XMED LUMBAR	Medicaid Expansion
63285	LAM BX/EXC ISPI NEO IDRL IMED CERVICAL	Medicaid Expansion
63286	LAM BX/EXC ISPI NEO IDRL IMED THORACIC	Medicaid Expansion
63287	LAM BX/EXC ISPI NEO IDRL IMED THORACOLMBR	Medicaid Expansion

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ND Committee Review

Internal Medical Policy Committee 3-16-2020 New policy *Effective May 04, 2020*

Internal Medical Policy Committee 3-17-2021 Annual Review *Effective May 03, 2021*

Internal Medical Policy Committee 3-23-2022 Coding update - **Effective May 02, 2022**

- *Added* Procedure Codes 63052 and 63053

Internal Medical Policy Committee 3-23-2023 - Revision - *Effective May 01, 2023*

- *Added* Summary of Evidence
- *Added* Procedure Codes 63271, 63276, 63281, and 63286
- *Updated* references

Internal Medical Policy Committee 5-14-2024 Annual Review

- *Added* Policy Application

Disclaimer

Current medical policy is to be used in determining a Member's contract benefits on the date that services are rendered. Contract language, including definitions and specific inclusions/exclusions, as well as state and federal law, must be considered in determining eligibility for coverage. Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information. Likewise, medical policy, which addresses the issue(s) in any specific case, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and the Company reserves the right to review and update medical policy periodically.