Medicare Medical Policy

Spinal Fusion and Decompression Procedures

MEDICARE MEDICAL POLICY NUMBER: 358

Effective Date: 11/1/2024

Last Review Date: 10/2024

Next Annual Review: 10/2025

INSTRUCTIONS FOR USE: Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PRODUCT AND BENEFIT APPLICATION

☒ Medicare Only

MEDICARE COVERAGE CRITERIA

IMPORTANT NOTE: More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

Note: Some spinal fusion and artificial disc replacement procedures may be reviewed for both medical necessity and inpatient site of service, the latter of which is performed using the separate Surgical Site of Service medical policy (MP184). See *Billing Guidelines* below.

Service	Medicare Guidelines
Percutaneous Image-Guided Lumbar Decompression (PILD) (aka, Minimally Invasive Lumbar Decompression or MILD) (CPT code 0275T; HCPCS code G0276)	National Coverage Determination (NCD): Percutaneous Image-Guided Lumbar Decompression (150.13) **NOTE:** Percutaneous image-guided lumbar decompression (PILD) is a procedure for treating lumbar spinal stenosis; however, the procedure is marketed by Vertos Medical Inc, along with a specialized instrument kit, as the MILD® procedure.[1]

As of 7/7/2024: *Cervical Fusion (CPT 22548, 22551, 22552, 22554, 22590, 22595, 22600, 22800, 22802, 22808, 22810, 22812) (**NOTE:** While CPT 22585 and 22614 are not included in the LCA, the same coverage criteria applied to the primary CPT code applies to these add-on codes. In addition, some codes are not specific to the cervical spinal region only. If one of these codes is used, but for a different region of the spine [thoracic, lumbar, etc.], this LCD does not apply.)*	**General coverage criteria**: Local Coverage Determination (LCD): Cervical Fusion (L39762) • **For decompression of *symptomatic cervical nerve root impingement*:** LCD Section A • **For decompression of *symptomatic cervical canal stenosis*:** LCD Section B **Use of biologicals used during cervical spinal surgery**: Local Coverage Article (LCA): Billing and Coding: Cervical Fusion (A59645) **NOTES:** **1. RE: axial neck or axial cervical pain**. According to the LCD, "There is not sufficient evidence to support surgical intervention for axial neck pain. Systematic review evaluating outcome for ACDF for axial neck pain with and without radiculopathy or myelopathy reported low quality evidence and the benefit of the surgery over time could not be established as compared to nonsurgical treatment options. The remaining evidence reviewed concludes very low quality and therefore this is not considered reasonable and necessary." Therefore, cervical fusion for axial neck pain is **not medically necessary**. 2. These LCD and LCA references **only** apply to cervical fusion procedures. - they do **not** apply to other joint procedures (e.g., facet, sacroiliitis, epidural or other spinal procedures). If a CPT code is not included in the column to the left, then this LCD will not be applied, even if the service is rendered on a cervical level of the spine.

Medicare Coverage Criteria: "MA organizations may create publicly accessible internal coverage criteria… when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs." *(§ 422.101(b)(6) – see Policy Guidelines below)*

- **Medicare Coverage Manuals:** While Medicare has established a nationwide prior authorization process for certain spinal services, including cervical fusion with disc removal[2], Medicare does not provide coverage criteria for spinal fusion or decompression procedures in a coverage manual.
- **National Coverage Determination (NCD):** With the exception of PILD (see above), Medicare does not have an NCD for spinal fusion or decompression procedures.
- **Noridian J-F Local Coverage Determination (LCD)/Local Coverage Article (LCA):** With the exception of the *cervical* fusion LCD that is effective July 2024, as of the most recent policy review, the Medicare Administrative Contractor (MAC) for the health plan's service area only has an LCD for *cervical* spinal fusion procedures. LCDs do exist for *lumbar* spinal fusion, but they are not for the health plan's service area and no MAC has an LCD for *thoracic* spinal fusion procedures.

• Therefore, in the absence of established Medicare coverage criteria in a manual, NCD, LCD, or other regulatory guidance for the health plan's service area, Company criteria below are applied for medical necessity decision-making.	
Spinal Fusion and Decompression Procedures Not Otherwise Addressed • ***Prior to 7/7/2024:*** *Cervical fusion procedures (see codes in row for fusion LCD above)* • *Any cervical procedure CPT not included in the fusion LCD row above.* • *Thoracic or lumbar laminectomy or spinal fusion* • *Vertebral Corpectomy* • *Microendoscopic discectomy (MED)* • *Percutaneous endoscopic discectomy* • *Automated percutaneous discectomy and disc decompression* • *Percutaneous laser discectomy and disc decompression* • *Endoscopic transforaminal lumbar interbody fusion* • *Axial lumbar interbody fusion (AxialLIF)* • *Annulus repair devices (e.g., Barricaid®)* • *Customized/personalized intervertebral cages* • *Lumbar total joint replacement (LTJR) (e.g., MOTUS device, by 3Spine) (0719U)*	Company medical policy for Spinal Fusion and Decompression Procedures I. These services may be considered **medically necessary** for Medicare when the Company medical policy criteria are met. II. These services are considered **not medically necessary** for Medicare Plan members either when the Company medical policy criteria are **not** met ***or*** when a service is deemed "not medically necessary" by the Company policy. See *Policy Guidelines below.*

IMPORTANT NOTICE: While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member's benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A).* If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. *(Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021)*

POLICY CROSS REFERENCES

- Artificial Intervertebral Discs, MP263
- Discography, MP11
- Spinal Epidural Steroid Injections, MP17
- Intradiscal Procedures for Low Back Pain, MP223
- Percutaneous Vertebroplasty and Sacroplasty, MP342
- Sacroiliac Joint Fusion or Stabilization, MP24
- Stabilization Devices and Interspinous Spacers, MP19

The full Company portfolio of Medicare Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

DOCUMENTATION REQUIREMENTS

In order to review for medical necessity, documentation to support medical necessity **must** be provided. For Medicare Advantage, see the Noridian local coverage article (LCA) A53975 for documentation requirements for spinal fusion procedures.

MEDICARE AND MEDICAL NECESSITY

Only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*. MA organizations (MAOs) make medical necessity determinations based on coverage and benefit criteria, current standards of care, the member's unique personal medical history (e.g., diagnoses, conditions, functional status, co-morbidities, etc.), physician recommendations, and clinical notes, as well as involvement of a plan medical director, where appropriate. *(§ 422.101(c)(1))*

In addition:

> "MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs. Current, widely-used treatment guidelines are those developed by organizations representing clinical medical specialties, and refers to guidelines for the treatment of specific diseases or conditions. Acceptable clinical literature includes large, randomized controlled trials or prospective cohort studies with clear results, published in a peer-reviewed journal, and specifically designed to answer the relevant clinical question, or large systematic reviews or meta-analyses summarizing the literature of the specific clinical question." *(§ 422.101(b)(6) and Medicare Managed Care Manual, Ch. 4, §90.5)*

The Company policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare's definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan's use of evidence-based processes for policy development.

As noted above (Criteria table), while Medicare has established a nationwide prior authorization process for certain services[2], Medicare does **not** provide any national coverage criteria for these services. Local coverage determinations (LCDs) exist for ***lumbar*** spinal fusion, but they are not for the health plan's service area. The Medicare Contractor (MAC) with jurisdiction over the health plan's service area recently developed an LCD for cervical spinal fusion procedures (July 2024), but does not have a local coverage policy for other spinal fusion services (for the lumbar or thoracic regions).

REGULATORY STATUS

U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

Note, the Lumbar total joint replacement (LTJR) (e.g., MOTUS device, by 3Spine) device does not appear to be available in the US.

BILLING GUIDELINES AND CODING

GENERAL

CPT code 22585 is an add-on code that may only be billed in conjunction with 22554, 22556, or 22558.

See associated local coverage article (LCA) for additional coding and billing guidance:

- Local coverage article (LCA): Billing and Coding: Cervical Fusion (A59645)

Percutaneous Image-Guided Lumbar Decompression (PILD) (CPT 0275T / HCPCS G0276)

According to the Billing Guidelines provided for the Medicare NCD for *Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis* (150.13), the MILD procedure (CPT code 0275T; HCPCS code G0276) may be considered medically necessary **only** for Medicare patients currently enrolled in a clinical trial. The procedure must be billed with ICD-10 code Z00.6 (for services rendered on or after 10/1/2015), Condition Code 30, Modifier Q0 **and** an 8-digit clinical trial identifier number listed on the CMS Coverage with Evidence Development website.

Additional billing information for the PILD® or MILD® procedure can be found in the Medicare Claims Processing Manual, Chapter 32 – Billing Requirements for Special Services, §330 – Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS).

HCPCS Code S2348 and CPT Code 22841

HCPCS code S2348 is considered "not medically necessary" under this policy. However, like all S-codes, the *National Physician Fee Schedule Relative Value File (NPFSRVF)*, which is published by the Centers for Medicare and Medicaid Services (CMS)[3], indicates HCPCS code S2348 has been assigned a Status Indicator of "I." This is defined as "Not valid for Medicare purposes." In addition, HCPCS code S2348 is not recognized as a valid code for claim submission as indicated in the relevant Company Coding Policy *(HCPCS S-Codes and H-Codes,* 22.0*).* Providers need to use alternate available CPT or HCPCS codes to report for the service. If no specific CPT or HCPCS code is available, then an unlisted code may be used. Note that unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. Thus, if an unlisted code is billed related to a non-covered service addressed in this policy, it will be denied as not covered.

In addition, the NPFSRVS indicates CPT code 22841 has been assigned a Status Indicator of "B," which is defined as a "Bundled Code." As a Medicare Status "B" code, CPT 22841 is not separately payable. This is also indicated in the relevant Company Coding Policy (*Bundled or Adjunct Services*, 13.0). While this service may be considered medically necessary when the primary spinal procedure is determined to be medically necessary, separate payment for CPT 22841 is not provided.

SURGICAL SITE OF SERVICE (SOS) REVIEW

- **Separate SOS Review Required:** Some spinal fusion and artificial disc replacement procedures (CPT codes 22551, 22554, 22612, 22630, 22633, 22856, 22858) are not included on the Medicare Inpatient Only list. Therefore, in addition to general medical necessity review using this policy, these CPT codes may require additional inpatient site of service review, which is performed using criteria found in the separate *Surgical Site of Service* medical policy (MP184).
- **Separate SOS Review Not Required:** Other spinal fusion or artificial disc replacement procedures require medical necessity review using criteria found in this Medicare medical policy, but they are not subject to the site of service policy criteria since they are included on the Medicare Inpatient Only list.

CODES*		
CPT	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
	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
	0719T	Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment
	22532	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic
	22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar

	22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)
	22548	Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process
	22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
	22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)
	22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2
	22556	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic
	22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
	22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)
	22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace
	22590	Arthrodesis, posterior technique, craniocervical (occiput-C2)
	22595	Arthrodesis, posterior technique, atlas-axis (C1-C2)
	22600	Arthrodesis, posterior or posterolateral technique, single interspace; cervical below C2 segment
	22610	Arthrodesis, posterior or posterolateral technique, single interspace; thoracic (with lateral transverse technique, when performed)
	22612	Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)
	22614	Arthrodesis, posterior or posterolateral technique, single interspace; each additional interspace (List separately in addition to code for primary procedure)
	22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar
	22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)
	22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar
	22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)

	22800	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments
	22802	Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments
	22804	Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments
	22808	Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments
	22810	Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments
	22812	Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments
	22818	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or 2 segments
	22819	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); 3 or more segments
	22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)
	22841	Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)
	22842	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)
	22843	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure)
	22844	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (List separately in addition to code for primary procedure)
	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)
	22848	Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure)
	22849	Reinsertion of spinal fixation device
	22852	Removal of posterior segmental instrumentation
	22853	Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)
	22854	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or

		complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
	22855	Removal of anterior instrumentation
	22859	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
	22899	Unlisted procedure, spine
	62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar
	62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar
	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
	63003	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; thoracic
	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)
	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
	63016	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; thoracic
	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
	63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical
	63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar
	63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)

	63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical
	63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar
	63043	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (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; cervical
	63046	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; thoracic
	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)
	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-segmental fixation devices [eg, wire, suture, mini-plates], when performed)
	63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)
	63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)
	63055	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; thoracic
	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)
	63064	Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; single segment
	63066	Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; each additional segment (List separately in addition to code for primary procedure)
	63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace
	63076	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)
	63077	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, single interspace
	63078	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, each additional interspace (List separately in addition to code for primary procedure)
	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)
	63085	Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment
	63086	Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, each additional segment (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)
	63101	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, single segment
	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
	63265	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical
	63266	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic
	63267	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar
HCPCS	C1831	Interbody cage, anterior, lateral or posterior, personalized (implantable)
	C2614	Probe, percutaneous lumbar discectomy
	C9757	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar
	G0276	Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (PILD) or placebo-control, performed in an approved coverage with evidence development (CED) clinical trial
	S2348	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 *(CMS-assigned Status "I" code – See "Billing Guidelines")*

***Coding Notes:**

- The code list above is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit. According to Medicare, "presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare." The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. *(Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician's Fee Schedule, A. Physician's Services)*
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

1. Medicare Decision Memo for *Percutaneous Image-guided Lumbar Decompression for Lumbar Spinal Stenosis* (CAG-00433N); Dated: 01/09/2014; Available at: https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&NCAId=269
2. Prior Authorization for Certain Hospital Outpatient Department (OPD) Services; Available at: https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives/prior-authorization-certain-hospital-outpatient-department-opd-services
3. CMS Physician Fee Schedule (PFS) Relative Value Files; Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
1/2023	New Medicare Advantage medical policy (converted to new format 2/2023)
11/2023	Annual review, no change to criteria
7/2024	Interim update; add new LCD for cervical fusion effective July 2024
11/2024	Annual review, no change to criteria; add cervical fusion codes from the LCA that are not in the policy already