Clinical Policy: Thoracic Laminectomy and/or Thoracic Discectomy

Reference Number: PA.CP.MP.OR.1010           Coding Implications
Effective Date: 04/01/2020     Revision Log
Last Review Date: NEW POLICY

See Important Reminder at the end of this policy for important regulatory and legal information.

Common Name: Thoracic Laminectomy and Discectomy

Definition: Thoracic laminectomy is a surgical procedure utilized to relieve vertebral compression of the thoracic spine.

I. Criteria for Inclusion
   A. Thoracic laminectomy and/or thoracic discectomy, with thoracic fusion where indicated for instability, is considered medically necessary for any of the following:
      1. Herniated discs or other sources of myelopathy (spinal cord compression) or radiculopathy (nerve root compression) when all of the following criteria are met:
         1. Other sources of pain have been ruled out
         2. Imaging evidence of thoracic nerve root or spinal cord compression correlates with thoracic pain and other neurological symptoms (e.g. myelopathy, sensory deficit)
         3. Failed conservative therapy for a minimum of 6 weeks, unless evidence of progressing thoracic cord compression requires more urgent intervention
   B. Thoracic laminectomy and/or thoracic discectomy, included with corpectomy where indicated, is considered medically necessary for imaging evidence of any of the following:
      1. Vertebral compression or burst fractures
      2. Spinal infection, tumor, or epidural hematoma
      3. Synovial cysts, arachnoid cysts, or severe spinal stenosis when all of the following are met:
         1. Spinal cord compression correlates with exam findings
         2. Pain and neurological symptoms interfere with daily activities and have failed to improve with at least 6 weeks of conservative treatment, unless evidence of progressing thoracic cord compression requires more urgent intervention
      4. Other mass lesions (subject to review on an individual basis)

II. Criteria for Exclusion
   A. Thoracic laminectomy is not considered medically necessary if the above criteria is not met.
   B. For persons with significant co-morbidities or complications, the medical record must detail the risk/benefit of thoracic laminectomy

III. Device Considerations
   A. Only implants with FDA approval are considered to be medically appropriate

IV. Surgical Considerations
   A. Pre-Operative Considerations:
      1. Preoperative care planning needs may include:
         1. Routine preoperative evaluation
         2. Diagnostic test scheduling, including:
            a. Lateral radiographs
b. Imaging (eg, MRI or CT myelogram)
c. Electromyography

3. Preoperative treatment, procedures, and stabilization, including:
   a. Physical and occupational therapy consultation for development of rehabilitation
      plan, including progressive exercises, muscle strengthening, and activity pacing
   b. Preoperative discharge planning as appropriate

B. Intra-Operative Considerations:
   1. Antibacterial wipes
   2. Antibacterial nasal swab

C. Post-Operative & Inpatient Considerations:
   1. Hospital evaluation and care needs may include:
      1. Treatment and procedure scheduling and completion, including:
         a. IV antibiotics
         b. Transfusion
   2. Consultation, assessment, and other services scheduling and completion, including:
      a. Physical therapy
      b. Occupational therapy
   3. Monitoring status for deterioration and comorbid conditions; key items include:
      a. Neurovascular status of lower extremities
      b. Pain management
      c. New-onset headache suspicious for dural tear and cerebrospinal fluid leak
      d. Urinary retention
      e. Hemodynamic stability
      f. Wound management, observing for healing at spine

D. Discharge Planning & Considerations
   1. Discharge planning includes:
      1. Assessment of needs and planning for care, including:
         a. Develop treatment plan (involving multiple providers as needed).
         b. Evaluate and address preadmission functioning as needed.
         c. Evaluate and address patient or caregiver preferences as indicated.
         d. Identify skilled services needed at next level of care, with specific attention to:
            i. Neurologic status assessment
            ii. Pain management
            iii. Wound or dressing management
            e. Evaluate and address psychosocial status issues as indicated
      2. Early identification of anticipated discharge destination; options include:
         a. Home, considerations include:
            i. Access to follow-up care
            ii. Home safety assessment
            iii. Self-care ability, if appropriate
            iv. Caregiver need, ability, and availability
         b. Post-acute skilled care or custodial care, as indicated
      3. Transition of care plan complete, which may include:
         a. Patient and caregiver education complete
         c. Medication reconciliation completion includes:
            i. Compare patient's discharge list of medications (prescribed and over-the-counter)
               against physician's admission or transfer orders.
            ii. Assess each medication for correlation to disease state or medical condition.
            iii. Report medication discrepancies to prescribing physician, attending physician, and
               primary care provider, and ensure accurate medication order is identified.
            iv. Provide reconciled medication list to all treating providers.
v. Confirm that patient, family, or caregiver can acquire medication.
vi. Educate patient, family, and caregiver.
   1. Provide complete medication list to patient, family, or caregiver.
   2. Confirm that patient, family, or caregiver understands importance of presenting personal medication list to all providers at each care transition, including all physician appointments.
   3. Confirm that patient, family, or caregiver understands reason, dosage, and timing of medication (eg, use "teach-back" techniques).

d. Plan communicated to patient, caregiver, and all members of care team, including:
   i. Inpatient care and service providers
   ii. Primary care provider
   iii. All post-discharge care and service providers

e. Post-discharge appointment plans made as needed, which may include:
   i. Primary care provider
   ii. Neurosurgeon
   iii. Orthopedic surgeon
   iv. Rehabilitation therapy services
   v. Specialists for management of comorbid conditions

f. Post-discharge testing and procedure plans made

g. Referrals made for assistance or support, which may include:
   i. Financial, for follow-up care, medication, and transportation
   ii. Smoking cessation counseling or treatment
   iii. Vocational rehabilitation

h. Medical equipment and supplies coordinated (ie, delivered or delivery confirmed) which may include:
   i. Ambulation devices (eg, cane, crutches, walker)
   ii. Wound care supplies

V. Length of Stay Considerations
   A. Goal length of stay – Not available
   B. Facility type criteria – Not available

VI. Coding
   A. CPT
   
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>63003</td>
<td>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</td>
</tr>
<tr>
<td>63016</td>
<td>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</td>
</tr>
<tr>
<td>63046</td>
<td>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</td>
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<tr>
<td>63048</td>
<td>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 (List separately in addition to code for primary procedure)</td>
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<tr>
<td>63055</td>
<td>Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; thoracic</td>
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<tr>
<td>63057</td>
<td>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)</td>
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<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>63064</td>
<td>Costovertebral approach with decompression of spinal cord or nerve root(s) (eg, herniated intervertebral disc), thoracic; single segment</td>
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<td>63066</td>
<td>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)</td>
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<tr>
<td>63077</td>
<td>Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytelectomy; thoracic, single interspace</td>
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<tr>
<td>63078</td>
<td>Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytelectomy; thoracic, each additional interspace</td>
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<tr>
<td>63085</td>
<td>Vertebral corpectomy (vertebral body resection), partial or complete, transthoracic approach with decompression of spinal cord and/or nerve root(s); thoracic, single segment</td>
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<tr>
<td>63086</td>
<td>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)</td>
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<tr>
<td>63090</td>
<td>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</td>
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<tr>
<td>63091</td>
<td>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)</td>
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<tr>
<td>63101</td>
<td>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</td>
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<tr>
<td>63103</td>
<td>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)</td>
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<tr>
<td>63170</td>
<td>Laminectomy with myelotomy (eg, Bischof or DREZ type), cervical, thoracic, or thoracolumbar</td>
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<tr>
<td>63172</td>
<td>Laminectomy with drainage of intramedullary cyst/syrinx; to subarachnoid space</td>
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<td>63173</td>
<td>Laminectomy with drainage of intramedullary cyst/syrinx; to peritoneal or pleural space</td>
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<tr>
<td>63185</td>
<td>Laminectomy with rhizotomy; 1 or 2 segments</td>
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<tr>
<td>63190</td>
<td>Laminectomy with rhizotomy; more than 2 segments</td>
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<tr>
<td>63191</td>
<td>Laminectomy with section of spinal accessory nerve</td>
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<tr>
<td>63195</td>
<td>Laminectomy with cordotomy, with section of 1 spinothalamic tract, 1 stage; thoracic</td>
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<tr>
<td>63197</td>
<td>Laminectomy with cordotomy, with section of both spinothalamic tracts, 1 stage; thoracic</td>
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<tr>
<td>63199</td>
<td>Laminectomy with cordotomy with section of both spinothalamic tracts, 2 stages within 14 days; thoracic</td>
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<td>63251</td>
<td>Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracic</td>
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<td>Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracolumbar</td>
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<td>63266</td>
<td>Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic</td>
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<td>63271</td>
<td>Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; thoracic</td>
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<td>63276</td>
<td>Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, thoracic</td>
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<td>Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, thoracic</td>
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<td>63286</td>
<td>Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracic</td>
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<td>63287</td>
<td>Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracolumbar</td>
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<td>63290</td>
<td>Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level</td>
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<td>63301</td>
<td>Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by transthoracic approach</td>
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<tr>
<td>63302</td>
<td>Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by thoracolumbar approach</td>
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A. HCPCS
   No HCPCS codes available

B. ICD-10 Procedure
   No ICD-10 Procedure codes

C. ICD-10 Diagnosis
   All associated ICD-10 Diagnosis codes

References

Regulatory Data

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<thead>
<tr>
<th>Policy Number/Name:</th>
<th>PA.CP.MP.OR.1010 Thoracic Laminectomy or Discectomy</th>
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<tr>
<td>Initial Approval and Effective Date:</td>
<td>01/20/2015</td>
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<tr>
<td>All Approval Dates:</td>
<td>01/20/2015; 01/22/2016; 3/3/2017; 1/29/2018; 3/5/2019</td>
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<td>Approval Authority:</td>
<td>Utilization Management Committee</td>
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<td>Business Owner:</td>
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<td>Applicable lines of business:</td>
<td>All</td>
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<td>Board approval, if appropriate:</td>
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<td>Approval Signature:</td>
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URAC Standards:                                                                                   
State Requirements:                                                                                
CMS/Federal Requirements:                                                                          
Corresponding policies:                                                                            

Reviews, Revisions, and Approvals |

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<tr>
<th>Date</th>
<th>Approval Date</th>
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<tr>
<td>03/20</td>
<td>7/8/2020</td>
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• New Policy created.
• Policy administered by Turning Point Healthcare Solutions

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by PA Health & Wellness, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.
This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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