All requests for thoracic spine surgery will be reviewed on case-by-case basis. The following criteria must be met for consideration.

1. **Indications for Decompression Surgery Only Include:**
   - Positive Clinical Findings of Myelopathy with evidence of progressive neurologic deficits consistent with worsening spinal cord compression — immediate surgical evaluation is indicated. Symptoms may include any of the following:
     - upper or lower extremity weakness
     - unsteady gait related to myelopathy/balance or generalized lower extremity weakness
     - disturbance with coordination
     - hyperreflexia
     - Hoffmann sign
     - positive Babinski sign
     - clonus
   - OR
     - Progressive neurological deficit (motor deficit, bowel or bladder dysfunction) or lower extremity weakness (0-3/5 on the strength scale) or paralysis with corresponding evidence of spinal cord or nerve root compression on an MRI or CT scan images — immediate surgical evaluation is indicated;
   - OR
     - When ALL of the following criteria are met:
       - Persistent or recurrent symptoms/pain with functional limitations that are unresponsive to at least 12 weeks of conservative treatment concerted conservative treatment to include completed and appropriate therapy (including stabilization exercises and epidural steroid injections);
   - AND
     - Imaging studies confirm the presence of spinal cord or spinal nerve root compression at the level corresponding with the clinical findings (MRI or CT).

2. **Indications for Thoracic Decompression with Fusion Surgery Include:**
   - Deformity Cases—please refer to our Deformity Spine Surgery (Adult) Guideline.
   - OR
     - For Myelopathy or radiculopathy secondary to cord or root compression (see criteria below) satisfying the indications for decompressive surgery requiring extensive decompression that results in destabilization of the thoracic spine.
       - Positive Clinical Findings of Myelopathy with evidence of progressive neurologic deficits consistent with worsening spinal cord compression — immediate surgical evaluation is indicated. Symptoms may include:
         - upper extremity weakness
         - unsteady gait related to myelopathy/balance or generalized lower extremity weakness
         - impaired coordination
         - hyperreflexia
         - Hoffmann sign
         - positive Babinski sign


- Clonus

OR

- Progressive neurological deficit (motor deficit, bowel or bladder dysfunction) or lower extremity weakness (0-3/5 on the strength scale) or paralysis with corresponding evidence of spinal cord or nerve root compression on an MRI or CT scan images — immediate surgical evaluation is indicated;

AND

- Anticipated intra-operative destabilization due to extensive thoracic decompression surgery;

OR

When ALL of the following criteria are met:

- Persistent or recurrent symptoms/pain with functional limitations that are unresponsive to at least 12 weeks of conservative treatment concerted conservative treatment to include completed and appropriate therapy (including stabilization exercises and epidural steroid injections);

AND

- Imaging studies confirm the presence of spinal cord or spinal nerve root compression commensurate with the clinical findings (MRI or CT);

AND

- Anticipated intra-operative destabilization due to extensive thoracic decompression surgery.

NOTE: There is no current evidence base to support fusion in the thoracic spine for degenerative disease without significant neurological compression or significant deformity as outlined above.

Contraindications for Spine Surgery

- Medical contraindications to surgery, e.g., severe osteoporosis; infection of soft tissue adjacent to the spine, whether or not it has spread to the spine; severe cardiopulmonary disease; anemia; malnutrition and systemic infection.
- Psychosocial risk factors. It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions mimicking radiculopathy or instability (e.g., peripheral neuropathy, piriformis syndrome, myofascial pain, sympathetically mediated pain syndromes, sacroiliac dysfunction, psychological conditions, etc.) prior to consideration of elective surgical intervention
- Active nicotine use prior to fusion surgery. The patient must refrain from nicotine use for at least four weeks prior to surgery and during the period of fusion healing.
- Morbid Obesity. Contraindication to surgery in cases where there is significant risk and concern for improper post-operative healing, post-operative complications related to morbid obesity, and/or an inability to participate in post-operative rehabilitation.

NOTE: Cases of severe myelopathy and progressive neurological dysfunction may require surgery despite these general contraindications.

Policy Guidelines

- N/A

Description

Thoracic Decompression with or without fusion:
Thoracic disc herniation with or without nerve root compression is usually treated conservatively (non-surgically). A back brace may be worn to provide support and limit back motion. Injection of local anesthetic and steroids around the spinal nerve (spinal nerve blocks) may be effective in relieving radicular pain. As symptoms subside, activity is gradually increased. This may include physical therapy and/or a home exercise program. Preventive and maintenance measures (e.g., exercise, proper body mechanics) should be continued indefinitely. Job modification may be necessary to avoid aggravating activities.

Simple laminectomy is rarely used in the treatment of thoracic disc herniation because of the high risk of neurologic deterioration and paralysis. Excision of the disc (discectomy) may be performed via several different surgical approaches—anteriorty, laterally, or transpedicularly. Fusion should be performed only if surgery causes instability in the spinal column. Many newer techniques do not usually destabilize the thoracic spine.

### Related Policies
- N/A

### Benefit Application
Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates [e.g., Federal Employee Program (FEP)] prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

### Regulatory Status
- N/A

### Rationale
- N/A

### References


Documentation for Clinical Review

Please provide the following documentation (if/when requested):

- History and physical and/or consultation notes including:
  - Reason for procedure
  - Clinical findings
  - Conservative treatments and duration
  - Activity limitations
  - Duration of back pain
  - Comorbidities
- Radiology report(s) (i.e., MRI, CT, discogram)

Post Service
- Procedure report(s)

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement.

MN/IE

The following services may be considered medically necessary in certain instances and investigational in others. Services may be considered medically necessary when policy criteria are met. Services may be considered investigational when the policy criteria are not met or when the code describes application of a product in the position statement that is investigational.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT®</td>
<td>0274T</td>
<td>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 (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic</td>
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<tr>
<td></td>
<td>22532</td>
<td>Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic</td>
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<td>22534</td>
<td>Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression);</td>
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<td>Type</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>22556</td>
<td>Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic</td>
<td></td>
</tr>
<tr>
<td>22585</td>
<td>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)</td>
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<tr>
<td>22610</td>
<td>Arthrodesis, posterior or posterolateral technique, single level; thoracic (with lateral transverse technique, when performed)</td>
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<tr>
<td>22614</td>
<td>Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)</td>
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<tr>
<td>22830</td>
<td>Exploration of spinal fusion</td>
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<td>63003</td>
<td>Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; thoracic</td>
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<td>63016</td>
<td>Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; thoracic</td>
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<tr>
<td>63046</td>
<td>Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; thoracic</td>
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<td>63048</td>
<td>Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., 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) (e.g., 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) (e.g., 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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<td>63064</td>
<td>Costovertebral approach with decompression of spinal cord or nerve root(s) (e.g., 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) (e.g., herniated intervertebral disc), thoracic; each additional segment (List separately in addition to code for primary procedure)</td>
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<td>Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophysectomy; 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 osteophysectomy; thoracic, each additional interspace (List separately in addition to code for primary procedure)</td>
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<table>
<thead>
<tr>
<th>HCPCS</th>
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<tbody>
<tr>
<td>ICD-10 Procedure</td>
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<td>ICD-10 Diagnosis</td>
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### Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Action</th>
<th>Reason</th>
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<tbody>
<tr>
<td>01/01/2017</td>
<td>Adoption of National Imaging Associates (NIA) Clinical Guidelines</td>
<td>Medical Policy Committee</td>
</tr>
</tbody>
</table>

### Definitions of Decision Determinations

**Medically Necessary:** A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

### Prior Authorization Requirements (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department. Please call (800) 541-6652 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.