Spinal Fusion and Decompression

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➲ Instructions for Use

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Related Commercial/Individual Exchange Policies

- Discogenic Pain Treatment
- Epidural Steroid Injections for Spinal Pain
- Facet Joint and Medial Branch Block Injections for Spinal Pain
- Interspinous Fusion and Decompression Devices
- Spinal Fusion and Bone Healing Enhancement Products
- Total Artificial Disc Replacement for the Spine
- Vertebral Body Tethering for Scoliosis

Community Plan Policy

- Spinal Fusion and Decompression

Application

UnitedHealthcare Commercial

This Medical Policy applies to UnitedHealthcare Commercial benefit plans.

UnitedHealthcare Individual Exchange

This Medical Policy applies to Individual Exchange benefit plans.

Coverage Rationale

Spinal procedures for the treatment of spine pain are proven and medically necessary in certain circumstances.
For medical necessity clinical coverage criteria, refer to the:

- InterQual® CP: Procedures:
  - Decompression +/- Fusion, Cervical
  - Decompression +/- Fusion, Thoracic
  - Fusion, Cervical Spine
  - Fusion, Lumbar Spine
  - Fusion, Thoracic Spine
  - Scoliosis or Kyphosis Surgery
  - Scoliosis or Kyphosis Surgery (Pediatric)
- InterQual® Client Defined, CP: Procedures, Decompression +/- Fusion, Lumbar (Custom) - UHG

Click here to view the InterQual® criteria.

Dividing treatment of symptomatic, multisite spinal pathology via an anterior or posterior approach into serial or Staged Multiple Sessions when one session can address all sites is unproven and not medically necessary due to insufficient evidence of safety and efficacy.

The following procedures for the treatment of spine pain are unproven and not medically necessary due to insufficient evidence of efficacy:

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- Dynamic Stabilization systems
- Facet Joint Replacement
- Isolated Facet Joint Fusion, with or without instrumentation
- Vertebral joint implants that replace the disc and facet joints (e.g., MOTUS)

Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested; refer to the guidelines titled Medical Records Documentation Used for Reviews.

Definitions

Anticipated Instability Due to Procedure: Surgical removal of stabilizing elements such as excision of greater than 50% of bilateral facet joints; removal of greater than 75% of one facet joint or 50% or more of the vertebral body, pedicles, transverse processes, or the pars interarticularis; or the presence of a pars interarticularis fracture beyond preserving thresholds, intraoperatively, causing the decompression to destabilize the motion segment [North American Spine Society (NASS), 2021].

Dynamic Stabilization: Also called flexible fusion or soft stabilization. A surgical procedure that stabilizes the spine with the insertion of a motion-preserving, flexible implant that is designed to provide more mobility than traditional spinal fusion. The procedure uses rods, cords, and spacers to stabilize spinal segments and reduce pressure on the intervertebral disc and facet joints (Hayes, 2025).

Facet Joint Replacement: Also called total facet arthroplasty. A surgical procedure that replaces the facet joints using flexible materials to stabilize the spine as an alternative to fusion (Nassr et al., 2024).

Instability: A loss of structural support of the spine that leads to abnormal and increased movement between vertebrae outside of normal physiological limits, measured by the difference in translational alignment between lumbar vertebrae greater than or equal to 3 mm between views, as documented by flexion-extension radiographs or comparison of a supine and upright image (NASS, 2021).

Isolated Facet Joint Fusion: Also called facet arthrodesis. Facet joint fusion without decompression. A surgical procedure that fuses the facet joint using allograft bone dowels made from donated cortical bone (ECRI, 2024).

Lumbar Spinal Decompression With Interbody Lumbar Spinal Fusion: Surgical procedure of the lumbar spine that involves removal of bony and/or disc material to relieve compression of spinal nerve(s), nerve roots, or the spinal cord combined with arthrodesis of one or more motion segments, using bone grafts, with or without instrumentation, to stabilize the spine (NASS, 2021).

Meyerding Classification System of Spondylolisthesis: A well-established spondylolisthesis classification system that evaluates the degree of vertebral slippage on standing, neutral, lateral lumbar radiographs to evaluate and manage spondylolisthesis.
Classification:
- Grade I: 0%-25%
- Grade II: 25%-50%
- Grade III: 50%-75%
- Grade IV: 75%-100%
- Grade V: greater than 100%

(Koslosky and Gendelberg, 2020)

Radiographic Dynamic Instability: Translational motion of 3 mm of movement on flexion-extension radiographs or Meyerding Classification System of Spondylolisthesis grade of ≥ II (NASS, 2021).

Staged Multiple Sessions: Includes procedures that are performed on different days or those that require an additional anesthesia session (Verma et al., 2025).

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Unstable Grade I Degenerative Spondylolisthesis: A static anterior translation of the vertebral body of less than 25% over the subjacent vertebra (Meyerding grade I), with Instability demonstrated by one or more of the following findings on flexion-extension lumbar radiographs:

- Sagittal (anteroposterior) translation greater than or equal to 3 mm
- Angular change of ≥ 15° between flexion and extension when compared with the adjacent motion segment

Grade I spondylolisthesis is also considered unstable when there is progressive anterior slippage over time on serial imaging. **Note**: These parameters do not apply to radiograph-confirmed isthmic spondylolisthesis with a pars defect. (NASS, 2014)

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other policies and guidelines may apply.

CPT Code	Description
0202T	Posterior vertebral joint(s) arthroplasty (e.g., facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine
0219T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical
0220T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic
0221T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar
0222T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment (List separately in addition to code for primary procedure)
0719T	Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment
22206	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., pedicle/vertebral body subtraction); thoracic
22207	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., pedicle/vertebral body subtraction); lumbar
22208	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (e.g., pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to code for primary procedure)
22210	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical
22212	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic
22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar
22216	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment (List separately in addition to primary procedure)
22220	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical
22222	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; thoracic
22224	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumbar
22226	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure)
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

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CPT Code	Description
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)
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, lumbar; 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, lumbar; each additional interspace (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
22830	Exploration of spinal fusion
22840	Posterior non-segmental instrumentation (e.g., 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)

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CPT Code	Description
22841	Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)
22842	Posterior segmental instrumentation (e.g., 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 (e.g., 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 (e.g., 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
22850	Removal of posterior nonsegmental instrumentation (e.g., Harrington rod)
22852	Removal of posterior segmental instrumentation
22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., 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) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., 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) (e.g., 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
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 (e.g., 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 (e.g., 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 (e.g., spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis
63012	Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)
63015	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; cervical
63016	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

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CPT Code	Description
63017	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; 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], [e.g., 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], [e.g., 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], [e.g., 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], [e.g., 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 [e.g., 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] [e.g., 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] [e.g., spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional vertebral segment (List separately in addition to code for primary procedure)
63055	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; thoracic
63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (e.g., far lateral herniated intervertebral disc)

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CPT Code	Description
63057	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)
63064	Costovertebral approach with decompression of spinal cord or nerve root(s) (e.g., herniated intervertebral disc), thoracic; single segment
63066	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)
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) (e.g., 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) (e.g., 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) (e.g., for tumor or retropulsed bone fragments); thoracic or lumbar, each additional segment (List separately in addition to code for primary procedure)
63266	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; thoracic

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CPT Code	Description
63267	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar
63270	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical
63271	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; thoracic
63272	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar
63275	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical
63277	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, lumbar
63280	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, cervical
63282	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, lumbar
63285	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, cervical
63286	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracic
63287	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, thoracolumbar
63290	Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level
63300	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, cervical
63301	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by transthoracic approach
63302	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, thoracic by thoracolumbar approach
63303	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, lumbar or sacral by transperitoneal or retroperitoneal approach
63304	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, cervical
63305	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, thoracic by transthoracic approach
63306	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, thoracic by thoracolumbar approach
63307	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, lumbar or sacral by transperitoneal or retroperitoneal approach
63308	Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; each additional segment (List separately in addition to codes for single segment)

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Description of Services

Back pain can occur when mechanical or structural problems develop in the spine or compress a nerve. Treatment varies depending on the cause and symptoms. Surgery may be an option for individuals whose pain cannot be controlled by more conservative methods (National Institute of Arthritis and Musculoskeletal and Skin Diseases, 2023). Several minimally invasive procedures that preserve motion and stabilize the spine are in development as an alternative to fusion.

Clinical Evidence

Multiple Serial/Staged Spine Procedures

There is insufficient evidence of efficacy to support dividing spine decompression procedures into serial, multiple, or staged sessions when one session can address all sites.

Dynamic Stabilization Systems

Due to the lack of data from well-designed, long-term randomized controlled trials (RCTs), the current evidence is insufficient to permit conclusions about whether any beneficial effect from dynamic stabilization provides a significant

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advantage over conventional fusion techniques. The published evidence is not robust; a majority of the studies are retrospective or prospective case series and lack controls. In addition, the complications such as device failure, progressive instability, and recurrent pain frequently require conversion to standard fusion; complication rates and reoperation rates with dynamic stabilization compared with those with conventional fusion are unknown.

Gunerbuyuk et al. (2025) conducted a retrospective analysis that compared the Dynesys dynamic stabilization system vs rigid stabilization in the surgical treatment of multisegmental lumbar degenerative disease. The Dynesys dynamic stabilization system offers an alternative by preserving motion while stabilizing the spine; however, data that compare Dynesys with fusion in multisegmental cases are limited. The retrospective analysis was conducted in 53 patients (mean age, 62.25 ±15.37 years) who underwent either Dynesys dynamic stabilization (n = 27) or posterior lumbar interbody fusion (n = 26) for multisegmental lumbar degenerative disease that involved at least seven motion segments. The Dynesys stabilization system surgery was performed in two stages. The visual analog scale (VAS) and Oswestry Disability Index (ODI) were assessed as clinical outcomes, and radiological parameters, including lumbar lordosis, sagittal vertical axis, and spinopelvic parameters, were analyzed. The authors concluded that both groups had significant improvements in VAS and ODI scores post operation ($p < 0.001$), with no statistically significant differences between them. Additionally, sagittal balance significantly influences surgical outcomes; the authors noted that the spinopelvic parameters were corrected to a greater extent than in the rigid stabilization group, which could be strongly correlated with reduced low back pain post operation. Limitations of this study include its retrospective design, which may introduce selection bias; small sample size; and lack of a comparison (control) group. Additionally, the dynamic stabilization group surgery was performed using a two-stage surgical technique, which involves longer overall treatment duration and repeat anesthesia exposure. Further prospective studies that include larger cohorts and longer follow-up are needed to effectively validate the long-term clinical utility of the Dynesys method.

Nunley et al. (2025) reported outcomes from a multicenter, investigational device exemption clinical trial that evaluated the MOTUS total joint replacement (TJR) device for treating lumbar spine degeneration. TJR is a motion-preserving surgical approach that combines decompression with dynamic stabilization using a device that replaces the function of both the disc and facet. Patient-reported outcomes in 152 TJR individuals who were implanted with the MOTUS device were compared with 142 propensity score–weighted transforaminal lumbar interbody fusion or posterior lumbar interbody spine fusion controls. Lumbar-related disability was measured with the ODI, and back and leg pain severity was measured with the VAS. At 12 months, the mean ODI decreased by 45 points (71%) with TJR and 37 points (59%) with transforaminal lumbar interbody fusion/posterior lumbar interbody spine fusion. The adjusted between-group difference was 8.1 points. VAS back and leg pain decreases were similar between groups. Minimal clinically important difference responder rates were high (> 85%) for both procedures. Study limitations include a lack of randomization and short-term follow-up. Further studies that include longer-term follow-up are necessary to confirm the safety and effectiveness of posterior lumbar decompression and dynamic stabilization with TJR.

Pham et al. (2016) conducted a review of the literature to explore complications associated with the Dynesys stabilization system. The researchers evaluated 21 studies, which included a total of 1,166 individuals, with a mean age of 55.5 years and a mean follow-up period of 33.7 months. The data demonstrated a surgical-site infection rate of 4.3%, pedicle screw loosening rate of 11.7%, pedicle screw fracture rate of 1.6%, and adjacent segment disease (ASD) rate of 7.0%. Among studies that reported surgical revision rates, 11.3% of individuals required reoperation. Of the individuals who developed ASD, 40.6% required reoperation for treatment. The authors concluded that the Dynesys stabilization system has a similar complication rate to those seen in lumbar fusion studies and has a slightly lower incidence of ASD.

Clinical Practice Guidelines

North American Spine Society (NASS)

Clinical guidelines on the diagnosis and treatment of low back pain evaluate the impact of motion-preserving systems, such as dynamic stabilization, on pain relief, functional outcomes, and ASD. A systematic review of the literature yielded limited studies. Due to the lack of clinical literature that addresses these questions, the work group was unable to make a recommendation (NASS, 2020).

Facet Joint Replacement

Due to the lack of data from well-designed, long-term RCTs, the current evidence is insufficient to permit conclusions about the benefits and safety of facet joint replacement.

ECRI published a report on the Total Posterior Spine System (TOPS™) for treating lumbar spinal stenosis. TOPS is a posterior, pedicle screw–based spinal implant that is used for lumbar facet joint replacement as an alternative to spinal fusion in individuals with lumbar stenosis and grade I spondylolisthesis. The device is composed of a titanium construct with an interlocking polycarbonate urethane articulating core. After posterior decompression, surgeons insert TOPS into

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the lumbar vertebral joint and affix it using pedicle screws. ECRI reported that evidence from a multicenter RCT shows that TOPS provided better clinical success (no reoperations, major device adverse events, fusion failures, or new neurological deficits and clinically significant ODI improvement) than decompression with fusion at the 2-year follow-up. Clinical success was 73% in TOPS individuals and 25% in fusion individuals (fusion failure was 43.9%). Data from four case series suggest that TOPS's effects may last beyond 2 years. ECRI rated the level of evidence as low (ECRI, 2024).

Hayes published a report on the TOPS device for treating symptomatic lumbar spondylolisthesis with spinal stenosis. A review of full-text clinical studies suggests minimal support for using the TOPS System. No systematic reviews that evaluated the device were identified (Hayes, 2024; updated 2025).

Nassr et al. (2024) performed a multicenter RCT in 321 participants with lumbar spinal stenosis and grade I degenerative spondylolisthesis. Overall, 321 adult participants were randomized in a 2:1 fashion, with 219 participants assigned to undergo facet arthroplasty and 102 participants assigned to undergo fusion. Of them, 113 participants (51.6%) in the arthroplasty group and 47 (46.1%) in the fusion group who had either reached 24 months of postoperative follow-up or were deemed early clinical failures were included in the primary outcome analysis. The arthroplasty group had a higher proportion of participants who achieved composite clinical success than did the fusion group (73.5% vs 25.5%; $p < 0.001$), equating to a between-group difference of 47.9% (95% CI, 33.0%-62.8%). The arthroplasty group outperformed the fusion group in most patient-reported outcome measures (PROMs; including the ODI, VAS back pain, and all Zurich Claudication Questionnaire component scores) at 24 months post operation. No significant differences between groups in surgical variables or complications were observed, except that the fusion group had a higher rate of developing symptomatic ASD. The study demonstrates that decompression plus lumbar facet arthroplasty was associated with superior PROMs across multiple metrics; lower rates of new or progressive neurological symptoms; and lower rates of symptomatic ASD, equating to higher rates of composite clinical success compared with decompression plus fusion at 24 months post operation. Long-term follow-up will be necessary to determine differences in implant longevity, PROMs, and radiographic parameters such as stability of the spondylolisthesis and maintenance of motion beyond 2 years. A future RCT may be considered to compare lumbar facet arthroplasty vs decompression alone in a broader sample of participants. The primary limitation of this study is the relatively short postoperative follow-up, which precludes evaluation of the long-term durability of lumbar facet arthroplasty. A second limitation is that industry funding was used to perform this study. Third, this study was unable to mask surgeons, participants, or radiologists to the participants' treatment allocation post operation. Therefore, detection bias is a distinct possibility. Fourth, the trial used strict inclusion and exclusion criteria to mitigate the impact of confounding variables on the outcomes reported. Finally, this study reported the primary outcome in only approximately half of the randomized sample; however, this is consistent with both the predetermined statistical plan and previous RCTs, in which a sufficiently large between-group difference was present at a preplanned interim analysis.

Pinter et al. (2023) conducted an interim analysis on the 1-year safety profile and clinical and radiographic outcomes in 153 participants who were randomized to the investigational arm of the U.S. Food and Drug Administration investigational device exemption clinical trial for the TOPS device. Among the participants, 145 devices were implanted at L4 to 5 and eight at L3 to 4. Overall, 105 participants reached the 1-year follow-up and were included in the results. The safety profile showed 11 total complications and included new neurological deficits, dural tears infection, seroma, and hematoma as well as retained drains, misplaced pedicle screws, and screw loosening. Nine of these required a total of 13 reoperations. PROMs showed sustained improvement from 6 weeks to 12 months in ODI scores as well as mean VAS scores for low back and leg pain. Zurich Claudication Questionnaire symptom scores also improved. Radiographic parameters included global lordosis; disc height; disc angle; and magnitude and direction of spondylolisthesis, which were evaluated in 90 of the participants. Static radiographic parameters demonstrated increased index disc angle and disc height, with a reduction in the magnitude of spondylolisthesis. Comparison of dynamic radiographic parameters showed increased flexion/extension range of motion and translation.

Clinical Practice Guidelines

North American Spine Society (NASS)

Clinical guidelines on the diagnosis and treatment of degenerative lumbar spondylolisthesis evaluate the impact of flexible fusion on outcomes for the treatment of degenerative lumbar spondylolisthesis compared with nonoperative treatment. Due to the lack of clinical literature that addresses this question, the work group was unable to make a recommendation (NASS, 2014).

Isolated Facet Joint Fusion

No studies were found that evaluated facet joint fusion when performed alone without an accompanying decompression procedure. The clinical evidence is insufficient to determine whether isolated facet arthroplasty is as effective or as safe as spinal fusion.

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Lumbar Fusion for Lumbar Spinal Stenosis Alone

Lumbar spinal stenosis is a common degenerative condition and a frequent indication for surgical intervention when conservative treatment fails. In the absence of radiographic instability, the role of posterior fusion remains controversial, and variability in the definition of instability across studies and guidelines may contribute to its use without clear justification. The current clinical evidence is insufficient to support lumbar fusion for lumbar spinal stenosis without instability.

Chen et al. (2025) conducted a meta-analysis that compared decompression alone with decompression combined with interbody fusion for degenerative lumbar diseases. The analysis included 35 studies, involving 12,030 individuals, with 7,442 individuals undergoing decompression alone and 4,588 undergoing decompression with fusion. The pooled analysis showed that decompression alone was associated with shorter operative duration [mean difference (MD), -89.09 minutes; 95% CI, -92.71 to -85.47 minutes]. Intraoperative blood loss was also lower in the decompression-alone group (MD, -242.26 mL; 95% CI, -252.16 to -232.36 mL). Individuals who underwent decompression alone experienced shorter hospital stays (MD, -2.36 days; 95% CI, -2.59 to -2.14 days). Time to ambulation following surgery was also shorter in the decompression-alone group (MD, -10.49 hours; 95% CI, -12.52 to -8.46 hours). Disability outcomes measured by the ODI were slightly better in the fusion group at the final follow-up (MD, 1.28; 95% CI, 0.35-2.21), although the difference was small. Pain outcomes measured by the VAS, quality-of-life measures such as the 12-Item Short Form Survey and EQ-5D, complication rates, and reoperation rates did not differ meaningfully between the groups. Benefits of decompression alone included shorter operative time, reduced blood loss, shorter hospitalization, and faster postoperative mobilization. The authors concluded that decompression alone and decompression with fusion demonstrate comparable clinical effectiveness and satisfaction among individuals, but decompression alone may be considered the preferred surgical approach for many individuals with degenerative lumbar disease unless specific indications for fusion exist; future research should identify subgroups of individuals who may benefit more from fusion procedures. Limitations include the heterogeneity among the included studies, variation in surgical techniques and individuals' characteristics, and differences in follow-up duration.

Tsuang et al. (2025) performed a systematic review and meta-analysis that investigated the reoperation rates following the addition of fusion after decompression in individuals with lumbar spinal stenosis without spondylolisthesis. Exclusionary criteria included cases of spondylolisthesis and instabilities. The occurrence of reoperation was summarized using odds ratios, while other outcomes were presented as MDs. A total of 48 studies met selection criteria, and 17 were included in the meta-analysis. The authors' comparison between the fusion and nonfusion groups in individuals with lumbar stenosis and neurological claudication revealed no significant difference in reoperation rates (odds ratio, 1.13; 95% CI, 0.88-1.46; 8,016 individuals; 14 studies; $I^2 = 0\%$). Additionally, the authors concluded that individual ODI and the back pain and leg pain VAS showed no significant differences. The addition of fusion after decompression demonstrated limited benefits in terms of reoperation rates, ODI, and leg pain. Limitations of the study include that the majority of the included studies were nonrandomized, which increases the risk of bias. Additionally, the data available to quantify possible delays in reoperation provided by fusion were limited to address the clinical utility in individuals.

Chen et al. (2020) conducted a systematic review and meta-analysis that evaluated decompression alone compared with decompression combined with fusion for the treatment of lumbar spinal stenosis. The literature search identified 13 eligible studies, which involved 29,066 individuals. The pooled analysis showed that decompression with fusion was associated with a higher incidence of complications than decompression alone (relative risk, 1.41; 95% CI, 1.26-1.57). Fusion procedures were also associated with longer operative time (weighted MD, 80.40 minutes; 95% CI, 44.40-116.40 minutes). In addition, estimated intraoperative blood loss was greater in the fusion group (weighted MD, 309.36 mL; 95% CI, 98.01-520.70 mL). Individuals who were undergoing fusion also experienced longer hospital stays (weighted MD, 1.87 days; 95% CI, 1.39-2.34 days). Despite these perioperative differences, there were no meaningful differences between the groups in pain outcomes measured by the VAS. Disability outcomes, as measured by the ODI, and quality-of-life measures, such as the 36-Item Short Form Survey, were also similar between groups. The benefits of decompression alone included shorter operative time, reduced blood loss, fewer perioperative complications, and shorter hospitalization. The authors concluded that decompression with fusion does not demonstrate clear clinical advantages compared with decompression alone for lumbar spinal stenosis and that surgical decisions should be guided by careful evaluation of individuals' symptoms, imaging findings, and clinical indications. Limitations include the heterogeneity among the included studies, variation in surgical techniques and populations of individuals, and limited long-term follow-up in some studies.

Shen et al. (2018) conducted a meta-analysis and systematic review on the clinical outcomes of spinal decompression, with or without spinal fusion, for degenerative lumbar spinal stenosis (DLSS). Five RCTs, involving 438 individuals, met the inclusion criteria. Low-quality evidence of the meta-analysis was evaluated for the heterogeneity of the included studies. A pooled analysis showed no significant differences between the decompression-alone and fusion groups for the ODI scores at baseline ($p = 0.50$) and the 2-year follow-up ($p = 0.71$), and the satisfaction rate of operations was also similar in the groups ($p = 0.53$). The authors reported that operative time, blood loss, and length of hospital stay were

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markedly higher in the fusion group. The success rate of operations was defined as the proportion of individuals who were satisfied with their outcomes. Decompression alone had a similar satisfactory rate of operation with fusion rate. The authors concluded, through their analysis, that there is little value in adding fusion to decompression surgery when DLSS is stable. The authors concluded that the analyzed five studies, which comprised 438 individuals, provided limited evidence that additional fusion surgery seems unlikely to result in better outcomes in individuals with DLSS. Limitations include the highly variable sample sizes and study heterogeneity.

Clinical Practice Guidelines

North American Spine Society (NASS)

In the evidence-based clinical guidelines on the diagnosis and treatment of DLSS (NASS, 2011), NASS lists the following recommendation regarding the addition of lumbar fusion, with or without instrumentation, to surgical decompression only in improved surgical outcomes in the treatment of lumbar spinal stenosis without instability: "Decompression alone is suggested for patients with leg predominant symptoms without instability."

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

There are several devices used in spinal fusion and decompression procedures. For additional information, see one of the following websites, and search by product name in the device field:

- http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm
- https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMA/pma.cfm

(Accessed April 13, 2026)

On June 15, 2023, the FDA granted premarket approval of the TOPS System (Premia Spine USA, Norwalk, CT), which is a motion-preserving spinal implant that is intended to stabilize the spine following decompression without using rigid fixation. Further information can be found at: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma.cfm?id=P220002. (Accessed April 13, 2026)

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Policy History/Revision Information

Date	Summary of Changes

09/01/2026	**Coverage Rationale**
	• Revised language pertaining to medical necessity clinical coverage criteria:
	  ○ Added reference to the InterQual® Client Defined, CP: Procedures, Decompression +/- Fusion, Lumbar (Custom) - UHG
	  ○ Removed reference to the InterQual® CP: Procedures, Decompression +/- Fusion, Lumbar
	Medical Records Documentation Used for Reviews
	• Updated list of Medical Records Documentation Used for Reviews:
	  ○ Added "diagnostic image(s) report(s) by a radiologist including presence or absence of signs of infection"
	  ○ Removed:
	  ▪ Failure of conservative therapy through lack of clinically significant improvement between at least two measurements on a validated pain or function scale or quantifiable symptoms despite concurrent conservative therapies
	  ▪ Progressive deficits with clinically significant worsening based on at least two measurements over time
	  ▪ Disabling symptoms
	  ▪ Diagnostic image(s) report(s) by a radiologist including presence or absence of disc herniation; quantification of subluxation, translation by flexion, angulation when appropriate; discitis; and epidural abscess
	  ▪ Physical exam, including neurologic exam and quantification of relevant muscle strength
	  ▪ For revision surgery include documentation of clinical complications, relevant laboratory findings, relevant imaging, and prior treatments for complications tried, failed, or contraindicated. Include the dates and reason for discontinuation
	  ○ Replaced:
	  ▪ "Surgical history, including dates and outcomes" with "*relevant* surgical history, including dates and outcomes"
	  ▪ "Diagnostic image(s) report(s) by a radiologist including presence or absence of segment(s) Instability and spinal cord compression" with "diagnostic image(s) report(s) by a radiologist including presence or absence of segment(s) Instability *using a validated scale (e.g., Meyerding Classification) and Radiographic Dynamic Instability* and spinal cord compression *including levels*"

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Date	Summary of Changes
	▪ "*Complete* report(s) of diagnostic tests *including results of* biopsy(ies) *and results of bone aspirate*" with "reports of *all relevant recent* diagnostic tests (*e.g.,* biopsy, *culture*)" ▪ "Describe the surgical technique(s) planned" with "describe the surgical technique(s) planned *and in the case of revision, provide rationale*" **Definitions** • Added definition of: ○ Anticipated Instability Due to Procedure ○ Instability ○ Lumbar Spinal Decompression With Interbody Lumbar Spinal Fusion ○ Meyerding Classification System of Spondylolisthesis ○ Radiographic Dynamic Instability ○ Unstable Grade I Degenerative Spondylolisthesis **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information • Archived previous policy version 2026T0639I

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its policies and guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

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