Lumbar Spine Decompression Surgery: Discectomy, Foraminotomy, Laminotomy, Laminectomy

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| Replaces | N/A |

Policy

Lumbar spine decompression surgery may be considered medically necessary when applicable criteria are met.

Note: See Policy Guidelines for documentation information.

Lumbar Discectomy (Discectomy), Foraminotomy, Laminotomy

Lumbar discectomy (discectomy), foraminotomy, laminotomy surgery may be considered medically necessary for the following:

- The rapid (48 hours or less) progression of neurologic impairment (e.g. cauda equina syndrome, foot drop, extremity weakness, saddle anesthesia, sudden onset of bladder or bowel dysfunction).

Lumbar discectomy (discectomy), foraminotomy, laminotomy may be considered medically necessary when ALL of the following criteria are met:

- All other sources of low back pain have been ruled out AND
- A lumbar spine magnetic resonance image (MRI) or lumbar spine computerized tomography (CT) scan with myelogram within the past 12 months shows nerve root compression that corresponds to symptoms and physical examination findings or there is definitive neurological localization by other means (e.g. selective nerve root injections) (See Policy Guidelines) AND
- Persistent, debilitating pain radiating from the low back down to the lower extremity is present on a daily basis that limits activities of daily living (ADLs) AND
- Neurological deficits (e.g., reflex change in the legs, dermatomal sensory loss, motor weakness) or alternative signs of lumbar root irritation (e.g. positive leg raising test) are present on physical examination AND
- The member has actively tried and failed at least 6 weeks of conservative medical management such as:
  - Activity modification
  - Oral analgesics and/or anti-inflammatory medications
  - Physical therapy
  - Chiropractic manipulation
  - Epidural steroid injections

Lumbar Laminectomy

Lumbar laminectomy may be considered medically necessary for the following:

- The rapid (48 hours or less) progression of neurologic impairment (e.g. cauda equina syndrome, foot drop, extremity weakness, saddle anesthesia, sudden onset of bowel or bladder dysfunction).
Spinal Stenosis
Lumbar laminectomy for spinal stenosis may be considered medically necessary when ALL of the following criteria are met:

- All other sources of low back pain have been ruled out AND
- Persistent, progressive, debilitating symptoms of neurogenic claudication (with or without back pain) are present on a daily basis that limits activities of daily living (ADLs) AND
- A lumbar spine MRI or lumbar spine CT scan with myelogram within the past 12 months shows lumbar spine stenosis that corresponds to the clinical findings on physical examination (See Policy Guidelines) AND
- The member has actively tried and failed at least 12 weeks of conservative medical management such as:
  - Activity modification
  - Oral analgesics and/or anti-inflammatory medications
  - Physical therapy
  - Chiropractic manipulation
  - Epidural steroid injections

Other conditions
Lumbar laminectomy may be considered medically necessary for ANY of the following:

- Dorsal rhizotomy for spasticity in cerebral palsy
- Lumbar spondylolisthesis confirmed by a lumbar MRI study
- Metastatic neoplasm of the spine, non-cancerous spinal tumor, cysts that cause nerve root or spinal cord compression with corresponding neurological deficit, confirmed by a lumbar MRI study
- Spinal infection confirmed by a lumbar MRI study
- Spinal injury confirmed by a lumbar MRI study (e.g. epidural hematoma or foreign body)
- Spinal trauma confirmed by a lumbar MRI study (e.g. spinal fracture, displaced fragment from a spinal fracture, vertebral dislocation together with instability, locked facets)

Lumbar spine decompression surgery may be considered not medically necessary when no clinical indication is documented and there are no confirmatory physical and radiologic findings that meet the relevant criteria listed in this policy.

Note: The provider’s choice of interventional surgery depends on the specific member’s symptoms and imaging findings.

See Related Policies for other spinal procedures not addressed by this policy.

Related Policies

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<td>Image-Guided Minimally Invasive Lumbar Decompression (IG-MLD) for Spinal Stenosis</td>
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Policy Guidelines

Administrative Guidelines
A pre-service review for all indications is strongly recommended. (See Benefit Application)

Medical necessity is established by documentation of medical history, physical findings, and diagnostic imaging results that demonstrate spinal nerve compression and support the surgical treatment intervention.

Documentation
Documentation in the medical record must clearly support the medical necessity of the surgery and include the following information:

Medical History
- Co-morbid physical and psychological health conditions
- History of back surgery, including minimally invasive back procedures
- Prior trial, failure, or contraindication to conservative medical/non-operative interventions that may include but are not limited to the following:
  - Activity modification for at least 6 weeks
  - Oral analgesics and/or anti-inflammatory medications
  - Physical therapy
  - Chiropractic manipulation
  - Epidural steroid injections

Physical Examination
Clinical findings including the patient’s stated symptoms and duration

Diagnostic Test
Radiologist’s report of a magnetic resonance image (MRI) or computerized tomography (CT) scan with myelogram of the lumbar spine within the past 12 months showing a lumbar spine abnormality. Report of the selective nerve root injection results, if applicable to the patient’s diagnostic workup.

Definition of Terms
Cauda equine: The nerve roots (resembling a horse’s tail) that continues from where the spinal cord ends, and branches down to the lower part of the body. (Cauda equina is Latin for horse’s tail).
Cauda Equina Syndrome (CES) - a serious condition caused by compression of the cauda equina nerves of the lower spine; it is considered a surgical emergency. CES may be caused by a herniated disk, infection, cancer, trauma, or spinal stenosis. A rapid progression of neurologic symptoms is seen that may include but are not limited to severe sharp/stabbing debilitating low back pain that starts in the buttocks and travels down one or both legs, with severe muscle weakness, inability to start/stop urine flow, inability to start/stop bowel movement, loss of sensation below the waist and absence of lower extremity reflexes.

Dermatome/dematomal: Each area of skin (dermis) has sensory nerve fibers coming from a single spinal nerve root (see Appendix).

- Myotome: Muscle of the back supplied by a nerve of the spine
- Sclerotome: Cartilage, tendons and endothelial cells that form the back bones and rib cartilage

Disc (intervertebral): Round flat “cushions” between each vertebra of the spine

Discectomy (diskectomy): The removal of herniated disc material/disc fragments that are compressing a nerve root or the spinal cord. A discectomy may be done to treat a ruptured disc. (Percutaneous discectomy is addressed in a separate policy. See Related Policies).

Dorsal rhizotomy: The cutting of selected nerves in the lower spine to reduce leg spasticity in patients with cerebral palsy.

Foraminotomy (foraminectomy): The removal of bone and tissue to enlarge the opening (foramen) where a spinal nerve root exits the spinal canal.

Hemilaminectomy: The removal of only one side of the posterior arch (lamina) of a vertebra.

Lamina: Bony arch of the vertebrae related to the facet joint that helps to cover & protect the spinal canal. Each spinal vertebra has two laminae.

Laminectomy: The removal of the whole posterior arch (lamina) of a vertebra.

Laminotomy: The removal of a portion of the posterior arch (lamina) of a vertebra.

Lumbar spinal stenosis: Abnormal narrowing of the spaces between the vertebrae where the nerve roots pass through from the spinal cord. Nerve impingement may occur in the central canal, in the lateral recess or at the neuroforamen causing pain and problems with walking.

Lumbar spondylolisthesis: A condition where one of the vertebrae slips out of place by moving forward or backward on an adjacent vertebra. Usually occurs at the location of L5-S1.

- Isthmic spondylolisthesis – the most common form of spondylolisthesis due to a defect or fracture of the bone that connects the upper and lower facet joints (the pars interarticularis). The disorder may be congenital when the bone fails to form properly or acquired due to a stress fracture and slippage of part of the spinal column. (Some athletes such as gymnasts, football players and weightlifters may suffer from this disorder).

Myelopathy: Refers to any neurologic deficit related to the spinal cord, usually caused by compression.

Neurogenic claudication (or pseudoclaudication): Symptoms of pain, paresthesia (numbness, tingling, burning sensation) in the back, buttocks and lower limbs and possible muscle tension, limping or leg weakness that worsens with standing/walking and is relieved by rest, sitting or leaning forward. Usually associated with lumbar spinal stenosis.

Paresthesia: Abnormal sensation of burning, prickling, pricking, tickling, tingling of the skin; often described as “pins and needles”.

Radicular pain: Pain that radiates along a dermatome of a nerve due to inflammation/irritation/compression of the nerve root that connects to the spinal column. Also known as radiculitis, a common form is sciatica.
**Radiculopathy:** A progressive neurologic deficit caused by disc material or boney changes like spurs compressing a spinal nerve root. Symptoms may include pain radiating from the spine, a motor deficit, reflex change or EMG changes.

**Saddle anesthesia:** A loss of feeling in the buttocks, perineum and inner thighs frequently related to cauda equina syndrome.

**Spinal cord/nerve roots:** The cord, surrounded by the vertebrae of the spinal column, connecting the brain to all parts of the body by pairs of nerve roots that extend from the cord and pass through spaces in between the vertebrae.

**Vertebrae:** The individual bones of the spinal column that consist of the cervical, thoracic and lumbar regions that surround and protect the spinal cord.

### Coding

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<th>CPT</th>
<th>Description</th>
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<tr>
<td>62287</td>
<td>Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method, single or multiple levels, lumbar (e.g., manual or automated percutaneous discectomy, percutaneous laser discectomy)</td>
</tr>
<tr>
<td>63005</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; lumbar, except for spondylolisthesis</td>
</tr>
<tr>
<td>63012</td>
<td>Laminectomy with removal of abnormal facets and/or pars inter-articulares with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)</td>
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<td>63017</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; lumbar</td>
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<tr>
<td>63030</td>
<td>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar</td>
</tr>
<tr>
<td>63035</td>
<td>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)</td>
</tr>
<tr>
<td>63042</td>
<td>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar</td>
</tr>
<tr>
<td>63044</td>
<td>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)</td>
</tr>
<tr>
<td>63047</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; lumbar</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], 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>
</tr>
<tr>
<td>63056</td>
<td>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)</td>
</tr>
<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>
</tr>
<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>63267</td>
<td>Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar</td>
</tr>
<tr>
<td>63272</td>
<td>Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar</td>
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### Description

Back pain, with and without radicular symptoms is one of the most common medical reasons that members seek medical care. The pain can vary from mild to disabling. Back pain is called chronic if it lasts more than three months. Chronic low back pain often improves on its own over time or with the help of non-surgical care.
There are many potential causes for low back pain. Several conditions may cause pinched or compressed nerves in the low back area putting pressure on the spinal cord that may cause tingling, muscle weakness and sudden loss or impairment of bowel and bladder function. Intervertebral disc herniation, spinal stenosis, and degenerative spondylolisthesis with stenosis are the most common conditions that have low back pain and leg symptoms and may require surgery to relieve the compression according to the findings in the Spine Patient Outcomes Research Trial (SPORT).

Normally, the spinal cord is protected by the back bones (vertebrae) that form the spine, but certain injuries to and disorders of the spine may cause cord compression, affecting its normal function. The spinal cord may be compressed by bone, the collection of blood outside a blood vessel (hematomas), pus (abscesses), tumors (both noncancerous and cancerous), or a herniated/ruptured or malformed disc. These injuries and disorders may also compress the spinal nerve roots that pass through the spaces between the back bones or the bundle of nerves that extend downward from the spinal cord (cauda equina). The spinal cord may be compressed suddenly, causing symptoms in minutes or over a few hours or days, or slowly, causing symptoms that worsen over many weeks or months.

Lumbar spine decompression is a broad definition of surgical procedures performed on the bones in the lower (lumbar) spine to relieve the pinched or compressed spinal cord and/or nerve(s). The goal is to “decompress” the spinal cord and/or nerve root(s) that are causing disabling pain and/or weakness due to damage to the spinal cord (myelopathy).

During a lumbar decompression surgery the surgeon removes portions of the intervertebral disc and/or adjacent bone and tissue in the lower spine to give the nerve root more space. Surgical procedures for spinal decompression include lumbar discectomy, foraminotomy, laminotomy, lumbar laminectomy.

### Scope

Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.

### Benefit Application

A pre-service review is strongly recommended for all indications with submission of clinical information that supports the medical necessity for spinal decompression surgery. Please call the customer service number on the member’s ID card for information about a pre-service review.

See Policy Guidelines for medical necessity documentation information. If a pre-service review is not obtained, a retrospective medical necessity review will be done. Services that are not medically necessary will not be covered.

### Rationale

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<td><strong>Interventions</strong></td>
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<td><strong>Outcomes</strong></td>
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<tr>
<td>Individuals:</td>
<td>Interventions of interest are:</td>
<td>Comparators of interest are:</td>
<td>Relevant outcomes include:</td>
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<tr>
<td>• With lumbar spinal stenosis and spinal cord or nerve root</td>
<td>• Lumbar laminectomy</td>
<td>• Conservative, nonsurgical care</td>
<td>• Symptoms</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Functional outcomes</td>
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<td></td>
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<td>• Health status measures</td>
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</table>
Back pain is a common medical problem that may affect 8 out of 10 people during their lifetime. Back pain is called chronic if it lasts more than three months. Age-related disc degeneration, facet joint arthrosis and segmental instability are leading factors causing chronic back pain. Back pain in a large majority of patients, up to approximately 90%, will improve over 2 months with minimal intervention.

The most common symptoms of spinal disorders are regional pain and range of motion limitations. A small subset of patients may experience radiating pain in addition to decreased range of motion and low back discomfort. For the majority of patients pain characteristics depend on activity levels. For example the pain intensity changes with increased physical activity, certain movements or postures and decreases with rest. However, night-time back pain may be present in the absence of serious specific spinal disorders. The precise location and originating point of back pain is often difficult for patients to describe. Interpretation of patients’ symptoms is difficult due to the overlap of referred sensations between adjacent spinal levels and the similarities between dermatomes, myotomes, and sclerotomes. (See Appendix).

Lumbar Discectomy (Diskectomy)
The most recent update covers the period through February 22, 2016.

Lumbar disc prolapse, protrusion, or extrusion accounts for less than 5% of all low back problems, but are the most common causes of nerve root pain and surgical interventions. The primary motivation for any form of surgery for disc prolapse is to relieve nerve root irritation or compression due to herniated disc material. (4) In order to visualize the disc, vertebrae and surrounding tissue, the surgery may be done as an open procedure or microscopically. (See Related Policies.) Decompression surgery is a common treatment for lumbar disc herniation...
The best evidence on the efficacy of discectomy consists of several RCTs comparing discectomy with conservative care, and systematic reviews of these trials. The RCTs form the main body of evidence for evaluating the efficacy of discectomy. However, conducting high-quality RCTs for this condition is challenging due to strong preferences for treatment on the part of both patients and physicians. This leads to difficulty enrolling a population that is representative of patients seen in clinical care, and also to high rates of crossover between treatment groups following randomization. For this reason, it is important to evaluate evidence from nonrandomized comparative trials. Some of the representative, larger nonrandomized comparative studies are also included in the review of evidence.

**Randomized Controlled Trials**

A total of 6 RCTs of discectomy versus conservative care were initially identified. One of these was from 1983 and was not included because it was unlikely that results reflect current surgical management. Another RCT compared percutaneous discectomy with conservative care. Because percutaneous discectomy is considered investigational (see evidence review 7.01.18), this study was also excluded, leaving 4 RCTs for review.

**The SPORT Trial**

This moderately large-sized trial compared discectomy with nonoperative care in patients with lumbar disc herniation and included both a randomized and nonrandomized component. The randomized component included 501 patients randomly assigned to either discectomy or usual care. Discectomy was performed by the open technique for all patients, and in some cases, the medial border of the superior facet joint was removed. Crossover was allowed and, during the course of the study, 107 (45%) of 245 patients assigned to usual care underwent surgery, and 140 (60%) of 245 patients assigned to the surgery group underwent surgery. The main outcomes were the 36-Item Short-Form Health Survey (SF-36) and the Oswestry Disability Index (ODI) measured at 3 months, 1 year, and 2 years. Secondary outcomes included self-reported improvement, work status, satisfaction with care, and a symptom severity measure (Sciatica Bothersomeness Index).

For the primary outcomes analyzed on intention-to-treat (ITT) analysis, improvement in the ODI score was superior for the surgery group at 3 months, but at the 1 year and 2 year time points, there were no significant group differences on any of the primary outcomes. For the secondary outcomes, there were significant improvements for the surgery group on the Sciatica Bothersomeness Index at all time points, and satisfaction with care was superior for the surgery group at 3 months, but not at longer time points. A secondary analysis was performed on a treatment-received basis, and this analysis showed significantly greater improvements for the surgery group at all time points. The estimated treatment effect for the SF-36 bodily pain and physical function subscales with 15.0 and 17.5, respectively, on a 0 to 100 scale. The estimated treatment effect on the ODI score was -15.0 on a 0 to 100 scale.

**Leiden-The Hague Spine Intervention Prognostic Study**

This was a multicenter RCT performed at 11 hospitals in the Netherlands comparing immediate surgery with continued conservative care and surgery as necessary. Patients were eligible if they were 18 to 65 years old, had severe sciatica for between 6 and 12 weeks, and had radiologically confirmed disc herniation. A total of 283 patients were randomized and followed for 1 year. Patients in the surgery group were treated with microdiscectomy, and patients in the conservative care group received continued conservative care from their primary care providers. The primary outcomes were the Roland-Morris Disability Questionnaire for sciatica, leg pain rating on a 0-to-100 visual analog scale (VAS), and self-rating of perceived recovery on a 7-point Likert scale. Secondary outcomes included observational assessment of neurologic status and disability, the SF-36, and sciatica symptom scales.

By the end of the study, 89% of the surgical group underwent surgery, and of the 142 patients assigned to initial conservative care, 55 (39%) had undergone surgery at 1 year. At early follow-up, there were some differences in favor of the surgery group. At 8 and 12 weeks, the surgery group had superior scores on disability and leg pain, and back pain was superior for the surgery group between 2 and 26 weeks. However, at 1-year follow-up, the scores were similar between groups with no significant group differences. For the outcome of perceived recovery, the median time to recovery was shorter in the surgery group (4.0 weeks; 95% confidence interval [CI], 3.7 to 4.4) compared with the conservative care group (12.1 weeks; 95% CI, 9.5 to 14.9). At 1 year, the recovery rates were
equivalent between groups, with 95% of patients reporting recovery.

**Osterman et al**
A small, single-center RCT comparing discectomy with conservative care was completed in 2006. A total of 56 patients referred to orthopedics for sciatica were eligible for inclusion, as defined by sciatica with pain radiating below the knee, at least 1 specific physical exam sign consistent with sciatica, and radiologic confirmation of a herniated disc. Patients in the surgical group were treated with microdiscectomy, and patients in the conservative care group were enrolled in a structured physical therapy program. The main outcome measure was intensity of leg pain measured on a 0-to-100 scale, and secondary outcomes were back pain, work ability, general quality of life, disability, depression, and satisfaction with care. Follow-up time points were 6 weeks, 3 months, 1 year, and 2 years.

All 28 patients in the surgery group underwent surgery, and 11 (39%) of 28 patients in the conservative care group underwent surgery by the end of the study. Over the course of the 2-year follow-up, there were no overall differences on any of the primary outcomes between the surgical and conservative care groups. At each time point, the surgery group had numerically superior results, but the differences did not reach statistical significance. On subgroup analysis, there were significant improvements for the surgery group on patients older than 37 years, and on patients with L4-5 herniation.

**Butterman et al**
A RCT comparing discectomy with epidural steroid injections was published by Butterman in 2004. This trial enrolled 169 patients referred for treatment of disc herniation. All patients had a large disc herniation, defined as greater than 25% the cross-sectional area of the spinal canal, at a single level. Patients with rapidly progressive symptoms and patients with recurrent disc herniation were excluded. Conservative care was administered for the first 6 weeks of the trial, with improvement in symptoms for 69 patients. The remaining 100 patients were randomized to discectomy or epidural spinal injections. Follow-up was for 2 to 3 years, but there was a large decrease in the percent of patients available for follow-up after the 3-month time period, particularly for the injection group, in which only approximately half of the patients were available at any time point longer than 3 months.

At 1- to 3-month follow-up, pain scores, scores on the ODI score, and medication use were lower in the surgery group compared with the injection group, but at later time points there were no significant differences between groups. The percent of patients describing their treatment as successful ranged from 92% to 98% at various time points for patients in the surgery group, compared with a range of 42% to 56% percent in the injection group.

**Systematic Reviews**
A systematic review based on a Cochrane Collaboration review was published by Jacobs et al in 2011. The authors included 5 RCTs, 4 of which were the trials previously discussed, with the additional trial being the older 1983 trial that was excluded from this review. The authors assigned a low risk of bias to 2 of the 4 trials, the SPORT trial and the Leiden-The Hague Spine Intervention Prognostic Study. The authors determined that pooling of the results was not appropriate due to differences in study methodology, and a qualitative synthesis of the data was performed. The review concluded that surgery was likely to lead to better short-term control of leg pain, but that the overall quality of the body of evidence for this outcome was low. There were no differences demonstrated between surgery and conservative care at time points of 1 year or longer.

Lewis et al performed a network meta-analysis comparing 21 different strategies for treatment of sciatica. This review included a total of 122 comparative studies, 90 of which were RCTs. For disc surgery, there were 8 studies comparing surgery with conservative care (3 RCTs, 1 quasi-RCT, 4 cohort studies), and 34 studies comparing discectomy with other alternative treatments, including other surgical variations. For the main outcome of overall recovery, surgery was better than exercise therapy, traction, and percutaneous discectomy. However, for the outcome of pain, disc surgery was not found to be better than alternative treatments.

Chou et al published a systematic review of the evidence for efficacy of different surgical procedures for back pain, in conjunction with development of clinical guidelines by the American Pain Society. For the question of discectomy versus nonsurgical care, 4 studies were included, 3 of which were previously reviewed. The studies were not pooled. The conclusions of this evidence review were that discectomy, performed either by open surgery
or microdiscectomy, had superior outcomes of pain and disability at up to 3 months, but no definite benefit at longer time points.

**Nonrandomized Comparative Studies**

The observational cohort component of the SPORT trial enrolled patients who met the eligibility criteria for the SPORT RCT but who declined randomization to treatment group. A total of 743 patients were enrolled, 528 underwent discectomy and 191 were treated with conservative care. The primary outcomes (SF-36, ODI) and secondary outcomes (self-reported improvement, work status, satisfaction, symptom severity) were the same as for the RCT, and follow-up was according to same schedule of 3 months, 1 year, and 2 years. Follow-up ranged between 82% and 89% for different time points. Study results reported that the surgery group had superior improvements at 2 years on all primary and secondary outcome measures, except work status. The treatment effect as measured by the SF-36 bodily pain subscale was 10.2 (95% CI, 5.9 to 14.5), the treatment effect on the SF-36 physical function subscale was 12.0 (95% CI, 7.9 to 16.1), and the treatment effect on the ODI score was -13.4 (95% CI, -17.0 to -9.7).

The Maine Lumbar Spine Study was a prospective cohort study that compared 10-year outcomes of discectomy with conservative care. There were 507 patients enrolled in the study, with 477 patients that survived until 10 years, and 10-year outcome data was available for 400 (84%) of 477, 217 who were treated surgically and 183 treated conservatively. Approximately 25% of patients who were originally treated with conservative care underwent a surgical procedure during the 10-year period. Baseline data were obtained from a physician questionnaire, and outcome data were obtained from questionnaires mailed to patients. Patients treated with surgery had worse symptoms and decreased functional status compared with patients treated conservatively. At 10 years, there was no difference in the percent of patients who reported improvement in their predominant symptom, no difference in the modified Roland functional status index, and no difference in work or disability status. There were significant differences in favor of surgery in the percent of patients who reported that their back or leg pain was completely gone or much better (56% vs 40%, p=0.006), and on the percent of patients who were satisfied with their care (71% vs 56%, p=0.002).

**Section Summary: Lumbar Discectomy**

The comparative evidence on lumbar discectomy versus conservative care consists of a small number of RCTs and nonrandomized comparative studies. The RCT evidence is limited by a lack of high-quality trials. In most trials, there is a high percentage of patients in the conservative group who cross over to receive surgery. This high degree of contamination leads to reduced power to detect a difference when an ITT analysis is used. Analysis by treatment received is also flawed because of the potential noncomparability of groups resulting from the high crossover.

Despite the methodologic limitations of the evidence, the RCTs are consistent in demonstrating a probable benefit for surgery in more rapid resolution of pain and disability. For the ITT analyses, there are small differences in favor of surgery that, which sometimes reach statistical significance and other times do not. In contrast, on analysis by treatment received and in the nonrandomized comparative studies, there are larger differences in favor of surgery that exceed the threshold for clinical significance. At time points of 1 year or longer, outcomes from surgery and conservative care appear to be equivalent.

**Lumbar Laminotomy**

A 2008 quasi-randomized study from Asia compared laminoforaminotomy with laminectomy (n=152). Inclusion criteria for participants was 1) neurogenic claudication as defined by leg pain that limited standing, ambulation, or both; 2) a history of exercise intolerance; 3) magnetic resonance imaging (MRI), myelogram, or computed tomography (CT) showing compressive central stenosis (central sagittal diameter less than 10 mm) with or without lateral recess stenosis (lateral recess diameter less than 3 mm); and 4) failure of conservative therapy after an adequate trial (not defined). Exclusion criteria for selecting participants was 1) previous surgery at the same level; 2) isthmic spondylolisthesis; 3) congenital spinal stenosis less than 8 mm caused by short pedicles; 4) dynamic instability; 5) cauda equina syndrome; 6) worker’s compensation claim or other litigation; 7) dying of other disease or otherwise lost to follow-up. An average of 40 months after surgery, the Oswestry Disability Index (ODI) and Visual Analog Scale (VAS) for back and leg pain were low (e.g., less than 1 on VAS) for both groups, and significantly lower for laminotomy. The proportion of patients with good to excellent results (absent or occasional mild back and leg pain and the ability to ambulate more than 1 mile or 20 minutes) was 89% for
patients treated with laminotomy and 63% for patients treated with laminectomy. Seven percent of patients treated with laminectomy had poor results at the final interview (range: 27–58 months), compared with none in the laminotomy group. The study limitations are the lack of blinding and the unknown number of patients lost to follow-up.

The most recent update covers the period through March 10, 2016.

**Lumbar Spinal Stenosis**

Two RCTs of laminectomy versus nonsurgical management for patients with spinal stenosis were identified. In the larger trial, Weinstein et al reported findings from the multicenter controlled trial (Spine Patient Outcomes Research Trial [SPORT]) that compared surgical and nonsurgical treatment for lumbar degenerative spondylolisthesis. All patients had neurogenic claudication or radicular leg pain associated with neurologic signs, spinal stenosis shown on cross-sectional imaging, and degenerative spondylolisthesis shown on lateral radiographs with symptoms persisting for at least 12 weeks. There were 304 patients in a randomized cohort and 303 patients in an observational cohort. About 40% of the randomized cohort crossed over in each direction by 2 years of follow-up. At the 4-year follow-up, 54% of patients randomized to nonoperative care had undergone surgery. Five percent of the surgically treated patients received decompression only and 95% underwent decompression with fusion.

Analysis of results by intention-to-treat analysis did not show any differences in outcomes between the surgical and nonsurgical groups. However, this analysis was limited by the high rate of crossover, with the rate of surgery in the patients assigned to nonsurgical management only slightly lower than the rate of surgery in patients assigned to surgical management (54% vs 66%). Therefore, analysis by treatment received was also performed. This analysis, controlled for baseline factors, showed a significant advantage for surgery at up to 4 years of follow-up for all primary and secondary outcome measures. The differences on the primary outcomes were: 17 points on the 36-Item Short-Form Health Survey (SF-36) bodily pain score (score range, 0-100; 95% confidence interval [CI], 13 to 20.9); 16.1 points on the SF-36 Physical Function score (score range, 0-100; 95% CI, 12.3 to 19.8); and -12.6 points on the Oswestry Disability Index (ODI; score range, 0-100; 95% CI, -15.5 to -9.7). All of these group differences are substantially larger than the minimally important clinical change for these measures.

Lurie et al published a follow-up analysis of the SPORT trial at 8 years. At this time point, 55% of the original patient population was available. Of available patients, 70% assigned to surgery and 52% assigned to medical care had undergone surgery. On intention-to-treat analysis, there were no differences on the primary outcomes. On as-treated analysis, the differences on the SF-36 and ODI measures were significant at 4-year follow-up, but not significant at the 6- to-8-year follow-up time points.

In a small RCT from Finland, 94 patients from 4 university hospitals were randomized to laminectomy with or without fusion versus conservative therapy and followed for 2 years. All patients had lumbar spinal stenosis, persistent back pain for at least 6 months, and imaging studies demonstrating spinal stenosis at a level corresponding with the patient’s symptoms. Crossover was allowed for progressive symptoms, and 4 of 44 patients assigned to nonoperative treatment underwent surgery over the 2 years of follow-up. The primary outcomes were the ODI (score range, 0-100) and visual analog scales (VAS) of leg pain and back pain (score range, 0-10). At 2-year follow-up, the surgical group showed greater improvement on all 3 of these primary outcome measures. The mean difference in the ODI was 7.8 points (95% CI, 0.8 to 14.9); the mean difference in leg pain was 1.51 points (95% CI, 0.25 to 2.77); and the mean difference in back pain was 2.13 points (95% CI, 0.98 to 3.28). There were 8 perioperative complications, 7 of 8 of these were injuries to the dural sac. An additional 4 complications occurred postoperatively, 1 hematoma requiring reoperation, 1 respiratory distress due to pulmonary edema, and 2 additional reoperations.

A number of nonrandomized comparative studies have been published, and some representative studies are reviewed here. The Maine Lumbar Spine Study was a prospective comparative cohort study of patients with lumbar spinal stenosis followed over a period of 10 years. Clinical data at baseline was obtained from a physician questionnaire, and follow-up surveys to patients were performed by mail at regular intervals. The surveys evaluated the main outcomes of back pain, leg pain, functional status, and satisfaction with treatment. A total of 148 patients were initially enrolled, 105 (67.7%) patients were alive at 10 years, and 97 (65.5%) had long-term follow-up data. At baseline, patients who underwent surgery were more severely ill, as evidenced by worse symptoms and functional status compared with patients who underwent nonsurgical care. At follow-up between 1 and 4 years, there was greater improvement in the surgical groups, but at longest follow-up of 8 to 10 years, the
groups had similar results on improvement in pain, functional status and satisfaction with care.

Amundsen et al reported a nonrandomized comparison of long-term outcomes of 100 patients with symptomatic lumbar spinal stenosis. Patients were allocated to surgery if severe symptoms were present. An additional 31 patients with intermediate symptoms were randomized to surgery or conservative care. A total of 31 patients were treated with surgery and 68 were treated conservatively. After a period of 4 years, the authors reported a satisfactory result in 80% of patients treated with surgery compared with 50% of patients treated conservatively (p not reported).

Section Summary: Spinal Stenosis
There is some evidence from RCTs on the efficacy of laminectomy versus nonsurgical treatment for lumbar spinal stenosis, but the RCTs have methodologic limitations. One RCT was small, with follow-up limited to 2 years, and the second RCT had a very high rate of crossover that may have subverted the randomization process. Both of the RCTs reported that improvements in pain and functional status were greater with surgery compared with nonsurgical treatment over the 2 to 4 year time frame. Results of nonrandomized comparative studies corroborate the findings of the RCTs, reporting greater improvement with surgical treatment. The benefit of surgery may diminish over time, with 1 long-term cohort study reporting that the initial benefit of surgery was no longer present at the 8- to 10-year time frame.

Summary
The decision to perform lumbar decompression surgery involves a holistic review of the patient. Symptoms including the presence of neurological deficits, pain acuity and duration, physical examination and MRI findings, along with the impact on activities of daily living are factors that influence the decision making discussion. Patients who fail to achieve symptom or functional improvement after actively participating in a 6-12 week conservative (non-surgical) treatment program may be candidates for a decompression surgery. The surgeon’s choice of interventional procedure(s) depends on the specific member’s symptoms and imaging findings.

Practice Guidelines and Position Statements
American Pain Society (APS)
In 2009 the APS published an evidence based clinical practice guidelines for Interventional Therapies, Surgery and Interdisciplinary Rehabilitation for Low Back Pain. Developed by a multidisciplinary panel of experts based on a systematic review of the literature. The recommendations are:

- **Recommendation 1**: In patients with chronic nonradicular low back pain, provocative discography is not recommended as a procedure for diagnosing discogenic low back pain (strong recommendation, moderate-quality evidence). There is insufficient evidence to evaluate validity or utility of diagnostic selective nerve root block, intra-articular facet joint block, medial branch block, or sacroiliac joint block as diagnostic procedures for low back pain with or without radiculopathy.

- **Recommendation 2**: In patients with nonradicular low back pain who do not respond to usual, noninterdisciplinary interventions, it is recommended that clinicians consider intensive interdisciplinary rehabilitation with a cognitive/behavioral emphasis (strong recommendation, high-quality evidence). Chronic back pain is a complex condition that involves biologic, psychological, and environmental factors. For patients with persistent and disabling back pain despite recommended noninterdisciplinary therapies, clinicians should counsel patients about interdisciplinary rehabilitation (defined as an integrated intervention with rehabilitation plus a psychological and/or social/occupational component) as a treatment option.

- **Recommendation 3**: In patients with persistent nonradicular low back pain, facet joint corticosteroid injection, prolotherapy, and intradiscal corticosteroid injection are not recommended (strong recommendation, moderate-quality evidence). There is insufficient evidence to adequately evaluate benefits of local injections, botulinum toxin injection, epidural steroid injection, intradiscal electrothermal therapy (IDET), therapeutic medial branch block, radiofrequency denervation, sacroiliac joint steroid injection, or intrathecal therapy with opioids or other medications for nonradicular low back pain.

- **Recommendation 4**: In patients with nonradicular low back pain, common degenerative spinal changes, and persistent and disabling symptoms, it is recommended that clinicians discuss risks and benefits of surgery as an option (weak recommendation, moderate-quality evidence). It is recommended that shared decision-making regarding surgery for nonspecific low back pain include a specific discussion about
intensive interdisciplinary rehabilitation as a similarly effective option, the small to moderate average benefit from surgery versus noninterdisciplinary nonsurgical therapy, and the fact that the majority of such patients who undergo surgery do not experience an optimal outcome (defined as minimum or no pain, discontinuation of or occasional pain medication use, and return of high-level function).

- **Recommendation 5**: In patients with nonradicular low back pain, common degenerative spinal changes, and persistent and disabling symptoms, there is insufficient evidence to adequately evaluate long-term benefits and harms of vertebral disc replacement (insufficient evidence).

- **Recommendation 6**: In patients with persistent radiculopathy due to herniated lumbar disc, it is recommended that clinicians discuss risks and benefits of epidural steroid injection as an option (weak recommendation, moderate-quality evidence). It is recommended that shared decision-making regarding epidural steroid injection include a specific discussion about inconsistent evidence showing moderate short-term benefits, and lack of long-term benefits. There is insufficient evidence to adequately evaluate benefits and harms of epidural steroid injection for spinal stenosis.

- **Recommendation 7**: In patients with persistent and disabling radiculopathy due to herniated lumbar disc or persistent and disabling leg pain due to spinal stenosis, it is recommended that clinicians discuss risks and benefits of surgery as an option (strong recommendation, high-quality evidence). It is recommended that shared decision-making regarding surgery include a specific discussion about moderate average benefits, which appear to decrease over time in patients who undergo surgery.

- **Recommendation 8**: In patients with persistent and disabling radicular pain following surgery for herniated disc and no evidence of a persistently compressed nerve root, it is recommended that clinicians discuss risks and benefits of spinal cord stimulation as an option (weak recommendation, moderate-quality evidence). It is recommended that shared decision-making regarding spinal cord stimulation include a discussion about the high rate of complications following spinal cord stimulator placement.

**American Academy/Association of Orthopaedic Surgeons (AAOS)**

**AAOS Lumbar Spinal Stenosis**
The educational section of the AAOS website states that nonsurgical treatment should focus on relieving pain and restoring function and may include PT, traction, anti-inflammatory medications, steroid injections, acupuncture and chiropractic manipulation. The society further states as part of their education that:

“Over the long term, 15% of patients will improve with nonsurgical modalities, and 70% will continue to experience neurogenic claudication. Therefore, most patients with LSS will, in time, require surgical intervention for a more definitive treatment. Surgery for lumbar spinal stenosis is generally reserved for patients who have poor quality of life due to pain and weakness. Patients may complain of inability to walk for an extended length of time without sitting. This is often the reason that patients consider surgery.

There are two main surgical options to treat lumbar spinal stenosis: laminectomy and spinal fusion. Both options can result in excellent pain relief. The advantages and disadvantages of both should be discussed.”

**North American Spine Society (NASS)**

**NASS Clinical Guidelines – Lumbar Herniated Disc with Radiculopathy**
The North American Spine Society issued 2012 evidence-based clinical guidelines on the diagnosis and treatment of lumbar disc herniation with radiculopathy. The guidelines state that discectomy is suggested to provide more effective symptom relief than medical/interventional care for patients with lumbar disc herniation with radiculopathy whose symptoms warrant surgical intervention. In patients with less severe symptoms, surgery of medical/interventional care appears to be effective for both short- and long-term relief (grade B recommendation). There is also a grade C recommendation stating that endoscopic percutaneous discectomy may be considered for the treatment of lumbar disc herniation with radiculopathy.

**NASS Clinical Guidelines – Degenerative Spinal Stenosis**
The society states the following treatment recommendations:
**Grade of Recommendation: I**
There is insufficient evidence to make a recommendation for or against the use of physical therapy or exercise as stand-alone treatments for degenerative lumbar spinal stenosis. In the absence of reliable evidence, it is the work group’s opinion that a limited course of active physical therapy is an option for patients with lumbar spinal stenosis.

**Grade of Recommendation: B**
Interlaminar epidural steroid injections are suggested to provide short term (two weeks to six months) symptom relief in patients with neurogenic claudication or radiculopathy. There is, however, conflicting evidence concerning long-term (21.5-24 months) efficacy.

**Grade of Recommendation: C**
A multiple injection regimen of radiographically-guided transforaminal epidural steroid injection or caudal injections is suggested to produce medium-term (3-36 months) relief of pain in patients with radiculopathy or neurogenic intermittent claudication (NIC) from lumbar spinal stenosis.

**Grade of Recommendation: B**
Decompressive surgery is suggested to improve outcomes in patients with moderate to severe symptoms of lumbar spinal stenosis.

**Grade of Recommendation: C**
Medical/interventional treatment may be considered for patients with moderate symptoms of lumbar spinal stenosis.

**NASS Clinical Guidelines – Lumbar spondylolisthesis**
The society states the following treatment recommendations:

Work Group Consensus Statement
“Medical/interventional treatment for degenerative lumbar spondylolisthesis, when the radicular symptoms of stenosis predominate, most logically should be similar to treatment for symptomatic degenerative lumbar spinal stenosis”.

**Grade of Recommendation: I**
Direct surgical decompression is recommended for treatment of patients with symptomatic spinal stenosis associated with low grade degenerative lumbar spondylolisthesis whose symptoms have been recalcitrant to a trial of medical/interventional treatment.

**Grade of Recommendation: I**
Indirect surgical decompression is recommended for treatment of patients with symptomatic spinal stenosis associated with low grade degenerative lumbar spondylolisthesis whose symptoms have been recalcitrant to a trial of medical/interventional treatment.

**Grade of Recommendation: B**
Surgical decompression with fusion is recommended for the treatment of patients with symptomatic spinal stenosis and degenerative lumbar spondylolisthesis to improve clinical outcomes compared with decompression alone.

**Grade of Recommendation: B**
The addition of instrumentation is recommended to improve fusion rates in patients with symptomatic spinal
stenosis and degenerative lumbar spondylolisthesis.

**Grade of Recommendation: B**
The addition of instrumentation is not recommended to improve clinical outcomes for the treatment of patients with symptomatic spinal stenosis and degenerative lumbar spondylolisthesis.

**Grade of Recommendation: I**
Reduction with fusion and internal fixation of patients with low grade degenerative lumbar spondylolisthesis is not recommended to improve clinical outcomes.

**Grade of Recommendation: C**
Decompression and fusion is recommended as a means to provide satisfactory long-term (4 years +) results for the treatment of patients with symptomatic spinal stenosis and degenerative lumbar spondylolisthesis.

NASS grades of recommendation for summaries or reviews of studies:
A=Good evidence (Level I studies with consistent findings) for or against recommending intervention.
B=Fair evidence (Level II or III studies with consistent findings) for or against recommending intervention.
C=Poor quality evidence (Level IV or V studies) for or against recommending intervention.
I=Insufficient or conflicting evidence not allowing a recommendation for or against intervention.

**Clinical Trials**

**Ongoing and Unpublished Clinical Trials**
Some currently unpublished trials that might influence this review are listed in Table 1.

**Table 1. Summary of Key Trials**

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
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<tbody>
<tr>
<td>Ongoing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT01335646</td>
<td>Surgery Versus Standardized Non-operative Care for the Treatment of Lumbar Disc Herniations: A Canadian Trial</td>
<td>140</td>
<td>Mar 2017</td>
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</tbody>
</table>

NCT: national clinical trial.

**Medicare National Coverage**
There is no national coverage determination (NCD) was found at the time this policy was developed.

**References**


Figure 1. Lumbosacral dermatome innervations (16)
Labels indicate the innervation of each lumbosacral dermatome. L=lumbar, S=sacral

<table>
<thead>
<tr>
<th>Dermatome</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L1,2,3,4</td>
<td>- front and inner surfaces of legs</td>
</tr>
<tr>
<td>L4,5, S1</td>
<td>- foot</td>
</tr>
<tr>
<td>L5, S1,S2</td>
<td>- back and outer surfaces of legs, buttocks</td>
</tr>
<tr>
<td>S1 – outer (lateral) margin of foot and little toe</td>
<td></td>
</tr>
<tr>
<td>S2,3,4</td>
<td>- perineum (urogenital and anal areas of pelvis)</td>
</tr>
</tbody>
</table>

Fig. 1
the diagnostic test reports, expanded definition of CES. Reference 16 added for Figure 1, second graphic removed. Policy statements changed as noted.

02/27/14 Updated Related Policies. Add 8.03.501.
04/04/14 Minor rewording of not medically necessary policy statement for clarity, intent is unchanged.
05/02/14 Update Related Policies. Add 7.01.537 and 8.03.503.
05/20/14 Update Related Policies. Remove 7.01.116 as it was deleted, and replace with 7.01.555.
06/26/14 Update Related Policies. Add 7.01.18.
09/11/14 Update Related Policies. Add 8.03.502.
09/25/14 Update Related Policies. Add 7.01.93.
12/22/14 Interim Update. Updated Related Policies added 8.03.09. Reference 7 removed from the additional resources and websites section; others renumbered. Policy statement unchanged.
01/06/15 Update Related Policies. Add 8.01.40.
09/24/15 Coding update; ICD-9 diagnosis and procedure codes removed. These were for informational purposes only.
10/13/15 Annual update. Reference 8 added. Policy statements unchanged. Coding update: Removed CPT codes 63200, 63252, 63277, 63282, 63287 and 63290; these are not specific to the procedures addressed in this policy.
11/10/15 Interim Review. Policy guidelines update to reflect imaging timeline of 12 from 6 to be consistent with all policies within documentation requirements.
03/21/16 Interim Update. Removed related policy 8.01.40 as it was archived.
06/14/16 Annual Review. Policy updated with literature review; references added. Policy statements unchanged but added clarification that “rapid” progression is defined as 48 hours or less.

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