The Difference Between Laminectomy and Laminotomy

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When a patient is found to have spinal stenosis with nerve impingement or "pinched nerve" that causes radiculopathy, which CPT code(s) should be used? I recently reviewed an Operative Report (OP Report) for a patient admitted with a right L4 to S1 stenosis with radiculopathy who underwent a right L4 to S1 minimally invasive decompression with foraminal decompression at right L4 to L5, right L5 to S1 and right S1 neural foraminal decompression. Per the OP Report: "Cranially and caudally at L4 and L5 for laminotomies and also L5 to S1 for laminotomies. We decompressed up to the pedicle face of L5 and also the pedicle face of S1. We decompressed the L4 to L5 foramen and L5 to S1 foramen on the right L4 to L5 interspace and also the L5 to S1 foramen and the S1 neuroforamen."

How would you code this? My gut instinct is that you would be tempted to Code 63030 because the word laminotomy is mentioned; but this is one of those cases where the diagnosis matters in how you pick the right CPT code.

Therefore, the difference is the purpose of the procedure: You should report 63030 when laminotomy is performed with a discectomy to treat spinal disc herniation using either an open procedure or under endoscopic assistance. By contrast, Code 63047 is used to report procedures performed for lateral recess stenosis, for example, caused by either ligamentum flavum hypertrophy or facet arthropathy.

By definition, laminotomy and laminectomy are both spinal decompression surgeries involving the lamina that covers and protects the spinal canal and the spinal cord. Laminotomy is the partial removal (or by making a larger opening) of the lamina. Laminectomy is the complete removal of the lamina. The problem is that providers tend to use the terms interchangeably and may not be aware of the coding impact.

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When the laminectomy or laminotomy is performed primarily for herniated discs and the decompression procedure is not the primary reason, CPT Codes 63020/63030 are used. When the laminectomy or laminotomy is performed primarily for spinal stenosis, the decompression procedure is the primary focus and if only a minor discectomy or no discectomy is performed in the procedure, then Codes 60345 or 63047 would be used.

CPT Code 63030 is defined as laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; one interspace, lumbar (including open or endoscopically-assisted approach) and; Code 63047, laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s) (e.g., spinal or recess stenosis), single vertebral segment, lumbar. They seem the same other than the utilization of laminotomy or laminectomy and code 63030 includes "and/or excision of herniated intervertebral disc." CPT explains that laminectomy is a surgical procedure for treating spinal stenosis by relieving pressure on the spinal cord. The surgeon removes or trims the lamina to widen the spinal canal and create more space for the spinal cord and spinal nerves. So even if the surgeon uses the word laminotomy, he is still decompressing the nerve preventing radiculopathy.

Use CPT 63045 for cervical or CPT 63047 for lumbar, with additional levels billed with add-on Code +63048 unilateral or bilateral. In this procedure, the physician removes the spinous process. If the stenosis is central, the lamina may be removed out to the articular facets using a burr. If the compression is in the lateral recess, only half of the lamina is removed. The ligamentum flavum is peeled away from the dura. Nerve root canals are freed by additional resection of the facet, and compression is relieved by removal of any bony or tissue overgrowth around the foramen. Removal of the lamina, facets and bony tissue or overgrowths may be performed bilaterally, when indicated. Do not use the -RT, -LT or -50 modifiers with these codes.

So in the case above, the first listed diagnosis for this patient would be M46.07 Spinal stenosis, lumbosacral region.

ICD-9-CM	ICD-10-CM
724.4 Thoracic or lumbosacral neuritis or radiculitis, unspecified	M54.14 Radiculopathy, thoracic region M54.15 Radiculopathy, thoracolumbar region M54.16 Radiculopathy, lumbar region M54.17 Radiculopathy, lumbosacral region
724.02 Spinal stenosis, lumbar region, without neurogenic claudication	M48.036 Spinal stenosis, lumbar region M48.07 Spinal stenosis, lumbosacral region M99.23 Subluxation stenosis of neural canal of lumbar region M99.43 Osseous stenosis of neural canal of lumbar region M99.53 Intervertebral disc stenosis of neural canal of lumbar region M99.63 Osseous and subluxation stenosis of intervertebral foramina of lumbar region M99.73 Connective tissue and disc stenosis of intervertebral foramina of lumbar region
724.03 Spinal stenosis, lumbar region, with neurogenic claudication	M48.06 Spinal stenosis, lumbar region G95.29 Other cord compression

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In coding the procedure, always remember the five steps in coding for spinal procedures which of course must be supported by the documentation found in the operative note.

1. Location: cervical, thoracic, lumbar or sacral.
2. Approach: anterior, posterior or lateral extra cavity or percutaneous.
3. Pathology: what was done and medical indication (decompression, discectomy, corpectomy and arthrodesis).
4. Instrumentation: rods, screws or cages.
5. Bone grafting: allograft or autograft.

Of course you also have to keep in mind that in a multiple-level decompression, the key to reporting is correlating the correct number to every root level being decompressed.

1. Location: lumbar and sacral.
2. Approach: posterior.
3. Pathology: decompression.

Since L4-5 and L5 to S1 were decompressed, the primary procedure would be CPT Code 63047 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral) with decompression of spinal cord, cauda equina and/or nerve root(s); single lumbar segment L4-5 and the secondary reported procedure would be CPT code 63048 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral) with decompression of spinal cord, cauda equina and/or nerve root(s); each additional segment lumbar L5 to S1. Per CPT, "It would be appropriate to report 63047 for the procedure, even though it describes a partial laminectomy only of the left lamina and foramen. The purpose of the procedure is to relieve spinal stenosis, which is the primary use of 63047."

Always remember that lumbar decompression codes are driven by the diagnosis as opposed to the technique involved.