DESCRIPTION:

Back pain or radiculopathy related to herniated discs is an extremely common condition and a frequent cause of chronic disability. Although many cases of acute low back pain and radiculopathy will resolve with conservative care, a surgical decompression is often considered when the pain is unimproved after several months and is clearly neuropathic in origin, resulting from irritation of the nerve roots.

Surgical management of herniated intervertebral discs most commonly involves discectomy or microdiscectomy. Traditionally, discectomy is performed manually through an open incision, using cutting forceps to remove nuclear material from within the disc annulus.

Automated percutaneous discectomy involves placement of a probe within the intervertebral disc under image guidance with aspiration of disc material using a suction cutting device.

Laser discectomy involves insertion of a needle or catheter under fluoroscopic guidance into the disc nucleus, with laser energy directed through it to vaporize tissue.

Percutaneous endoscopic discectomy involves the percutaneous placement of a working channel under image guidance, followed by visualization of the working space and instruments through an endoscope, and aspiration of disc material. Endoscopic techniques may be intradiscal or may involve extraction of noncontained and sequestered disc fragments from inside the spinal canal using an interlaminar or transforaminal approach. Disc nucleoplasty (radiofrequency coblation) uses bipolar radiofrequency energy directed into the disc to ablate tissue.
**POSITION STATEMENT:**
Automated percutaneous discectomy, laser discectomy, percutaneous endoscopic discectomy, DISC nucleoplasty™ (radiofrequency coblation), and all other methods of percutaneous disc decompression are considered experimental or investigational. The evidence is insufficient to permit conclusions on safety, effectiveness, and net health outcomes.

**BILLING/CODING INFORMATION:**

**CPT Coding**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>62287</td>
<td>Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar. (Investigational)</td>
</tr>
<tr>
<td>62380</td>
<td>Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar (Investigational)</td>
</tr>
<tr>
<td>0274T*</td>
<td>Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic. (Investigational)</td>
</tr>
<tr>
<td>0275T*</td>
<td>Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar. (Investigational)</td>
</tr>
</tbody>
</table>

*Note: Percutaneous discectomy is also a component of 0274T and 0275T.

**HCPCS Coding:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S2348</td>
<td>Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single of multiple levels, lumbar (Investigational)</td>
</tr>
</tbody>
</table>

**REIMBURSEMENT INFORMATION:**
Refer to section entitled **POSITION STATEMENT**.

**PROGRAM EXCEPTIONS:**

**Federal Employee Program (FEP):** Follow FEP guidelines.

**State Account Organization (SAO):** Follow SAO guidelines.

**Medicare Advantage products:**

The following National Coverage Determinations (NCD) were reviewed on the last guideline reviewed date: Laser Procedures (140.5); Thermal Intradiscal Procedures (TIPS) (150.11); and Percutaneous image-guided lumbar decompression for lumbar spinal stenosis (150.13), located at cms.gov.
The following Local Coverage Determination (LCD) was reviewed on the last guideline reviewed date: Non-covered Services (L33777) located at fcso.com.

**DEFINITIONS:**

Annulus: a ring of fibrous or fibrocartilaginous tissue (as of an intervertebral disk or surrounding an orifice of the heart).

Discectomy: surgical removal of an intervertebral disk.

Nucleus pulposus: an elastic pulpy mass lying in the center of each intervertebral fibrocartilage and regarded as a remnant of the notochord.

**RELATED GUIDELINES:**

Thermal Intratidiscal Procedures (e.g., IDET, IDB, PIRFT), 02-61000-20

**OTHER:**

None applicable.

**REFERENCES:**

7. Benyamin RN, Staats PS. MILD® is an Effective Treatment for Lumbar Spinal Stenosis with Neurogenic Claudication: MiDAS ENCORE Randomized Controlled Trial. Pain Physician 2016; 19:229-242 • ISSN 1533-3159.


18. Centers for Medicare and Medicaid Services (CMS). National Coverage Determination (NCD) for Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis (150.13). (06/27/17)


42. First Coast Service Options (FCSO) Local Coverage Determination for Non-covered Services (L29288) (01/29/13). (Retired 06/30/15).

43. First Coast Service Options (FCSO) Local Coverage Determination for Non-covered Services (L33777). (07/03/18).


51. Hayes, Inc. HAYES Medical Technology Directory™. Automated Percutaneous Lumbar Discectomy. Lansdale, PA: Hayes, Inc.; 05/12/06. Update performed 05/20/08.

52. Hayes, Inc. HAYES Medical Technology Directory™. Laser Discectomy. Lansdale, PA: Hayes, Inc.; 06/10/02. Update performed 04/30/06.


COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy & Coverage Committee on 04/25/19.

GUIDELINE UPDATE INFORMATION:

<table>
<thead>
<tr>
<th>Date</th>
<th>Change Description</th>
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</thead>
<tbody>
<tr>
<td>05/15/04</td>
<td>New Medical Coverage Guideline. Investigational.</td>
</tr>
<tr>
<td>11/15/04</td>
<td>Revision to guideline; consisting of the addition of CPT code 62287.</td>
</tr>
<tr>
<td>01/01/05</td>
<td>Annual HCPCS update: consisting of the addition of S2348.</td>
</tr>
<tr>
<td>08/15/05</td>
<td>Scheduled review and revision of guideline; consisting of updated references.</td>
</tr>
<tr>
<td>08/15/06</td>
<td>Scheduled review and revision of guideline consisting of updated references.</td>
</tr>
<tr>
<td>07/15/07</td>
<td>Annual review; investigational status maintained; reformatted guideline, references updated.</td>
</tr>
<tr>
<td>07/15/08</td>
<td>Review and revision of guideline consisting of updated references.</td>
</tr>
<tr>
<td>01/01/09</td>
<td>Annual HCPCS coding update: revised descriptor for code 62287.</td>
</tr>
<tr>
<td>09/15/09</td>
<td>Scheduled review; no change to position statement; references updated.</td>
</tr>
<tr>
<td>07/15/10</td>
<td>Scheduled review; position statement unchanged, references updated.</td>
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<tr>
<td>01/01/12</td>
<td>Annual HCPCS coding update: revised descriptor for code 62287.</td>
</tr>
<tr>
<td>07/15/12</td>
<td>Scheduled review; position statement revised to include additional methods of percutaneous disc decompression; policy title revised; references updated.</td>
</tr>
<tr>
<td>07/15/13</td>
<td>Scheduled review; position statement unchanged; Program Exceptions section updated; references updated.</td>
</tr>
<tr>
<td>07/15/14</td>
<td>Scheduled review; position statement unchanged; CPT codes 0274T and 0275T added; references updated.</td>
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<tr>
<td>11/01/15</td>
<td>Revision: ICD-9 Codes deleted.</td>
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<tr>
<td>01/01/17</td>
<td>Annual CPT/HCPCS update. Revised descriptors for 62287, 0274T, and 0275T. Revised Program Exceptions section.</td>
</tr>
<tr>
<td>09/15/18</td>
<td>Scheduled review. Revised description section. Maintained position statement. Revised program exceptions section. Updated references.</td>
</tr>
<tr>
<td>10/03/18</td>
<td>Revision: added CPT code 62380.</td>
</tr>
<tr>
<td>05/15/19</td>
<td>Unscheduled review. Revised description. Maintained position statement and updated references.</td>
</tr>
<tr>
<td>06/15/19</td>
<td>Unscheduled review. Maintained position statement and updated references.</td>
</tr>
<tr>
<td>12/15/19</td>
<td>Revision: maintained position statement and updated references.</td>
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