02-61000-32

Original Effective Date: 05/15/04

Reviewed: 10/26/23

Revised: 11/15/23

Subject: Automated Percutaneous Discectomy, Laser Discectomy, Percutaneous Endoscopic Discectomy, and DISC Nucleoplasty™

THIS MEDICAL COVERAGE GUIDELINE IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS MEDICAL COVERAGE GUIDELINE APPLIES TO ALL LINES OF BUSINESS UNLESS OTHERWISE NOTED IN THE PROGRAM EXCEPTIONS SECTION.

Position Statement	Billing/Coding	Reimbursement	Program Exceptions	Definitions	Related Guidelines
Other	References	Updates			

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 (e.g., Deuk Laser Disc Repair®), DISC nucleoplasty™ (radiofrequency coblation), image-guided minimally invasive lumbar decompression, 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

62287	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)**
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 (**Investigational**)
0274T*	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)**
0275T*	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)**

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

HCPCS Coding:

S2348	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single of multiple levels, lumbar (**Investigational**)

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.

If this Medical Coverage Guideline contains a step therapy requirement, in compliance with Florida law 627.42393, members or providers may request a step therapy protocol exemption to this requirement if based on medical necessity. The process for requesting a protocol exemption can be found at Coverage Protocol Exemption Request.

DEFINITIONS:

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

Deuk Laser Disc Repair®: an anterior, full endoscopic, transdiscal, laser-assisted surgery during which a selective partial discectomy, foraminoplasty, and annular debridement are performed under direct visualization of the local anatomy. The entire procedure is performed on the cervical spine without the use of implants, biologics, or fusion.

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:

Percutaneous Intradiscal Electrothermal Annuloplasty, Radiofrequency Annuloplasty, Biacuplasty and Intraosseous Basivertebral Nerve Ablation, 02-61000-20

OTHER:

None applicable.

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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy and Coverage Committee on 10/26/23.

GUIDELINE UPDATE INFORMATION:

05/15/04	New Medical Coverage Guideline. Investigational.
11/15/04	Revision to guideline; consisting of the addition of CPT code 62287.
01/01/05	Annual HCPCS update: consisting of the addition of S2348.
08/15/05	Scheduled review and revision of guideline; consisting of updated references.
08/15/06	Scheduled review and revision of guideline consisting of updated references.
07/15/07	Annual review; investigational status maintained; reformatted guideline, references updated.
07/15/08	Review and revision of guideline consisting of updated references.
01/01/09	Annual HCPCS coding update: revised descriptor for code 62287.
09/15/09	Scheduled review; no change to position statement; references updated.
07/15/10	Scheduled review; position statement unchanged, references updated.
01/01/12	Annual HCPCS coding update: revised descriptor for code 62287.
07/15/12	Scheduled review; position statement revised to include additional methods of percutaneous disc decompression; policy title revised: references updated.
07/15/13	Scheduled review; position statement unchanged; Program Exceptions section updated; references updated.
07/15/14	Scheduled review; position statement unchanged; CPT codes 0274T and 0275T added; references updated.
11/01/15	Revision: ICD-9 Codes deleted.
01/01/17	Annual CPT/HCPCS update. Revised descriptors for 62287, 0274T, and 0275T. Revised Program Exceptions section.

09/15/18	Scheduled review. Revised description section. Maintained position statement. Revised program exceptions section. Updated references.
10/03/18	Revision: added CPT code 62380.
05/15/19	Unscheduled review. Revised description. Maintained position statement and updated references.
06/15/19	Unscheduled review. Maintained position statement and updated references.
12/15/19	Revision: maintained position statement and updated references.
11/15/20	Scheduled review. Maintained position statement and updated references.
12/15/21	Scheduled review. Maintained position statement and updated references.
04/01/23	Revision. Added reference to Deuk Laser Disc Repair®. Updated Definitions section and references.
08/21/23	Update to Program Exceptions section.
11/15/23	Scheduled review. Maintained position statement and updated references.