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Medicare Advantage Policy Manual **Policy ID:** M-SUR131

Decompression of Intervertebral Discs Using Laser Energy (Laser Discectomy) or Radiofrequency Energy (Nucleoplasty)

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IMPORTANT REMINDER

The Medicare Advantage Medical Policy manual is not intended to override the member Evidence of Coverage (EOC), which defines the insured's benefits, nor is it intended to dictate how providers are to practice medicine. Physicians and other health care providers are expected to exercise their medical judgment in providing the most appropriate care for the individual member.

The Medicare Advantage Medical Policies are designed to provide guidance regarding the decision-making process for the coverage or non-coverage of services or procedures in accordance with the member EOC and the Centers of Medicare and Medicaid Services (CMS) policies, when available. In the event of a conflict, applicable CMS policy or EOC language will take precedence over the Medicare Advantage Medical Policy. In the absence of CMS guidance for a requested service or procedure, the health plan may apply their Medical Policy Manual or MCG™ criteria, both of which are developed with an objective, evidence-based process using scientific evidence, current generally accepted standards of medical practice, and authoritative clinical practice guidelines.

Medicare and EOCs exclude from coverage, among other things, services or procedures considered to be investigational, cosmetic, or not medically necessary, and in some cases, providers may bill members for these non-covered services or procedures. Providers are encouraged to inform members in advance when they may be financially responsible for the cost of non-covered or excluded services.

DESCRIPTION

Ablation of the nucleus pulposus using laser energy (laser discectomy) and radiofrequency energy (coblation or nucleoplasty) is being evaluated as a technique for decompression of the intervertebral disc as a treatment of back pain. In some cases, chemonucleolysis is used as an adjunct to disc nucleoplasty.

MEDICARE ADVANTAGE POLICY CRITERIA

Note: This policy does not address percutaneous and endoscopic discectomy, which is considered in a separate medical policy (see Cross References below).

CMS Coverage Manuals*	None

National Coverage Determinations (NCDs)*	For percutaneous intradiscal ***techniques that use a radiofrequency (RF) energy source (i.e., disc nucleoplasty)***: ✓ Thermal Intradiscal Procedures (TIPs) (150.11) *(disc nucleoplasty is non-covered, according to the NCD 150.11. Services related to or required as a result of non-covered services are not covered services under Medicare.[1] Therefore, if chemonucleolysis [CPT code 62292] is performed in conjunction with or as an adjunct to percutaneous disc decompression procedures including, but not limited to disc nucleoplasty, both services are considered non-covered.)* **Note:** Percutaneous disc decompression or nucleoplasty procedures that do not use a RF energy source are not addressed within this NCD. See below.
Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles (LCAs)*	For the percutaneous ***decompression of nucleus pulposus of an of intervertebral disc by any method (CPT code 62287), including those that use a laser energy source[2]***: ✓ Non-Covered Services (L35008) *(CPT code 62287 is non-covered, according to the Noridian LCD L35008. Services related to or required as a result of non-covered services are not covered services under Medicare.[1] Therefore, if chemonucleolysis [CPT code 62292] is performed in conjunction with or as an adjunct to percutaneous disc decompression procedures, both services are considered non-covered.)* **Scroll to the "Public Version(s)" section at the bottom of the LCD for links to prior versions if necessary.

POLICY GUIDELINES

REGULATORY STATUS

Several laser devices have received U.S. Food and Drug Administration (FDA) 510(k) clearance for incision, excision, resection, ablation, vaporization, and coagulation of tissue.

Intended uses described in FDA summaries include a wide variety of procedures, including percutaneous discectomy.

- Trimedyne Holmium Laser System Ho1mium: Yttrium Aluminum Garnet (Ho1mium:YAG) (Trimedyne, Inc.) received 510(k) clearance in 2002;
- Revolix Duo Laser System (Lisa Laser Products) in 2007; and
- Quanta System LITHO Laser System (Quanta System SpA) in 2009.
- Perc-D SpineWands™ (ArthroCare) in 2001. It is used in conjunction with the ArthroCare Coblation System 2000 for ablation, coagulation, and decompression of disc material to treat symptomatic patients with contained herniated discs. Smith & Nephew acquired ArthroCare in 2014.

All were cleared based on equivalence with predicate devices for percutaneous laser disc decompression/discectomy, including foraminoplasty, percutaneous cervical disc decompression/discectomy, and percutaneous thoracic disc decompression/discectomy.

Note, the fact a service or procedure has been issued a CPT/HCPCS code or "is FDA approved for a specific indication does not, in itself, make the procedure medically reasonable and necessary." Medicare contractors evaluate services, procedures, drugs or technology to determine if they may be considered Medicare covered services. *(Noridian LCD L35008)*

CROSS REFERENCES

Automated Percutaneous and Percutaneous Endoscopic Discectomy, Surgery, Policy No. M-145

REFERENCES

1. Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, §180 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare
2. NCD for Laser Procedures (140.5) – Coverage of procedures performed with a laser is at contractor discretion.

CODING

NOTE: HCPCS code S2348 is a Medicare Status "I" code, and therefore, is not valid for Medicare or Medicare Advantage use.

CPT code 62287 specifically describes a percutaneous aspiration or decompression procedure of the lumbar spine. This code does not distinguish between a laser decompression procedure (addressed in this policy) and an aspiration procedure (addressed in a separate medical policy). Also note this code is specifically limited to the lumbar region.

Codes	Number	Description
CPT	62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material

Codes	Number	Description
		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
	62292	Injection procedure for chemonucleolysis including discography, intervertebral disc, single or multiple levels, lumbar
HCPCS	S2348	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single or multiple levels, lumbar *(Not valid for Medicare purposes)*

***IMPORTANT NOTE:** Medicare Advantage medical policies use the most current Medicare references available at the time the policy was developed. Links to Medicare references will take viewers to external websites outside of the health plan's web control as these sites are not maintained by the health plan.*