Automated Percutaneous and Percutaneous Endoscopic Discectomy

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DESCRIPTION

This policy addresses percutaneous and endoscopic removal of disc material as minimally invasive alternatives to open surgical excision for disc decompression. This percutaneous approach involves placement of a probe within the intervertebral disc and aspiration of disc material using a suction cutting device. Endoscopic decompression is performed under visual control and may be intradiscal or may involve the extraction of non-contained and sequestered disc fragments from inside the spinal canal using an interlaminar or transforaminal approach. Endoscopic discectomy may also be referred to as arthroscopic discectomy.

MEDICARE ADVANTAGE POLICY CRITERIA

Note: This policy does not address intradiscal electrothermal annuloplasty (IDET) or percutaneous intradiscal radiofrequency thermocoagulation (PIRFT), which are considered non-covered according to the Medicare NCD for Thermal Intradiscal Procedures (TIPs)
nor does this policy address laser discectomy and radiofrequency disc decompression, which are considered in a separate medical policy (see Cross References below).

**CMS Coverage Manuals***
None

**National Coverage Determinations (NCDs)**
None

**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)*:
- Non-Covered Services (L35008)

**Scroll to the “Public Version(s)” section at the bottom of the LCD for links to prior versions if necessary.

**Medical Policy Manual**
Medicare coverage guidance is not available for percutaneous endoscopic discectomy. Therefore, the health plan’s medical policy is applicable.

For an *endoscopic discectomy (CPT code 62380)*:
- Automated Percutaneous and Percutaneous Endoscopic Discectomy, Surgery, **Policy No. 145** (see “NOTE” below)

**NOTE:** If a procedure or device lacks scientific evidence regarding safety and efficacy because it is investigational or experimental, the service is noncovered as not reasonable and necessary to treat illness or injury. (*Medicare IOM Pub. No. 100-04, Ch. 23, §30 A*). According to Title XVIII of the Social Security Act, §1862(a)(1)(A), only medically reasonable and necessary services are covered by Medicare. In the absence of a NCD, LCD, or other coverage guideline, CMS guidelines allow a Medicare Advantage Organization (MAO) to make coverage determinations, applying an **objective, evidence-based process, based on authoritative evidence**. (*Medicare IOM Pub. No. 100-16, Ch. 4, §90.5*). The Medicare Advantage Medical Policy - Medicine Policy No. M-149 - provides further details regarding the plan’s evidence-assessment process (see Cross References).

### POLICY GUIDELINES

**REGULATORY STATUS**

The Stryker DeKompressor® Percutaneous Discectomy Probe (Stryker) and the Nucleotome® (Clarus Medical) are examples of percutaneous discectomy devices that received clearance from the U.S. Food and Drug Administration (FDA) through the 510(k) process. Both have the same labeled intended use - “for use in aspiration of disc material during percutaneous discectomies in the lumbar, thoracic and cervical regions of the spine.”
A variety of endoscopes and associated surgical instruments have received marketing clearance through the FDA’s 510(k) process.

CROSS REFERENCES

Investigational (Experimental) Services and New and Emerging Medical Technologies and Procedures, Medicine, Policy No. M-149

Decompression of Intervertebral Discs Using Laser Energy (Laser Discectomy) or Radiofrequency Energy (Nucleoplasty), Surgery, Policy No. M-131

REFERENCES

None

CODING

NOTE: CPT code 62287 specifically describes a percutaneous aspiration or decompression procedure of the lumbar spine. This code does not distinguish between an aspiration procedure (addressed in this policy) and a laser decompression procedure (addressed in Medicare Advantage Surgery Policy No. M-131). Also note this code is specifically limited to the lumbar region. While the majority of percutaneous discectomies are performed on lumbar vertebrae, the FDA labeling of the Stryker DeKompressor Percutaneous Discectomy Probe includes the thoracic and cervical vertebrae.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<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</td>
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<tr>
<td>62380</td>
<td></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</td>
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<tr>
<td>64999</td>
<td></td>
<td>Unlisted procedure; nervous system</td>
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<tr>
<td>HCPCS</td>
<td>C2614</td>
<td>Probe, percutaneous lumbar discectomy</td>
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*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.