

Image-Guided Minimally Invasive Decompression (IG-MSD) for Spinal Stenosis

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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 MCGTM 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

Image-guided minimally invasive spinal decompression (IG-MSD) describes a novel percutaneous procedure for decompression of the spinal canal in patients with spinal stenosis using image-guided navigation systems for the purpose of improving orientation to the unexposed anatomy.

MEDICARE ADVANTAGE POLICY CRITERIA

Note: This policy only addresses image-guided minimally invasive spinal decompression (IG-MSD) for spinal stenosis of the **cervical and thoracic** levels. It does **not** address partial IG-MSD for **lumbar** spinal stenosis (LSS; Category III code 0275T, HCPCS code G0276), which is considered to be medically necessary for beneficiaries with LSS enrolled in a Medicare-approved clinical study (Medicare NCD for *Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis* [150.13]).

CMS Coverage Manuals*	None
National Coverage Determinations (NCDs)*	None
Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles*	None
Medical Policy Manual	<p><i>Medicare coverage guidance is not available for image-guided minimally invasive cervical or thoracic decompression. Therefore, the health plan's medical policy is applicable.</i></p> <p>For cervical or thoracic decompression (Category III code 0274T):</p> <ul style="list-style-type: none"> ✓ Image-Guided Minimally Invasive Decompression (IG-MSD) for Spinal Stenosis, Surgery, Policy No. 176 (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

There are no FDA approved guidance tool kits for image-guided cervical or thoracic spinal decompression.

Note, the fact a new 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. The FDA determines safety and effectiveness of a device or drug, but does not establish medical necessity. While Medicare may adopt FDA determinations regarding safety and effectiveness, Medicare or Medicare contractors evaluate whether or not the drug or device is reasonable and necessary for the Medicare population under §1862(a)(1)(A).

CROSS REFERENCES

[Investigational \(Experimental\) Services, New and Emerging Medical Technologies and Procedures, and Other Non-Covered Services](#), Medicine, Policy No. M-149

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

[Dynamic Stabilization of the Spine](#), Surgery, Policy No. M-143

[Automated Percutaneous and Percutaneous Endoscopic Discectomy](#), Surgery, Policy No. M-145

[Percutaneous Axial Lumbosacral Fusion \(LIF\)](#), Surgery, Policy No. M-157

[Total Facet Arthroplasty](#), Surgery, Policy No. M-171

[Interspinous Fixation \(Fusion\) Devices](#), Surgery, Policy No. M-172

REFERENCES

1. Medicare Claims Processing Manual, Chapter 32 - Billing Requirements for Special Services, [§330 – Percutaneous Image-guided Lumbar Decompression \(PILD\) for Lumbar Spinal Stenosis \(LSS\)](#) (and all related subsections)

CODING

Codes	Number	Description
CPT	0274T	Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic
HCPCS	None	

***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.