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Medicare Advantage Policy Manual **Policy ID:** M-SUR145

Automated Percutaneous and Percutaneous Endoscopic Discectomy

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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, including care that may be both medically reasonable and necessary.

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 Centers of Medicare and Medicaid Services (CMS) policies and manuals, along with general CMS rules and regulations. 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 a specific CMS coverage determination for a requested service, item or procedure, the health plan may apply CMS regulations, as well as their Medical Policy Manual or other applicable utilization management vendor criteria developed with an objective, evidence-based process using scientific evidence, current generally accepted standards of medical practice, and authoritative clinical practice guidelines.

Some services or items may appear to be medically indicated for an individual, but may be a direct exclusion of Medicare or the member's benefit plan. Medicare and member EOCs exclude from coverage, among other things, services or procedures considered to be investigational (experimental) or cosmetic, as well as services or items considered not medically reasonable and necessary under Title XVIII of the Social Security Act, §1862(a)(1)(A). 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. Members, their appointed representative, or a treating provider can request coverage of a service or item by submitting a pre-service organization determination prior to services being rendered.

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) (150.11)*, 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*	None
Medical Policy Manual	*Medicare coverage guidance is not available for percutaneous endoscopic discectomy or decompression of nucleus pulposus of an of intervertebral disc. Therefore, the health plan's medical policy is applicable.* 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.

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. 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, CMS 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

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.

Codes	Number	Description
CPT	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
	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
	64999	Unlisted procedure; nervous system
HCPCS	C2614	Probe, percutaneous lumbar discectomy

***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.*