**Percutaneous and Endoscopic Spinal Surgery**  
(Discogenic Pain Treatment)

**Policy Number:** 2016M0033B  
**Effective Date:** May 1, 2016

### Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
<th>Cross Reference Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>POLICY DESCRIPTION</td>
<td>2</td>
<td>Artificial Intervertebral Disc Replacement, 2015M0006</td>
</tr>
<tr>
<td>COVERAGE RATIONALE/CLINICAL CONSIDERATIONS</td>
<td>2</td>
<td>Epidural Steroid Injections For Low Back Pain And Sciatica, 2016M0014B</td>
</tr>
<tr>
<td>BACKGROUND</td>
<td>3</td>
<td>Interspinous Spacers In The Lumbar Spine, 2015M0017A</td>
</tr>
<tr>
<td>REGULATORY STATUS</td>
<td>6</td>
<td>Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty, 2016M0026A</td>
</tr>
<tr>
<td>CLINICAL EVIDENCE</td>
<td>7</td>
<td>Radiofrequency Ablation For Chronic Spinal Pain, 2016M0019B</td>
</tr>
<tr>
<td>APPLICABLE CODES</td>
<td>9</td>
<td>Sacroiliac Fusion, 2016M0029A</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>10</td>
<td>Spinal Cord Stimulator, 2016M0002B</td>
</tr>
<tr>
<td>POLICY HISTORY/REVISION INFORMATION</td>
<td>15</td>
<td>Spinal Fusion Surgery, 2015M0052A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>iFuse Implant System for Sacroiliac Joint Fusion, 2015M0069A</td>
</tr>
</tbody>
</table>

**INSTRUCTIONS:**

“Medical Policy assists in administering UCare benefits when making coverage determinations for members under our health benefit plans. When deciding coverage, all reviewers must first identify enrollee eligibility, federal and state legislation or regulatory guidance regarding benefit mandates, and the member specific Evidence of Coverage (EOC) document must be referenced prior to using the medical policies. In the event of a conflict, the enrollee’s specific benefit document and federal and state legislation and regulatory guidance supersede this Medical Policy. In the absence of benefit mandates or regulatory guidance that govern the service, procedure or treatment, or when the member’s EOC document is silent or not specific, medical policies help to clarify which healthcare services may or may not be covered. This Medical Policy is provided for informational purposes and does not constitute medical advice. In addition to medical policies, UCare also uses tools developed by third parties, such as the InterQual Guidelines®, to assist us in administering health benefits. The InterQual Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice. Other Policies and Coverage Determination Guidelines may also apply. UCare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary and to provide benefits otherwise excluded by medical policies when necessitated by operational considerations.”
POLICY DESCRIPTION:

This policy addresses arthroscopic microdiscectomy (AMD), a percutaneous and endoscopic surgical intervention designed to relieve pain and disability caused by a herniated disc. The aim of surgery is to prevent permanent injury to the spinal nerve by removing the herniated material directly or by removing disc material from the center of the disc, thus allowing the herniation to subside.

AMD is performed by neurosurgeons or orthopedic surgeons, in an operating room. An anesthetist provides monitoring and conscious sedation, to allow communication between the surgeon and patient during the procedure. The operation can be performed on an outpatient basis.

COVERAGE RATIONALE / CLINICAL CONSIDERATIONS:

Arthroscopic microdiscectomy (AMD), percutaneous discectomy and thermal intradiscal procedures are considered EXPERIMENTAL AND/OR INVESTIGATIONAL and NOT MEDICALLY NECESSARY for relief of discogenic pain or other indications. Procedures include but are not limited to the following:

1. Arthroscopic Microdiscectomy
2. Thermal intradiscal procedures:
   a. Intradiscal Biacuplasty (IDB)
   b. Intradiscal Electrothermal Annuloplasty (IEA)
   c. Intradiscal Electrothermal Therapy (IDET)
   d. Percutaneous Intradiscal Annuloplasty
   e. Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)
   f. Radiofrequency Annuloplasty (RA)
3. Percutaneous Endoscopic Discectomy and Disc Decompression Procedures
   a. Laser Disc Decompression (PLDD)
   b. Laser-Assisted Disc Decompression (LADD)
   c. Nucleoplasty (also known as percutaneous radiofrequency thermomodulation, percutaneous disc decompression (PDD), or percutaneous plasma discectomy)
   d. Percutaneous Endoscopic Discectomy, with or without laser (PELD)
   e. Yeung Endoscopic Spinal Surgery (YESS)
4. Annulo-nucleoplasty (The Disc-FX procedure)

The evidence in the published medical literature on arthroscopic microdiscectomy, percutaneous discectomy and thermal intradiscal procedures for the treatment of low back pain is inadequate to permit scientific conclusions and/or demonstrate beneficial health outcomes. Evidence from large comparative studies with long-term follow-up, using well-defined procedures, is needed to determine its clinical role among other minimally invasive techniques for lumbar disc herniation.
Clinical Considerations:
The operation can be performed on an outpatient basis and patients are encouraged to ambulate immediately and to avoid long periods of sitting, bending, or climbing for about a week.

Complications: Percutaneous discectomy procedures have the potential for complications that may arise with any spinal surgery, including dural tears, nerve root damage, bowel and/or bladder incontinence, bleeding, and infection. Reported overall complication rates range from 1% to 3.5%, including dural tear, wound infection, causalgic-type pain, psoas muscle hematoma, and thrombophlebitis.

Contraindications: Percutaneous discectomy procedures may be contraindicated in patients with spinal stenosis, mechanical instability, or cauda equina syndrome. Relative contraindications include prior disc surgery, obesity, anatomical characteristics limiting accessibility (e.g., elevated iliac crest), large central herniations, stenosis of the spinal canal, migrated sequestered herniations, drug dependency, and psychological disorders.

**BACKGROUND:**

Disc herniation is a condition affecting the spinal column in which one or more of the cushioning discs between the vertebrae are damaged and the inner gel-like substance (nucleus pulposus) bulges or protrudes through the tougher outer layer of the disc (annulus). Most herniations occur in the lower back, where this bulge or protrusion exerts pressure on the nerves that exit the spinal cord. This causes sciatica (a pain and weakness in the leg, also referred to as radicular pain or lumbar radiculopathy) and lower back pain. Disc herniation can be caused by injury or degenerative disc disease (DDD). DDD is a common condition that refers to gradual wear and tear leading to deterioration and weakening of the intervertebral disc as a person ages. At least 30% of patients aged 30 to 50 years have DDD, and in patients > 60 years, some degree of DDD is considered normal.

While the majority of disc herniations (90%) resolve with conservative therapy, some may require surgery. Conservative measures include a short period of rest followed by physical therapy and slow and controlled exercise, with anti-inflammatory, muscle relaxant, and analgesic medications as required. Taking short walks and avoiding sitting for long periods can also help keep symptoms from returning. Cold compresses or ice may be helpful; gentle heat may be applied after spasms cease. With failure of nonsurgical treatments, epidural cortisone-like injections may lessen nerve irritation and allow for more effective physical therapy.

If conservative therapy fails, or if recovery is unacceptably slow, surgery is indicated to relieve pain and disability. The aim of surgery is to prevent permanent injury to the spinal nerve by removing the herniated material directly or by removing disc material from the center of the disc, thus allowing the herniation to subside. This procedure is referred to as a discectomy, and a considerable number of open and minimally invasive procedures have been investigated. Open discectomy is the treatment of choice for severe pain or weakness and complicated herniations. Minimally invasive surgical techniques have been developed to reduce postoperative recovery time, scarring, and instability. These procedures differ from each other in terms of access of the herniated disc, visualization of the operative site, and the method by which pressure on the nerve roots is alleviated.
**Arthroscopic microdiscectomy (AMD)**

AMD is a term coined by the originator of this surgical procedure, which has evolved into a number of similar procedures sometimes referred to as percutaneous (through the skin) or posterolateral (in back and away from the midline) lumbar endoscopic discectomy. AMD describes an endoscopically guided posterolateral approach bolstered by illumination and magnification that removes nuclear material and herniated material through cannulas placed within the disc. The technique has evolved over time, with a number of investigators describing similar or modified approaches under a number of different terms (percutaneous or posterolateral endoscopic discectomy; selective endoscopic discectomy). The disc is accessed through one or two 1-cm (centimeter) incisions or ports, either uniportal or biportal. The uniportal approach is most commonly used, with the biportal approach being reserved for large central herniations or fragments of nuclear material that have completely detached from the disc within the spinal canal (sequestered herniations). The technology does not involve muscle dissection or bone removal.

For the AMD, the patient receives a single dose of antibiotic prophylaxis, and is placed in a lateral decubitus position, so that the symptomatic side is facing upwards. Under fluoroscopic control, the level, entrance point, and angle of the injured disc(s) are confirmed. Using a local anesthetic, a spinal needle is inserted through the skin at a point 8 to 12 cm lateral from the midline under C-arm fluoroscopic guidance. The needle is advanced to the posterolateral surface of the annulus adjacent to the spinal canal through a triangular working zone. The triangular working zone is bordered superiorly by the exiting nerve root, inferiorly by the proximal plate of the lower vertebrae, posteriorly by the vertebral articular processes, and medially by the traversing nerve root and dura of the spinal cord. Cannulas large enough to accommodate the endoscope and surgical instruments are inserted. Disc material is excised manually using forceps, or utilizing automated shavers and suction punch forceps, to relieve the pressure on the nerve. Herniations within the opening of the foramen and outside this structure can be targeted directly. Medial herniations that intrude on the center of the spinal canal can be accessed from within the disc. In cases where visualization permits, the cannula can also be directed toward the spinal canal to retrieve fragments that have dislodged. Coagulation of small blood vessels in the annulus surface may be accomplished using lasers or radiofrequency ablation.

**Thermal Intradicinal Procedures (TIPs)**

In general, TIP procedures involve the insertion of a catheter or probe into the spinal disc, under fluoroscopic guidance, to produce or apply heat within the disc to relieve low back pain. TIPs remove unwanted tissue, such as herniated discs; create a seal to limit expression of matrix components; shrink collagen tissue; and destroy nociceptors.

- **Intradiscal Electrothermal Therapy (IDET):** IDET is one type of TIP. Since degeneration of the intervertebral disc can be the source of severe low back pain, IDET has been proposed as an alternative treatment to spinal fusion for those patients with symptomatic internal disc disruption, who are nonresponsive to conservative medical care. IDET is a minimally invasive, outpatient procedure, during which patients are administered local anesthesia and mild sedation. Under x-ray imaging (fluoroscopy), a disposable flexible catheter (SpineCATH) and a heating element is inserted into the spinal disc, directly to the annulus fibrosis, the outer component of the intervertebral discs. IDET destroys the nerve fibers and “toughens” the disc tissue, sealing any small tears. The heating of the electrode denatures the collagen of the annulus and coagulates the nerve endings with the goal of alleviating pain.
- **Intradiscal Biacuplasty (IDB) or Biacuplasty:** IDB or biacuplasty is a modification of IDET that destroys the nerve fibers that generate pain sensations. IDB is a minimally invasive outpatient procedure that requires local anesthesia or mild sedation. IDB uses radiofrequency energy to heat the tissue, while circulating water is used to cool the tissue near the disc. This bilateral approach is intended to facilitate controlled lesioning between the electrodes in the disc.

- **Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT):** PIRFT is a minimally invasive method similar to IDET. PIRFT is also known as intradiscal electrothermal annuloplasty (IEA), intradiscal radiofrequency thermomodulation, radiofrequency (RF) annuloplasty, or radiofrequency posterior annuloplasty. Compared with IDET, PIRFT uses a radiofrequency probe that is placed into the center of the disc, rather than around the annulus. The device is activated for 90 seconds at a temperature of 70°C Celsius. PIRFT does not ablate the disc material, but instead alters the biomechanics of the disc or destroys nociceptive pain fibers. PIRFT is performed using the Radionics RF Disc Catheter System. The Radionics catheter system is designed for patients with chronic discogenic back pain for the coagulation and decompression of disc material to treat symptomatic patients with annular disruption of contained herniated discs. This is an outpatient procedure utilizing either sedative or local anesthesia.

- **Nucleoplasty:** This procedure is also known as percutaneous disc decompression (PDD) or percutaneous plasma discectomy. It uses x-ray images (fluoroscopy) for guidance to insert a multifunctional device called a SpineWand™ to reach the disc nucleus. Radiofrequency energy is used to ablate (coablate) nuclear material and create small channels within the disc. This decompresses the disc, reducing the pressure both inside the disc and on nerve roots. Typically patients are awake and able to speak to the physician during the procedure. Nucleoplasty is performed on an outpatient basis with minimal anesthesia requirements.

- **Laser Discectomy:** Laser disc decompression (PLDD), laser-assisted disc decompression (LADD), and percutaneous endoscopic discectomy, with or without laser (PELD) are minimally-invasive procedures proposed as an alternative to discectomy or microdiscectomy. These procedures are performed under local anesthesia since patient cooperation is required during the procedure. The disc space is punctured with a cannula and the tip of the needle is placed into the center of the disc. A second cannula is placed on the opposite lateral side of the disc. Parts of the nucleus pulposus are removed to allow for examination. The remaining disc material is vaporized using a laser.

- **Yeung Endoscopic Spinal Surgery (YESS):** YESS (also known as arthroscopic microdiscectomy or percutaneous endoscopic discectomy (PELD)), is a minimally-invasive procedure designed to relieve symptoms caused by herniated discs pressing on nerves. The YESS system uses an endoscopic approach to selectively remove the nucleus pulposus within annular tears. This is an outpatient procedure utilizing either sedative or local anesthesia. The Yeung Endoscopic Spinal System (Richard Wolf Surgical Instrument Corporation) is a specialized endoscope developed for percutaneous spinal endoscopy and discectomy. This endoscope has multichannel inflow and outflow ports, allowing visualization through one port and suction or other therapeutic services through the working port.

Arthroscopic microdiscectomy (AMD), percutaneous discectomy and thermal intradiscal procedures are performed by neurosurgeons or orthopedic surgeons, in an operating room. An anesthetist provides monitoring and conscious sedation with e.g., midazolam, to allow communication between the surgeon and patient to detect inadvertent placement of instruments near neural tissue. These procedures have a relatively steep learning curve, requiring specific instruction and training. The operation can be performed
on an outpatient basis and patients are encouraged to ambulate immediately and to avoid long periods of
sitting, bending, or climbing for about a week. Exercises such as aquatherapy and swimming are
encouraged after 2 weeks, followed by more vigorous exercise including isokinetic exercises.

**REGULATORY STATUS:**

1. **U.S. FOOD AND DRUG ADMINISTRATION (FDA):**

   AMD is a procedure and, therefore, is not subject to regulation by the FDA. However, the devices used
to perform this procedure are regulated by the FDA premarket approval process. Arthroscopes are
captured in the FDA 510(k) database.

   There are numerous catheters that have received 510(K) clearance from the FDA for use in thermal
procedures. Some catheters have a specific indication for use in the intervertebral disc and many are
indicated for the creation of heat lesions for the relief of pain.

   The SpineCATH™ Intradiscal Catheter and the SpineCATH™ Intradiscal Catheter, Model 92002 received
FDA 510(k) clearance (product code GEI) for marketing in the US in 1998 and 1999.

   There were two 510(k) approvals for the SpineWand device. There are additional approvals for the
Controller (radiofrequency electrosurgical generator); these listings are available from the Center for
Devices and Radiological Health 510(k):

   - PercD Spinewand. Arthrocare Corporation (04/16/03)
   - PercD Spinewand. Arthrocare Corporation (05/31/01)

   The ArthroCare System 2000 (K001588) received 510(k) approval on August 17, 2000. It is a bipolar,
high-frequency electrosurgical system that has three components: an electrosurgical generator
(Controller), disposable, single use Wand, and a reusable cable. The ArthroCare System 2000 (K001588)
received a special 510(k) approval on December 6, 2005. The Perc™ received 510(k) approval (K010811)
on May 30, 2001 for ablation, coagulation, and decompression of disc material to treat symptomatic
patients with contained herniated discs.

   Three subsequent 510(k) approvals (K020621, K030954, and K053447) were issued for the ArthroCare®
Perc-D® SpineWand™ on March 28, 2002, April 16, 2003, and December 27 2005, respectively, noting
modifications in dimensional and performance specifications, materials, and labeling for the device.
Indications for both approvals for use, technology, principle of operation, packaging, and sterilization
parameters of the wands were unchanged from those of the predicate device. The ArthroCare® Perc-
D® SpineWand™ marking. Endoscopes, catheters, and needles that can be used for epidural lysis of
adhesions are regulated by the FDA as Class II devices and a number of these devices have been
approved via the FDA 510(k) process. The Racz Catheter received FDA approval on October 8, 1996
(K954584). The Myelotec Myeloscope received 510(k) approval on September 4, 1996 (K960194).

   Other devices include the PercScope, Yeung Endoscopic Spine System, and The Spine Endoscope,
discTRODE, Accutherm and TransDiscal electrodes.

   The Radionics RF Disc Catheter Electrode System received FDA 510(k) clearance in October 2000.
2. CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS):

Medicare does not cover Thermal Intradiscal Procedures (TIPs). Effective for services performed on or after September 29, 2008, CMS has determined that Thermal Intradiscal Procedures (TIPs) are not reasonable and necessary for the treatment of low back pain. Refer to the National Coverage Determination (NCD) for Thermal Intradiscal Procedures (TIPs) (150.11). Local Coverage Determinations (LCDs) for TIPs do not exist at this time.

Medicare does not have a National Coverage Determination (NCD) for Thermal Intradiscal Annuloplasty procedures (TIPs), Intradiscal Biacuplasty (IDB), Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT), Nucleoplasty, Laser Discectomy, Yeung Endoscopic Spinal Surgery (YESS), or Arthroscopic/Percutaneous/Endoscopic Microdiscectomy. Local Coverage Determinations (LCDs) do not exist at this time.

National Coverage Determination (NCD) for Percutaneous image-guided LUMBAR DECOMPRESSION for LUMBAR spinal stenosis (150.13). Implementation date: 10/6/2014.

Percutaneous image-guided LUMBAR DECOMPRESSION (PILD) for LUMBAR spinal stenosis is a posterior decompression of the lumbar spine performed under indirect image guidance without any direct visualization of the surgical area. This is a procedure proposed as a treatment for symptomatic LSS unresponsive to conservative therapy. This procedure is generally described as a non-invasive procedure using specially designed instruments to percutaneously remove a portion of the lamina and debulk the ligamentum flavum. The procedure is performed under x-ray guidance (e.g., fluoroscopic, CT) with the assistance of contrast media to identify and monitor the compressed area via epiduragram.

Effective for services performed on or after January 09, 2014, the Centers for Medicare & Medicaid Services (CMS) has determined that PILD will be covered by Medicare when provided in a clinical study under section 1862(a)(1)(E) through Coverage with Evidence Development (CED) for beneficiaries with LSS who are enrolled in an approved clinical study that meets CMS criteria.

Endoscopically assisted laminotomy/laminectomy, which requires open and direct visualization, as well as other open lumbar decompression procedures for LSS are not within the scope of this NCD.

3. MINNESOTA DEPARTMENT OF HUMAN SERVICES (DHS):

Minnesota DHS does not have a policy statement regarding Thermal Intradiscal Annuloplasty procedures (TIPs), Intradiscal Biacuplasty (IDB), Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT), Nucleoplasty, Laser Discectomy, Yeung Endoscopic Spinal Surgery (YESS), or Arthroscopic/Percutaneous/Endoscopic Microdiscectomy in its Provider Manual or other specific provider references.

CLINICAL EVIDENCE:

1. EXTERNAL SOURCES/ GROUPS POLICY:

National Institute for Health and Clinical Excellence (NICE): The National Institute for Health and Clinical Excellence (NICE) published guidance in 2005 on automated percutaneous mechanical lumbar discectomy, indicating that there is limited evidence of efficacy based on uncontrolled case series of
heterogeneous groups of patients and evidence from small RCTs showing conflicting results. In view of the uncertainties about the efficacy of the procedure, it should not be used without special arrangements for consent and for audit or research (NICE, 2005). This guideline did not mention AMD or PED.

**American Society of Interventional Pain Physicians (ASIPP):** An updated ASIPP Evidence-Based Practice Guidelines in the Management of Chronic Spinal Pain (Manchicanti, et al., 2013) states that the evidence for intradiscal electrothermal therapy (IDET) and discTRODE (PIRFT) is limited. In a 2009 update of guidelines for management of chronic spinal pain, a task force of the American Society of Interventional Pain Physicians (ASIPP) published a 1C recommendation for automated percutaneous lumbar discectomy, defined as a strong recommendation based on low-quality to very low-quality evidence from observational and case series studies. The 1C definition further states that this recommendation “may change when higher quality evidence becomes available.” Questions remain about the appropriate patient selection criteria (particularly related to the size and migration of the disc herniation) for this procedure (Manchikanti et al., 2009). This guideline did not mention AMD or PED.

**Work Loss Data Institute (WLDI):** In a set of guidelines on acute and chronic low back pain, the WLDI mentions percutaneous discectomy, but does not recommend this procedure for treatment of this type of pain (WLDI, 2011).

**American College of Occupational and Environmental Medicine (ACOEM):** The ACOEM practice guidelines on low back disorders (originally published in 2007 and updated in 2011) states that PIRFT is strongly not recommended for treatment of acute, subacute, or chronic low back pain, particularly including discogenic low back pain.

**American Pain Society:** The evidence-based clinical practice guideline from the American Pain Society, Interventional Therapies, Surgery, and Interdisciplinary Rehabilitation for Low Back Pain, states that there are no trials evaluating Coblation nucleoplasty. The authors were unable to estimate the net benefit of the procedure in the treatment of patients with back pain, with or without radiculopathy.

**SUMMARY:**

The evidence in the published medical literature on arthroscopic microdiscectomy, percutaneous discectomy and thermal intradiscal procedures for the treatment of low back pain is inadequate to permit scientific conclusions and/or demonstrate beneficial health outcomes. Evidence from large comparative studies with long-term follow-up, using well-defined procedures, is needed to determine its clinical role among other minimally invasive techniques for lumbar disc herniation.

The best available evidence for AMD was provided by two randomized controlled trials, one prospective case series, and two retrospective case series. The evidence was insufficient to demonstrate equivalent or superior efficacy of AMD or percutaneous endoscopic discectomy compared with standard open microdiscectomy. A review of the data suggests that the procedure broadly has comparable results with open microdiscectomy, and it has some advantages in terms of a shorter hospitalization and reduced postoperative disability. Reported success rates for AMD were similar or slightly higher than those reported after standard microdiscectomy. Reported procedure success rates ranged from 70% to 97% in the randomized controlled studies and case series.

The overall quality of the evidence was very low. The studies were relatively old, had short follow-up times,
and were subject to potential bias due to poor study design and non-standardized assessment of outcomes. In addition, bias in favor of the treatment on the part of some investigators cannot be excluded and may have influenced interpretation of the results. Assessments of the efficacy of AMD, percutaneous discectomy and thermal intradiscal procedures were further complicated by the continuous further development of technologies, which led to a diversity of procedures in use, prohibiting generalization of study results. Given the inadequate quality of the comparative data, lack of data on long-term outcomes, and the paucity of recent literature evaluating these procedures it is not possible to draw definitive conclusions.

**APPLICABLE CODES:**

The Current Procedural Terminology (CPT®) codes and HCPCS codes listed in this policy are for reference purposes only. Listing of a service or device code in this policy does not imply that the service described by this code is a covered or non-covered health service. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment. Other medical policies and coverage determination guidelines may apply.

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S2348</td>
<td>Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single or multiple levels, lumbar [DISC nucleoplasty]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-9 Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>80.59</td>
<td>Other destruction of intervertebral disc [when specified as percutaneous lumbar disc decompression, laser discectomy, coblation nucleoplasty]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10 Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>OR533ZZ-0R5B4ZZ</td>
<td>Destruction of vertebral disc, percutaneous or percutaneous endoscopic approach [cervical, cervicothoracic, thoracic or thoracolumbar; includes codes OR533ZZ, OR534ZZ, OR553ZZ, OR554ZZ, OR593ZZ, OR594ZZ, OR5B3ZZ, OR5B4ZZ]</td>
</tr>
<tr>
<td>ORB33ZZ-0RBB4ZZ</td>
<td>Excision of vertebral disc, percutaneous or percutaneous endoscopic approach [cervical, cervicothoracic, thoracic or thoracolumbar; includes codes ORB33ZZ, ORB34ZZ, ORB53ZZ, ORB54ZZ, ORB93ZZ, ORB94ZZ, ORBB3ZZ, ORBB4ZZ]</td>
</tr>
<tr>
<td>ORN33ZZ-0RNB4ZZ</td>
<td>Release vertebral disc, percutaneous or percutaneous endoscopic approach [cervical, cervicothoracic, thoracic or thoracolumbar; includes codes ORN33ZZ, ORN34ZZ, ORN53ZZ, ORN54ZZ, ORN93ZZ, ORNB3ZZ, ORNB4ZZ]</td>
</tr>
<tr>
<td>0S523ZZ-0S544ZZ</td>
<td>Destruction of vertebral disc, percutaneous or percutaneous endoscopic approach [lumbar or lumbosacral; includes codes OS523ZZ, OS524ZZ, OS543ZZ, OS544ZZ]</td>
</tr>
<tr>
<td>0SB23ZZ-0SB44ZZ</td>
<td>Excision of vertebral disc, percutaneous or percutaneous endoscopic approach [lumbar or lumbosacral; includes codes OSB23ZZ, OSB24ZZ, OSB43ZZ, OSB44ZZ]</td>
</tr>
<tr>
<td>0SN23ZZ-0SN44ZZ</td>
<td>Release vertebral disc, percutaneous or percutaneous endoscopic approach [lumbar or lumbosacral; includes codes OSN23ZZ, OSN24ZZ, OSN43ZZ, OSN44ZZ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22526</td>
<td>Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level</td>
</tr>
</tbody>
</table>
| 22527      | Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for...
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<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 the use of an endoscope, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar primary procedure)</td>
</tr>
<tr>
<td>0062T</td>
<td>Percutaneous intradiscal anuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; single level</td>
</tr>
<tr>
<td>0063T</td>
<td>1 or more additional levels (List separately in addition to 0062T for primary procedure)</td>
</tr>
<tr>
<td>0274T</td>
<td>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 (e.g., fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic</td>
</tr>
<tr>
<td>0275T</td>
<td>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 (e.g., fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar</td>
</tr>
<tr>
<td>64999</td>
<td>Unlisted procedure, nervous system [when specified as percutaneous decompression or laser procedures of cervical or thoracic spine]</td>
</tr>
</tbody>
</table>

CPT® is a registered trademark of the American Medical Association.

**REFERENCES:**


### POLICY HISTORY:

<table>
<thead>
<tr>
<th>DATE</th>
<th>ACTION/DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/23/2014</td>
<td>Reviewed and approved by the Quality Improvement Advisory and Credentialing Council (QIACC).</td>
</tr>
<tr>
<td>11/1/2014</td>
<td>Published to ucare.org</td>
</tr>
<tr>
<td>03/23/2016</td>
<td>Revised and approved by Medical Policy Committee.</td>
</tr>
<tr>
<td></td>
<td>• Title was changed from Arthroscopic Microdiscectomy for Lumbar Disc Herniation to Percutaneous and Endoscopic Spinal Surgery.</td>
</tr>
<tr>
<td></td>
<td>• Policy number was updated to 2016M0033B.</td>
</tr>
<tr>
<td></td>
<td>• Policy content was expanded to include percutaneous discectomy and thermal intradiscal procedures.</td>
</tr>
</tbody>
</table>