



MASSACHUSETTS

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Medical Policy

Automated Percutaneous and Percutaneous Discectomy

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Policy Number: 231

BCBSA Reference Number: 7.01.18 (For Plan internal use only)

NCD/LCD: N/A

Related Policies

- Decompression of the Intervertebral Disc Using Laser Energy (Laser Discectomy) or Radiofrequency Coblation (Nucleoplasty), #[271](#)
- Percutaneous Intradiscal Electrothermal Annuloplasty, Radiofrequency Annuloplasty, and Biacuplasty, #[482](#)

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO BlueSM and Medicare PPO BlueSM Members

Automated percutaneous discectomy is considered **INVESTIGATIONAL** as a technique of intervertebral disc decompression in individuals with back pain and/or radiculopathy related to disc herniation in the lumbar, thoracic, or cervical spine.

Percutaneous endoscopic discectomy is considered **INVESTIGATIONAL** as a technique of intervertebral disc decompression in individuals with back pain and/or radiculopathy related to disc herniation in the lumbar, thoracic, or cervical spine.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	This is not a covered service.
Commercial PPO and Indemnity	This is not a covered service.
Medicare HMO Blue SM	This is not a covered service.

Medicare PPO Blue SM	This is not a covered service.
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CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The following CPT codes are considered investigational for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

CPT Codes

CPT codes:	Code Description
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 the use of an endoscope, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar

Description

Back pain or radiculopathy related to herniated discs is an extremely common condition and a frequent cause of chronic disability. Although many cases of acute low back pain and radiculopathy will resolve with conservative care, surgical decompression is often considered when the pain is unimproved after several months and is clearly neuropathic in origin, resulting from irritation of the nerve roots. Open surgical treatment typically consists of discectomy in which the extruding disc material is excised. When performed with an operating microscope, the procedure is known as a microdiscectomy.

Minimally invasive options have also been researched, in which some portion of the disc is removed or ablated, although these techniques are not precisely targeted at the offending extruding disc material. Ablative techniques include laser discectomy and radiofrequency decompression (see policy [#271](#)). Intradiscal electrothermal annuloplasty is another minimally invasive approach to low back pain. In this technique, radiofrequency energy is used to treat the surrounding disc annulus (see policy [#482](#)).

Herein, BCBSA addresses automated percutaneous and endoscopic discectomy, in which the disc decompression is accomplished by the physical removal of disc material rather than its ablation. Traditionally, discectomy was performed manually through an open incision, using cutting forceps to remove nuclear material from within the disc annulus. This technique was modified by automated devices that involve placement of a probe within the intervertebral disc and aspiration of disc material using a suction cutting device. Endoscopic techniques may be intradiscal or may involve extraction of noncontained and sequestered disc fragments from inside the spinal canal using an interlaminar or transforaminal approach. Following insertion of the endoscope, decompression is performed under visual control.

Automated percutaneous discectomy, is a procedure in which the disc decompression is accomplished by the physical removal of disc material rather than its ablation. Traditionally, discectomy was performed manually through an open incision, using cutting forceps to remove nuclear material from within the disc annulus. This technique was modified by automated devices that involve placement of a probe within the intervertebral disc and aspiration of disc material using a suction cutting device, under indirect visual guidance using CT or fluoroscope.

Summary

Description

Surgical management of herniated intervertebral discs most commonly involves discectomy or microdiscectomy, performed manually through an open incision. Automated percutaneous discectomy involves placement of a probe within the intervertebral disc under image guidance with aspiration of disc material using a suction cutting device. Endoscopic discectomy involves the percutaneous placement of a working channel under image guidance, followed by visualization of the working space and instrumentation through an endoscope, and aspiration of disc material.

Summary of Evidence

For individuals who have herniated intervertebral disc(s) who receive automated percutaneous discectomy, the evidence includes randomized controlled trials (RCTs) and systematic reviews of observational studies. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. The published evidence from small RCTs is insufficient to evaluate the impact of automated percutaneous discectomy on the net health outcome. Well-designed and executed RCTs are needed to determine the benefits and risks of this procedure. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have herniated intervertebral disc(s) who receive percutaneous endoscopic discectomy, the evidence includes a number of RCTs, systematic reviews, and observational studies. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. Many of the more recent RCTs are conducted at institutions within China. There are few reports from the United States. Results do not reveal a consistently significant improvement in patient-reported outcomes and treatment-related morbidity with percutaneous endoscopic discectomy in comparison to other discectomy interventions. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Additional Information

2018 Input

Clinical input was sought to help determine whether the use of automated percutaneous discectomy or endoscopic percutaneous discectomy for individuals with herniated intervertebral discs would provide a clinically meaningful improvement in net health outcome and whether the use is consistent with generally accepted medical practice. In response to requests, clinical input was received from 3 respondents, including 2 specialty society-level response(s); no physician-level responses identified through a specialty society; 1 physician-level response identified through an academic medical center.

For individuals who have herniated intervertebral discs who receive automated percutaneous discectomy or percutaneous endoscopic discectomy, clinical input does not support a clinically meaningful improvement in net health outcome and does not indicate this use is consistent with generally accepted medical practice. Clinical input suggests that automated percutaneous discectomy may be an appropriate treatment option for the highly selected patient who has a small focal disc fragment compressing a lumbar nerve causing radiculopathy in the absence of lumbar stenosis or severe bony foraminal stenosis. Similarly, clinical input suggests that endoscopic percutaneous discectomy may be an appropriate treatment option for the highly selected patient who has a small focal disc herniation causing lumbar radiculopathy. However, respondents were mixed in the level of support for this indication, and overall the clinical input is not generally supportive of a clinically meaningful improvement in net health outcome.

Policy History

Date	Action
8/2022	Annual policy review. References added. Minor editorial refinements to policy statements; intent unchanged.
8/2020	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
12/2019	Investigational criteria on endoscopic discectomy removed. Endoscopic discectomy is considered a covered service. Clarified coding information. Effective 12/1/2019.

2/2019	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
6/2017	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2017	Clarified coding information for the 2017 code changes.
5/2016	Annual policy review. New references added.
11/2015	Added coding language.
6/2015	Annual policy review. New references added.
7/2014	Annual policy review. New references added.
10/2013	Annual policy review. Policy statement clarified to read: back pain and/or radiculopathy.
2/2013	Annual policy review. Changes to policy statement. Effective 2/2013.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
1/2011	Medical Policy Group – Neurology and Neurosurgery. No changes to policy statements.
9/1/10	Medical Policy 231, effective 9/1/10, describing ongoing non-coverage.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

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