Medical Policy
Image-Guided Minimally Invasive Decompression for Spinal Stenosis

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Policy Number: 240
BCBSA Reference Number: 7.01.126

Related Policies
Interspinous and Interlaminar Stabilization/Distraction Devices (Spacers), #584

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

Image-guided minimally invasive spinal decompression is considered INVESTIGATIONAL.

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.

<table>
<thead>
<tr>
<th>Commercial Managed Care (HMO and POS)</th>
<th>Outpatient</th>
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<td>This is not a covered service.</td>
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<th>Commercial PPO and Indemnity</th>
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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 code is considered investigational for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

**CPT Codes**

<table>
<thead>
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<th>CPT codes:</th>
<th>Code Description</th>
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<tr>
<td>0275T</td>
<td>Percutaneous laminotomy/laminectomy (interlaminar 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; lumbar</td>
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**Description**

**Spinal Stenosis**

In spinal stenosis, the space around the spinal cord narrows, compressing the spinal cord and its nerve roots. The goal of surgical treatment is to "decompress" the spinal cord and/or nerve roots.

The most common symptoms of lumbar spinal stenosis are back pain with neurogenic claudication (ie, pain, numbness, weakness) in the legs that worsens with standing or walking and is alleviated by sitting or leaning forward. Compression of neural elements generally occurs from a combination of degenerative changes, including ligamentum flavum hypertrophy, bulging of the intervertebral disc, and facet thickening with arthropathy. Spinal stenosis is often linked to age-related changes in disc height and arthritis of the facet joints. Lumbar spinal stenosis is among the most common reasons for back surgery and the most common reason for lumbar spine surgery in adults over the age of 65.

The most common symptoms of cervical/thoracic spinal stenosis are neck pain and radiculopathy of the shoulder and arm. The most common cause of cervical radiculopathy is degenerative changes, including disc herniation.

**Treatment**

**Conventional Posterior Decompression Surgery**

For patients with lumbar spinal stenosis, surgical laminectomy has established benefits in reducing pain and improving quality of life.

For patients with cervical or thoracic stenosis, surgical treatment includes discectomy or foraminal decompression.

A systematic review by Chou et al (2009) assessed surgery for back pain; it was commissioned by the American Pain Society and conducted by an evidence-based center. Four higher quality randomized trials were reviewed; they compared surgery with nonsurgical therapy for spinal stenosis, including two studies from the multicenter Spine Patient Outcomes Research Trial that evaluated laminectomy for spinal stenosis (specifically with or without degenerative spondylolisthesis). All 4 studies found that initial decompressive surgery (laminectomy) was slightly to moderately superior to initial nonsurgical therapy (eg, average 8- to 18-point differences on the 36-Item Short-Form Health Survey and Oswestry Disability Index). However, there was insufficient evidence to determine the optimal adjunctive surgical methods for laminectomy (ie, with or without fusion, instrumented vs noninstrumented fusion) in patients with or without degenerative spondylolisthesis. Spine Patient Outcomes Research Trial continues to be referenced as the highest quality evidence published on decompressive surgery.

Less invasive surgical procedures include open laminotomy and microendoscopic laminotomy. In general, the literature comparing surgical procedures is limited. The literature has suggested that less invasive surgical decompression may reduce perioperative morbidity without impairing long-term outcomes when performed in appropriately selected patients. Posterior decompressive surgical procedures include decompressive laminectomy, hemilaminotomy and laminotomy, and microendoscopic decompressive laminotomy.
Decompressive laminectomy, the classic treatment for lumbar spinal stenosis, unroofs the spinal canal by extensive resection of posterior spinal elements, including the lamina, spinous processes, portions of the facet joints, ligamentum flavum, and the interspinous ligaments. Wide muscular dissection and retraction is needed to achieve adequate surgical visualization. The extensive resection and injury to the posterior spine and supporting musculature can lead to instability with significant morbidity, both postoperatively and longer term. Spinal fusion, performed at the same time as laminectomy or after symptoms have developed, may be required to reduce resultant instability. Laminectomy may also be used for extensive multilevel decompression.

Hemilaminotomy and laminotomy, sometimes termed laminoforaminotomy, are less invasive than laminectomy. These procedures focus on the interlaminar space, where most of the pathologic changes are concentrated, minimizing resection of the stabilizing posterior spine. A laminotomy typically removes the inferior aspect of the cranial lamina, superior aspect of the subjacent lamina, ligamentum flavum, and the medial aspect of the facet joint. Unlike laminectomy, laminotomy does not disrupt the facet joints, supra- and interspinous ligaments, a major portion of the lamina, or the muscular attachments. Muscular dissection and retraction are required to achieve adequate surgical visualization.

Microendoscopic decompressive laminotomy, similar to laminotomy, uses endoscopic visualization. The position of the tubular working channel is confirmed by fluoroscopic guidance, and serial dilators are used to dilate the musculature and expand the fascia. For microendoscopic decompressive laminotomy, an endoscopic curette, rongeur, and drill are used for the laminotomy, facetectomy, and foraminotomy. The working channel may be repositioned from a single incision for multilevel and bilateral dissections.

**Image-Guided Minimally Invasive Lumbar Decompression**

Posterior decompression for lumbar spinal stenosis has been evolving toward increasingly minimally invasive procedures in an attempt to reduce postoperative morbidity and spinal instability. Unlike conventional surgical decompression, the percutaneous mild® decompressive procedure is performed solely under fluoroscopic guidance (eg, without endoscopic or microscopic visualization of the work area). This procedure is indicated for central stenosis only, without the capability of addressing nerve root compression or disc herniation, should either be required.

Percutaneous image-guided minimally invasive lumbar decompression using a specially designed tool kit (mild®) has been proposed as an ultra-minimally invasive treatment of central lumbar spinal stenosis. In this procedure, the epidural space is filled with contrast medium under fluoroscopic guidance. Using a 6-gauge cannula clamped in place with a back plate, single-use tools (portal cannula, surgical guide, bone rongeur, tissue sculpter, trocar) are used to resect thickened ligamentum flavum and small pieces of lamina. The tissue and bone sculpting is conducted entirely under fluoroscopic guidance, with contrast media added throughout the procedure to aid visualization of the decompression. The process is repeated on the opposite side for bilateral decompression of the central canal. The devices are not intended for use near the lateral neural elements and are contraindicated for disc procedures.

**Summary**

Image-guided minimally invasive lumbar decompression describes a percutaneous procedure for decompression of the central spinal canal in patients with spinal stenosis and hypertrophy of the ligamentum flavum. In this procedure, a specialized cannula and surgical tools (mild®) are used under fluoroscopic guidance for bone and tissue sculpting near the spinal canal. Image-guided minimally invasive lumbar decompression is proposed as an alternative to existing posterior decompression procedures.

For individuals who have lumbar spinal stenosis, or cervical or thoracic spinal stenosis who receive image-guided minimally invasive lumbar decompression, the evidence includes a large, ongoing randomized controlled trial (n=302), a systematic review of a small randomized controlled trial (n=38), and a number of prospective and retrospective cohort studies and case series. Relevant outcomes are symptoms, functional outcomes, health status measures, and treatment-related morbidity. The largest randomized controlled trial compared image-guided minimally invasive lumbar decompression with epidural steroid injections (control) in patients who had ligamentum flavum hypertrophy and who failed
conservative therapy. Early results have suggested reductions in pain and improvements in function scores in the image-guided minimally invasive lumbar decompression group vs the control group. The trial was unblinded and there is evidence of differing expectations and follow-up in the 2 groups, suggesting a high-risk of bias. The available evidence is insufficient to determine the efficacy of mild® compared with placebo or to determine the efficacy of image-guided minimally invasive lumbar decompression compared with open decompression. Trials with relevant control groups could provide greater certainty on the risks and benefits of this procedure. The evidence is insufficient to determine the effects of the technology on health outcomes.

Policy History

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<td>Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.</td>
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<tr>
<td>6/2017</td>
<td>BCBSA National medical policy review. Policy statement clarified from “lumbar” to “spinal” to include cervical/thoracic decompression. “Lumbar” removed from title. 6/1/2017</td>
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<td>5/2016</td>
<td>New references added from BCBSA National medical policy.</td>
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<tr>
<td>12/2015</td>
<td>Added coding language.</td>
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<td>6/2015</td>
<td>New references added from BCBSA National medical policy.</td>
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<td>7/2014</td>
<td>New references added from BCBSA National medical policy.</td>
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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

References