



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Medical Policy

Decompression of the Intervertebral Disc Using Laser Energy (Laser Discectomy) or Radiofrequency Coblation (Nucleoplasty)

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Policy Number: 271

BCBSA Reference Number: 7.01.93

NCD/LCD: National Coverage Determination (NCD) for Thermal Intradiscal Procedures (TIPs) (150.11)

Related Policies

- Automated Percutaneous Discectomy and Percutaneous Lumbar Discectomy, #[231](#)
- Percutaneous Intradiscal Electrothermal (IDET) Annuloplasty and Percutaneous Intradiscal Radiofrequency Annuloplasty, #[482](#)
- Percutaneous Intradiscal Electrothermal Annuloplasty, Radiofrequency Annuloplasty, and Biacuplasty, #[482](#)

Policy

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

Laser discectomy and radiofrequency coblation (disc nucleoplasty) as techniques of disc decompression and treatment of associated pain are [INVESTIGATIONAL](#).

Medicare HMO BlueSM and Medicare PPO BlueSM Members

Laser discectomy as a technique of disc decompression and treatment of associated pain is [INVESTIGATIONAL](#).

BCBSMA does not cover thermal intradiscal procedures (i.e., radiofrequency coblation) for the treatment of low back pain for Medicare HMO Blue and Medicare PPO Blue members in accordance with CMS NCD.

Medical necessity criteria and coding guidance can be found through the link below.

[National Coverage Determinations \(NCDs\)](#)

National Coverage Determination (NCD) for Thermal Intradiscal Procedures (TIPs) (150.11)

Note: To review the specific NCD, please remember to click “accept” on the CMS licensing agreement at the bottom of the CMS webpage.

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 BlueSM	This is not a covered service.
Medicare PPO BlueSM	This is not a covered service.

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 and HCPCS 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 discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar
0275T	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

HCPCS Codes

HCPCS codes:	Code Description
S2348	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single or multiple levels, lumbar

Description

Discogenic Low Back Pain

Discogenic low back pain is a common, multifactorial pain syndrome that involves low back pain without radicular symptoms findings, in conjunction with radiologically confirmed degenerative disc disease.

Treatment

Typical treatment includes conservative therapy with physical therapy and medication management, with potential for surgical decompression in more severe cases.

A variety of minimally invasive techniques have been investigated as treatment of low back pain related to disc disease. Techniques can be broadly divided into those designed to remove or ablate disc material, and thus decompress the disc, and those designed to alter the biomechanics of the disc annulus. The former category includes chymopapain injection, automated percutaneous lumbar discectomy, laser discectomy, and, most recently, disc decompression using radiofrequency energy, referred to as a disc nucleoplasty.

Techniques that alter the biomechanics of the disc (disc annulus) include a variety of intradiscal electrothermal procedures discussed in policy [#482](#).

A variety of different lasers have been investigated for laser discectomy, including YAG (yttrium aluminum garnet), KTP (potassium titanyl phosphate), holmium, argon, and carbon dioxide lasers. Due to differences in absorption, the energy requirements and the rates of application differ among the lasers. In addition, it is unknown how much disc material must be removed to achieve decompression. Therefore, protocols vary by the length of treatment, but typically the laser is activated for brief periods only.

Radiofrequency coblation uses bipolar low-frequency energy in an electrically conductive fluid (eg, saline) to generate a high-density plasma field around the energy source. This creates a low-temperature field of ionizing particles that break organic bonds within the target tissue. Coblation technology is used in a variety of surgical procedures, particularly related to otolaryngology. The disc nucleoplasty procedure is accomplished with a probe mounted using a radiofrequency coblation source. The proposed advantage of coblation is that the procedure provides for controlled and highly localized ablation, resulting in minimal damage to surrounding tissue.

Summary

Laser energy (laser discectomy) and radiofrequency coblation (nucleoplasty) are being evaluated for decompression of the intervertebral disc. For laser discectomy under fluoroscopic guidance, a needle or catheter is inserted into the disc nucleus, and a laser beam is directed through it to vaporize tissue. For disc nucleoplasty, bipolar radiofrequency energy is directed into the disc to ablate tissue. These minimally invasive procedures are being evaluated for the treatment of discogenic back pain.

For individuals who have discogenic back pain or radiculopathy who receive laser discectomy, the evidence includes systematic reviews of observational studies. Relevant outcomes are symptoms, functional outcomes, and treatment-related morbidity. While numerous case series and uncontrolled studies have reported improvements in pain levels and functioning following laser discectomy, the lack of well-designed and -conducted controlled trials limits interpretation of reported data. The evidence is insufficient to determine the effect of the technology on health outcomes.

For individuals who have discogenic back pain or radiculopathy who receive disc nucleoplasty with radiofrequency coblation, the evidence includes randomized controlled trials and systematic reviews. Relevant outcomes are symptoms, functional outcomes, and treatment-related morbidity. For nucleoplasty, there are 2 randomized controlled trials in addition to several uncontrolled studies. These randomized controlled trials are limited by the lack of blinding, an inadequate control condition in one, and inadequate data reporting in the second. The available evidence is insufficient to permit conclusions concerning the effect of these procedures on health outcomes due to multiple confounding factors that may bias results. High-quality randomized trials with adequate follow-up (at least 1 year), which control for selection bias, the placebo effect, and variability in the natural history of low back pain, are needed. The evidence is insufficient to determine the effect of the technology on health outcomes.

Policy History

Date	Action
6/2020	BCBSA National medical policy review. Description, summary and references updated. Policy statements unchanged.
5/2019	BCBSA National medical policy review. Description, summary and references updated. Policy statements unchanged.
2/2017	New references added from BCBSA National medical policy.
1/2017	Clarified coding information for the 2017 code changes.
12/2015	Added coding language.
10/2013	New references from BCBSA National medical policy.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
1/2011	Updated - Medical Policy Group - Neurology and Neurosurgery. No changes to policy statements.
1/1/2011	Medical Policy 271 effective 1/1/2011.
5/09	BCBSA National medical policy review. No changes to policy statements.
12/07	BCBSA National medical policy review. No changes to policy statements.

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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