Minimally invasive and laser spine procedures

These services may or may not be covered by your HealthPartners plan. Please see your plan documents for your specific coverage information. If there is a difference between this general information and your plan documents, your plan will be used to determine your coverage.

Administrative Process

Prior authorization is required when requested for the following non-covered conditions:
1. Laser facet ablation / denervation / rhizotomy (64633, 64634, 64635, 64636)
2. Epidurolysis / percutaneous adhesiolysis (when coded with 64640)

Prior authorization is not required for microdisectomy, also known as percutaneous manual nucleotomy.

Prior authorization is not applicable for minimally invasive spine procedures and laser spine procedures because these services are considered investigational/experimental. The provider and facility will be liable for payment unless:
1. The provider notifies the member that a specific service has been determined by HealthPartners to be investigational/experimental; and
2. The member signs a waiver agreeing to pay for the specific non-covered service being rendered; and
3. The claim has been billed with a GA modifier indicating such. If the member has signed a waiver agreeing to pay for the specific service then the member will be liable for payment.

Coverage

- Microdisectomy, also known as percutaneous manual nucleotomy, is generally covered subject to the indications listed below and per your plan documents.
- Minimally invasive back procedures are considered investigational/experimental and therefore not covered.

Procedures that are covered

Microdisectomy, also known as percutaneous manual nucleotomy

Procedures that are not covered

The following procedures are considered investigational and not covered because the reliable evidence does not permit conclusions concerning safety, effectiveness, or effect on health outcomes.

1. Laser spine procedures, including but not limited to:
   A. Laser discectomy, also known as laser-assisted discectomy, laser disc decompression or laser-assisted disc decompression (LADD) (62287)
   B. Percutaneous laser discectomy (62287)
   C. Laparoscopic laser discectomy
   D. Endoscopic laser foraminoplasty
   E. Endoscopic laser foraminotomy
   F. Endoscopic laser laminotomy
   G. Laser laminecctomy
   H. Laser facet ablation / denervation / rhizotomy (64633, 64634, 64635, 64636)
   Clinical studies have not shown a clinically significant benefit of use of laser over any other method of tissue resection in spinal surgery. No additional benefit will be provided for the use of a laser in spinal surgery.

2. Percutaneous and endoscopic laminectomy and disc decompression procedures of the cervical, thoracic, or lumbar spine including but not limited to:
   A. Percutaneous endoscopic discectomy with or without laser (PELD) (also known as arthroscopic microdiscectomy or Yeung Endoscopic Spinal Surgery System (Y.E. S.S.))
   B. APLD (Automated percutaneous lumbar discectomy) (62287)
   C. Endoscopic procedures using the DiscFX™ System
   D. Minimally invasive lumbar decompression – “MILD” procedure. (0274T, 0275T)

3. Thermal intradiscal procedures (TIPs) including but not limited to:
   A. Intradiscal electrothermal therapy (IDET) / Intradiscal electrothermal annuloplasty (IEA) / Intradiscal thermal annuloplasty (IDTA) (22526, 22527)
B. Nucleoplasty/decompression nucleoplasty/percutaneous (or plasma) disc decompression (PDD) (e.g., SpineWand™ coblation therapy)
C. Transdiscal biacuplasty/ Intradiscal biacuplasty (IDB)/cooled radiofrequency ablation (RFA) (22526, 22527)
D. Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT) (22526, 22527)

4. Intradiscal steroid injection (0213T-0218T)
5. Devices for annulus repair (i.e. X-close)
6. Epidurolysis / percutaneous epidural adhesiolysis (62263, 62264, 64640)
7. Endoscopic radiofrequency denervation/rhizotomy

Definitions

Discectomy is the incision and removal of part or the whole spinal disc.

Foraminectomy and foraminotomy are performed to expand the openings (foramen) for the nerve roots to exit the spinal cord by removing some bone and other tissue. A foraminectomy or foraminotomy is often performed on an individual who has arthritis, a lateral disc herniation, or spinal stenosis. The term foraminectomy is used to refer to a procedure that removes a large amount of bone and tissue, and foraminotomy when a smaller amount is removed.

Intradiscal steroid injection is sometimes performed at the same time as a discography is performed.

Intradiscal thermal procedures are proposed to treat back pain arising from spinal disc abnormalities. The goal is to relieve pain arising from the disc and repair structural abnormalities. Heat is generated by the direct or indirect radiofrequency energy.

- Cooled radiofrequency ablation (RFA) / Transdiscal biacuplasty is similar to IDET but is performed via a bipolar method, producing a field between two introducer needles.
- Intradiscal biacuplasty is a minimally invasive transdiscal radiofrequency technique for treatment of back pain. Intradiscal biacuplasty uses two internally water-cooled radiofrequency probes to lesion nociceptors in the intervertebral disc.
- IDET (intradiscal electrothermal therapy (also known as intradiscal electrothermal annuloplasty (IDTA) or IEA) involves a heat probe being inserted into the spine (usually via an endoscope) at the point causing pain. The tissue is heated by the probe, which causes it to shrink and scar
- Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT) applies radiofrequency energy directly to the center of the disc.

Lumbar disc herniation is the most common cause of sciatic pain (nerve pain radiating down the leg). Lumbar disc herniation or radiculopathy is caused when the casing around the disc bursts and some of the gel like disc material seeps out, sometimes causing pain. In some instances it presses on the sciatic nerve, causing the nerve pain radiating down the leg.

Microdiscectomy is a discectomy done with a very small incision, usually about 1 inch long using manual instruments and technique.

Minimally invasive lumbar decompression (MILD) - An emerging minimally invasive surgery for lumbar spinal stenosis is known as MILD (minimally invasive lumbar decompression), a percutaneous decompression technique that increases the dimensions of the spinal canal, thereby achieving nerve decompression. The MILD procedure is an image-guided surgery—the surgical site is not directly visualized but rather surgery is guided by fluoroscopy.

Percutaneous refers to the insertion of a cannula, tube or endoscope through the skin. An endoscope is a highly flexible viewing instrument with capabilities of diagnostic (biopsy) or even therapeutic functions through special channels. It looks like a large flexible needle and makes a very small incision. Many percutaneous discectomy procedures are performed by inserting the different devices through an endoscope.

Percutaneous intradiscal procedures are minimally invasive techniques providing percutaneous access to pain-generating discs. These procedures have been developed to treat discogenic LBP, including radiculopathy and sciatica by way of partial removal of the nucleus pulposus (gel like disc material) to reduce intradiscal pressure. Partial removal of the nucleus pulposus has been shown to decompress herniated discs, relieving pressure on nerve roots and, in some cases, offering relief from discogenic pain. Percutaneous intradiscal procedures may surgically extract disc material, destroy disc material or alter the disc through the application of heat.

- APLD (Automated percutaneous lumbar discectomy) involves a probe inserted through a cannula and used both as a cutting instrument and for aspiration of disc material.
- Disc nucleoplasty (also known as percutaneous radiofrequency thermomodulation, percutaneous
plasma discectomy or plasma disc decompression (PDD) is a minimally invasive procedure to treat individuals with symptomatic low back and leg pain caused by herniated discs. The procedure utilizes a device called the ArthroCare Perc-D SpineWand, which includes the Perc DLR, the Perc DLG and the Perc DC. The SpineWand is designed to relieve pressure on spinal nerves adjacent to the disc by removing disc material. This procedure relies on a patented technology referred to as Coblation, in which the SpineWand applies a high-frequency electric current directly to the saline medium inside the disc, generating a tightly focused field of highly energized molecules around the tip of the wand.

- **Laser Discectomy** is a percutaneous procedure which uses a laser device to shrink the enlarged disc that is causing the low back pain. There are several FDA approved laser discectomy devices, including LASE® (laser-assisted spinal endoscopy), LADD (laser assisted disc decompression), and others.
- **Percutaneous lumbar discectomy (PLD)** is a term for two minimally invasive surgical techniques / intradiscal procedures for treating contained herniated discs.
- **Percutaneous manual nucleotomy** refers to the technique involving the use of specialized forceps and curettes to remove the disc through a cannula.

### Codes

*If available, codes for a procedure, device or diagnosis are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all inclusive.*

#### CPT codes that are covered services:

Lumbar microdiscectomy/Percutaneous manual nucleotomy

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>63030</td>
<td>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar</td>
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#### CPT codes that are NOT covered services:

Laser discectomy, also known as laser-assisted discectomy, laser disc decompression or laser-assisted disc decompression

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<tr>
<th>Codes</th>
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<tbody>
<tr>
<td>22526</td>
<td>Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level</td>
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<tr>
<td>22527</td>
<td>Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)</td>
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<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</td>
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<tr>
<td>62380</td>
<td>Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar</td>
</tr>
<tr>
<td>C2614</td>
<td>Probe, percutaneous lumbar discectomy</td>
</tr>
<tr>
<td>22899</td>
<td>Unlisted procedure, spine</td>
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<tr>
<td>64999</td>
<td>Unlisted procedure, nervous system</td>
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#### Intradiscal steroid injection

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<tr>
<td>0213T – 0218T</td>
<td>Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, various levels, etc.</td>
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#### CPT codes that require prior authorization:

Laser facet ablation / denervation /rhizotomy - These codes also refer to the policy titled: Radiofrequency ablative denervation (RFA) procedures for chronic facet-mediated neck & back pain.

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<tr>
<td>64633</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint</td>
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<tr>
<td>64634</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>64635</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy</td>
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or CT); lumbar or sacral, single facet joint

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<tr>
<td>64636</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)</td>
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Epidurolysis / percutaneous adhesiolysis

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<tr>
<td>62263</td>
<td>Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days</td>
</tr>
<tr>
<td>62264</td>
<td>Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day</td>
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<tr>
<td>64640</td>
<td>Destruction by neurolytic agent; other peripheral nerve or branch</td>
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Percutaneous laminotomy/laminectomy, “MILD” procedure – minimally invasive lumbar decompression

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<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 (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic</td>
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<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 (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar</td>
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Products

This information is for most, but not all, HealthPartners plans. Please read your plan documents to see if your plan has limits or will not cover some items. If there is a difference between this general information and your plan documents, your plan documents will be used to determine your coverage. These coverage criteria may not apply to Medicare Products if Medicare requires different coverage. For more information regarding Medicare coverage criteria or for a copy of a Medicare coverage policy, contact Member Services at 952-883-7979 or 1-800-233-9645.

References