Medical Policy
Automated Percutaneous and Percutaneous Endoscopic Discectomy

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Policy Number: 231
BCBSA Reference Number: 7.01.18
NCD/LCD: NA

Related Policies
- Laser Discectomy and Radiofrequency Decompression, #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 patients 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 patients with back pain and/or radiculopathy related to disc herniation in the lumbar, thoracic, or cervical spine.

Prior Authorization Information
Pre-service approval is required for all inpatient services for all products. See below for situations where prior authorization may be required or may not be required for outpatient services.
Yes indicates that prior authorization is required.
No indicates that prior authorization is not required.
N/A indicates that this service is primarily performed in an inpatient setting.

<table>
<thead>
<tr>
<th>Outpatient</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
<td>This is not a covered service.</td>
</tr>
<tr>
<td>Commercial PPO and Indemnity</td>
<td>This is not a covered service.</td>
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<tr>
<td>Medicare HMO BlueSM</td>
<td>This is not a covered service.</td>
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<tr>
<td>Medicare PPO BlueSM</td>
<td>This is not a covered service.</td>
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</table>
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:

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Code Description</th>
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<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</td>
</tr>
<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>
</tbody>
</table>

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 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 we address 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 transformaminal approach. Following insertion of the endoscope, decompression is performed under visual control.

Summary

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. Removal of disc herniations under endoscopic visualization is also
being investigated. Endoscopic discectomy involves the percutaneous placement of a working channel under image guidance, followed by visualization of the working space and instruments through an endoscope, and aspiration of disc material.

For individuals who have herniated intervertebral disc(s) who receive automated percutaneous discectomy, the evidence includes randomized controlled trials (RCTs) and systematic reviews of RCTs. 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 net health outcomes. Well-designed and executed RCTs are needed to determine the benefits and risks of this procedure. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have herniated intervertebral disc(s) who receive percutaneous endoscopic discectomy, the evidence includes a number of RCTs and systematic reviews of RCTs. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. Many of the RCTs were conducted at a single center in Europe. Some trials have reported outcomes at least as good as traditional approaches with an open incision, while 1 RCT from a different center in Europe reported a trend toward increased complications and reherniations using an endoscopic approach. There are few reports from the United States. Results from a number of moderately large ongoing RCTs are anticipated in the next 2 to 3 years. The evidence is insufficient to determine the effects of the technology on health outcomes.

### Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>6/2017</td>
<td>BCBSA National medical policy review.</td>
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<tr>
<td></td>
<td>Policy title changed. Summary and background description clarified.</td>
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<tr>
<td></td>
<td>New references added. 6/1/2017</td>
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<tr>
<td>1/2017</td>
<td>Clarified coding information for the 2017 code changes.</td>
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<tr>
<td>5/2016</td>
<td>New references added from BCBSA National medical policy.</td>
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<td>11/2015</td>
<td>Added coding language.</td>
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<td>6/2015</td>
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<td>7/2014</td>
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<td>10/2013</td>
<td>BCBSA National medical policy review.</td>
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<td>Policy statement clarified to read: back pain and/or radiculopathy.</td>
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<td>2/2013</td>
<td>BCBSA National medical policy review.</td>
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<td>Changes to policy statement. Effective 2/2013</td>
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<tr>
<td>9/1/10</td>
<td>Medical Policy 231, effective 9/1/10, describing ongoing non-coverage.</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


