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

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.

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

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>Service Type</th>
<th>Coverage Status</th>
</tr>
</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>
</tr>
<tr>
<td>Medicare HMO Blue&lt;sup&gt;SM&lt;/sup&gt;</td>
<td>This is not a covered service.</td>
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<tr>
<td>Medicare PPO Blue&lt;sup&gt;SM&lt;/sup&gt;</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 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**

<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 discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar</td>
</tr>
<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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**HCPCS Codes**

<table>
<thead>
<tr>
<th>HCPCS codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>S2348</td>
<td>Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single or multiple levels, lumbar</td>
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**Description**

A variety of minimally invasive techniques have been investigated over the years as a treatment of low back pain related to disc disease. Laser discectomy and DISC nucleoplasty™ are the subjects of this policy. Patients considered candidates for DISC nucleoplasty™ or laser discectomy include patients with bulging discs and sciatica.

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. The Disc nucleoplasty™ procedure uses bipolar radiofrequency energy into the disc to ablate tissue in a process referred to as coblation.
technology. The proposed advantage of this coblation technology is that the procedure provides for a controlled and highly localized ablation, resulting in minimal therapy damage to surrounding tissue.

Note that the IDET and PIRT procedures, chymopapain injection, and automated percutaneous lumbar discectomy are considered in separate policies.

Examples of laser devices for incision, excision, resection, ablation, vaporization, and coagulation of tissue include Holmium Laser System Ho1mium: Yttrium Aluminum Garnet from Trimedyne, Inc., Revolix Duo Laser System from Lisa Laser Products, and LITHO Laser System from Quanta System. All laser devices for incision, excision, resection, ablation, vaporization, and coagulation of tissue for the uses described in this statement are considered investigational regardless of the commercial name, the manufacturer, or FDA approval.

Summary
While numerous case series and uncontrolled studies report improvements in pain and functioning following laser discectomy and nucleoplasty, the lack of well-designed and conducted controlled trials limits interpretation of reported data. Questions remain about the safety and efficacy of these treatments. Reconsideration of the policy position awaits randomized trials with adequate follow-up (at least 1 year) that control for selection bias, the placebo effect, and variability in the natural history of low back pain. These procedures are considered investigational.

Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>2/2017</td>
<td>New references added from BCBSA National medical policy.</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>12/2015</td>
<td>Added coding language.</td>
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<tr>
<td>10/2013</td>
<td>New references from BCBSA National medical policy.</td>
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<tr>
<td>5/09</td>
<td>BCBSA National medical policy review.</td>
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<tr>
<td>12/07</td>
<td>BCBSA National medical policy review.</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


