PriorityHealth

# MEDICAL POLICY No. 91581-R12

## SPINE PROCEDURES

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**Summary of Changes**

Clarifications:

- Pg. 17, Section VII. IDET and Other Thermal Intradiscal Procedures (TIPs): Clarification was provided to "Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (PILD) or placebo-control" to indicate that this procedure is covered ONLY for Medicare ONLY when performed in an approved coverage with evidence development (CED) clinical trial).

## POLICY/CRITERIA

### Covered Procedures

### I. Artificial Intervertebral Discs

A. Artificial intervertebral cervical discs are covered according to eviCore criteria. *Note:* Single level reconstruction (C3-C7) following discectomy, or 2-level contiguous reconstruction (C3-C7) following discectomy are covered according to eviCore criteria.

B. Artificial Lumbar Discs:
Artificial intervertebral lumbar discs are not a covered benefit because there is insufficient evidence on their long-term safety and effectiveness, including impact on other discs and bony structures of the back.

### II. Radiofrequency Ablation for Back Pain

A. Coverage is provided for radiofrequency ablation (RFA) targeting pain originating in the cervical, thoracic, or lumbar spinal regions under the following conditions:
   1. Patient's symptoms are not consistent with identifiable pathology including disc herniation, spondylolisthesis, spinal stenosis
   2. Absence of any neurologic deficit
   3. Back or neck pain predominates over leg pain or arm pain, respectively
   4. Two diagnostic medial branch nerve blocks, provided under a standard protocol that alternates long- and short-acting anesthetic blocks, produce $\geq$ 50% symptom relief physiologically consistent with medial nerve branch pathology. (Dreyfuss, P, Spine 2000), Peterson and Hodler, Skeletal Radiol 2010, 39: 5-9; Stone and Bartynski, Tech Vasc Interv Radiol 2009, 12: 22-32)

B. Limitations

1. For the purposes of this policy, an RFA procedure consists of one or more ablations during a single visit.
2. RFA procedures are limited to two per year.
3. RFA procedures beyond two per year require medical review.
4. RFA of the SI (sacroiliac) joint is not a covered benefit.

**III. Kyphoplasty or Vertebroplasty**

Percutaneous Vertebroplasty and Kyphoplasty are a covered benefit according to eviCore criteria

**IV. Sacroiliac Joint Fusion**

Sacroiliac (SI) joint fusion (open or minimally invasive percutaneous procedure including implants [e.g. iFuse implant system]) may be covered when all of the following are met:

1. Patient is skeletally mature
2. Patient has lower back pain for >6 months inadequately responsive to conservative care
3. Diagnosis of sacroiliac joint disruption or degenerative sacroiliitis based on BOTH of the following:
    a. Patient has pain at or close to the posterior superior iliac spine (PSIS) with possible radiation into buttocks, posterior thigh or groin and can point with a single finger to the location of pain (Fortin Finger Test), and
    b. Patient has improvement in lower back pain numeric rating scale (NRS) of at least 80% after a minimum of two local anesthetic blocks into affected SI joint(s)
4. Prior authorization by Priority Health. See Sacroiliac (SI) Joint Fusion prior authorization form.

And none of the following exclusion criteria:

1. Other known sacroiliac pathology such as:
    a. Sacral dysplasia
    b. Inflammatory sacroiliitis (e.g., ankylosing spondylitis or other HLA-associated spondyloarthropathy)
    c. Tumor
    d. Infection
    e. Crystal arthropathy
2. Osteomalacia or other metabolic bone disease
3. Chondropathy
4. Known allergy to titanium or titanium alloys
5. Prominent neurologic condition that would interfere with physical therapy
6. Current local or systemic infection that raises the risk of surgery
7. Currently pregnant or planning pregnancy in the next 2 years

**V. Automated Percutaneous Lumbar Discectomy (APLD)**

Automated percutaneous lumbar discectomy (APLD) is considered investigational and is not a covered benefit.

Percutaneous discectomies at levels other than lumbar (i.e. cervical or thoracic), and done manually or with a laser, are also considered investigational and not covered.

The following procedures (coded the same as APLD) are also not covered:

- DISC Nucleoplasty
- Intradiscal Thermal Annuloplasty
- Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)
- Percutaneous endoscopic diskectomy with or without laser (PELD) (also known as arthroscopic microdiskectomy or Yeung Endoscopic Spinal Surgery System (Y.E.S.S.))
- Percutaneous lumbar discectomy or laser-assisted disc decompression (LADD)
- Microendoscopic discectomy (MED) procedure for decompression of lumbar spine stenosis, lumbar disc herniation, or other indications
- Percutaneous HydroDiscectomy Surgical Technique /HydroCision/SpineJet HydroSurgery System

**VI. AxiaLIF® Axial Lumbar Interbody Fusion**

The AxiaLIF® axial lumbar interbody fusion system is considered experimental and investigational and is not a covered benefit.

**VII. IDET and Other Thermal Intradiscal Procedures (TIPs)**

Review of the evidence for the use of IDET and other TIPs for low back pain does not demonstrate improved health outcomes. Lacking evidence of clinical improvement, the following procedures are considered experimental and investigational and are not a covered benefit:

a. Intradiscal electrothermal therapy (IDET)
b. Intradiscal electrothermal annuloplasty (IEA)
c. Intradiscal thermal annuloplasty (IDTA)
d. Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT)
e. Percutaneous radiofrequency thermomodulation
f. Coblation percutaneous disc decompression
g. Nucleoplasty
h. Radiofrequency annuloplasty (RA)
i. Intradiscal biacuplasty (IDB)
j. Percutaneous (or plasma) disc decompression (PDD)
k. Targeted disc decompression (TDD)

TIPs may also be identified or labeled based on the name of the catheter/probe that is used (e.g., SpineCath, discTRODE, Accuthem, or TransDiscal electrodes).

**VIII. Concentrated Bone Marrow Aspirate for Spinal Surgery**
Concentrated bone marrow aspirate for spinal surgery is not a covered benefit. There is insufficient evidence to determine safety and efficacy of this treatment.

**IX.** Lumbar Fusion and Lumbar Laminectomy procedures are covered according to eviCore criteria.

**X.** The Coflex® interlaminar stabilization device for lumbar spinal stenosis is a covered benefit. Prior authorization is not required.

**MEDICAL NECESSITY REVIEW**
**Covered Procedures**
**Artificial Cervical Discs**
☒ Required through eviCore
**Radiofrequency Ablation for Back Pain**
☒ Required after two (2) radiofrequency ablation procedures per plan year
**Kyphoplasty/Vertebroplasty**
☒ Required through eviCore *(Medicare PA effective Jan 1, 2018)*
**Sacroiliac Joint Fusion**
☒ Required
**Lumbar Fusion**
☒ Required through eviCore
**Lumbar Laminectomy**
☒ Required through eviCore

**Non-Covered Procedures**
**Artificial Lumbar Discs**
☒ Not Covered
**Automated Percutaneous Lumbar Discectomy (APLD)**
☒ Not Covered
**IDET and Other Thermal Intradiscal Procedures (TIPs)**
☒ Not Covered
**Concentrated Bone Marrow Aspirate for Spinal Surgery**
☒ Not Covered
**AxiaLIF™ Axial Lumbar Interbody Fusion**
☒ Not Covered

## APPLICATION TO PRODUCTS

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- **HMO/EPO:** ***This policy applies to insured HMO/EPO plans.***
- **POS:** ***This policy applies to insured POS plans.***
- **PPO:** ***This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.***
- **ASO:** ***For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.***
- **INDIVIDUAL:** ***For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.***
- **MEDICARE:** ***Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.***
- **MEDICAID/HEALTHY MICHIGAN PLAN:** ***For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.***

## DESCRIPTION/BACKGROUND

### Back Pain

Back pain affects 80% of Americans at some time in their lives. According to an article by Diwan and Khan, published in Orthopedic Clinics of North America in 2003, over $80 billion is spent annually in American to treat chronic back pain. Progressive back pain is more likely to occur when the person is in their most productive period in life, between the years of 30 and 50.[3] In a study conducted by the U.S. Dept of Health and Human Services in 2003, the total age-adjusted percentages per 100,000 people who reported severe (pain that lasted a whole day or more) low back pain in the prior three (3) months were: 27.4% and neck pain 14.7%.[11] Uncontrolled pain remains one of the greatest healthcare crises affecting Americans to date. Pain is the major cause of disability, a leading reason for physician office visits, and the most frequent indication for diagnostic studies, including MRIs and X-rays and is purported to cost Americans upwards of $100 billion annually in direct health care costs.[10]

Definition of Chronic Pain:[1]

1. Pain, which persists beyond the usual course of an acute disease, or a reasonable time for any injury to heal that is associated with chronic pathological processes that cause continuous pain or pain at intervals for months or years.
2. Persistent pain that is not amenable to routine pain control methods.
3. Pain that exists beyond an expected time frame for healing.
4. Pain, where healing may never occur.

**Back Pain Procedures**

**Artificial Intervertebral Discs**

When conservative treatment of degenerative disc disease fails, a common surgical approach is spinal fusion; over 200,000 spinal fusions are performed each year. However, the outcomes of spinal fusion have been controversial over the years, in part due to the difficulty in determining whether a patient's back pain is related to degenerative disc disease, and in part due to the success of the procedure itself. Additionally, spinal fusion alters the biomechanics of the back, potentially leading to premature disc degeneration at adjacent levels, a particular concern for younger patients. As an alternative, a variety of artificial intervertebral discs have been investigated over the past thirty years. This approach, also referred to as total disc replacement or spinal arthroplasty, is intended to maintain motion at the operative level once the damaged disc has been removed, and to maintain the normal biomechanics of the adjacent vertebrae.

The major potential advantage of a prosthetic intervertebral disc over current therapies for degenerated disks (such as spinal fusion or diskectomy) is that the prosthetic intervertebral disk is intended to restore or preserve the natural biomechanics of the intervertebral segment and to reduce further degeneration of adjacent levels. Investigators have found, however, that creation of an intervertebral disc prosthesis poses significant challenges with respect to prosthetic design and materials:

- The biomechanics of the intervertebral segment are difficult to replicate
- It is a challenge to find materials that are both biocompatible and effective
- The prosthetic disc should achieve long-term mechanical fixation.

Several moderate-size randomized controlled trials (RCTs) comparing different types of artificial cervical discs with anterior cervical discectomy and fusion (ACDF) have been published. Evidence to date demonstrates that total disc replacement (TDR) is at least as effective as ACDF in improving signs and symptoms associated with degenerative disease and improving quality of life (QOL) for up to 2 years. The evidence also shows that total disc replacement (TDR) reduces the need for reoperation. Low-quality evidence suggests that TDR reduces the risk of new adjacent segment disease (ASD) but may have higher rates of intraoperative and perioperative complications. Reliable follow-up data for more than 3 years are lacking, which is an especially serious limitation regarding the evidence for the intended advantage of TDR (reduction in long-term ASD).

The best available evidence for 2-level TDR is limited to the pivotal trial (NCT00389597; Davis et al., 2013). The Mobi-C pivotal trial was conducted at 24 U.S. centers and randomized 330 patients with cervical DDD at 2 contiguous levels to receive TDR with the Mobi-C (n=225) or ACDF with allograft bone and anterior plating n=105).
Primary outcome measure was overall success rate at 24-month follow-up. While both groups significantly improved in Neck Disability Index (NDI) score, visual analog scale (VAS) neck pain score, and VAS arm pain score, the group receiving the Mobi-C showed significantly greater improvements in NDI score (37 ± 20 versus 30 ± 19 mean change from baseline; $P<0.05$), and VAS neck pain score at 6 weeks and at 3, 6, and 12 months after surgery. ASD was significantly lower at 24 months in the group receiving TDR with the Mobi-C; 13.1% and 2.9% of TDR patients had ASD at the superior and inferior segments, compared with 33.3% and 18.1% of ACDF patients ($P<0.03$). Reoperation rates were significantly lower in the Mobi-C group (3.1% versus 11.4%); ACDF and TDR had similar mean hospitalization time and perioperative blood loss; procedural time was significantly longer for TDR (2.2 hours versus 1.8 hours; $P=0.0002$) (Davis et al., 2013).

**Radiofrequency Ablation for Back Pain**
Radiofrequency ablation, or rhizotomy, is a therapeutic procedure designed to decrease or eliminate pain symptoms within the spinal facets. Facet joints are located in the posterior compartment of the spinal column, innervated by nerve endings from the medial branches of the posterior rami. The primary function of the facet joints is stabilization of movement between vertebrae, and assisting in axial weight-bearing.

Fluoroscopy-guided injections with local anesthetics, corticosteroids, or phenol into or around the facet joints have been used to treat facet joint pain. The facet joints are considered to be the source of pain if diagnostic blocks of the medial branch of the posterior primary ramus significantly reduce or eliminate pain and if the individual has no definite localizing clinical or imaging findings.

Radiofrequency ablation utilizes radiowave-induced heat to create a lesion in a sensory nerve, which then interrupts the nerve impulse to the involved facet joints for up to six months or longer.

According to the American Society of Interventional Pain Physicians in their Practice Guide of 2005, "the lifetime prevalence of spinal pain has been reported as 54% to 80%, with as many as 60% of patients continuing to have chronic pain five (5) years or longer after the initial episode. Spinal pain is associated with significant economic, societal, and health impact. "[1]

There is not a universally agreed upon method of identifying those most likely to benefit from the procedure. Patients must not have identifiable pathology including disc herniation, spondylolisthesis, and spinal stenosis; should be absent of any neurologic deficit; and have back or neck pain predominating over leg pain or arm pain, respectively. Facet joint blocks are limited because capsular rupture can result in anesthetic leakage into the extracapsular space with non-discriminant anesthetization and pain relief. The medial

branch double block paradigm alternates long and short acting anesthetic blocks of the medial branch nerve and may be the optimal technique available. This reduces the false positive response rate from 30% to 10% when using less than 1 cc of anesthetic.

In a prospective Canadian trial (Gofeld, 2007), patients with an appropriate response to comparative double diagnostic blocks underwent standardized radiofrequency denervation of the lumbar zygapophysial joints. Of the 209 patients, 174 completed the study, and 35 were lost to follow-up or did not provide complete data for assessment. Of the 174 patients with complete data, 55 (31.6%) experienced no benefit from the procedure. One hundred and nineteen patients (68.4%) had good (> 50%) to excellent (> 80%) pain relief lasting from 6 to 24 months. The authors conclude that proper patient selection and anatomically correct radiofrequency denervation of the lumbar zygapophysial joints provide long-term pain relief in a routine clinical setting.

The optimal technique for the procedure appears to be placement of the electrode parallel to the medial branch nerve. If electrodes are placed parallel to the target nerve, the lesions made can be expected to encompass the target nerves. If electrodes are placed perpendicular to the nerve, the nerve may escape coagulation, or be only partially coagulated parallel to the nerve (Lau, 2004).

The expected duration of effect in an appropriately performed radiofrequency ablation of a medial branch nerve when using the appropriate technique is at least six months. The average duration is expected to be ten (10) months for both cervical (Schofferman, 2004; McDonald, 1999, Lord 1996) and lumbar rhizotomy (Dreyfuss, 2000).

**Vertebroplasty/Kyphoplasty**

Percutaneous vertebroplasty is an interventional radiologic procedure that involves injection of bone cement into an osteolytic or osteoporotic vertebral body compression fracture with the goal of relieving pain, improving mobility, and preventing further collapse of the bone.

Kyphoplasty is a modification of the vertebroplasty procedure that involves use of an inflatable bone tamp to reduce the fracture prior to injection of the bone cement. The goal of this additional step is to restore height to the bone, thus reducing deformity of the spine.

Two published RCTs published in the *New England Journal of Medicine* have found no significant benefit with vertebroplasty. In the Investigational Vertebroplasty Safety and Efficacy Trial (INVEST), Kallmes et al (2009) reported that pain and disability outcomes at 1 month in a group of patients who underwent vertebroplasty were similar to those in a control group that underwent a sham procedure. In the other trial, Buchbinder et al (2009) measured pain, quality of life, and functional status at 1 week and at 1, 3, and 6 months after sham and active vertebroplasty and found there were no significant between-group differences at any time point. As in INVEST, patients in the 2 study groups had improvement in pain.

In Lancet (2010) VERTOSS 2 trial found vertebroplasty resulted in greater pain relief than did conservative treatment with a difference in mean VAS score between baseline and 1 month was -5.2 (95% CI -5.88 to -4.72) after vertebroplasty and -2.7 (-3.22 to -1.98) after conservative treatment, and between baseline and 1 year was -5.7 (-6.22 to -4.89) after vertebroplasty and -3.7 (-4.35 to -3.05) after conservative treatment. The difference between groups in reduction of mean VAS score from baseline was 2.6 (95% CI 1.74-3.37, p<0.00001) at 1 month and 2.0 (1.13-2.80, p<0.00001) at 1 year. No serious complications or adverse events were reported. Researchers conclude pain relief after vertebroplasty is immediate, sustained, and greater than achieved with conservative treatment.

**Automated Percutaneous Lumbar Discectomy (APLD)**

Automated percutaneous lumbar discectomy (APLD) is a minimally invasive surgical technique for treatment of herniated lumbar intervertebral discs. For this procedure, a thin, blunt-tipped suction and cutting probe is inserted through the skin, and the end of the probe is placed into the middle of the herniated disc under fluoroscopic guidance. This device is then used to remove some or all of the degenerated portion of the center of the disc. The goal of this procedure is to relieve pressure on nerve roots without damaging surrounding tissues, thereby minimizing postoperative complications and morbidity. APLD is intended as an alternative to chemonucleolysis, open discectomy, or other types of percutaneous discectomy for individuals who have a relatively small degree of lumbar disc protrusion without fragmentation or complete extrusion of disc material and who have failed conservative therapy.

The Stryker DeKompressor Percutaneous Discectomy Probe (Stryker) and the Nucleotome (Clarus Medical) are examples of percutaneous discectomy devices that received clearance from the U.S. Food and Drug Administration (FDA) through the 510(k) process. Both have the same labeled intended use, i.e., "for use in aspiration of disc material during percutaneous discectomies in the lumbar, thoracic and cervical regions of the spine."

Among the studies of APLD identified in the literature search were two randomized trials in which APLD was compared with either chemonucleolysis or microdiscectomy (Revel et al., 1993; Chatterjee et al., 1995). Revel et al. compared APLD with chemonucleolysis in 141 patients with lumbar disc herniation. Treatment was considered successful in 61% patients in the chemonucleolysis group compared with 44% in the APLD group ($P<0.05$). The complication rate was low in both groups, although 42% patients in the chemonucleolysis group reported back pain. Chatterjee et al. compared APLD with microdiscectomy in 71 patients with contained lumbar disc herniation. Only 29% patients had satisfactory outcome in the APLD group compared with 80% in the microdiscectomy group ($P<0.001$). Although the study was originally designed for 160 patients, recruitment was halted due to the inferior results in the APLD group. The authors concluded that APLD is ineffective for the treatment of small, contained lumbar disc herniation.

Results from a meta-analysis by Gibson et al. (2006) came to similar findings. These authors analyzed 27 randomized controlled trials of surgery for lumbar disc prolapse that were published up to December 1999 and indexed in the MEDLINE database, including 3

trials that evaluated the effect of APLD for lumbar herniation. Analysis of the pooled data from these trials indicated that there is moderate evidence that APLD results in poorer clinical outcomes than standard discectomy or chymopapain treatment.
In addition, there were two randomized trials that were too small to warrant detailed analysis. Haines et al. (2002) compared APLD with conventional open discectomy in patients with lumbar disc herniation. Although designed to enroll 330 patients, there were significant difficulties with recruitment, and only 34 patients were actually enrolled and randomized to percutaneous discectomy (n=21) or to conventional open discectomy (n=13). Fifteen of the 21 patients in the percutaneous treatment group underwent APLD with the Nucleotome. Of the 27 patients evaluable at 6 months, 41% of the APLD patients and 40% of the conventional discectomy patients were assessed as having successful outcomes, which as defined as an excellent or good rating, based on ability to return to work and daily activities, absence of pain, and no need for analgesic medication. Due to small sample size, the results of this study are inconclusive. In another small, randomized trial, Krugluger and Knahr (2000) evaluated 22 patients assigned to treatment with APLD or chemonucleolysis. Based on severity of neurological deficit and Oswestry scores, neither treatment provided significant improvement.

There were also a number of prospective and retrospective uncontrolled studies of APLD that met the criteria for detailed review (≥ 100 patients); success rates in these studies were variable. Two of the studies (Teng et al., 1997; Bonaldi, 2003) were quite large (n=1525 and n=1047, respectively), while the others ranged in size from 137 to 518 patients. In the two larger studies, results were judged to be excellent in 54% to 58% of patients several months after APLD; however, since these studies lacked control or comparison groups and outcome measures were primarily subjective, the true treatment effect of APLD cannot be determined.

The overall quality of evidence regarding the efficacy of APLD is relatively poor, consisting primarily of uncontrolled studies, retrospective studies, and case series reports, with only two randomized trials comparing APLD with other treatment methods.
Some of the uncontrolled prospective studies and large case series reports describe a relatively high initial success rate for APLD in patients with herniated lumbar discs and no free disc fragments. However, other studies report much lower success rates in similar patient groups. Moreover, results with APLD were clearly inferior when directly compared with results obtained with chemonucleolysis or microdiscectomy. In addition, several studies with periodic scheduled follow-up documented a decline in treatment effect over the first year, suggesting that the benefits of APLD may not be long lasting. The immediate benefits described after APLD may result from a reduction in inflammatory substances at the herniation site after the saline lavage that occurs during the procedure. This hypothesis is supported by reports that there is an immunocompetent cellular response at the epidural interface of lumbar herniations and the identification of high levels of phospholipase $A_2$, an inflammatory enzyme, in herniated and degenerative discs (Saal, 1995). Therefore, the action of APLD may be to remove inflammatory mediators, at least temporarily, and thereby reduce the symptoms associated with the herniated disc rather than to reduce significantly the bulk of the herniated disc material. Further studies of APLD, with

appropriate controls and length of follow-up, are needed before conclusions regarding efficacy can be made.

An important issue that was not addressed in any of the reviewed studies is the outcome of lumbar disc herniation in patients who are treated with medical therapy alone. Since the studies evaluating APLD did not include a control group of medically treated patients, and, in some cases, patients had received only 6 to 8 weeks of some kind of conservative therapy, it is not known if APLD improved the outcome or enhanced the speed of recovery compared with medical treatment alone. This issue is relevant in evaluation of all surgical treatments for disc herniation and will only be resolved by randomized trials that include a medical treatment control group.

APLD was reviewed by Priority Health's Technology Assessment Committee (TAC) in September 2006 and is based on the recommendations of the TAC review.

**AxiaLIF™ Axial Lumbar Interbody Fusion**

The AxiaLIF™ axial lumbar interbody fusion system is manufactured by TranS1® Inc. of Wilmington, NC. The system consists of instruments designed to allow minimally invasive presacral access to the lumbar spine. The AxiaLIF™ System enables surgeons to access the surgical area via small incisions, decreasing the degree of soft-tissue injury and trauma to the patient. The system includes stainless steel and titanium surgical instruments, titanium alloy implantable devices, and a proprietary anterior fixation rod (3D Axial Rod™). AxiaLIF™ is used for decompression, distraction and spinal fusion at the L5-S1 junction in conjunction with facet and pedicle screw systems. It is used to treat a variety of disorders including pseudo arthrosis, spinal stenosis, Grade 1 or 2 spondylolisthesis, unsuccessful previous fusion, or degenerative disc disease.

The FDA issued 510(k) approval (K050965) for the TranS1® AxiaLIF™ System on June 14, 2005. It is listed as substantially equivalent to another product developed by TranS1, the TranS1 Axial Fixation System (K040426), which was approved on December 17, 2004. According to the FDA approval summary, the AxiaLIF™ system is an anterior spinal fixation device intended for patients requiring spinal fusion to treat pseudo arthrosis, unsuccessful previous fusion, spinal stenosis, spondylolisthesis (Grade 1or 2), or degenerative disc disease defined as back pain of discogenic origin with degeneration of the disc confirmed by history and radiographic studies. The device is not intended to treat severe scoliosis, severe spondylolisthesis (Grades 3 and 4), tumor or trauma. Its usage is limited to anterior supplemental fixation of the lumbar spine at L5-S1 in conjunction with legally marketed facet and pedicle screw systems.

**IDET and Other Thermal Intradiscal Procedures (TIPs)**

Intradiscal electrothermal annuloplasty (IDET) is a minimally invasive surgical procedure developed for the treatment of chronic discogenic low back pain. Thermocoagulation of one or more defective intervertebral discs is accomplished using a percutaneously inserted catheter with a heating element enclosed in the tip. IDET is an outpatient procedure done under local anesthetic. The goal of the procedure is shrinkage of the disc material and

destruction of the annular nerve receptors with the desired result of decreasing nerve root compression and pain from the degenerative discs.

In addition to IDET, other thermal intradiscal procedures (TIPs) are available including PIRFT (percutaneous intradiscal radiofrequency thermocoagulation), annuloplasty (electrothermal or thermal), nucleoplasty, and disc biacuplasty. These various TIPs techniques use heat and/or disruption, seeking the same desired outcome of pain relief. Numerous catheters have FDA approval for use in intradiscal thermal procedures. The devices for discogenic back pain in the TIPs' category utilize the transfer of energy to heat and/or disruption in the cartilaginous disc to treat back pain. All of these devices passed through the FDA under 510(K), meaning that they were found to be substantially equivalent to previous devices without the requirement of clinical trials.
The Centers for Medicare and Medicaid Services (CMS) issued a national noncoverage determination for IDET and other TIPs in September 2008. Noncoverage decision was made by CMS following review of the clinical evidence and determination that the mechanism of action of the TIPs is unclear and the evidence did not demonstrate improved outcomes. (Decision Memo for Thermal Intradiscal Procedures, September 29, 2008. http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=215)

**Interlaminar Stabilization**
The coflex Interlaminar Stabilization device is a functionally dynamic, implantable, titanium interspinous process device (IPD) that is intended to limit lumbar spinal extension in order to maintain direct neurological decompression, unload the facet joints, and stabilize the motion segment at the treated vertebral level(s). The coflex is a U-shaped implant with 2 pairs of serrated wings extending from the upper and lower long arms of the U. The U portion is inserted horizontally between 2 adjacent spinous processes. The wings are crimped over bone to hold the implant in place. The device is implanted after decompression of stenosis at the affected level(s). Hayes, Inc. 2018

## CODING INFORMATION

** Contact eviCore for prior authorization*

**I. <u>Artificial Intervertebral Discs</u>**

**ICD-10 Codes** that <u>may</u> apply:

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|---|---|
| G54.2 | Cervical root disorders, not elsewhere classified |
| G54.9 | Nerve root and plexus disorder, unspecified |
| M46.41 – M46.43 | Discitis, unspecified |
| M47.011 – M47.029 | Anterior spinal artery compression syndromes |
| M47.11 – M47.13 | Other spondylosis with myelopathy, head and neck |
| M48.01 – M48.03 | Spinal stenosis, head and neck |
| M50.00 – M50.93 | Cervical disc |
| | |
| M99.20 | Subluxation stenosis of neural canal of head region |
| M99.21 | Subluxation stenosis of neural canal of cervical region |
| M99.30 | Osseous stenosis of neural canal of head region |

| | |
|---|---|
| M99.31 | Osseous stenosis of neural canal of cervical region |
| M99.40 | Connective tissue stenosis of neural canal of head region |
| M99.41 | Connective tissue stenosis of neural canal of cervical region |
| M99.50 | Intervertebral disc stenosis of neural canal of head region |
| M99.51 | Intervertebral disc stenosis of neural canal of cervical region |
| M99.60 | Osseous and subluxation stenosis of intervertebral foramina of head region |
| M99.61 | Osseous and subluxation stenosis of intervertebral foramina of cervical region |
| M99.70 | Connective tissue and disc stenosis of intervertebral foramina of head region |
| M99.71 | Connective tissue and disc stenosis of intervertebral foramina of cervical region |

**CPT/HCPCS Codes**

22856* Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical

22858* Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)

22861* Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical

0098T* Revision including replacement of total disc arthroplasty, anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure) *(Not covered for Priority Medicare or Medicaid)*

22864 Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical *(No prior authorization required)*

0095T Removal of total disc arthroplasty, anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure) *(Not covered for Priority Medicare or Medicaid) (No prior authorization required)*

**<u>Not Covered:</u>**

22857 Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, single interspace

22862 Revision including replacement of total disc arthroplasty (artificial disc) anterior approach, lumbar, single interspace

22865 Removal of total disc arthroplasty (artificial disc), anterior approach, lumbar, single interspace

0163T Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, each additional interspace

0164T Removal of total disc arthroplasty, anterior approach, lumbar, each additional interspace

0165T Revision of total disc arthroplasty, anterior approach, lumbar, each additional interspace

0274T 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 (e.g., fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic

0275T 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 (e.g., fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar

0375T Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), cervical, three or more levels

## II. Radiofrequency Ablation for Back Pain

**ICD-10 Codes** that may apply:

| | |
|---|---|
| G89.21 – G89.29 | Chronic pain due to trauma |
| R52 | Pain, unspecified |
| G89.3 | Neoplasm related pain (acute) (chronic) |
| G89.4 | Chronic pain syndrome |
| M54.03 - M54.09 | Panniculitis affecting regions of neck and back |
| M62.830 | Muscle spasm of back |
| M54.5 – M54.9 | Other back pain |

**CPT/HCPCS Codes:**

64633 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint

64634 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)

64635 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint

64636 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)

## III. Kyphoplasty/Vertebroplasty

**ICD-10 Codes** that may apply:

| | |
|---|---|
| C79.52 | Secondary malignant neoplasm of bone marrow |
| D18.09 | Hemangioma of other sites |
| D47.Z9 | Other specified neoplasms of uncertain behavior of lymphoid, hematopoietic and related tissue |
| C88.8 | Other malignant immunoproliferative diseases |
| C94.40 | Acute panmyelosis with myelofibrosis not having achieved remission Acute myelofibrosis NOS |

| | |
|---|---|
| C94.41 | Acute panmyelosis with myelofibrosis, in remission |
| C94.42 | Acute panmyelosis with myelofibrosis, in relapse |
| C94.6 | Myelodysplastic disease, not classified |
| D47.1 | Chronic myeloproliferative disease |
| D47.9 | Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified |
| D47.Z9 | Other specified neoplasms of uncertain behavior of lymphoid, hematopoietic and related tissue |
| M48.50xA – M48.58 | Collapsed vertebra |
| M80.08xA – M80.08xS | Age-related osteoporosis with current pathological fracture, vertebra (e) |
| M80.88xA – M80.88xS | Other osteoporosis with current pathological fracture, vertebra (e) |
| M81.0 – M81.8 | Age-related osteoporosis without current pathological fracture |
| M84.48xA – M84.48xS | Pathological fracture, other site |
| M84.58xA - M84.58xS | Pathological fracture in neoplastic disease |
| M84.68xA - M84.68xS | Pathological fracture in other disease |
| S22.000A – S22.089S | Fracture of vertebrae, thoracic |
| S23.100A - S23.100A | Subluxation and dislocation, thoracic vertebrae |
| S32.000A – SA32.059S | Fracture of vertebrae, lumbar |
| T50.905 | Adverse effect of unspecified drugs, medicaments and biological substances |

**CPT/HCPCS Codes:**

Vertebroplasty:

22510* Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic

22511* Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral

22512* Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)

Kyphoplasty:

22513* Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., Kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic

22514* Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., Kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar

22515* Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., Kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

**Not Covered**

0200T Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles includes imaging guidance and bone biopsy, when performed

0201T Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed

S2360 Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; cervical

S2361 Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; each additional cervical vertebral body

## IV. Sacroiliac (SI) Joint fusion

**ICD-10 Codes that may apply:**

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|---|---|
| M46.1 | Sacroiliitis, not elsewhere classified |
| M99.14 | Subluxation complex (vertebral) of sacral region |
| M53.88 | Other specified dorsopathies, sacral and sacrococcygeal region |
| S33.6XXS | Sprain of sacroiliac joint, sequela |
| S33.2XXS | Dislocation of sacroiliac and sacrococcygeal joint, sequela |

**CPT/HCPCS Codes**

27279 Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device

27280 Arthrodesis, sacroiliac joint (including obtaining graft)

## V. Automated Percutaneous Lumbar Discectomy (APLD)

**CPT/HCPCS Codes:**

**Not Covered**

62287 Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar (e.g., manual or automated percutaneous diskectomy, percutaneous laser diskectomy)

62380 Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar

S2348 Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single or multiple levels, lumbar

S2350 Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; lumbar, single interspace

S2351 Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; lumbar, each additional interspace (list separately in addition to code for primary procedure)

C2614 Probe, percutaneous lumbar discectomy

22899 Unlisted procedure of the spine

64999 Unlisted procedure, nervous system

*(Explanatory notes must accompany unlisted codes.)*

**VI. AxiaLIF™ Axial Lumbar Interbody Fusion**

**CPT/HCPCS Codes:**

**Not covered**

0195T Arthrodesis, pre-sacral interbody technique, disc space preparation, discectomy, without instrumentation, with image guidance, includes bone graft when performed; L5-S1 interspace

0196T Arthrodesis, pre-sacral interbody technique, disc space preparation, discectomy, without instrumentation, with image guidance, includes bone graft when performed; L4-L5 (List separately in addition to code for primary procedure)

0309T Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft, when performed, lumbar, L4-L5 interspace (List separately in addition to code for primary procedure)

22586 Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace

**VII. IDET and Other Thermal Intradiscal Procedures (TIPs)**

**ICD-9 Codes that may support medical necessity**

*Not applicable*

**HCPCS/CPT Codes**

**Not Covered**

22526 Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level

22527 Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; one or more additional levels (List separately in addition to code for primary procedure)

22899 Unlisted procedure, spine (when billed for any of the listed, not covered procedures)

64999 Unlisted procedure, nervous system

*Explanatory notes must accompany claims billed with unlisted codes*

S2348 Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single or multiple levels, lumbar

**Other Not Covered Procedures**

0275T 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 (e.g., fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar

(*Exception: Covered ONLY for Medicare ONLY when performed in an approved coverage with evidence development (CED) clinical trial – notification required)*

G0276 Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (PILD) or placebo-control

**VIII. Concentrated Bone Marrow Aspirate**

20939 Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision (List separately in addition to code for primary procedure)
*Not separately payable:*

**IX.** Codes related to retired policies 91590 Lumbar Fusion and 91591 Lumbar Laminectomy
** Contact eviCore for prior authorization (auth required for add on procedure if primary procedure is authorized)*

22102 Partial excision of posterior vertebral component (e.g., spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; lumbar
22114 Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; lumbar
22533* Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
22534* Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)
22558* Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
22585* Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)
22612* Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)
22614* Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)
22630* Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar
22632* Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)
22633* Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar
22634* Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; each additional interspace and segment (List separately in addition to code for primary procedure)
22800 Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments
22802 Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments
22804 Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments

| | |
|---|---|
| 22808 | Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments |
| 22810 | Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments |
| 22812 | Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments |
| 22840 | Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial Trans articular screw fixation, sub laminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure) |
| 22841* | Internal spinal fixation by wiring of spinous processes (list separately in addition to code for primary procedure) |
| 22842* | Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sub laminar wires); 3 to 6 vertebral segments (list separately in addition to code for primary procedure) |
| 22843* | Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sub laminar wires); 7 to 12 vertebral segments (list separately in addition to code for primary procedure) |
| 22844* | Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sub laminar wires); 13 or more vertebral segments (list separately in addition to code for primary procedure) |
| 22845* | Anterior instrumentation; 2 to 3 vertebral segments (list separately in addition to code for primary procedure) |
| 22846* | Anterior instrumentation; 4 to 7 vertebral segments (list separately in addition to code for primary procedure) |
| 22847* | Anterior instrumentation; 8 of more vertebral segments (list separately in addition to code for primary procedure) |
| 22848* | Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (list separately in addition to code for primary procedure) |
| 22849 | Reinsertion of spinal fixation device |
| 22853* | Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when conjunction with interbody arthrodesis, each interspace (list performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (list separately in addition to code for primary procedure) |
| 22854* | Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy (ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (list separately in addition to code for primary procedure) |
| 22859* | Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous effect (list separately in addition to code for primary procedure) |

63005* Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis

63012* Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)

63015* Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; cervical

63017* Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; lumbar

63020* Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical

63030* Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; 1 interspace, lumbar

63035* Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)

63040* Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, re-exploration, single interspace; cervical

63042* Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, re-exploration, single interspace; lumbar

63043* Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, re-exploration, single interspace; each additional cervical interspace (list separately in addition to code for primary procedure)

63044* Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, re-exploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)

63045* Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis], single vertebral segment; cervical

63047* Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; lumbar

63048* Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; each additional segment,

cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

63050* Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments

63051* Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (e.g., wire, suture, mini-plates), when performed)

63056* Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (e.g., far lateral herniated intervertebral disc)

63057* Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)

63075* Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace

63076* Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (list separately in addition to code for primary procedure)

63081* Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment

63082* Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure)

63087 Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; single segment

63088 Vertebral corpectomy (vertebral body resection), partial or complete, combined thoracolumbar approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic or lumbar; each additional segment (List separately in addition to code for primary procedure)

63090 Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment

63091 Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; each additional segment (List separately in addition to code for primary procedure)

63102 Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (e.g., for tumor or retropulsed bone fragments); lumbar, single segment

63185 Laminectomy with rhizotomy; 1 or 2 segments

63190 Laminectomy with rhizotomy; more than 2 segments

63191 Laminectomy with section of spinal accessory nerve

63200 Laminectomy, with release of tethered spinal cord, lumbar
63265 Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical
63267 Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar
63270 Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; cervical
63272 Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar
63277 Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, lumbar
63280 Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, cervical
63282 Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, extramedullary, lumbar
63285 Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, cervical
63290 Laminectomy for biopsy/excision of intraspinal neoplasm; combined extradural-intradural lesion, any level
63295 Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)
63303 Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, lumbar or sacral by transperitoneal or retroperitoneal approach
63307 Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, lumbar or sacral by transperitoneal or retroperitoneal approach

**Not Covered**:

0200T Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles
0201T Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles
0202T Posterior vertebral joint(s) arthroplasty (e.g. facet joint(s) replacement) inc facetectomy, laminectomy, foraminotomy and vertebral column fixation, with or without injection of bone cement, inc fluoroscopy, single level, lumbar spine
0219T Placement of posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical
0219T Placement of posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical
0220T Placement of posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic
0221T Posterior vertebral joint(s) arthroplasty (e.g., facet joint[s] replacement) including facetectomy, laminectomy, foraminotomy and vertebral column fixation, with or without injection of bone cement, including fluoroscopy, single level, lumbar spine

0222T Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), each additional vertebral segment (List separately in addition to code for primary procedure)

0274T 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 (e.g., fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic

22869 Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level

22870 Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)

22899 Unlisted procedure, spine (*when billed for any of the listed, not covered procedures) Explanatory notes must accompany claims billed with unlisted codes*

62287 Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method, single or multiple levels, lumbar (e.g., manual or automated percutaneous discectomy, percutaneous laser discectomy)

64999 Unlisted procedure, nervous system

C2614 Probe, percutaneous lumbar discectomy

S2348 Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single or multiple levels, lumbar

S2350 Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; lumbar, single interspace

S2351 Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; lumbar, each additional interspace (list separately in addition to code for primary procedure)

**X. Coflex® Interlaminar Stabilization Device**

22867 Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level

22868 Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)

22869 Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level

22870 Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when

performed, lumbar; second level (List separately in addition to code for primary procedure)

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