

MEDICAL POLICY



MEDICAL POLICY DETAILS	
Medical Policy Title	Intervertebral Disc Decompression: Laser (Laser Discectomy) and Radiofrequency Coblation (Disc Nucleoplasty) Techniques
Policy Number	7.01.62
Category	Technology Assessment
Original Effective Date	02/19/04
Committee Approval Date	10/20/04, 09/15/05, 07/20/06, 05/17/07, 04/17/08, 03/19/09, 01/21/10, 01/20/11, 01/19/12, 01/17/13, 01/16/14, 12/18/14, 12/17/15, 12/15/16, 12/21/17, 06/21/18, 07/18/19, 12/19/19, 12/17/20, 12/16/21, 12/22/22, 11/16/23, 11/21/24
Current Effective Date	11/21/24
Archived Date	N/A
Archive Review Date	N/A
Product Disclaimer	<ul style="list-style-type: none"> • Services are contract dependent; if a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply. • If a commercial product (including an Essential Plan or Child Health Plus product), medical policy criteria apply to the benefit. • If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit. • If a Medicare product (including Medicare HMO-Dual Special Needs Program(DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit. • If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY STATEMENT

Based upon our criteria and assessment of the peer-reviewed literature, decompression of the intervertebral disc using percutaneous laser (laser discectomy) or radiofrequency energy (Disc Nucleoplasty) has not been medically proven to be effective and, therefore, is considered **investigational**.

Refer to Corporate Medical Policy #7.01.16 Automated Percutaneous Discectomy and Image-Guided, Minimally Invasive Decompression

Refer to Corporate Medical Policy #7.01.17 Percutaneous Intradiscal Electrothermal Annuloplasty (IDET/IDTA, PIRFT, biacuplasty) and Intradiscal Injections

Refer to Corporate Medical Policy #11.01.03 Experimental or Investigational Services

POLICY GUIDELINES

This policy does not address annuloplasty therapies, which utilize radiofrequency energy to thermally treat discogenic low back pain.

DESCRIPTION

A variety of techniques have been developed to treat low back pain related to disc disease. Decompression of the intervertebral disc is accomplished by removing or ablating herniated disc material. A number of procedures have been developed as alternatives to open and microsurgical techniques.

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Laser discectomy and radiofrequency ablation are newer percutaneous techniques for disc decompression. Laser discectomy delivers laser energy to the nucleus under fluoroscopic guidance, to ablate tissue. Radiofrequency ablation or disc nucleoplasty uses bipolar radiofrequency energy in a process called coblation technology, in which small, multiple electrodes ablate tissue with a low-temperature plasma field of ionized particles. The particles break organic molecular bonds within the tissue, creating small channels in the disc.

RATIONALE

Indications approved by the U.S. Food and Drug Administration (FDA) for the Homium YAG laser include discectomy. The FDA granted Section 510(k) premarket approval for the use of Arthrocare’s Perc-D SpineWand with the ArthroCare System 2000 for ablation, coagulation, and decompression of disk material.

In 2016, the National Institute for Health and Care Excellence (NICE) updated its guidance on laser lumbar discectomy for the treatment of sciatica. The guidance stated that current evidence “is inadequate in quantity and quality.” NICE also updated its guidance on percutaneous disc decompression using coblation for lower back pain and sciatica in 2016. NICE stated, “Current evidence on percutaneous coblation of the intervertebral disc for low back pain and sciatica raises no major safety concerns. The evidence on efficacy is adequate and includes large numbers of patients with appropriate follow-up periods.” The guidance also noted that patients should be informed of the range of treatment options available.

While numerous case series and uncontrolled studies have reported improvements in pain levels and functioning following laser discectomy, the lack of well-designed and well-conducted controlled trials limits interpretation of reported data. The evidence is insufficient to determine the effect of the technology on health outcomes.

For nucleoplasty, there are two randomized, controlled trials (RCT), in addition to several uncontrolled studies. These RCTs are limited by the lack of blinding, an inadequate control condition in one, and inadequate data reporting in the second. The available evidence is insufficient to permit conclusions concerning the effect of these procedures on health outcomes, due to multiple confounding factors that may bias results. High-quality, randomized trials with adequate follow-up (at least one year), that control for selection bias, the placebo effect, and variability in the natural history of low back pain, are needed. The evidence is insufficient to determine the effect of the technology on health outcomes.

CODES

- Eligibility for reimbursement is based upon the benefits set forth in the member’s subscriber contract.
- **CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.**
- Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.
- Code Key: Experimental/Investigational = (E/I), Not medically necessary/ appropriate = (NMN).

CPT Codes

Code	Description
62287 (E/I)	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 levels(s), when performed, single or multiple levels, lumbar

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HCPCS Codes

Code	Description
S2348 (E/I)	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single or multiple levels, lumbar

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ICD10 Codes

Code	Description
M51.06	Intervertebral disc disorders with myelopathy, lumbar
M51.16	Intervertebral disc disorders with radiculopathy, lumbar
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.26	Other intervertebral disc displacement, lumbar region
M51.27	Other intervertebral disc displacement, lumbosacral region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region

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*Key Article

KEY WORDS

Radiofrequency coblation, laser discectomy, disc nucleoplasty, decompression nucleoplasty, plasma disc decompression, radiofrequency thermocoagulation nucleoplasty (RFTC), percutaneous laser discectomy /decompression, laser-assisted disc decompression (LADD), targeted percutaneous laser disc decompression (targeted PLDD), coblation percutaneous disc decompression

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

There is currently a National Coverage Determination (NCD) for thermal intradiscal procedures (150.11) and a NCD for laser procedures (140.5). Please refer to the following NCD websites for Medicare Members:

Thermal Intradiscal Procedures (NCD#150.11):

[<http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=324&ncdver=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=New+York+-+Upstate&CptHcpcsCode=365jff14&bc=gAAAABAAAA&>] accessed 09/23/24.

Laser Procedures (NCD#140.5):

[<http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=69&ncdver=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=New+York+-+Upstate&CptHcpcsCode=36514&bc=gAAAABAAAAAAA%3d%3d&>] accessed 09/23/24.