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

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

Commercial Members: Managed Care (HMO and POS)
This is NOT a covered service.

Commercial Members: PPO, and Indemnity
This is NOT a covered service.

Medicare Members: HMO Blue™
This is NOT a covered service.

Medicare Members: PPO Blue™
This is NOT a covered service.

CPT Codes / HCPCS Codes / ICD-9 Codes
The following codes are included below for informational purposes. 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.

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 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>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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HCPCS Codes

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<th>HCPCS codes:</th>
<th>Code Description</th>
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<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 lumber 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**

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<th>Date</th>
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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. No changes to policy statements.</td>
</tr>
<tr>
<td>12/07</td>
<td>BCBSA National medical policy review. No changes to policy statements.</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**

