GUIDELINES
This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder contract. Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards. This guideline is solely for explaining correct procedure reporting and does not imply coverage and reimbursement.

DESCRIPTION
Most back pain will resolve spontaneously or can be treated with conservative therapies, such as pharmacological therapy (e.g., analgesics, anti-inflammatory drugs, muscle relaxants), exercise, physical therapy, spinal manipulation, and acupuncture. Numerous alternative minimally invasive techniques and approaches have been proposed for the treatment of back and neck pain for patients with pain that persists despite conservative treatment.

PERCUTANEOUS AND ENDOSCOPIC SPINAL SURGERY

Automated Percutaneous Lumbar Discectomy (APLD)/Automated Percutaneous Nucleotomy
Automated percutaneous lumbar discectomy (APLD), also referred to as automated percutaneous nucleotomy, is a minimally-invasive surgical procedure used in the treatment of herniated lumbar intervertebral discs. In this procedure, a cannula is placed in the center of the disc under fluoroscopic guidance using a posterolateral approach. A probe connected to an automated cutting and aspiration device is then introduced through the cannula. The disc is then aspirated until no more nuclear material is obtained.

Endoscopic Anterior Spinal Surgery / Yeung Endoscopic Spinal Surgery (YESS) / Selective Endoscopic Discectomy (SED)
The Yeung Endoscopic Spinal System (Richard Wolf Surgical Instrument Corporation) is a specialized endoscope developed for percutaneous spinal endoscopy and discectomy. This endoscope has multi-channel inflow and outflow ports, allowing visualization through one port and suction or other therapeutic services through the working port. The YESS is also used for other spinal procedures, including arthroscopic microdiscectomy, radiofrequency ablation, injection of intraoperative steroids, and laser disc decompression and ablation. Selective Endoscopic Discectomy™ (SED), performed with the YESS endoscope, is used to shrink and remove herniated discs.

Endoscopic Disc Decompression, Ablation, or Annular Modulation Using the DiscFX™ System
The Disc-FX™ system is a single-use disposable kit used to perform minimally invasive lumbar disc procedures, including endoscopic disc decompression, nucleus ablation and annulus modulation.

Percutaneous Laminotomy/Laminectomy, Percutaneous Spinal Decompression Using the mild® Device Kit
The mild® Device Kit is a set of specialized arthroscopic surgical instruments intended to be used to perform lumbar decompressive procedures for the treatment of various spinal conditions.

Laser Discectomy (Percutaneous or Laparoscopic)/, Laser Disc Decompression/Laser Assisted Disc Decompression (LADD)
Laser-assisted discectomy, also called laser-assisted disc decompression (LADD) or laser disc decompression, is a minimally-invasive procedure proposed as an alternative to discectomy/microdiscectomy. It is intended to provide symptomatic relief of pain caused by a contained herniated intervertebral disc. Laser light energy is used to vaporize part of the nucleus pulposus, resulting in a reduction in intradiscal pressure. Several approaches may be used, depending on the location of the disc and type of laser being used. With one method, a needle is inserted percutaneously into the disc approximately one centimeter (cm) posterior to the disc center, and a flexible optical quartz fiber is threaded through the needle into the disc, delivering laser energy to vaporize and coagulate the nucleus pulposus. In the laparoscopic approach, a trocar is inserted periumbilically and the abdomen is inflated with carbon dioxide. Additional trocars are placed above the pelvic brim. The large and small bowels are retracted, and the iliac bifurcation is identified. The posterior peritoneum is opened and retracted. The L5-S1 interspace is identified, and its margins confirmed by x-ray. The annulus of the disc is opened and excised with the neodymium: yttrium-aluminum-garnet (Nd: YAG) laser.
THERMAL INTRADISCAL PROCEDURES

Percutaneous Intradiscal Electrothermal Annuloplasty (e.g., intradiscal electrothermal therapy [IDET™])
Percutaneous intradiscal electrothermal annuloplasty, also referred to as intradiscal electrothermal therapy (IDET™), intradiscal electrothermal annuloplasty (IEA), intradiscal thermal annuloplasty, or targeted intradiscal thermal therapy is a minimally invasive procedure that has been proposed as an alternative to spinal fusion for the treatment of chronic discogenic low back pain. This procedure is performed by inserting a catheter into the annulus and threading a flexible electrode through the catheter and around the inside of the disc, pressing against the posterior edge of the annulus. The electrode is then heated to a temperature of 90º F for up to 17 minutes. Analgesics and/or antibiotics are then injected and the catheter is withdrawn. The heating of the electrode denatures the collagen of the annulus and coagulates the nerve endings, with the ultimate goal of relieving back pain.

Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)/ Intradiscal Radiofrequency Thermomodulation/Percutaneous Radiofrequency Thermomodulation
PIRFT may also be referred to as intradiscal radiofrequency thermomodulation or percutaneous radiofrequency thermomodulation. This procedure, used to treat chronic discogenic low back pain, is similar to intradiscal IDET. With IDET, a catheter with a temperature-controlled, thermal-resistive coil is inserted under fluoroscopic guidance into the posterior annular wall of the affected disc, causing annular denervation. With PIRFT, the catheter is placed into the center of the disc rather than the annulus.

Coblation® Nucleoplasty™/Disc Nucleoplasty/Decompression Nucleoplasty/Plasma Disc Decompression
Coblation Nucleoplasty, also referred to as disc nucleoplasty, decompression nucleoplasty, or plasma disc decompression, is a minimally invasive technique for decompression of contained herniated discs using the Arthrocare Perc-D Coblation Spine Wand. The Spine Wand is a bipolar radiofrequency device designed to decompress the disc nucleus with energy and heat. The tip of the wand is slightly curved to allow channeling. Nucleoplasty uses Coblation technology, which generates a low temperature plasma field intended to allow precise ablation with minimal risk of thermal injury.

POLICY
Percutaneous & Endoscopic Spinal Surgery and Thermal Intradiscal Procedures (22526, 22527, 62287, 0274T, 0275T, S2348) are non-covered for HMO, PPO, & Individual Marketplace.

Percutaneous & Endoscopic Spinal Surgery and Thermal Intradiscal Procedures (22526, 22527, 62287, 0274T, S2348) are non-covered for Elite.
Procedure 0275T does not require prior authorization for Elite.

Percutaneous & Endoscopic Spinal Surgery and Thermal Intradiscal Procedures (22526, 22527, 62287) require prior authorization for Advantage.
Procedures 0274T, 0275T, S2348 are non-covered for Advantage.

HMO, PPO, Individual Marketplace
Paramount does not cover percutaneous or endoscopic spinal surgery, including but not limited to the following, because it is considered experimental, investigational or unproven (this list may not be all-inclusive):
- Automated Percutaneous Lumbar Discectomy (APLD)/Automated Percutaneous Nucleotony (62287)
- Endoscopic Anterior Spinal Surgery / Yeung Endoscopic Spinal Surgery (YESS) / Selective Endoscopic Discectomy (SED) (62287)
- Endoscopic Disc Decompression, Ablation, or Annular Modulation Using the DiscFX™ System (62287)
- Percutaneous laminotomy/laminectomy, percutaneous spinal decompression (e.g., mild® procedure) (0274T, 0275T)
- Percutaneous Laser Discectomy / Decompression, Laser Assisted Disc Decompression (LADD) (62287)

Paramount does not cover ANY of the following thermal intradiscal procedures because each is considered experimental, investigational or unproven (this list may not be all-inclusive):
- Percutaneous Intradiscal Electrothermal Annuloplasty (e.g., intradiscal electrothermal therapy [IDET™]) (22526, 22527)
- Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)/ Intradiscal Radiofrequency Thermomodulation/Percutaneous Radiofrequency Thermomodulation (S2348)
- Coblation® Nucleoplasty™/Disc Nucleoplasty/Decompression Nucleoplasty/Plasma Disc Decompression (62287)
Elite
For claims with dates of service on or after January 9, 2014, Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS) (0275T) is a covered service only when billed as part of a clinical trial per CMS NCD-150.13.

Paramount does not cover percutaneous or endoscopic spinal surgery, including but not limited to the following, because it is considered experimental, investigational or unproven (this list may not be all-inclusive):
- Automated Percutaneous Lumbar Discectomy (APLD)/Automated Percutaneous Nucleotony (62287)
- Endoscopic Anterior Spinal Surgery / Yeung Endoscopic Spinal Surgery (YESS) / Selective Endoscopic Discectomy (SED) (62287)
- Endoscopic Disc Decompression, Ablation, or Annular Modulation Using the DiscFX™ System (62287)
- Percutaneous laminotomy/laminectomy, percutaneous spinal decompression (e.g., mild procedure) (0274T)
- Percutaneous Laser Discectomy / Decompression, Laser Assisted Disc Decompression (LADD) (62287)

Paramount does not cover ANY of the following thermal intradiscal procedures because each is considered experimental, investigational or unproven (this list may not be all-inclusive):
- Percutaneous Intradiscal Electrothermal Annuloplasty (e.g., intradiscal electrothermal therapy [IDET™]) (22526, 22527)
- Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)/ Intradiscal Radiofrequency Thermomodulation/Percutaneous Radiofrequency Thermomodulation (S2348)
- Coblation® Nucleoplasty™/Disc Nucleoplasty/Decompression Nucleoplasty/Plasma Disc Decompression (62287)

Advantage
While there is insufficient evidence in the published medical literature to demonstrate the safety, efficacy and long-term outcomes of Percutaneous & Endoscopic Spinal Surgery and Thermal Intradiscal Procedures (22526, 22527, 62287), The Ohio Department of Medicaid requires this procedure be reviewed for medical necessity. Therefore it may be covered with a prior authorization for Advantage members.

Procedures 0274T, 0275T, S2348 are non-covered for Advantage.

CODING/BILLING INFORMATION
The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>22526</td>
<td>Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level</td>
</tr>
<tr>
<td>22527</td>
<td>Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)</td>
</tr>
<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 injections(s) at the treated levels(s), when performed, single or multiple levels, lumbar</td>
</tr>
<tr>
<td>0274T</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), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic</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), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar</td>
</tr>
</tbody>
</table>

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

TAWG REVIEW DATES: 05/13/2009, 05/18/2010, 08/10/2011, 08/15/2012, 08/14/2013, 01/15/2014, 08/22/2014, 05/21/2015, 05/27/2016

REVISION HISTORY EXPLANATION
12/01/06: Added new procedure codes 22526 and 22527
11/30/07: Added code 62287
07/01/10: Procedures 0062T and 0063T were deleted, added S2348
03/18/13: Updated to deny these services "EM" for Advantage members (Medicaid Appendix DD with fee listed).
01/15/14: Percutaneous intradiscal electrothermal annuloplasty (22526, 22527) may now be covered with prior authorization for Advantage members per The Ohio Department of Medicaid. Changed name of medical policy from Intradiscal Electrothermal/Any Method Annuloplasty (IDET), Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT) to Thermal Intradiscal Procedures. Policy reviewed by TAWG and updated to reflect most current clinical evidence.
05/13/14: Approved by Medical Policy Steering Committee as revised.
08/22/14: Changed name of medical policy from Thermal Intradiscal Procedures to Minimally Invasive Treatment of Back and Neck Pain. Procedure code 62287 may now be covered with prior authorization for Advantage members per The Ohio Department of Medicaid. Policy reviewed and updated to reflect most current clinical evidence per TAWG.
05/21/15: Policy reviewed and updated to reflect most current clinical evidence per TAWG.
05/27/16: Added code 0274T to policy as non-covered for all product lines. Added code 0275T to policy as non-covered for HMO, PPO, Individual Marketplace & Advantage and covered without prior authorization only when part of a clinical trial for Elite. Policy reviewed and updated to reflect most current clinical evidence per TAWG.

REFERENCES/RESOURCES
Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
Ohio Department of Medicaid http://jfs.ohio.gov/
American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services
Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
Industry Standard Review
Hayes, Inc.