Sentara® Health Plans

Commercial

Lumbar Discectomy, Surgical 120

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Effective Date	2/1992
Next Review Date	10/2025
Coverage Policy	Surgical 120
Version	5

Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details *.

Purpose:

This policy addresses the medical necessity of Lumbar Discectomy of the spine.

Description & Definitions:

A **Lumbar Discectomy** is surgery that removes the damaged part of a disk in the spine that has herniated its soft center, pushing out through the tough outer lining. The surgical technique allows for all or part of the disk between the lumbar vertebrae to be removed to ease the pressure on nearby nerves.

Criteria:

Lumbar Discectomy is considered medically necessary for **1 or more** of the following:

- Cauda equina or spinal cord compression (myelopathy), as indicated by **ALL of the** following are present and will be approved as ambulatory (outpatient) unless additional criteria are met as noted by MCG's Ambulatory Surgery or Procedure criteria located at the bottom of this section:
  - Progressive or severe neurologic deficits consistent with cauda equina or spinal cord compression (eg, bladder or bowel incontinence)
  - Imaging findings of compression that correlate with clinical findings
- Lumbar radiculopathy and **ALL of the** following are present and will be approved as ambulatory (outpatient) unless additional criteria are met as noted by MCG's Ambulatory Surgery or Procedure criteria located at the bottom of this section:
  - Individual has unremitting radicular pain or progressive weakness secondary to nerve root compression
  - Failure of 6 weeks of nonoperative therapy that includes **1 or more** of the following:
    - Medication (eg, NSAIDs, analgesics)
    - Physical therapy
    - Epidural or oral corticosteroid
  - MRI or other neuroimaging finding correlates with clinical signs and symptoms.

- Lumbar spondylolisthesis, as indicated by **1 or more** of the following are present and will be approved as ambulatory (outpatient) unless additional criteria are met as noted by MCG's Ambulatory Surgery or Procedure criteria located at the bottom of this section:
    - Rapidly progressive or very severe neurologic deficits (eg, bowel or bladder dysfunction)
    - Symptoms requiring treatment, as indicated by ALL of the following:
        - Individual has persistent disabling symptoms, including **1 or more** of the following:
            - Low back pain
            - Neurogenic claudication
            - Radicular pain
        - Treatment is indicated by **ALL of the** following:
            - Listhesis demonstrated on imaging
            - Symptoms correlate with findings on MRI or other imaging.
            - Failure of 3 months of nonoperative therapy

As noted in MCG's Ambulatory Surgery or Procedure GRG PG-AS (ISC GRG):
This surgery or procedure will be traditionally approved ambulatory (outpatient), but may receive initial approval for Inpatient Care when **one or more of the following** are met:k

- Inpatient care needed for clinically significant disease or condition identified preoperatively, as indicated by **one or more of the following**:
    - Severe infection
    - Altered mental status
    - Dangerous arrhythmia
    - Hypotension
    - Hypoxemia
- Complex surgical approach or situation anticipated, as indicated by **1 or more** of the following:
    - Prolonged airway monitoring required (eg, severe obstructive sleep apnea, open neck procedure)
    - Other aspect or feature of procedure that indicates a likely need for prolonged postoperative care or monitoring
- High patient risk identified preoperatively, as indicated by **1 or more** of the following:
    - American Society of Anesthesiologists class IV or greater American Society of Anesthesiologists (ASA) Physical Status Classification System
    - Severe frailty
    - Severe valvular disease (eg, severe aortic stenosis)
    - Symptomatic coronary artery disease, or heart failure
    - Symptomatic chronic lung disease (eg, COPD, chronic lung disease of prematurity)
    - Severe renal disease (eg, glomerular filtration rate (GFR) less than 30 mL/min/1.73m^2 (0.5 mL/sec/1.73m^2) or on dialysis) eGFR - Adult Calculator
    - Morbid obesity (eg, body mass index greater than 40 BMI Calculator) with hemodynamic or respiratory problems (eg, severe obstructive sleep apnea, hypoventilation)
    - Complex chronic condition in children (eg, ventilator-dependent, neuromuscular, genetic, or immunologic disease)
    - Other patient condition or finding that places patient at increased anesthetic risk such that prolonged postoperative inpatient monitoring or treatment is anticipated
- Presence of drug-related risk identified preoperatively, as indicated by **1 or more** of the following:
    - Procedure requires discontinuing medication (eg, antiarrhythmic medication, antiseizure or anticoagulant medication), which necessitates preoperative or prolonged postoperative inpatient monitoring or treatment.

- Preoperative use of drugs that may interact with anesthetic (eg, cocaine, amphetamines, monoamine oxidase inhibitor) such that prolonged postoperative monitoring or treatment is needed

Lumbar discectomy is NOT COVERED for ANY of the following:

- Devices for annular repair (e.g., Inclose Surgical Mesh System)
- Endoscopic anterior spinal surgery/Yeung endoscopic spinal system (YESS)/percutaneous endoscopic diskectomy (PELD) arthroscopic microdiscectomy, selective endoscopic discectomy (SED)
- Endoscopic disc decompression, ablation, or annular modulation using the DiscFX System
- Epidural fat grafting during lumbar decompression laminectomy/discectomy
- Far lateral microendoscopic diskectomy (FLMED) for extra-foraminal lumbar disc herniations or other indications
- Intradiscal and/or paravertebral oxygen/ozone injection
- Laser-assisted discectomy
- Microendoscopic discectomy (MED; same as lumbar endoscopic discectomy utilizing microscope) procedure for decompression of lumbar spine stenosis, lumbar disc herniation, or other indications
- Minimally invasive thoracic discectomy for the treatment of back pain

Coding:

Medically necessary with criteria:

Coding	Description
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 or more vertebral segments (List separately in addition to code for primary procedure)
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
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar
63044	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)

Considered Not Medically Necessary:

Coding	Description

62287	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

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 2024: June – added codes 22845-22847

Reviewed Dates:

- 2024: October – no changes references updated
- 2023: October

Effective Date:

- July 2023

References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Special Notes: *

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving, and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

Keywords:

annular repair, arthroscopic microdiscectomy, Cauda equina, decompression of lumbar spine stenosis, DiscFX System, Endoscopic anterior spinal surgery, Endoscopic disc decompression, Epidural fat grafting during lumbar decompression laminectomy/discectomy, Far lateral microendoscopic diskectomy, FLMED, Inclose Surgical Mesh System, Intradiscal oxygen/ozone injection, Laser-assisted discectomy, lumbar disc herniation, lumbar endoscopic discectomy utilizing microscope, Lumbar radiculopathy, Lumbar spondylolisthesis, Microendoscopic discectomy, Minimally invasive thoracic discectomy, myelopathy, neurologic deficits, paravertebral oxygen/ozone injection, PELD, percutaneous endoscopic diskectomy, SED, selective endoscopic discectomy, SHP Lumbar Discectomy, SHP Surgical 120, spinal cord compression, YESS, Yeung endoscopic spinal system