Sentara Health Plans

Commercial

Lumbar Discectomy, Surgical 120

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Effective Date	12/1/2025
Next Review Date	8/2026
Coverage Policy	Surgical 120
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Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details *.

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.

Other common names: Percutaneous endoscopic lumbar discectomy (PELD), Microdiscectomy

Criteria:

Lumbar Discectomy is considered medically necessary for **ALL** of the following:

- Individual has diagnoses with **1 or more** of the following:
  - Cauda equina or spinal cord compression (myelopathy)
  - Infection involving the disc space
  - Lumbar radiculopathy
  - Lumbar spondylolisthesis
  - Primary or recurrent lumbar disc herniation
- Individual has disabling symptoms, requiring treatment, as indicated by **1 or more** of the following:
  - Individual has unremitting radicular pain or progressive weakness secondary to nerve root compression
  - Progressive or severe neurologic deficits consistent with cauda equina or spinal cord compression (eg, bladder or bowel incontinence)
  - Chronic low back pain
  - Neurogenic claudication
- Individual must be a nonsmoker and in the absence of progressive neurological compromise will refrain from use of tobacco products for at least 6 weeks prior to the planned surgery and 6 weeks after the surgery (If individual is a smoker, cessation must be confirmed by a negative urine nicotine test, prior to surgery approval.
- Surgical treatment is indicated by **ALL** of the following:
  - Confirmed by imaging studies (e.g., CT or MRI) at the levels corresponding to the neurologic findings
  - Failure of nonoperative therapy that includes **1 or more** of the following:
    - Medication (eg, NSAIDs, analgesics, gabapentinoids) for 6 weeks

        - Physical therapy for 6 weeks
        - Epidural steroid injection(s) or selective nerve root block(s) performed at the same level(s) as the requested surgery
- Present and will be approved as ambulatory (outpatient) unless additional criteria are met as noted by Level of Care Guidance for Observation (OBS) vs Inpatient (IP) Hospital Stays criteria located in Medical 350.

Lumbar Discectomy is considered **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- Devices for annular repair (e.g., Inclose Surgical Mesh System)
- Endoscopic anterior spinal surgery/Yeung endoscopic spinal system (YESS)/percutaneous endoscopic diskectomy (PELD), 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

Document History:

Revised Dates:

- 2025: August – Implementation date of December 1, 2025. Housekeeping (simplify criteria) and new format
- 2024: June – added codes 22845-22847

Reviewed Dates:

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

Origination Date: July 2023

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.

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) 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 of these services as it applies to an individual member.

Special Notes: *

- Coverage:
  - See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products:
  - Policy is applicable to Sentara Health Plan Commercial products.
- Authorization requirements:
  - Pre-certification by the Plan is required.
- Special Notes:
  - Commercial
    - 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.

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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Provider Manual. (2025). Retrieved 7 2025, from DMAS: https://www.dmas.virginia.gov/for-providers/

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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