

This content has been created to supplement the MCG care guidelines. MCG Health has neither reviewed nor approved the modified material.

SHP Coccygectomy

AUTH: SHP Surgical 114 v2 (AC)

MCG Health
Ambulatory Care
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Coverage

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See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.

Application to Products

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Policy is applicable to all products.

Authorization Requirements

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Pre-certification by the Plan is required.

Description of Item or Service

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Coccygectomy is the surgical removal of the tailbone.

Exceptions and Limitations

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- There is insufficient scientific evidence to support the medical necessity of Coccygectomy for uses other than those listed in the clinical indications for procedure section.

Clinical Indications for Procedure

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- Coccygectomy is considered medically necessary for **ALL** of the following
 - Intractable coccydynia
 - Failure of 6 months of conservative therapy including physical therapy, medications (NSAIDS etc.)

Document History

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- Revised Dates:
 - 2022: July
 - 2021: September
 - 2020: August
 - 2016: April
 - 2015: February, May, September
 - 2014: January, June, August, November
 - 2013: May, June
 - 2012: February, May
- Reviewed Dates:
 - 2019: April
 - 2018: November
 - 2017: December
 - 2016: May
 - 2014: May
 - 2011: June, November
- Effective Date: May 2011

Coding Information

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- CPT/HCPCS codes covered if policy criteria is met:
 - CPT 27080 - Coccygectomy, primary
- CPT/HCPCS codes considered not medically necessary per this Policy:
 - None

References

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References used include but are not limited to the following:

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