

# Lumbar Discectomy, Surgical 120

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**All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.\*.**

## 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 discectomy (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 discectomy (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)
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#### 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

*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.*

#### Policy Approach and 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 Virginia Medicaid Products
- Authorization requirements
  - Precertification required by Plan
- Special Notes:
  - This medical policy express Sentara Health Plan's determination of medical necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
  - 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.
  - The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. [EPSDT Supplement B \(updated 5.19.22\) Final.pdf](#)
  - Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider within 60 days of the date of service requested.

#### References:

**References used include but are not limited to the following:** Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

(2025). Retrieved 6 2025, from MCG: <https://careweb.careguidelines.com/ed29/index.html>

(2025). Retrieved 7 2025, from CMS: [https://www.cms.gov/medicare-coverage-database/search-results.aspx?keyword=lumbar&keywordType=all&areald=all&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1\\_F,P&contractOption=all&sortBy=relevance](https://www.cms.gov/medicare-coverage-database/search-results.aspx?keyword=lumbar&keywordType=all&areald=all&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1_F,P&contractOption=all&sortBy=relevance)

(2025). Retrieved 7 2025, from Hayes:

<https://evidence.hayesinc.com/search?q=%257B%2522text%2522:%2522Lumbar%2520Discectomy%2522,%2522title%2522:null,%2522termsource%2522:%2522searchbar%2522,%2522page%2522:%257B%2522page%2522:0,%2522size%2522:50%257D,%2522type%2522:%2522all%2522,%2522sources%>

NASS Coverage Policy Recommendations. (2025). Retrieved 7 2025, from North American Spine Society (NASS): <https://www.spine.org/>

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

Spine Surgery 2024-10-20. (n.d.). Retrieved 7 2025, from Carelon:

<https://guidelines.carelonmedicalbenefitsmanagement.com/spine-surgery-2024-10-20/>

Subacute and chronic low back pain: Surgical treatment. (2023, 9). Retrieved 7 2025, from UpToDate:

[https://www.uptodate.com/contents/subacute-and-chronic-low-back-pain-surgical-treatment?search=Lumbar%20Discectomy&source=search\\_result&selectedTitle=1~3&usage\\_type=default&display\\_rank=1](https://www.uptodate.com/contents/subacute-and-chronic-low-back-pain-surgical-treatment?search=Lumbar%20Discectomy&source=search_result&selectedTitle=1~3&usage_type=default&display_rank=1)

**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 discectomy, 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 discectomy, SED, selective endoscopic discectomy, SHP Lumbar Discectomy, SHP Surgical 120, spinal cord compression, YESS, Yeung endoscopic spinal system