Lumbar Discectomy

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Effective Date	2/1992
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Coverage Policy	Surgical 120
Version	2

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.*.

Purpose:

This policy addresses 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:
  - 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:
  - 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:
  - 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

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) 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
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:
Reviewed Dates:

- 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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Spine Surgery. (2023, Sep 10). Retrieved Oct 02, 2023, from Carelon Medical Benefits Management: https://guidelines.carelonmedicalbenefitsmanagement.com/spine-surgery-2023-09-10/

Special Notes: *

This medical policy express Sentara Health Plan's determination of medically 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 by 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.*

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