



## Medica Central Coverage Policy

**Policy Name:** Percutaneous Disc Decompression Procedures (Percutaneous Discectomies, Nucleoplasty) MP9734

**Effective Date:** 08/01/2024

### Important Information – Please Read Before Using This Policy

These services may or may not be covered by all Medica Central plans. Coverage is subject to requirements in applicable federal or state laws. Please refer to the member's plan document for other specific coverage information. If there is a difference between this general information and the member's plan document, the member's plan document will be used to determine coverage. With respect to Medicare, Medicaid, and other government programs, this policy will apply unless these programs require different coverage.

Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions may call the Provider Service Center. Please use the Quick Reference Guide on the Provider Communications page for the appropriate phone number. <https://mo-central.medica.com/Providers/SSM-employee-health-plan-for-IL-MO-OK-providers>

Medica Central coverage policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care, and treatment.

### Coverage Policy

Note: This policy is no longer scheduled for routine review of the scientific literature.

Percutaneous disc decompression procedures (manual, automated, or laser percutaneous discectomies; nucleoplasty) are investigative and unproven and therefore NOT COVERED. There is insufficient reliable evidence in the form of high quality peer-reviewed medical literature to establish the efficacy or effects on health care outcomes.

Note: See also related coverage policy, Intradiscal Electrothermal Therapy (IDET).

### Description

Percutaneous disc decompression (PDD) includes a variety of minimally invasive surgical procedures intended as less invasive alternatives to chemonucleolysis or open surgical methods for treatment of herniated intervertebral discs. The intended outcome is the removal or destruction of some of the nucleus pulposus (i.e., the gelatinous matter within the center of each disc), elimination or reduction of pressure on the corresponding nerve root(s), and relief of pain and other symptoms. Types of PDD techniques include manual or automated percutaneous discectomy (also referred to as percutaneous nucleotomy), percutaneous laser discectomy, and nucleoplasty (also known as plasma disc decompression or coblation).

PDDs are performed under fluoroscopic guidance using a large-bore needle and/or cannula, which are inserted through the skin and disc into the nucleus pulposus. Percutaneous manual and automated discectomy uses cutting and/or suction instruments to remove some or all of the tissue. Laser discectomy uses laser energy to vaporize and coagulates a portion of the nucleus pulposus. Nucleoplasty uses a radiofrequency coblation device to thermally ablates (i.e.,



## Medica Central Coverage Policy

coagulate) disc material, thus creating several channels within the tissue intended to reduce the amount of pressure on the nerve root and decrease the level of pain. Generally these procedures are performed as outpatient procedures under local anesthesia, with conscious sedation as needed.

### FDA Approval

PDDs are procedures and, therefore, not subject to FDA regulation. However, devices and related

equipment used in these procedures are subject to FDA 510(k) marketing approval. Examples of FDA-approved devices include, but are not limited to:

1. Dekompressor® Percutaneous Discectomy Probe (Stryker)
2. Nucleotome® System (Clarus Medical)
3. SpineJet HydroDiscectomy System (HydroCision)
4. SpineWand® (ArthroCare®)
5. Yeung Endoscopic Spinal System (Y.E.S.S.)

### Prior Authorization

Prior authorization is not applicable. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

### Coding Considerations

Use the current applicable CPT/HCPCS code(s). The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.

### CPT Codes

- 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

### HCPCS

- S2348 - Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single or multiple levels, lumbar

	Committee/Source	Date(s)
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