Medical Policy

Minimally Invasive Procedures for Back Pain (Including Thermal Intradiscal Procedures, Interspinous Spacers, Interlaminar Stabilization Devices, and Minimally Invasive Surgical Procedures to Remove Disc Material)

Policy Number: OCA 3.713
Version Number: 11
Version Effective Date: 06/01/16

Product Applicability

All Plan* Products

Well Sense Health Plan
- New Hampshire Medicaid
- NH Health Protection Program

Boston Medical Center HealthNet Plan
- MassHealth
- Qualified Health Plans/ConnectorCare/Employer Choice Direct
- Senior Care Options ◊

Notes:
+ Disclaimer and audit information is located at the end of this document.
◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member’s product-specific benefit documents at www.SeniorsGetMore.org to determine coverage guidelines for Senior Care Options.

Policy Summary

The Plan considers the minimally invasive procedures specified in the Description of Item or Service, Limitations, and Applicable Coding sections of this Plan policy to be experimental and investigational for the treatment of pain associated with disc disease, back pain, and/or for any other indication. These services include thermal intradiscal procedures, interspinous spacers, interlaminar stabilization

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devices, and/or minimally invasive surgical procedures to remove disc material. Prior authorization is required for all services included in this Plan policy.

It will be determined during the Plan’s prior authorization process if the service is considered experimental and investigational for the requested use. See the Plan’s policy, *Experimental and Investigational Treatment* (policy number OCA 3.12), for the product-specific definitions of experimental or investigational treatment.

**Description of Item or Service**

Types of minimally invasive procedures for the treatment of back pain may include the following, as specified below in items 1 through 3:

1. **Thermal Intradiscal Procedures (TIPS):** Intradiscal techniques employing devices that utilize a radiofrequency energy source or electrothermal energy to apply or create heat and/or disruption within the disc for coagulation and/or decompression of disc material to treat symptomatic patients with annular disruption of contained herniated disc, to seal annular tears or fissures, or destroy nociceptors for the purpose of relieving pain. Examples include the following, as specified below in items a through e:

   a. **Disc Nucleoplasty:** Also known as percutaneous (or plasma) disc decompression (PDD) or ablation, disc nucleoplasty is a disc decompression procedure using bipolar radiofrequency energy in a process called Coblation® technology. The device (ArthroCare Perc-D SpineWand) uses multiple, small electrodes that are designed to ablate a portion of nucleus tissue with a low-temperature plasma field of ionized particles. The proposed advantage of Coblation® technology is that the procedure provides for a controlled and highly localized ablation, resulting in minimal therapy damage to surrounding tissue.

   b. **Intradiscal Biacuplasty (IDB):** A radiofrequency procedure that uses two (2) electrodes placed on the opposite posterior lateral side of the disc annulus; it is proposed as a treatment alternative to lumbar disc replacement or fusion in a patient with discogenic pain.

   c. **Intradiscal Electrothermal Therapy (IDET):** Also known as percutaneous intradiscal electrothermal annuloplasty or intradiscal thermal annuloplasty (IDTA), IDET is a minimally invasive treatment for discogenic back pain that involves the application of thermal energy percutaneously into a suspected painful disc as an alternative to disc surgery. The heating catheter is inserted through the nucleus of the disc until it penetrates the inner layers of the annulus; the effect is to destroy nociceptor nerve fibers in the annulus and change the collagen structure within the disc for the reduction of pain.
d. **Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT):** A disc decompression procedure using radiofrequency energy to alter the biomechanics of the disc annulus. The radiofrequency catheter is inserted into the center of the disc nucleus to cause collagen in the disc to contract and thicken.

e. **Targeted Disc Decompression (TDD):** A minimally invasive spinal procedure that uses the ACCUTHERM Decompression Catheter (Smith & Nephew), which is a heating coil to coagulate the collagen; this causes tissue contraction designed to treat herniated discs.

2. **Minimally Invasive Treatments to Remove Disc Material:** Percutaneous disc decompression (PDD) or nucleoplasty procedures that do not utilize a radiofrequency energy source or electrothermal energy. These surgical procedures use lasers or other cutting probes to remove or ablate disc material and decompress the disc, or use instrumentation via a port to decompress neural elements. Examples include but are not limited to the following, as specified below in items a through d:

a. **Arthroscopic Microdiscectomy (AMD):** Also referred to as a percutaneous or posterolateral endoscopic discectomy, AMD is endoscopically guided decompression using a posterolateral (in back and away from the midline) approach bolstered by visual controls, illumination, and magnification, to remove the herniated disc fragments through cannulas placed within the disc.

b. **Automated Percutaneous Discectomy:** A minimally invasive intradiscal procedure that uses a blunt-tipped suction and cutting probe that is inserted through the skin and placed in the middle of a herniated disc under fluoroscopic guidance. The cut disc material is removed and aspirated through the side port of the device. This procedure is designed to remove or ablate disc material and thus decompress the disc. The Stryker DeKompressor® Percutaneous Discectomy Probe (Stryker) and the Nucleotome® (Clarus Medical) are examples of percutaneous discectomy devices that received clearance from the U.S. Food and Drug Administration (FDA) through the 510(k) process.

c. **Percutaneous Laminotomy/Laminectomy for Decompression of Neural Elements:** A minimally invasive procedure wherein, under indirect guidance, a port is docked on the inferior vertebral segment lamina via stab incision. Various instrumentation is utilized to remove bone, and possible other structures (including a disc), in order to decompress neural elements. Percutaneous image-guided lumbar decompression (PILD) is a posterior decompression of the lumbar spine performed percutaneously to remove a portion of the lamina and debulk the ligamentum flavum; the procedure is performed without any direct visualization of the surgical area using indirect image guidance (e.g., fluoroscopic, CT) with contrast media to identify and monitor the compressed area via epiduragram4.
d. **Percutaneous Laser Discectomy or Laser Discectomy**: A minimally invasive disc decompression technique for the treatment of symptomatic disc herniation. This procedure uses a laser placed within the nucleus of the disc under fluoroscopic guidance to remove or ablate disc material and thus decompress the material that has herniated and is causing nerve impingement. An example of this technology includes the mild (minimally invasive lumbar decompression) technique using the mild Device Kit (by Vertos Medical Inc.).

3. **Interspinous and Interlaminar Stabilization/Distraction Devices (Spacers)**: Interspinous and interlaminar implants (spacers) stabilize or distract the adjacent lamina and/or spinous processes and restrict extension in order to reduce pain in patients with lumbar spinal stenosis and neurogenic claudication, as specified below in item a or item b.

   a. **Interspinous Spacer**: Device that is implanted between vertebral spinous processes via a procedure that is less invasive than open decompression procedures. An expandable implant is inserted through a single small incision (general up to 1 inch in length) in the patient’s back during a brief procedure under local or general anesthesia. The procedure typically does not require removal of bone or soft tissue. This allows for potentially faster recovery than more invasive decompression procedures. The implants expand the neural foramen and limit lumbar extension, thereby relieving pain in patients with spinal stenosis and neurogenic claudication. Examples of this type of device include the Superion Interspinous Spacer (by VertiFlex Inc.) and the X-Stop Interspinous Spacer (by Medtronic Inc.)

   b. **Interlaminar Stabilization Device**: Device is implanted after decompression of lumbar spinal stenosis at the affected level(s). The device is implanted between adjacent lamina and have 2 sets of wings that are placed around the inferior and superior spinous processes. The implant aims to restrict painful motion while otherwise enabling normal motion. The devices (spacers) distract the laminar space and/or spinous processes and restrict extension. An example of the device includes the Coflex Interlaminar Stabilization Device (Paradigm Spine LLC).

**Medical Policy Statement**

These services are considered experimental and investigational.

**Limitations**

The Plan considers thermal intradiscal procedures, interspinous spacers, and/or other minimally invasive surgical procedures when used in the treatment of pain associated with disc disease and/or back pain to be experimental and investigational, including but not limited to ANY of the following, as specified below in items 1 through 14:

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1. Automated percutaneous discectomy
2. AxiaLIF (axial lumbar interbody fusion)
3. Disc nucleoplasty or percutaneous (or plasma) disc decompression (PDD) or ablation
4. Interlaminar stabilization device following decompressive surgery
5. Interspinous spacers (e.g., the Superion Interspinous Spacer by VertiFlex Inc. and X-Stop Interspinous Spacer by Medtronic Inc.)
6. Intradiscal biacuplasty
7. Intradiscal electrothermal therapy (IDET)
8. Intradiscal thermal annuloplasty (IDTA)
9. METRx microendoscopic discectomy
10. Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT)
11. Percutaneous image-guided lumbar decompression
12. Percutaneous laminotomy/laminectomy
13. Percutaneous laser discectomy and laser discectomy
14. Targeted disc decompression (TDD)

Definitions

**Discogenic Back Pain:** Back pain that is caused by the intervertebral disc that is externally intact, as opposed to disc prolapse or herniation that applies pressure on the nearby nerve roots. Discogenic back pain is confined to the back and does not radiate down the legs.

**Neurogenic Claudication:** A clinical syndrome of intermittent gluteal pain, lower extremity pain, and/or fatigue with or without back pain caused by symptomatic lumbar spinal stenosis (LSS). LSS is a common condition in aging adults that results from degenerative changes in the spine, causing compression of nerves at the level of the lumbar vertebra. LSS symptoms are typically provoked by upright exercise such as walking, and symptoms (which can range from mild to severe) are relieved with forward flexion, sitting, or recumbency.

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**Nociceptors:** Group of cells that acts as a receptor for painful stimuli and transmits information about those sensations to the central nervous system. These specialized nerve endings are responsible for nociception, one (1) of the two (2) types of persistent pain (the other, neuropathic pain, occurs when nerves in the central or peripheral nervous system are damaged). Nociceptors can become chronically activated and send persistent pain signals; the level of pain depends on the level of irritation at the nociceptor.

**Spine Anatomy:** The spine is divided into three (3) major areas: the cervical or neck area, the thoracic or mid-back area, and the lumbar or low back area. The areas are comprised of individual bones or vertebrae that are the primary target of weight bearing and provide a resting area for the disc, which act as shock absorbers between the vertebrae. Each disc is comprised of two (2) parts, the outer layer or the annulus and the center or the nucleus. The annulus is a tough outer ligament and the nucleus is a soft gel-like substance in the center of the disc.

**Applicable Coding**

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Because the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Medical Policy Statement section and Limitation section of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in the Applicable Coding section of this Plan policy. Coverage for services is subject to benefit eligibility under the member’s benefit plan. Please refer to the member’s benefits document in effect at the time of the service to determine coverage or non-coverage as it applies to an individual member. See Plan reimbursement policies for Plan billing guidelines.
<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description: Codes Considered Experimental and Investigational</th>
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<tbody>
<tr>
<td>22526</td>
<td>Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance, single level</td>
</tr>
<tr>
<td></td>
<td>Plan note: An example is IDET</td>
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<tr>
<td>22527</td>
<td>Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance, 1 or more additional levels (list separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>22899</td>
<td>Unlisted procedure, spine</td>
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<tr>
<td></td>
<td>Plan note: Use for percutaneous intradiscal annuloplasty using method other than electrothermal</td>
</tr>
<tr>
<td>62287</td>
<td>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</td>
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<tr>
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<td>Plan note: Examples include manual or automated percutaneous discectomy, percutaneous laser discectomy, disc nucleoplasty</td>
</tr>
<tr>
<td>0171T</td>
<td>Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; single level</td>
</tr>
<tr>
<td></td>
<td>Plan note: Use for interspinous and interlaminar stabilization/distraction devices (spacers)</td>
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<tr>
<td>0172T</td>
<td>Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion, and imaging guidance), lumbar; each additional level</td>
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<tr>
<td></td>
<td>Plan note: Use for interspinous and interlaminar stabilization/distraction devices (spacers)</td>
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<tr>
<td>0274T</td>
<td>Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic</td>
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</table>

Minimally Invasive Procedures for Back Pain (Including Thermal Intrascial Procedures, Interspinous Spacers, Interlaminar Stabilization Devices, and Minimally Invasive Surgical Procedures to Remove Disc Material)

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Clinical Background Information

Back pain is a significant health problem with social and economic impact. In most cases, low back pain is temporary and can be relieved by conservative medical management; however for some individuals, back pain becomes a chronic and disabling condition. Internal disc disruption (IDD) is one perceived cause of discogenic back pain but controversy surrounds diagnosis and management of this condition. IDD identifies the syndrome of back pain and non-radicular referred pain in the setting of degenerative disc disease. In IDD, there is no associated herniation or prolapse of disc material, and radiological findings are often inconclusive. Generally, first-line treatment for chronic discogenic back pain is conservative, consisting of pharmacotherapy and/or a multidisciplinary pain management program that may include exercises, education, and physical therapy. If the pain does not improve, patients may then choose to continue with conservative management or to undergo surgery (i.e., spinal fusion).

Many different minimally invasive surgical procedures have been developed as a treatment for low back pain related to disc disease. These procedures can be broadly divided into those that are designed to remove or ablate disc material and thus decompress the disc (e.g., automated percutaneous discectomy or laser discectomy), those that are designed to alter the biomechanics of the disc annulus utilizing thermal intradiscal techniques (e.g., disc nucleoplasty, intradiscal biacuplasty, intradiscal electrothermal annuloplasty or IDET, percutaneous intradiscal radiofrequency thermocoagulation or PIRFT, or targeted disc decompression or TDD), and interspinous and interlaminar implants (spacers).

Thermal intradiscal procedures (TIPS) are intradiscal techniques utilizing devices that use a radiofrequency energy source or electrothermal energy to apply or create heat and/or disruption within the disc; this results in coagulation and/or decompression of disc material to treat symptomatic patients with annular disruption of contained herniated disc, to seal annular tears or fissures, or destroy nociceptors for the purpose of relieving pain. At times, TIPS may be identified or labeled based on the name of the catheter/probe(s) that is used (e.g., SpineCath, discTRODE, SpineWand, Accutherm, or TransDiscal electrodes).

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Other types of minimally invasive surgical procedures for back pain utilize lasers or other cutting devices to remove or ablate disc tissue and decompress the disc. Many types of lasers have been designed for laser discectomy, including YAG, KTP, holmium, argon, and carbon dioxide lasers. Several types of cutting devices have been developed to remove or ablate disc material, including the Stryker Dekompressor Percutaneous Discectomy Probe or the Endius MDS MicroDebrider System. Regardless of the type of laser or cutting probe, the procedure involves placement of the laser and probes within the nucleus under fluoroscopic guidance. The lasers are activated for short periods to ablate disc material, and cutting probes generally suction out some or all of the disc material.

Interspinous and interlaminar implants (spacers) stabilize or distract the adjacent lamina and/or spinous processes and restrict extension in order to reduce pain in patients with lumbar spinal stenosis and neurogenic claudication. Interspinous spacers are implants that expand the neural foramen and limit lumbar extension to relieve pain in patients with spinal stenosis and neurogenic claudication. The Superion Interspinous Spacer (by VertiFlex Inc.) is a one-piece, expandable implant that is delivered through a single small incision in the patient’s back. The Superion Interspinous Spacer was FDA approved in May 2015 to treat skeletally mature patients suffering from neurogenic intermittent claudication due to moderate degenerative lumbar spinal stenosis with or without grade 1 spondylolisthesis, who have undergone at least 6 months of non-operative treatment. It is unclear whether the Superion device provides clinically meaningful benefits. The X-Stop Interspinous Spacer (by Medtronic Inc.) is an FDA-approved interspinous spacer, but the manufacturer elected to voluntarily cease the sale and distribution of this device. The Plan considers the use of all interspinous spacers to be experimental and investigational. When conservative treatment does not relieve pain from lumbar spinal stenosis, surgical alternatives to interspinous spacers include laminectomy with or without spinal fusion, laminotomy, or hemilaminotomy.

An interlaminar stabilization device is implanted after decompression of lumbar spinal stenosis at the affected level(s). The device is implanted between adjacent lamina and has two (2) sets of wings that are placed around the inferior and superior spinous processes; the intent of the procedure is to enlarge the neural foramen and decompresses the cauda equina in patients with spinal stenosis and neurogenic claudication. The devices (spacers) distract the laminar space and/or spinous processes and aim to restrict painful extension while otherwise enabling normal motion. This procedure is performed by a neurosurgeon or orthopedic surgeon in a hospital setting after lumbar decompression with the patient under general or local anesthesia. An example of an interlaminar stabilization device includes the Coflex Interlaminar Stabilization Device (Paradigm Spine LLC). The Coflex device is intended for use in skeletally mature patients with one or two-level lumbar spinal stenosis from L1 to L5, at least moderate impairment in function, relief from leg/buttocks/groin pain and symptoms when in flexion, and at least six (6) months of non-operative treatment; back pain does not have to be present. The available evidence suggests that interlaminar implantation after lumbar decompression is relatively safe and efficacious for relieving pain and improving function in adult patients with symptomatic lumbar spinal stenosis. The short-term, clinical benefits of interlaminar implantation appear similar to those of standard procedures for treating lumbar spinal stenosis. However, the

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overall quality of the evidence to validate the use of interlaminar stabilization devices is low due to inadequate patient follow-up time, small sample size, retrospective design, and lack of control group with applicable clinical studies. Surgical alternatives to interlaminar stabilization for lumbar spinal stenosis include decompressive procedures such as laminectomy, laminotomy, foraminectomy, facetectomy, and discectomy, alone or followed by spinal fusion.

Currently, there is insufficient clinical evidence to support the medical efficacy of thermal intradiscal procedures, interspinous spacers, interlaminar stabilization devices, and other minimally invasive spinal procedures used in the treatment of pain associated with disc disease and/or low back pain; therefore these procedures are considered experimental and investigational. Randomized controlled trials are needed to evaluate the efficacy of these procedures against alternative medical and surgical treatments. These services and/or devices are not proven to be clinically effective and therefore are not considered to be medically necessary.

At the time of the Plan’s most recent policy review, the Centers for Medicare and Medicaid Services (CMS) has concluded that the scientific evidence does not demonstrate that thermal intradiscal procedures improve health outcomes, and therefore has issued a national non-coverage determination for TIPs under §1862(a)(1)(A) of the Social Security Act in national coverage determination (NCD) #150.11; procedures included in this determination include but are not limited to the following: Intradiscal electrothermal therapy (IDET), intradiscal thermal annuloplasty (IDTA), percutaneous intradiscal radiofrequency thermocoagulation (PIRFT), radiofrequency annuloplasty (RA), intradiscal biacuplasty (IDB), percutaneous (or plasma) disc decompression (PDD) or coblation, or targeted disc decompression (TDD). CMS has determined that percutaneous image-guided lumbar decompression (PILD) for lumbar spinal stenosis (LSS) is not a medically necessary treatment under section 1862(a)(1)(A) of the Social Security Act with NCD #150.13; PILD may be covered by Medicare when provided in a clinical study under section 1862(a)(1)(E) for beneficiaries with LSS who are enrolled in an approved clinical study that meets CMS established criteria for clinical trials. No CMS clinical guidelines were found for interspinous spacers or interlaminar stabilization devices. Verify CMS criteria for the specified service in the applicable NCD or local coverage determination (LCD) on the date of the prior authorization request for a Senior Care Options member.

References


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<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date* and Version Number</th>
<th>Policy Owner</th>
<th>Approved by</th>
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<tbody>
<tr>
<td>Regulatory Approval: N/A</td>
<td>09/01/09 Version 1</td>
<td>Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) and member of Quality Improvement Committee (QIC)</td>
<td>MPCTAC, QIC, and Utilization Management Committee (UMC)</td>
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<tr>
<td>Internal Approval: 05/26/09: MPCTAC 05/26/09: UMC 06/24/09: QIC</td>
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*Effective Date for the BMC HealthNet Plan Commercial Product(s): 01/01/12
*Effective Date for the Well Sense Heath Plan New Hampshire Medicaid Product(s): 01/01/13
*Effective Date for Senior Care Options Product(s): 01/01/16

Effective 09/01/09, this policy replaced the IDET policy. Policy title from 09/01/09 to 05/31/16 was Thermal Intradiscal and Other Minimally Invasive Surgical Treatments for Back Pain. Policy renamed Minimally Invasive Minimally Invasive Procedures for Back Pain (Including Thermal Intrascal Procedures, Interspinous Spacers, Interlaminar Stabilization Devices, and Minimally Invasive Surgical Procedures to Remove Disc Material)

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### Policy Revisions History

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Summary of Revisions</th>
<th>Revision Effective Date and Version Number</th>
<th>Approved by</th>
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<tbody>
<tr>
<td>04/01/10</td>
<td>Annual review. Updated references.</td>
<td>Version 2 04/27/10: MPCTAC 05/26/10: QIC</td>
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<tr>
<td>04/01/11</td>
<td>Annual review. No changes to criteria. Updated references.</td>
<td>Version 3 04/20/11: MPCTAC 05/25/11: QIC</td>
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<tr>
<td>04/01/12</td>
<td>Annual review. Updated criteria, updated coding, updated references.</td>
<td>Version 4 04/18/12: MPCTAC 06/27/12: QIC</td>
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<tr>
<td>07/29/12</td>
<td>Off cycle review for Well Sense Health Plan. Revised Summary statement, revised Medical Policy Statement, revised language in Applicable Coding section, revised Limitations.</td>
<td>Version 5 08/03/12: MPCTAC 09/05/12: QIC</td>
<td></td>
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<tr>
<td>02/01/13</td>
<td>Annual review for effective date 06/01/13. References updated, updated code definitions, revised introductory paragraph in Applicable Coding section, revised Summary section and referenced Experimental and Investigational Treatment policy, reformatted Description of Item or Service section, revised the Medical Policy Statement section (formerly named the Clinical Guideline Statement section) and Limitations section, moved list of experimental and investigation procedures from the Medical Policy Statement section to the Limitations section and added procedures, added definition for nociceptors, changed name of policy category from “Clinical Coverage Guidelines” to “Medical Policy.”</td>
<td>06/01/13 Version 6 02/20/13: MPCTAC 03/21/13: QIC</td>
<td></td>
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<tr>
<td>08/14/13 and 08/15/13</td>
<td>Off cycle review for Well Sense Health Plan and merged policy format. Incorporate policy revisions dated 02/01/13 (as specified above) for the Well Sense Health Plan product; these policy revisions were approved by MPCTAC on 02/20/13 and QIC on 03/21/13 for applicable Plan products.</td>
<td>Version 7 08/14/13: MPCTAC (electronic vote) 08/15/13: QIC</td>
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</table>

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<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Revision Date</th>
<th>Authorizing Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/01/14</td>
<td>Annual review for effective 03/01/14. Added arthroscopic microdiscectomy (AMD) and examples of percutaneous discectomy devices to the Description of Item or Service section. Updated references.</td>
<td>03/01/14</td>
<td>02/19/14: MPCTAC 02/26/14: QIC</td>
</tr>
<tr>
<td>02/01/15</td>
<td>Annual review for effective date 04/01/15. Updated references. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available.</td>
<td>04/01/15 Version 9</td>
<td>02/18/15: MPCTAC 03/11/15: QIC</td>
</tr>
<tr>
<td>11/25/15</td>
<td>Review for effective date 01/01/16. Updated template with list of applicable products and notes. Revised language in the Applicable Coding section.</td>
<td>01/01/16 Version 10</td>
<td>11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC</td>
</tr>
<tr>
<td>02/01/16</td>
<td>Review for effective date 06/01/16. Updated Summary, Description of Item or Service, Limitations, Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Added experimental and investigational codes to the applicable code list and revised the policy title.</td>
<td>06/01/16 Version 11</td>
<td>02/17/16: MPCTAC 03/09/16: QIC</td>
</tr>
</tbody>
</table>

**Last Review Date**
02/01/16

**Next Review Date**
02/01/17

**Authorizing Entity**
QIC

**Other Applicable Policies**
Medical Policy - *Experimental and Investigational Treatment*, policy number OCA 3.12

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Reference to Applicable Laws and Regulations


Disclaimer Information: *

Medical Policies are the Plan’s guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member’s benefit document, and when appropriate, coordinates with the Member’s health care Providers to consider the individual Member’s health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan’s service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member’s benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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