Spine Procedures

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Instructions for Use

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Related Medicare Advantage Policy Guidelines

- Category III CPT Codes
- Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis (NCD 150.13)
- Percutaneous Minimally Invasive Fusion
- Thermal Intradiscal Procedures (TIPs) (NCD 150.11)
- Vertebral Augmentation Procedure (VAP)/ Percutaneous Vertebroplasty

Coverage Guidelines

Spine procedures may be covered when Medicare criteria are met.

Lumbar Spinal Fusion

Medicare does not have a National Coverage Determination (NCD) for lumbar spinal fusion. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Lumbar Spinal Fusion.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Surgical Treatment for Spine Pain.
Note: After checking the Lumbar Spinal Fusion table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

When coflex-F® implant system is used as part of spinal fusion, refer to Interlaminar Lumbar Instrumented Fusion (ILIF).

Cervical Spinal Fusion

Medicare does not have a National Coverage Determination (NCD) for cervical spinal fusion. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy title Surgical Treatment for Spine Pain. Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

For lumbar spinal fusion, refer to Lumber Spinal Fusion above.

Thermal Intradiscal Procedures (TIPs)

Effective for services performed on or after September 29, 2008, the CMS has determined that percutaneous thermal intradiscal procedures (TIPs) are not reasonable and necessary for the treatment of low back pain. Therefore, TIPs, which include procedures that employ the use of a radiofrequency energy source or electrothermal energy to apply or create heat and/or disruption within the disc for the treatment of low back pain, are non-covered.

Note: Although not intended to be an all-inclusive list, TIPs are commonly identified as 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). At times, TIPs are identified or labeled based on the name of the catheter/probe that is used (e.g., SpineCath, discTRODE, SpineWand, Accutherm, or TransDiscal electrodes). Each technique or device has its own protocol for application of the therapy. Percutaneous disc decompression or nucleoplasty procedures that do not utilize a radiofrequency energy source or electrothermal energy (such as the disc decompressor procedure or laser procedure) are not within the scope of this policy. Refer to the NCD for Thermal Intradiscal Procedures (TIPs) (150.11). (Accessed November 11, 2021)

Spinal Decompression and Interspinous Process Decompression Systems for the Treatment of Lumbar Spinal Stenosis [e.g., Interspinous Process Decompression (IPD), Minimally Invasive Lumbar Decompression (mild®)]

Medicare does not have a National Coverage Determination (NCD) for spinal decompression and interspinous process decompression systems. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Surgical Treatment for Spine Pain. Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policy.

Notes:

- X STOP® Interspinous Process Decompression System (“X STOP”) (CPT codes 22869 and 22870)
  The X-STOP is a titanium implant that fits between the spinous processes yard of the lower (lumbar) spine. It is made from titanium alloy and consists of two components: a spacer assembly and a wing assembly. FDA Approval Information for X STOP® Interspinous Process Decompression System; available at https://www.accessdata.fda.gov/cdrh_docs/pdf4/P040001b.pdf. (Accessed November 11, 2021)
- Coflex® Interlaminar Technology (CPT codes 22867 and 22868)
  The Coflex® Interlaminar Technology is an interlaminar stabilization device indicated for use in one or two level lumbar stenosis from L1-L5 in skeletally mature patients with at least moderate impairment in function, who experience relief in flexion from their symptoms of leg/buttocks/groin pain, with or without back pain, and who have undergone at least 6 months of non-operative treatment. The coflex® is intended to be implanted midline between adjacent lamina of 1 or 2 contiguous lumbar motion segments. Interlaminar stabilization is performed after decompression of stenosis at the affected level(s).FDA Approval Information for coflex® Interlaminar Technology; available at https://www.accessdata.fda.gov/cdrh_docs/pdf11/P110008b.pdf. (Accessed November 11, 2021)

Interlaminar Lumbar Instrumented Fusion (ILIF) Utilizing an interspinous Process Fusion Device (e.g., coflex-F® Implant System) (CPT code 22899)

Medicare does not have a National Coverage Determination (NCD) for interlaminar lumbar instrumented fusion (ILIF), e.g., Coflex-F® implant system. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Surgical Treatment for Spine Pain. Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Note: Coflex-F® Implant System (CPT code 22899)
A spinous process fixation device that stabilizes the spinous processes and spine to act as an adjunct to fusion. It consists of a single, U-shaped component, fabricated from medical grade titanium alloy (Ti6Al4V). A set of two wings extends vertically from the superior long arm of the device, with a second set of wings extending below the inferior long arm. A screw and sleeve are inserted through a prepared hole and fixes the crimped wings to the superior and inferior spinous processes. FDA approval information for coflex-F® implant system; available at https://www.accessdata.fda.gov/cdrh_docs/pdf11/K112595.pdf. (Accessed November 11, 2021)

Arthrodesis, Pre-sacral Interbody Technique (CPT code 22586)

Medicare does not have a National Coverage Determination (NCD). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Surgical Treatment for Spine Pain. Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Intra-facet Implants (CPT codes 0219T, 0220T, 0221T and 0222T)

Medicare does not have a National Coverage Determination (NCD) for intra-facet implants. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist for all states/territories and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Intra-facet Implants.

Decompression Procedure, Percutaneous, of Nucleus Pulposus (CPT code 62287)

Medicare does not have a National Coverage Determination (NCD) for decompression procedure, percutaneous, of nucleus pulposus. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Discogenic Pain Treatment. Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Percutaneous Image-Guided Lumbar Decompression (PILD)

PILD is a posterior decompression of the lumbar spine performed under indirect image guidance without any direct visualization of the surgical area. This is a procedure proposed as a treatment for symptomatic lumbar spinal stenosis (LSS) unresponsive to conservative therapy. This procedure is generally described as a non-invasive procedure using specially designed instruments to percutaneously remove a portion of the lamina and debulk the ligamentum flavum. The procedure is performed under x-ray guidance (e.g., fluoroscopic, CT) with the assistance of contrast media to identify and monitor the compressed area via epidurogram.

Covered Indications

I. Effective for services performed on or after January 9, 2014, the Centers for Medicare and Medicaid Services (CMS) has determined that PILD will be covered by Medicare when provided in a clinical study under section 1862(a)(1)(E) through coverage with evidence development (CED) for beneficiaries with LSS who are enrolled in an approved clinical study that meets the criteria outlined in the NCD.

II. Effective for services performed on or after December 7, 2016, CMS will cover through a prospective, longitudinal study PILD procedures using an FDA-approved/cleared device that completed a CMS-approved randomized control trial (RCT) that met the criteria that are listed in section I.

Non-Covered Indications

Effective for services performed on or after January 9, 2014, CMS has determined that PILD for LSS may only be covered under the context of a clinical trial as described in the above section according to section 1862(a)(1)(E) of the Social Security Act. CMS has determined that PILD for LSS is not reasonable and necessary under section 1862(a)(1)(A) of the Act.

Refer to the:

- NCD for Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis (150.13). (Accessed November 11, 2021)
- Coverage Summary titled Experimental Procedures and Items, Investigational Devices and Clinical Trials.
- The list of Medicare approved clinical trials is available at http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/PILD.html. (Accessed November 11, 2021)

Percutaneous Vertebroplasty and Percutaneous Vertebral Augmentation (also known as Balloon-Assisted Percutaneous Vertebroplasty, Kyphoplasty) (CPT codes 22510, 22511, 22512, 22513, 22514 and 22515)

Medicare does not have a National Coverage Determination (NCD) for percutaneous vertebroplasty and percutaneous vertebral augmentation. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist for all states/territories and compliance with these policies is required where applicable. For-specific LCDs/LCAs, refer to the table for Percutaneous Vertebroplasty and Percutaneous Vertebral Augmentation.

Percutaneous Sacral Augmentation (Sacroplasty) (CPT codes 0200T and 0201T)

Medicare does not have a National Coverage Determination (NCD) for sacroplasty. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Surgical Treatment for Spine Pain. Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Stereotactic Computer Assisted Volumetric and/or Navigational Procedure

Refer to the Coverage Summary titled Radiologic Therapeutic Procedures.

Percutaneous Minimally Invasive Fusion/Stabilization of the Sacroiliac Joint for the Treatment of Back Pain (CPT code 27279)

Medicare does not have a National Coverage Determination (NCD) for percutaneous minimally invasive fusion/stabilization of the sacroiliac joint for the treatment of back pain. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Percutaneous Minimally Invasive Fusion/Stabilization of the Sacroiliac Joint for the Treatment of Back Pain.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the Wisconsin Physicians Service Insurance Corp. LCD/LCA for Percutaneous Minimally Invasive Fusion/Stabilization of the Sacroiliac Joint for the Treatment of Back Pain (L36000).
Note: After checking the Percutaneous Minimally Invasive Fusion/Stabilization of the Sacroiliac Joint for the Treatment of Back Pain table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Supporting Information

Important Note: When searching the Medicare Coverage Database, if no LCD/LCA is found, then use the applicable referenced default policy below for coverage guidelines.

Intra-facet Implants Accessed November 8, 2021				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L38773 (A58364)	Facet Joint Interventions for Pain Management	Part A and B MAC	CGS Administrators, LLC	KY, OH
L33930 (A57787)	Facet Joint Interventions for Pain Management	Part A and B MAC	First Coast Service Options, Inc.	FL, PR, VI
L35936 (A57826)	Facet Joint Interventions for Pain Management	Part A and B MAC	National Government Services, Inc	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
L38801 (A58403)	Facet Joint Interventions for Pain Management	Part A and B MAC	Noridian Healthcare Solutions, LLC	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
L38803 (A58405)	Facet Joint Interventions for Pain Management	Part A and B MAC	Noridian Healthcare Solutions, LLC	AS, CA, GU, HI, MP, NV
L34892 (A56670)	Facet Joint Interventions for Pain Management	Part A and B MAC	Novitas Solutions, Inc.	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
L38765 (A58350)	Facet Joint Interventions for Pain Management	Part A and B MAC	Palmetto GBA	AL, GA, NC, SC, TN, VA, WV
L38841 (A58477)	Facet Joint Interventions for Pain Management	Part A MAC	Wisconsin Physicians Service Insurance Corporation	AK*, AL*, AR*, AZ*, CA*, CO*, CT*, DE*, FL*, GA*, HI*, IA, ID*, IL*, IN, KS, KY*, LA*, MA*, MD*, ME*, MI, MO, MS*, MT*, NC*, ND*, NE, NH*, NJ*, NM*, NV*, OH*, OK*, OR*, PA*, RI*, SC*, SD*, TN*, TX*, UT*, VA*, VT*, WA*, WI*, WV*, WY* Note: States notated with an asterisk (*) should follow the other available state-specific LCD/LCA listed in this table. This WPS LCD/LCA only applies to states without asterisk.
L38841 (A58477)	Facet Joint Interventions for Pain Management	Part B MAC	Wisconsin Physicians Service Insurance Corporation	IA, IN, KS, MI, MO, NE
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Percutaneous Vertebroplasty and Percutaneous Vertebral Augmentation (Also Known as Balloon-Assisted Percutaneous Vertebroplasty, Kyphoplasty) Accessed November 10, 2021				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L38201 (A57282)	Percutaneous Vertebral Augmentation (PVA) for	Part A and B MAC	CGS Administrators, LLC	KY, OH

Percutaneous Vertebroplasty and Percutaneous Vertebral Augmentation (Also Known as Balloon-Assisted Percutaneous Vertebroplasty, Kyphoplasty) Accessed November 10, 2021				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
	Vertebral Compression Fracture (VCF)			
L34976 (A55960)	Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF)	Part A and B MAC	First Coast Service Options, Inc.	FL, PR, VI
L33569 (A56178)	Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF)	Part A and B MAC	National Government Services, Inc	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
L34106 (A57695)	Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF)	Part A and B MAC	Noridian Healthcare Solutions, LLC	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
L34228 (A57694)	Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF)	Part A and B MAC	Noridian Healthcare Solutions, LLC	AS, CA, GU, HI, MP, NV
L35130 (A57752)	Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF)	Part A and B MAC	Novitas Solutions, Inc.	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
L38213 (A57630)	Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF)	Part A MAC	Wisconsin Physicians Service Insurance Corporation	AK*, AL, AR*, AZ*, CA*, CO*, CT*, DE*, FL*, GA, HI*, IA, ID*, IL*, IN, KS, KY*, LA*, MA*, MD*, ME*, MI, MO, MS*, MT*, NC, ND*, NE, NH*, NJ*, NM*, NV*, OH*, OK*, OR*, PA*, RI*, SC, SD*, TN, TX*, UT*, VA, VT*, WA*, WI*, WV*, WY* Note: States notated with an asterisk (*) should follow the other available state-specific LCD/LCA listed in this table. This WPS LCD/LCA only applies to states without asterisk.
L38213 (A57630)	Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF)	Part B MAC	Wisconsin Physicians Service Insurance Corporation	IA, IN, KS, MI, MO, NE
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Lumbar Spinal Fusion Accessed November 10, 2021				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L33382 (A57654)	Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions	Part A and B MAC	First Coast Service Options, Inc.	FL, PR, VI
L37848 (A56396)	Lumbar Spinal Fusion	Part A and B MAC	Palmetto GBA	AL, GA SC, TN, VA, WV, NC
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Percutaneous Minimally Invasive Fusion/Stabilization of the Sacroiliac Joint for the Treatment of Back Pain Accessed November 10, 2021				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L36494 (A56535)	Minimally-Invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint	Part A and B MAC	CGS Administrators, LLC	KY, OH
L36406 (A57431)	Minimally-invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint	Part A and B MAC	National Government Services, Inc.	IL, MN, WI, CT, NY, ME, MA, NH, RI, VT
A53452	Sacroiliac-Bone Implant System	Part A and B MAC	Palmetto GBA	AL, GA, NC, SC, TN, VA, WV
L36000 (A57596)	Percutaneous minimally invasive fusion/stabilization of the sacroiliac joint for the treatment of back pain	Part A MAC	Wisconsin Physicians Service Insurance Corp.	AK, AL*, AR, AZ, CA, CO, CT*, DE, FL*, GA*, HI, IA, ID, IL*, IN, KS, KY*, LA, MA*, MD, ME*, MI, MO, MS, MT, NC*, ND, NE, NH*, NJ, NM, NV, OH*, OK, OR, PA, RI*, SC*, SD, TN*, TX, UT, VA*, VT*, WA, WI*, WV*, WY Note: States notated with an asterisk (*) should follow the other available state-specific LCD/LCA listed in this table. This WPS LCD/LCA only applies to states without asterisk.
L36000 (A57596)	Percutaneous minimally invasive fusion/stabilization of the sacroiliac joint for the treatment of back pain	Part B MAC	Wisconsin Physicians Service Insurance Corp.	IA, IN, KS, MI, MO, NE
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Policy History/Revision Information

Date	Summary of Changes

11/16/2021	**Coverage Guidelines**
	Spinal Decompression and Interspinous Process Decompression Systems for the Treatment of Lumbar Spinal Stenosis [e.g., Interspinous Process Decompression (IPD), Minimally Invasive Lumbar Decompression (mild®)]
	• Modified content heading; previously titled *Spinal Decompression and Interspinous Process Decompression Systems*
	• Updated language to clarify Medicare does not have a National Coverage Determination (NCD) for *spinal decompression and* interspinous process decompression systems
	• Revised description of "coflex® Interlaminar Technology" (CPT codes 22867 and 22868) to indicate:
	  ○ The coflex® Interlaminar Technology is an interlaminar stabilization device indicated for use in one or two level lumbar stenosis from L1-L5 in skeletally mature patients with at least moderate impairment in function, who experience relief in flexion from their symptoms of leg/buttocks/groin pain, with or without back pain, and who have undergone at least 6 months of non-operative treatment
	  ○ The coflex® is intended to be implanted midline between adjacent lamina of 1 or 2 contiguous lumbar motion segments
	  ○ Interlaminar stabilization is performed after decompression of stenosis at the affected level(s)
	• Removed notation addressing incorrect coding/billing of IPD as spinal fixation; removed CPT codes 22842, 22843, 22844, and 22849
	Interlaminar Lumbar Instrumented Fusion (ILIF) Utilizing an interspinous Process Fusion Device (e.g., coflex-F® Implant System) (CPT code 22899)
	• Modified content heading; previously titled *Interlaminar Lumbar Instrumented Fusion (ILIF) (e.g., coflex-F® Implant System)*
	• Removed notation addressing coding/billing of spinal fixation/instrumentation during spinal fusion; removed CPT codes 22842, 22843, 22844, and 22849
	Intra-facet Implants (CPT codes 0219T, 0220T, 0221T and 0222T)
	• Modified content heading; previously titled *Total Facet Joint Arthroplasty, Facetectomy and Stand-Alone Facet Fusion without an Accompanying Decompressive Procedure (CPT codes 0219T, 0220T, 0221T and 0222T)*
	• Updated language to clarify Medicare does not have a NCD for *intra-facet implants*
	• Revised language to indicate Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) *exist for all states/territories and compliance with these policies is required where applicable*
	• Removed default guidelines for states/territories with no LCDs/LCAs
	Percutaneous Image-Guided Lumbar Decompression (PILD)
	• Modified content heading; previously titled *Percutaneous Image-Guided Lumbar Decompression (PILD) [Includes Minimally Invasive Lumbar Decompression (mild®)]*
	Covered Indications
	• Added language to indicate, effective for services performed on or after Dec. 7, 2016, the Centers for Medicare & Medicaid Services (CMS) will cover through a prospective, longitudinal study, PILD procedures using an FDA-approved/cleared device that completed a CMS-approved randomized control trial (RCT) that met the criteria listed [in the policy]
	Supporting Information
	• Updated list of available LCDs/LCAs to reflect the most current reference links
	• Archived previous policy version MCS089.01

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resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member's Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member's EOC/SB, the member's EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).