Coverage Summary

**Spine Procedures**

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<th>Policy Number:</th>
<th>Products: UnitedHealthcare Medicare Advantage Plans</th>
<th>Original Approval Date: 05/22/2008</th>
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<tr>
<td>Approved by:</td>
<td>UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td>Last Review Date: 11/20/2018</td>
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**Related Medicare Advantage Policy Guidelines:**

- Epidural Injection
- Insertion of Posterior Spinous Process Device
- Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis (NCD 150.13)
- Percutaneous Minimally Invasive Fusion
- Thermal Intradiclal Procedures (TIPs) (NCD 150.11)
- Vertebral Augmentation Procedure (VAP)/Percutaneous Vertebroplasty

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference 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 comply 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).

**INDEX TO COVERAGE SUMMARY**

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I. COVERAGE

Coverage Statement: Spine procedures may be covered when Medicare criteria are met.

Guidelines/Notes:

1. 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 state-specific LCDs/LCAs, refer to the LCD Availability Grid (Attachment F).
   - For states with no LCDs/LCAs, see the UnitedHealthcare Commercial Medical Policy for Surgical Treatment for Spine Pain for coverage guidance. (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
   - Committee approval date: November 20, 2018
   - Accessed June 20, 2019

When coflex-F® Implant System is used as part of spinal fusion, see Guideline 12 [Interlaminar Lumbar Instrumented Fusion (ILIF)].

2. 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 for Surgical Treatment for Spine Pain. (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
   - Committee approval date: November 20, 2018
   - Accessed November 7, 2018

For lumbar spinal fusion, refer to Guidelines #1 above.

3. 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 noncovered.

**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 biaxoplasty (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. See the [NCD for Thermal Intradiscal Procedures (TIPs) (150.11)](https://www.accessdata.fda.gov/cdrh_docs/pdf4/P040001b.pdf) (Accessed November 12, 2018)

4. **Interspinous Process Decompression (IPD) [X STOP® and coflex® Interlaminar Technology (CPT codes 22867, 22868, 22869 and 22870)]**

(Note: May also see IPD requested inappropriately as spinal fixation; CPT codes 22842, 22843, 22844, and 22849.)

- Medicare does not have a National Coverage Determination (NCD) for interspinous process decompression system such as X STOP® and coflex® Interlaminar Technology. (see description below)
- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the [LCD Availability Grid (Attachment A)](https://www.accessdata.fda.gov/cdrh_docs/pdf4/P040001b.pdf).
- **For states with no LCDs/LCAs**, see the UnitedHealthcare Commercial Medical Policy for Surgical Treatment for Spine Pain for coverage guideline. (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
- **Committee approval date: November 20, 2018**
- **Accessed June 20, 2019**


**coflex® Interlaminar Technology**: A U-shaped, titanium alloy implant that fits between two bones called the spinous processes located in the lower back (lumbar region) of the spine. The device is placed between two adjacent lower back bones after surgical relief of pressure on the spinal cord and nerves (decompression) to ease the pain associated with lumbar spinal stenosis, a narrowing of the passages for the spinal cord and nerves. FDA Approval Information for coflex® Interlaminar Technology; available at [https://www.accessdata.fda.gov/cdrh_docs/pdf11/P110008b.pdf](https://www.accessdata.fda.gov/cdrh_docs/pdf11/P110008b.pdf). (Accessed November 12, 2018)
5. **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) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the [LCD Availability Grid (Attachment B)](attachment). For states with no LCDs/LCAs, see the [UnitedHealthcare Commercial Medical Policy for Surgical Treatment for Spine Pain](https://www.unitedhealthcare.com) for coverage guideline. (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
   - Committee approval date: November 20, 2018
   - Accessed June 20, 2019

6. **Spinal Stabilization (CPT codes 0200T - 0202T and 0219T-0222T)**
   - Medicare does not have a National Coverage Determination (NCD) for Spinal Stabilization.
   - Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the [LCD Availability Grid (Attachment C)](attachment). For states with no LCDs/LCAs, see the [UnitedHealthcare Commercial Medical Policy for Surgical Treatment for Spine Pain](https://www.unitedhealthcare.com) for coverage guideline. (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
   - Committee approval date: November 20, 2018
   - Accessed June 20, 2019

7. **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) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the [LCD Availability Grid (Attachment D)](attachment). For states with no LCDs/LCAs, see the [UnitedHealthcare Commercial Medical Policy for Discogenic Pain Treatment](https://www.unitedhealthcare.com) for coverage guideline. (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
   - Committee approval date: November 20, 2018
   - Accessed June 20, 2019

8. **Percutaneous Image-guided Lumbar Decompression (PILD) [Includes Minimally Invasive Lumbar Decompression (mild®)]**
   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:**
Effective for services performed on or after January 9, 2014, the Centers for Medicare & 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 National Coverage Determination (NCD) for Percutaneous Image-guided Lumbar Decompression for Lumbar Spinal Stenosis (150.13). (Accessed November 12, 2018)


For payment rules for NCDs requiring CED, see the Coverage Summary for Experimental Procedures and Items, Investigational Devices and Clinical Trials.

**Non-Covered Indications:**
Effective for services performed on or after January 9, 2014, CMS has determined that PILD for LSS is not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act.

See the National Coverage Determination (NCD) for Percutaneous image-guided lumbar decompression for lumbar Spinal Stenosis (150.13). (Accessed November 12, 2018)

Also see the Coverage Summary for Experimental Procedures and Items, Investigational Devices and Clinical Trials.

9. Percutaneous Vertebroplasty and Percutaneous Vertebral Augmentation (also known as balloon-assisted percutaneous vertebroplasty, kyphoplasty) (CPT codes 22510-22515, 0200T and 0201T)
   - Medicare does not have a National Coverage Determination (NCD) for percutaneous vertebroplasty and percutaneous kyphoplasty.
   - Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist for all 50 states and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the LCD Availability Grid (Attachment E).
   - Committee approval date: November 20, 2018
   - Accessed June 20, 2019

10. Stereotactic Computer Assisted Volumetric and/or Navigational Procedure; see the Coverage Summary for Radiologic Therapeutic Procedures.

11. Percutaneous Minimally Invasive Fusion (CPT code 27279)
   - Medicare does not have a National Coverage Determination (NCD) for percutaneous minimally invasive fusion.
   - Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the LCD Availability Grid (Attachment G).
   - For states with no LCDs/LCAs, see the Wisconsin Physicians Services LCD for Percutaneous Minimally Invasive Fusion/Stabilization of the Sacroiliac Joint for the Treatment of Back pain (L36000) for coverage guideline. (IMPORTANT NOTE: After
Committee approval date: November 20, 2018  
Accessed June 20, 2019

12. Interlaminar Lumbar Instrumented Fusion (ILIF), e.g., coflex-F® Implant System  
(\textit{Note:} May see billed as spinal fixation/instrumentation during spinal fusion; CPT codes 22842, 22843, 22844, and 22849.)

- Medicare does not have a National Coverage Determination (NCD) for interlaminar lumbar instrumented fusion (ILIF), e.g., Coflex-F® Implant System (see description below)
- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.
- For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy for Surgical Treatment for Spine Pain. (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)

- Committee approval date: November 20, 2018  
- Accessed November 12, 2018

Coflex-F® Implant System: 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.


\textit{For coflex® Interlaminar Technology, see Guideline 4 [Interspinous Process Decompression (IPD)].}

II. DEFINITIONS

III. REFERENCES

IV. REVISION HISTORY

04/01/2019  
- Updated policy introduction; added language to clarify:
  - There are instances where [the Coverage Summary] 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)

- Retitled reference links that direct users to UnitedHealthcare Commercial policies

11/20/2018 Annual review with the following update:
Guideline 5 (Arthrodesis, Pre-sacral Interbody Technique) - removed reference to CPT codes 0195T and 0196T (Effective January 1, 2019)

09/18/2018 Updated Local Coverage Determination (LCD) Availability Grids; removed instruction to “use the applicable LCD based on member’s residence/place and type of service” (this note only applies when selecting the appropriate DME LCD Policy)

01/16/2018 Re-review with the following updates:
Guideline 1 (Lumbar Spinal Fusion) – Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.

Guideline 4 [Interspinous Process Decompression (IPD®) [X STOP® and coflex ® Interlaminar Technology (CPT codes 22867, 22868, 22869 and 22870)] – Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.

Guideline 5 [Arthrodesis, Pre-sacral Interbody Technique (CPT codes 0195T, 0196T and 22586)] – Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.

Guideline 6 [Spinal Stabilization (CPT codes 0200T - 0202T and 0219T - 0222T)] – Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.

Guideline 7 [Decompression procedure, percutaneous, of nucleus pulposus (CPT code 62287)] – Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.

Guideline 9 [Percutaneous Vertebroplasty and Percutaneous Vertebral Augmentation (also known as balloon-assisted percutaneous vertebroplasty, kyphoplasty) (CPT codes 22510-22515, 0200T and 0201T)] – Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.

Guideline 11 [Percutaneous Minimally Invasive Fusion (CPT code 27279)] – Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.

11/20/2017 Annual review with the following update:
Guideline 5 (Arthrodesis, Pre-sacral Interbody Technique) - removed reference to CPT code 0309T (code deleted effective January 1, 2018)

Guideline 8 [Percutaneous Image-guided Lumbar Decompression (PILD) (Includes
Minimally Invasive Lumbar Decompression (*mild*) - deleted language pertaining to the Decision Memo for Percutaneous Image-guided Lumbar Decompression for Lumbar Spinal Stenosis (CAG-00433R); same information is already in the National Coverage Determination (NCD) for Percutaneous image-guided lumbar decompression for lumbar Spinal Stenosis (150.13).

01/17/2017 Re-review with the following updates:
- Deleted CPT code 0171T and 0172T and replaced with the new CPT codes, 22867, 22868, 22869 and 22870. All available LCDs are now updated with new codes.
- Changed default policy for states with no LCDs from Wisconsin L35490 (LCD no longer address this procedure) to the UnitedHealthcare Medical Policy for Surgical Treatment for Spine Pain.

12/20/2016 Re-review with the following update:
Guideline 8 [Percutaneous Image-guided Lumbar Decompression (PILD)] – added reference link to the CMS Decision Memo for PILD for Lumbar Decompression for Lumbar Spinal Stenosis issued December 7, 2016.

11/15/2016 Annual review with the following recommended update:
Guideline #4 (IPD®) [X STOP® and coflex® Interlaminar Technology (CPT Codes 0171T and 0172T)] - changed default policy for states with no LCDs from the UnitedHealthcare Medical Policy for Surgical Treatment for Spine Pain to the LCD for Category III Codes (L35490). UHC Medical Policy states IPD as unproven; LCD uniformity met; all available LCDs now cover based on FDA approved indications (specific to X-stop); use to have some LCDs which did not cover, but now retired.

08/16/2016 Re-review with the following recommended updates:
Guideline 1 (Lumbar Spinal Fusion) – added the following:
When coflex-F® Implant System is used as part of spinal fusion, see Guideline 12 [Interlaminar Lumbar Instrumented Fusion (ILIF)].

Guideline 4 [Interspinous Process Decompression (IPD®)]
Guideline 4.a [X STOP® and coflex® Interlaminar Technology (CPT Codes 0171T and 0172T)] – added the following note: May also see IPD requested inappropriately as spinal fixation; CPT codes 22842, 22843, 22844, and 22849.

Guideline 4.b [Coflex (If requested or billed using CPT codes 22800, 22802, 22804)] – deleted guideline

Guideline 4.c [Coflex (If requested or billed using CPT codes 22842, 22843, 22844, 22849)] – deleted guideline

Guideline 12 [Interlaminar Lumbar Instrumented Fusion (ILIF), e.g., coflex-F® Implant System] – added new guideline

03/15/2016 Guideline 11 (Percutaneous Minimally Invasive Fusion) – added guideline (new to the policy)

01/19/2016 Re-review with the following updates:
- Guideline 10 (Stereotactic Computer Assisted Volumetric and/or Navigational Procedure) - Added reference link to the Coverage Summary for Radiologic
Therapeutic Procedures

- Updated reference link(s) of the applicable LCDs to reflect the new condensed LCD link(s).

11/17/2015 Annual review with the following updates:
Guideline #4.b Coflex (If requested or billed using CPT codes 22800, 22802, 22804)
- Added “If requested or billed using” to title.
- Updated language to reflect addition of LCD Availability Grid – Attachment G.

Guideline #4.c Coflex (If requested or billed using CPT codes 22842, 22843, 22844, 22849) - Added “If requested or billed using” to title.

Guideline #9 Percutaneous Vertebroplasty and Percutaneous Vertebral Augmentation (also known as balloon-assisted percutaneous vertebroplasty, kyphoplasty) (CPT codes 22510-22515, 0200T, 0201T)
- Removed expired CPT® codes 22520-22525, 72291 and 72292 from title.
- Added new CPT® codes 22510-22515, 0200T and 0201T to title.

06/16/2015 Guideline1 (Lumbar Fusion) - Added new available LCDs

04/21/2015 Guideline #8 (Percutaneous Image-guided Lumbar Decompression) - Added reference link to the Coverage Summary for Experimental Procedures and Items, Investigational Devices and Clinical Trials for payment rules for NCDs requiring CED

03/24/2015 Guideline 4.b [Coflex (CPT codes 22800, 22802 and 22804)]: Added guideline (new to the policy) with default for states with no LCDs to the First Coast LCDs for Lumbar Spinal Fusion (L32074 and L32076)
Guideline 4.c [Coflex (CPT codes 22842, 22843, 22844 and 22849)]: Added guideline (new to the policy) with default for states with no LCDs to the UnitedHealthcare Medical Policy for Surgical Treatment for Spine Pain

03/12/2015 Formatting change only

02/17/2015 Guideline 1 (Lumbar Spinal Fusion) - Changed default guideline for states with no LCDs from LCD for Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions (L32074 and L32076) to UnitedHealthcare Medical Policy for Surgical Treatment for Spine Pain

12/16/2014 Annual review with the following updates:
Guideline 5 (Arthrodesis, Pre-sacral Interbody Technique) - Added language to indicate: Coverage guidelines of the available LCDs (not covered) align with the UnitedHealthcare Medical Policy for Surgical Treatment of Spine Pain (unproven)

Guideline 6 (Spinal Stabilization) - Added language to indicate: Coverage guidelines of the available LCDs (not covered) align with the UnitedHealthcare Medical Policy for Surgical Treatment of Spine Pain (unproven)

Guideline 7 (Decompression procedure, percutaneous, of nucleus pulposus) - Added language to indicate:
All available LCDs state not covered which align with the of the UnitedHealthcare Medical Policy for Discogenic Pain Treatments (unproven).
Guideline 8 [Percutaneous Image-guided Lumbar Decompression (PILD)] - Added reference link to the:
  o CMS approved clinical trials/clinical research studies
  o National Coverage Determination (NCD) for Percutaneous Image-guided Lumbar Decompression for Lumbar Spinal Stenosis (150.13).
  o Coverage Summary for Experimental Procedures and Items, Investigational Devices and Clinical Trials

Guideline 9 (Percutaneous Vertebroplasty and Percutaneous Vertebral Augmentation) - Added language to indicate:

Local Coverage Determinations (LCDs) exist for all states/geographic areas. Compliance with these LCDs is required where applicable

Definitions - Removed the definition of:
  o Intradiscal Electrothermal Therapy (no CMS reference available)
  o Kyphoplasty (definition found in the referenced LCDs)
  o Percutaneous Vertebroplasty (definition found in the referenced LCDs)
  o Recent Fracture (not used within this Coverage Summary)

10/21/2014 Guideline # 4 [Interspinous Process Decompression (IPD®)]
  • Added coflex® Interlaminar Technology
  • Changed the default guidelines for states with no LCDs from LCD for Interspinous Process Decompression (L28775 and L29204) to UnitedHealthcare Medical Policy for Surgical Treatment for Spine Pain.

08/19/2014 Guideline #1 (Lumbar Spinal Fusion) - Replaced guidelines in the Coverage Summary with reference link to the First Coast LCDs for Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions (L32074 and L32076).

02/18/2014 Guideline #4 (Interspinous Process Decompression) – deleted one of the default guidelines for states with no LCDs, i.e., Novitas LCD for Interspinous Process Decompression (L32594) as LCD was retired October 31, 2013

Guideline #8 (Minimally Invasive Lumbar Decompression)
Guideline title changed from Minimally Invasive Lumbar Decompression to Percutaneous Image-guided Lumbar Decompression (PILD) [Includes Minimally Invasive Lumbar Decompression (mild®)]
Guideline updated based on the January 9, 2014 CMS Decision Memo for Percutaneous Image-guided Lumbar Decompression for Lumbar Spinal Stenosis (CAG-00433N)

12/17/2013 Annual Review with the following recommended updates:
  • Guideline #4 (Interspinous Process Decompression) - New LCDs are now available; changed the statement “coverage within the available LCDs all align” to “coverage within the available LCDs vary”
  • Guideline #7 (Decompression Procedure, Percutaneous) - Changed the statement “Local Coverage Determinations (LCDs) do not exist” to “Local Coverage Determinations (LCDs) exist. These codes are listed in the LCDs for NonCovered Services and LCDs for Category III Codes as “noncovered” and compliance with these LCDs is required where applicable”
  • Guideline #9 (Percutaneous Vertebroplasty and Percutaneous Kyphoplasty) - Added applicable coverage guidelines (from the retired Percutaneous Vertebroplasty and
Percutaneous Kyphoplasty Coverage Summary

04/29/2013  Annual review; Guidelines #1 (Lumbar Spinal Fusion) updated based on the January 1, 2013 updates to the default guidelines for states with no LCDs, First Coast LCDs for Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions (L32074 and L32076)

02/19/2013 Guidelines #5 (Arthrodesis, Pre-sacral Interbody Technique) revised; changed the default guidelines for states with no Local Coverage Determinations (LCDs), from the available LCDs to the UHC Medical Policy for Surgical Treatment for Spine Pain for coverage guidelines. Added the CPT Codes 0309T and 22586

Guidelines #8 (Minimally Invasive Lumbar Decompression) added

01/04/2013 Guidelines #4 (Interspinous Process Decompression) updated, i.e., default LCD for states with no LCDs, Pinnacle L29494, replaced with the corresponding Novitas LCD, L32594 due to the MAC transition from Trailblazer to Novitas effective 11/19/2012; no change in guidelines.

10/31/2012 Updated to include Guidelines #7-Decompression procedure, percutaneous, of nucleus pulposus; also updated Guidelines #6 - Spinal Stabilization.

04/23/2012  Annual review with the addition of the following guidelines:
- Guidelines #1 (Lumbar Spinal Fusion)
- Guidelines #2 (Cervical Spinal Fusion)
- Guidelines # 5 (Arthrodesis, Pre-sacral Interbody Technique)
- Guidelines #6 (Spinal Stabilization)

10/13/2011 Annual review, no updates

08/19/2011 Guidelines #2 (X STOP Interspinous Process Decompression (IPD®)) - updated using the standard CS format
Links to the NCD and LCDs were updated

03/04/2011 Guidelines #3 (Minimally Invasive Lumbar Spinal Fusion)
Updated the reference to the UHC Medical Policy for Minimally Invasive Lumbar Spinal Fusion (retired) to the UHC Medical Policy for Surgical Treatment For Spine Pain.

12/08/2010 Updated the superseded links to the LCDs for Interspinous Process Decompression System

09/07/2010 Policy updated to include the guidelines for Minimally Invasive Lumbar Spinal Fusion

V. ATTACHMENT(S)

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### Attachment A - LCD Availability Grid
#### Interspinous Process Decompression
(CPT codes 22867, 22868, 22869 and 22870)
CMS website accessed June 20, 2019

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
</tr>
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<tbody>
<tr>
<td>L35094</td>
<td><strong>Services That Are Not Reasonable and Necessary</strong></td>
<td>A and B MAC</td>
<td>Novitas Solutions, Inc.</td>
<td>AR, CO, DC, DE, LA, MD, MS, NM, NJ, OK, PA, TX</td>
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</tbody>
</table>

End of Attachment A

### Attachment B - LCD Availability Grid
#### Arthrodesis, Pre-sacral Interbody Technique
(CPT codes 22586)
CMS website accessed June 20, 2019

<table>
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<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
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<th>States</th>
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<tbody>
<tr>
<td>L33777</td>
<td>Noncovered Services</td>
<td>A and B MAC</td>
<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
</tr>
<tr>
<td>L33382</td>
<td>Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions</td>
<td>A and B MAC</td>
<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
</tr>
<tr>
<td>L36954</td>
<td>Noncovered Services other than CPT® Category III Noncovered Services</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>AL, GA, NC, SC, TN, VA, WV</td>
</tr>
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</table>

End of Attachment B

### Attachment C - LCD Availability Grid
#### Spinal Stabilization
(CPT codes 0200T, 0201T, 0202T, 0219T, 0220T, 0221T and 0222T)
CMS website accessed June 20, 2019

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
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</thead>
<tbody>
<tr>
<td>L34106</td>
<td>Percutaneous Vertebral Augmentation</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY</td>
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<tr>
<td>L35008</td>
<td>Non-Covered Services</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY</td>
</tr>
<tr>
<td>L34228</td>
<td>Percutaneous Vertebral Augmentation</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AS, CA, GU, HI, MP, NV</td>
</tr>
<tr>
<td>L36219</td>
<td>Non Covered Services</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AS, CA, GU, HI, MP, NV</td>
</tr>
<tr>
<td>L35310</td>
<td>Vertebroplasty, Vertebral Augmentation (Kyphoplasty) Percutaneous</td>
<td>A and B MAC</td>
<td>Novitas Solutions, Inc.</td>
<td>AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX</td>
</tr>
<tr>
<td>L35094</td>
<td>Services That Are Not Reasonable and Necessary</td>
<td>A and B MAC</td>
<td>Novitas Solutions, Inc.</td>
<td>AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX</td>
</tr>
<tr>
<td>L33777</td>
<td>Noncovered Services</td>
<td>A and B MAC</td>
<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
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<tr>
<td>L33392</td>
<td>Category III CPT® Codes</td>
<td>MAC - Part A and National Government</td>
<td></td>
<td>CT, IL, MA, ME, MN, NH, NY, RI, VT, WI</td>
</tr>
</tbody>
</table>
### Attachment C - LCD Availability Grid

**Spinal Stabilization**

(CPT codes 0200T, 0201T, 0202T, 0219T, 0220T, 0221T and 0222T)

CMS website accessed June 20, 2019

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
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<tr>
<td>L34555</td>
<td>Non-Covered Category III CPT Codes</td>
<td>B</td>
<td>Services, Inc.</td>
<td>AL, GA, NC, SC, TN, VA, WV</td>
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</table>

End of Attachment C

### Attachment D - LCD Availability Grid

**Decompression procedure, percutaneous, of nucleus pulposus**

(CPT code 62287)

CMS website accessed June 20, 2019

<table>
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<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
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<tbody>
<tr>
<td>L36219</td>
<td>Non Covered Services</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AS, CA, GU, HI, MP, NV</td>
</tr>
<tr>
<td>L35008</td>
<td>Non-Covered Services</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY</td>
</tr>
<tr>
<td>L36954</td>
<td>Noncovered Services other than CPT® Category III Noncovered Services</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>AL, GA, NC, SC, TN, VA, WV</td>
</tr>
</tbody>
</table>

End of Attachment D

### Attachment E - LCD Availability Grid

**Percutaneous Vertebroplasty/Percutaneous Vertebral Augmentation (also known as balloon-assisted percutaneous vertebroplasty, kyphoplasty)**

CMS website accessed June 20, 2019

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
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<tbody>
<tr>
<td>L34106</td>
<td>Percutaneous Vertebral Augmentation</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY</td>
</tr>
<tr>
<td>L34228</td>
<td>Percutaneous Vertebral Augmentation</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AS, CA (Northern, Southern), GU, HI, MP, NV</td>
</tr>
<tr>
<td>L34048</td>
<td>Vertebroplasty and Vertebral Augmentation (Percutaneous)</td>
<td>A and B MAC</td>
<td>CGS Administrators, LLC</td>
<td>KY, OH</td>
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<tr>
<td>L35130</td>
<td>Vertebroplasty, Vertebral Augmentation (Kyphoplasty) Percutaneous</td>
<td>A and B MAC</td>
<td>Novitas Solutions, Inc.</td>
<td>AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX</td>
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<tr>
<td>L34976</td>
<td>Vertebroplasty, Vertebral Augmentation; Percutaneous</td>
<td>A and B MAC</td>
<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
</tr>
<tr>
<td>L34592</td>
<td>Vertebroplasty (Percutaneous) and Vertebral Augmentation including cavity creation</td>
<td>MAC - Part A and B</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>IA, IN, KS, MI, MO, NE</td>
</tr>
</tbody>
</table>
### Attachment E - LCD Availability Grid

**Percutaneous Vertebroplasty/Percutaneous Vertebral Augmentation (also known as balloon-assisted percutaneous vertebroplasty, kyphoplasty)**

CMS website accessed June 20, 2019

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>L34592</td>
<td>Percutaneous Vertebroplasty and Vertebral Augmentation including cavity creation</td>
<td>MAC - Part A</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>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</td>
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<tr>
<td>L33569</td>
<td>Vertebral Augmentation (Percutaneous)</td>
<td>A and B MAC</td>
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<td>CT, IL, MA, ME, MN, NH, NY, RI, VT, WI</td>
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<tr>
<td>L33473</td>
<td>Vertebral Kyphoplasty</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>AL, GA, NC, SC, TN, VA, WV</td>
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</table>

End of Attachment E

### Attachment F - LCD Availability Grid

**Lumbar Spinal Fusion**

CMS website accessed June 20, 2019

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
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<tbody>
<tr>
<td>L3382</td>
<td>Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions</td>
<td>A and B MAC</td>
<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
</tr>
<tr>
<td>L37848</td>
<td>Lumbar Spinal Fusion</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>AL, GA SC, TN, VA, WV, NC</td>
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<tr>
<td>A53972</td>
<td>Spinal Fusion Services: Documentation Requirements</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AS, CA (Northern, Southern), GU, HI, MP, NV</td>
</tr>
<tr>
<td>A53975</td>
<td>Spinal Fusion Services: Documentation Requirements</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, ID, OR, WA, AZ, MT, ND, SD, UT, WY</td>
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</table>

End of Attachment F

### Attachment G - LCD Availability Grid

**Percutaneous Minimally Invasive Fusion (CPT Code 27279)**

CMS website accessed June 20, 2019

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
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</thead>
<tbody>
<tr>
<td>L36944</td>
<td>Minimally-Invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint</td>
<td>MAC – Part A</td>
<td>CGS Administrators, LLC</td>
<td>KY, OH</td>
</tr>
<tr>
<td>L36000</td>
<td>Percutaneous minimally invasive fusion/stabilization of the sacroiliac joint for the treatment of back pain</td>
<td>MAC – Part A</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>IA, IN, KS, MI, MO, NE</td>
</tr>
<tr>
<td>L36000</td>
<td>Percutaneous minimally invasive fusion/stabilization of the sacroiliac joint for the treatment of back pain</td>
<td>MAC – Part A</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>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</td>
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</table>
### Attachment G - LCD Availability Grid

**Percutaneous Minimally Invasive Fusion**

(CPT Code 27279)

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
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<tbody>
<tr>
<td>L36406</td>
<td>Minimally-invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint</td>
<td>A and B MAC</td>
<td>National Government Services, Inc.</td>
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<tr>
<td>A53452</td>
<td>Sacroiliac-Bone Implant System</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>AL, GA, NC, SC, TN, VA, WV</td>
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<td>A55120</td>
<td>Medical review article for percutaneous minimally invasive fusion/stabilization of the sacroiliac joint</td>
<td>A and B MAC</td>
<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
</tr>
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</table>

End of Attachment G