Spine Procedures

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Instructions for Use

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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 10, 2020)

Spinal Decompression and Interspinous Process Decompression Systems

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

Note: May also refer to 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, refer to 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 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.

X STOP® Interspinous Process Decompression System ("X STOP")

A titanium implant that fits between the spinous processes 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 10, 2020)

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. (Accessed November 10, 2020)

Interlaminar Lumbar Instrumented Fusion (ILIF), e.g., coflex-F® Implant System

Note: May refer to 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 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.

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. FDA approval information for coflex-F® implant system; available at https://www.accessdata.fda.gov/cdrh_docs/pdf11/K112595.pdf. (Accessed November 10, 2020)

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.

Total Facet Joint Arthroplasty, Facetectomy and Stand-Alone Facet Fusion without an Accompanying Decompressive Procedure (CPT codes 0219T, 0220T, 0221T and 0222T)

Medicare does not have a National Coverage Determination (NCD) for total facet joint arthroplasty, facetectomy and stand-alone facet fusion without an accompanying decompressive procedure. 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.

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) [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 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.

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. (additional language added to align with NCD)

Refer to the:

- NCD for Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis (150.13). (Accessed November 12, 2020)
- 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 12, 2020)

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.

Percutaneous Vertebroplasty and Percutaneous Vertebral Augmentation (Also Known as Balloon-Assisted Percutaneous Vertebroplasty, Kyphoplasty) Accessed June 4, 2021				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L38201 (A57282)	Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF)	Part A and B MAC	CGS Administrators, LLC	KY, OH
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	Part A and B MAC	Noridian Healthcare Solutions, LLC	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
L34228 (A57694)	Percutaneous Vertebral Augmentation	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
L33473 (A56819)	Vertebroplasty/Kyphoplasty	Part A and B MAC	Palmetto GBA	AL, GA, NC, SC, TN, VA, WV
L38213 (A57630)	Percutaneous Vertebral Augmentation (PVA) for Osteoporotic 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.

Percutaneous Vertebroplasty and Percutaneous Vertebral Augmentation (Also Known as Balloon-Assisted Percutaneous Vertebroplasty, Kyphoplasty) Accessed June 4, 2021				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L38213 (A57630)	Percutaneous Vertebral Augmentation (PVA) for Osteoporotic 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 June 4, 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 June 4, 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
A55120	Medical review article for percutaneous minimally invasive fusion/stabilization of the sacroiliac joint	Part A and B MAC	First Coast Service Options, Inc.	FL, PR, VI
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

Percutaneous Minimally Invasive Fusion/Stabilization of the Sacroiliac Joint for the Treatment of Back Pain Accessed June 4, 2021				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
				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
05/01/2021	**Template Update** • Reformatted policy; transferred content to new template

11/17/2020	• Reorganized coverage guidelines
	Related Medicare Advantage Policy Guidelines
	• Added reference link to the policy titled *Category III CPT Codes*
	• Removed reference link to the policy titled *Epidural Injection* (retired)
	Arthrodesis, Pre-sacral Interbody Technique (CPT code 22586)
	• Revised language pertaining to Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) to indicate LCDs/LCAs do not exist at this time
	Total Facet Joint Arthroplasty, Facetectomy and Stand-Alone Facet Fusion without an Accompanying Decompressive Procedure (CPT codes 0219T, 0220T, 0221T and 0222T)
	• Changed guideline title; previously titled *Spinal Stabilization (CPT codes 0200T-0202T, 0219T, and 0222)*
	• Updated list of applicable CPT codes; removed 0200T, 0201T, and 0202T (refer to *Percutaneous Sacral Augmentation (Sacroplasty) (CPT codes 0200T and 0201T)*
	• Updated language to clarify Medicare does not have a National Coverage Determination (NCD) for *total facet joint arthroplasty, facetectomy and stand-alone facet fusion without an accompanying decompressive procedure*
	Non-Covered Indications
	• Added language to indicate CMS has determined that Percutaneous Image-Guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS) may only be covered under the context of a clinical trial as described [in the policy] according to *Section 1862(a)(1)(E) of the Social Security Act* (the Act)
	Percutaneous Vertebroplasty and Percutaneous Vertebral Augmentation (also known as balloon-assisted percutaneous vertebroplasty, kyphoplasty) (CPT codes 22510, 22511, 22512, 22513, 22514, and 22515)
	• Updated list of applicable CPT codes:
	  ○ Added 22511, 22512, 22513, and 22514
	  ○ Removed 0200T and 0201T [refer to *Percutaneous Sacral Augmentation (Sacroplasty) (CPT codes 0200T and 0201T)*]
	Percutaneous Sacral Augmentation (Sacroplasty) (CPT codes 0200T and 0201T) (new to policy)
	• Added coverage guidelines to indicate:
	  ○ Medicare does not have a National Coverage Determination (NCD) for Sacroplasty
	  ○ LCDs/LCAs do not exist at this time

Date	Summary of Changes
	○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Surgical Treatment for Spine Pain* **Percutaneous Minimally Invasive Fusion /Stabilization of the Sacroiliac Joint for the Treatment of Back Pain (CPT code 27279)** • Changed guideline title; previously titled *Percutaneous Minimally Invasive Fusion (CPT code 27279)* • Updated language to clarify Medicare does not have a NCD for *Percutaneous Minimally Invasive Fusion/Stabilization of the Sacroiliac Joint for the Treatment of Back Pain* **Supporting Information** • Updated *LCD/LCA Availability Grids* to reflect the most current reference links • Removed *LCD/LCA Availability Grid for Arthrodesis, Pre-sacral Interbody Technique*

Instructions for Use

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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).