## Coverage Summary

### Spine Procedures

**Policy Number:** S-005  
**Products:** UnitedHealthcare Medicare Advantage Plans  
**Original Approval Date:** 05/22/2008  
**Approved by:** UnitedHealthcare Medicare Benefit Interpretation Committee  
**Last Review Date:** 11/19/2019

#### 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 Intradiscal Procedures (TIPs) (NCD 150.11)
- Vertebral Augmentation Procedure (VAP)/Percutaneous Vertebroplasty

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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).

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5. Arthrodesis, Pre-sacral Interbody Technique
6. Spinal Stabilization
7. Decompression procedure, percutaneous, of nucleus pulposus
8. Percutaneous Image-guided Lumbar Decompression (PILD) [Includes Minimally Invasive Lumbar Decompression (mild®)]
9. Percutaneous Vertebroplasty and Percutaneous Vertebral Augmentation
10. Stereotactic Computer Assisted Volumetric and/or Navigational Procedure
11. Percutaneous Minimally Invasive Fusion
12. Interlaminar Lumbar Instrumented Fusion (ILIF), e.g., coflex-F® Implant System

#### II. DEFINITIONS

#### III. REFERENCES
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/LCA Availability Grid (Attachment F).
   - For states with no LCDs/LCAs, see the UnitedHealthcare Commercial Medical Policy for Surgical Treatment for Spine Pain for coverage guideline. (IMPORTANT NOTE: After checking the LCD/LCA 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 19, 2019
   - Accessed February 28, 2020

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 19, 2019
   - Accessed November 12, 2019

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 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. See the NCD for Thermal Intradiscal Procedures (TIPs) (150.11). (Accessed November 12, 2019)

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/LCA Availability Grid (Attachment A).
- 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 19, 2019
- Accessed February 28, 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](https://www.accessdata.fda.gov/cdrh_docs/pdf11/P110008b.pdf). (Accessed November 12, 2019)

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/LCA Availability Grid (Attachment B).
- For states with no LCDs/LCAs, see the UnitedHealthcare Commercial Medical Policy for Surgical Treatment for Spine Pain for coverage guideline. (IMPORTANT NOTE: After checking the LCD/LCA 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 19, 2019
- Accessed February 28, 2020
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/LCA Availability Grid (Attachment C).
   - **For states with no LCDs/LCAs**, see the UnitedHealthcare Commercial Medical Policy for Surgical Treatment for Spine Pain for coverage guideline. (IMPORTANT NOTE: After checking the LCD/LCA 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 19, 2019
   - Accessed February 28, 2020

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/LCA Availability Grid (Attachment D).
   - **For states with no LCDs/LCAs**, see the UnitedHealthcare Commercial Medical Policy for Discogenic Pain Treatment for coverage guideline. (IMPORTANT NOTE: After checking the LCD/LCA 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 19, 2019
   - Accessed February 28, 2020

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 NCD for Percutaneous Image-guided Lumbar Decompression for Lumbar Spinal Stenosis (150.13). (Accessed November 12, 2019)


   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 NCD for Percutaneous image-guided lumbar decompression for lumbar Spinal Stenosis (150.13). (Accessed November 12, 2019)

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/LCA Availability Grid (Attachment E).
   - Committee approval date: November 19, 2019
   - Accessed February 28, 2020

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 for all 50 states and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the LCD/LCA Availability Grid (Attachment G).
    - Committee approval date: November 19, 2019
    - Accessed February 28, 2020

12. Interlaminar Lumbar Instrumented Fusion (ILIF), e.g., coflex-F® Implant System
    (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 19, 2019
    - Accessed November 13, 2019

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

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

II. DEFINITIONS

None

III. REFERENCES

None

IV. REVISION HISTORY

11/19/2019  • Routine review; no change to coverage guidelines

Attachments
  • Updated Local Coverage Determination (LCD) Availability Grids to reflect the most current reference links

V. ATTACHMENTS

Attachment A-LCD/LCA Availability Grid

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<tr>
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<th>Title</th>
<th>Contractor Type</th>
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<td>L34006</td>
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<td>FL, PR, VI</td>
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End of Attachment A

Attachment B-LCD/LCA Availability Grid

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End of Attachment B
### Attachment C-LCD/LCA Availability Grid

**Spinal Stabilization**

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

CMS website accessed February 28, 2020

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<td>L34106</td>
<td><strong>Percutaneous Vertebral Augmentation</strong></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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<td>Novitas Solutions, Inc.</td>
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<td>L35094</td>
<td><strong>Services That Are Not Reasonable and Necessary</strong></td>
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<td>Novitas Solutions, Inc.</td>
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<td>A and B MAC</td>
<td>Palmetto GBA</td>
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End of Attachment C

### Attachment D-LCD/LCA Availability Grid

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

(CPT code 62287)

CMS website accessed February 28, 2020

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<td><strong>Non-Covered Services</strong></td>
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<td>L35008</td>
<td><strong>Non-Covered Services</strong></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>L36954</td>
<td><strong>Non-covered Services other than CPT® Category III Non-covered Services</strong></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 D

### Attachment E-LCD/LCA Availability Grid

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

CMS website accessed February 28, 2020

<table>
<thead>
<tr>
<th>ID#</th>
<th>Title</th>
<th>Contractor Type</th>
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<tr>
<td>L34106</td>
<td><strong>Percutaneous Vertebral Augmentation</strong></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>L34228</td>
<td><strong>Percutaneous Vertebral Augmentation</strong></td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AS, CA (Northern, Southern), GU, HI, MP, NV</td>
</tr>
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</table>

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UHC MA Coverage Summary: Spine Procedures

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

**Attachment E-LCD/LCA Availability Grid**

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<td>L38201</td>
<td>Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF)</td>
<td>A and B MAC</td>
<td>CGS Administrators, LLC</td>
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<tr>
<td>L38213</td>
<td>Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF)</td>
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<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>IA, IN, KS, MI, MO, NE</td>
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<td>L35130</td>
<td>Vertebroplasty, Vertebral Augmentation (Kyphoplasty) Percutaneous</td>
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<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
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<td>L34976</td>
<td>Vertebroplasty, Vertebral Augmentation; Percutaneous</td>
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<td>L33569</td>
<td>Vertebroplasty/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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# Lumbar Spinal Fusion

**Attachment F-LCD/LCA Availability Grid**

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<td>L33382</td>
<td>Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions</td>
<td>A and B MAC</td>
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<td>FL, PR, VI</td>
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<td>Lumbar Spinal Fusion</td>
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<td>AL, GA SC, TN, VA, WV, NC</td>
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<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>
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End of Attachment E

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<td>L36494</td>
<td>Minimally-Invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint</td>
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<tr>
<td>L36000</td>
<td>Percutaneous minimally invasive fusion/stabilization of the sacroiliac joint for the treatment of back pain</td>
<td>MAC-Part B</td>
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<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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<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>
<td>IL, MN, WI, CT, NY, ME, MA, NH, RI, VT</td>
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<td>(A57431)</td>
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<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>
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