Cigna Medical Coverage Policies – Musculoskeletal Intradiscal Procedures Guidelines

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Instructions for use

The following coverage policy applies to health benefit plans administered by Cigna. Coverage policies are intended to provide guidance in interpreting certain standard Cigna benefit plans and are used by medical directors and other health care professionals in making medical necessity and other coverage determinations. Please note the terms of a customer's particular benefit plan document may differ significantly from the standard benefit plans upon which these coverage policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a coverage policy.

In the event of a conflict, a customer's benefit plan document always supersedes the information in the coverage policy. In the absence of federal or state coverage mandates, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of:

1. The terms of the applicable benefit plan document in effect on the date of service
2. Any applicable laws and regulations
3. Any relevant collateral source materials including coverage policies
4. The specific facts of the particular situation

Coverage policies relate exclusively to the administration of health benefit plans. Coverage policies are not recommendations for treatment and should never be used as treatment guidelines.

This evidence-based medical coverage policy has been developed by eviCore, Inc. Some information in this coverage policy may not apply to all benefit plans administered by Cigna.

CMM-308: Intradiscal Procedures

Definitions

- **Intradiscal Procedures:** minimally invasive surgical procedures with the goal of to treat symptomatic individuals with discogenic pain attributed to annular disruption of contained herniated disc, to seal annular tears or fissures, or to destroy nociceptors for the purpose of relieving pain. These procedure techniques can include any of the following methods:
  - The percutaneous placement of an intradiscal probe into the suspected painful disc(s) and through the use of radiofrequency energy or electrothermal energy, produce heat to either coagulate and/or disrupt (shrink) type I collagen within the disc for decompression of the disc material (TIPs)
  - The injection of agents into the nucleus pulposus or annulus of the disc to decompress disc material
  - Percutaneous procedures to decompress disc material using indirect/direct visualization.
- **Thermal Intradiscal Techniques:** intradiscal procedure techniques that use single or multiple probes/catheters. They further utilize a resistance coil or other delivery system technology, are flexible or rigid, and are placed within the nucleus pulposus, the nuclear-annular junction or within the annulus.

General Guidelines

- Intradiscal procedures include, but are not limited to, the following:
  - Annulo-nucleoplasty (The Disc-FX procedure)
  - Cervical intradiscal radiofrequency lesioning
  - Coblation percutaneous disc decompression
  - Intradiscal biacuplasty (IDB)/intervertebral disc biacuplasty/cooled radiofrequency
  - Intradiscal electrothermal annuloplasty (IEA)
  - Intradiscal electrothermal therapy (IDET)
  - Intradiscal thermal annuloplasty (IDTA)
  - Nucleoplasty (also known as percutaneous radiofrequency thermomodulation or percutaneous plasma discectomy)
  - Percutaneous (or plasma) disc decompression (PDD)
  - Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT)/intradiscal radiofrequency thermomodulation/percutaneous radiofrequency thermomodulation
  - Radiofrequency annuloplasty (RA)
  - Targeted disc decompression (TDD)

- Intradiscal injections (not an all-inclusive list) (e.g., methylene blue, hyaluronate, ozone, oxygen/ozone, bone marrow concentrate, chymopapain, platelet rich plasma (PRP), mesenchymal stem cells, glucocorticoids, hyaluronidase, growth factors, etc.)

Non-Indications

- Based on the lack of conclusive scientific evidence demonstrating the clinical efficacy of intradiscal procedures and the potential to expose individuals to serious adverse side effects or complications, the use of intradiscal procedures is considered **experimental, investigational, or unproven (EIU)** because their effectiveness has not been established.

Procedure (CPT®) Codes (CMM-308)

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

CPT®	Code Description/Definition
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (list separately in addition to code for primary procedure)
62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar
62292	Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar
0232T	Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed
0274T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopy, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic
0275T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopy, CT), single or multiple levels, unilateral or bilateral; lumbar
0481T	Injection(s), autologous white blood cell concentrate (autologous protein solution), any site, including image guidance, harvesting and preparation, when performed
0627T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level
+0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; each additional level (List separately in addition to code for primary procedure)
0629T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level
+0630T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; each additional level (List separately in addition to code for primary procedure)

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

CPT®	Code Description/Definition
S2348	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single or multiple levels, lumbar

This list may not be all-inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.

References (CMM-308)

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