Geisinger

Geisinger Health Plan Policies and Procedure Manual

Policy: MP072

Section: Medical Benefit Policy

Subject: Percutaneous Discectomy and Disc Decompression Nucleoplasty

Applicable Lines of Business

Commercial	**X**	**CHIP**	**X**
Medicare	**X**	**ACA**	**X**
Medicaid	**X**		

I. Policy: Percutaneous Discectomy and Disc Decompression (Nucleoplasty™)

II. Purpose/Objective:
To provide a policy of coverage regarding Percutaneous Discectomy and Disc Decompression (Nucleoplasty™)

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking

into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

Coblation - is a method of non-thermal volumetric tissue removal through molecular dissociation, using the electrically conductive fluid employed in arthroscopic surgeries in the gap between the electrode and tissue. When electrical current is applied to this fluid, it turns into a charged layer of particles, called a plasma layer. Charged particles accelerate through the plasma and gain sufficient energy to break the molecular bonds within cells. This causes the cells to disintegrate molecule by molecule, so that tissue is volumetrically removed.

DESCRIPTION:
Percutaneous manual disc decompression utilizing a cutting forceps or automated mechanical intervertebral disc decompression utilizing a Stryker Dekompressor® (a.k.a. Automated Percutaneous Nucleotomy) or SpineJet hydrodiskectomy involves placement of a probe within the intervertebral disc under image guidance with mechanical aspiration of disc material using a suction cutting device.

Laser discectomy is a minimally invasive alternative to open surgical or mechanical methods of disc decompression for the treatment of symptomatic intervertebral disc herniation that has not responded to conservative therapy. The primary goals of laser discectomy are to relieve intractable back pain and/or neuropathy and allow return to normal activities

Percutaneous disc decompression using low-temperature, localized, radiofrequency energy (DISC Nucleoplasty™) is a minimally invasive surgical volumetric reduction of the nucleus pulposis utilizing Coblation technology to ablate or remove tissue as a treatment for discogenic back pain.

Geisinger Health Plan requires prior authorization through Cohere for Cardiology services for members enrolled in its Commercial HMO and PPO, Medicare Advantage. GHP Family Medicaid and CHIP products. To direct the application of these services for Geisinger Health Plan members, Cohere utilizes its proprietary clinical criteria, Utilization Management decision-support tools, and evidence-based medical treatment guidelines. For more information about the services that require prior authorization, refer to https://payerinfo.zendesk.com/hc/en-us

Medicaid Business Segment:
Any requests for services that do not meet criteria set in the PARP may be evaluated on a case by case basis

CODING ASSOCIATED WITH: Percutaneous Discectomy and Disc Decompression (Nucleoplasty™)

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov ***or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.***

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 (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic	0274T
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LINE OF BUSINESS:
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

This policy will be revised as necessary and reviewed no less than annually.

Devised: 5/02

Revised: 6/03 (added definition, code); 7/04; 4/05; 4/06; 4/07; 4/09 (coding); 5/10 (refs); 4/17 (coverage clarification and combine related policies); 12/20 (Transition to Health Help); 10/23 (transition to Cohere)

Reviewed: 4/08, 5/11, 5/12, 5/13, 5/14, 5/15, 5/16, 4/18, 4/19, 4/20, 4/21, 4/22