Automated Percutaneous and Endoscopic Discectomy

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Replaces N/A

Policy

Automated Percutaneous discectomy is considered investigational as a technique of intervertebral disc decompression in patients with back pain and/or radiculopathy related to disc herniation in the lumbar, thoracic, or cervical spine.

Endoscopic discectomy is considered investigational as a technique of intervertebral disc decompression in patients with back pain and/or radiculopathy related to disc herniation in the lumbar, thoracic, or cervical spine.

Related Policies

7.01.72  Percutaneous Intradiscal Electrothermal Annuloplasty (IDET) Annuloplasty and Percutaneous Intradiscal Radiofrequency Annuloplasty
7.01.93  Decompression of the Intervertebral Disc Using Laser Energy (Laser Discectomy) or Radiofrequency Coblation (Nucleoplasty)
7.01.126 Image-Guided Minimally Invasive Lumbar Decompression (IG-MLD) for Spinal Stenosis
7.01.551 Lumbar Spine Decompression Surgery: Discectomy, Foraminotomy, Laminotomy, Laminectomy

Policy Guidelines

CPT code 62287 specifically describes a percutaneous decompression procedure of the lumbar spine. This code is specifically limited to the lumbar region. Although most percutaneous disectomies are performed on lumbar vertebrae, FDA labeling of the Stryker DeKompressor Percutaneous Discectomy Probe and the Nucleotome includes the thoracic and cervical vertebrae. Code 62287 includes procedures performed using endoscopic approaches.

Percutaneous discectomy is also a component of the following codes.
Coding

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>0274T</td>
<td>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., fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic</td>
</tr>
<tr>
<td>0275T</td>
<td>Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method, single or multiple levels, lumbar (e.g., manual or automated percutaneous discectomy, percutaneous laser discectomy)</td>
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</table>

Description

Traditionally, discectomy and microdiscectomy are performed manually through an open incision. Percutaneous discectomy describes techniques by which disc decompression is accomplished by the physical removal of disc material rather than its ablation. These techniques have been modified by the use of automated devices that involve placement of a probe within the intervertebral disc and aspiration of disc material using a suction cutting device. Removal of disc herniations under endoscopic visualization is also being investigated. Endoscopic discectomy involves the percutaneous placement of a working channel under image guidance, followed by visualization of the working space and instruments through an endoscope.

Background

Back pain or radiculopathy related to herniated discs is an extremely common condition and a frequent cause of chronic disability. Although many cases of acute low back pain and radiculopathy will resolve with conservative care, a surgical decompression is often considered when the pain is unimproved after several months and is clearly neuropathic in origin, resulting from irritation of the nerve roots. Open surgical treatment typically consists of discectomy in which the extruding disc material is excised. When performed with an operating microscope, the procedure is known as microdiscectomy.

Minimally invasive options have also been researched, in which some portion of the disc material is removed or ablated, although these techniques are not precisely targeted at the offending extruding disc material. Ablative techniques include laser discectomy and radiofrequency decompression. (See Related Policies.) In addition, intradiscal electrothermal annuloplasty is another minimally invasive approach to low back pain. In this technique, radiofrequency energy is used to treat the surrounding disc annulus. (See Related Policies.)

This policy addresses automated percutaneous and endoscopic discectomy, in which the disc decompression is accomplished by the physical removal of disc material rather than its ablation. Traditionally, discectomy is performed manually through an open incision, using cutting forceps to remove nuclear material from within the disc annulus. This technique has been modified by automated devices that involve placement of a probe within the intervertebral disc and aspiration of disc material using a suction cutting device. Endoscopic techniques may be intradiscal or may involve the extraction of non-contained and sequestered disc fragments from inside the spinal canal using an interlaminar or transfomaminal approach. Following insertion of the endoscope, the decompression is performed under visual control.

Regulatory Status

The Stryker DeKompressor® Percutaneous Discectomy Probe (Stryker) and the Nucleotome® (Clarus Medical) are examples of percutaneous discectomy devices that received clearance from FDA through the 510(k) process. Both have the same labeled intended use, i.e., “for use in aspiration of disc material during percutaneous discectomies in the lumbar, thoracic and cervical regions of the spine.” FDA product code: HRX

A variety of endoscopes and associated surgical instruments have received marketing clearance through FDA’s 510(k) process.
**Scope**

Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.

**Benefit Application**

Percutaneous discectomy may be performed by surgeons, but anesthesiologists or other physicians whose practices focus on pain management may also perform this procedure.

**Rationale**

This policy was originally based on a 1990 TEC Evaluation, which concluded that percutaneous discectomy met the TEC criteria. Therefore, the original policy concluded that percutaneous discectomy was considered medically necessary in carefully selected patients. Since the 1990 TEC Evaluation, the methodology of evidence-based medicine in general has grown in sophistication. Specifically, it is recognized that randomized clinical trials are extremely important to assess treatments of painful conditions and low back pain in particular, due both to the expected placebo effect, the subjective nature of pain assessment in general, and also the variable natural history of low back pain that often responds to conservative care. Therefore, this evidence review was assessed again in 2005. Since 2005, this policy has been updated regularly with searches of the MEDLINE database. The most recent literature review was performed through February 23, 2016.

**Automated Percutaneous Discectomy**

**Systematic Reviews**

In 2007, Gibson and Waddell published an updated Cochrane review of surgical interventions for lumbar disc prolapse, concluding that there is insufficient evidence on percutaneous discectomy techniques to draw firm conclusions. (1) In the same year, a task force of the American Society of Interventional Pain Physicians reported that percutaneous disc decompression remains controversial; although all observational studies were positive, the evidence from 4 of 4 randomized published studies was negative. (2) Questions also remained about the appropriate patient selection criteria (particularly related to the size and migration of the disc herniation) for this procedure.

Freeman and Mehdian assessed the current evidence for three minimally invasive techniques used to treat discogenic low back pain and radicular pain: electrothermal therapy (intradiscal electrothermal therapy), percutaneous discectomy, and nucleoplasty in a 2008 article. (3) They reported that trials of automated percutaneous discectomy suggest that clinical outcomes are at best fair and often worse when compared with microdiscectomy.

Systematic reviews have analyzed the literature for different devices. Singh et al. and Vorobeychik et al. performed a systematic analysis of studies in which the Dekompressor device was used; no randomized controlled trials (RCTs) were identified. (4, 5) In 2009, Hirsch et al. reviewed 4 RCTs and 76 observational studies in their analysis of studies in which the Nucleotome was used. (6) One of those RCTs is described next. (7) The other 3 RCTs failed to meet study quality criteria.

Two systematic reviews by Manchikanti et al. in 2013 found limited evidence for percutaneous mechanical
discectomy (including the Nucleotome®) or for disc decompression with the Dekompressor®. There were no RCTs that met the study inclusion criteria. (8,9) A 2015 network meta-analysis found that percutaneous discectomy was one of the least effective treatment strategies for sciatica of 21 assessed. (10)

A cross-section of trials included in these systematic reviews is described next.

**Randomized Controlled Trials**

Revel et al. compared the outcomes of percutaneous discectomy with chymopapain injection in 141 patients with disc herniation and sciatica in a randomized study from 1993. (7) Treatment was considered successful in 61% of patients in the chymopapain group compared with 44% in the percutaneous discectomy group. Chatterjee et al. reported on the results of a study that randomly assigned 71 patients with lumbar disc herniation to undergo either percutaneous discectomy or lumbar microdiscectomy in 1995. (11) A successful outcome was reported in only 29% of those undergoing percutaneous discectomy compared with 80% in the microdiscectomy group. The trial was halted early due to this inferior outcome.

The 2002 LAPDOG study compared percutaneous and open discectomy in patients with lumbar disc herniation. (12) This trial was designed to recruit 330 patients but was only able to recruit 36 patients, for reasons that were not readily apparent to the authors. The authors concluded that this trial was unable to enroll sufficient numbers of patients to reach a definitive conclusion and stated, "It is difficult to understand the remarkable persistence of percutaneous discectomy in the face of a virtually complete lack of scientific support for its effectiveness in treated lumbar disc herniation."

No additional RCTs have been identified in literature updates since the 2002 LAPDOG study. In addition, all of the trials reviewed here focused on lumbar disc herniation. There were no RCTs of percutaneous discectomy of cervical or thoracic disc herniation. A 2013 review of the evidence from the American Society of Interventional Pain Physicians noted that "even though Dekompressor may be considered a new interventional modality, the early studies were published approximately 8 years ago. Consequently, one would expect that the technique’s continued use would be supported by more recent, high-quality evaluations." (13)

**Endoscopic Discectomy**

**Systematic Reviews**

A 2014 Cochrane review evaluated 11 studies of minimally invasive discectomy compared with microdiscectomy/open discectomy. (14) Included in the review were 8 RCTs or quasi-randomized controlled trials that evaluated percutaneous endoscopic lumbar discectomy. Also included were 3 studies on transmuscular tubular microdiscectomy and automated percutaneous lumbar discectomy. Seven of the studies reviewed had a high risk of bias. The review concluded that minimally invasive discectomy may be inferior in terms of relief of leg pain, low back pain, and rehospitalization; however, differences in pain relief appeared to be small and may not be clinically important. In addition, potential advantages of minimally invasive discectomy are a lower risk of surgical site infection and shorter hospital stay.

In 2013, Smith et al. published a systematic review of microendoscopic discectomy for lumbar disc herniation. (15) A search for controlled trials published through September 2012 identified 4 RCTs. None of the studies found a significant difference in ODI scores compared with open discectomy or microdiscectomy. The largest study with 240 patients (Teli et al., described next) reported an increase in the number of severe complications in the microendoscopic discectomy group. (16) Another large study with 112 patients (Garg et al., also described next) found a shorter hospital stay with no significant changes in ODI or complication rates but recommended that microendoscopic discectomy should not be attempted without appropriate training. (17) The 2 other trials included in the review were small with 22 and 40 patients.

A 2016 meta-analysis identified 9 RCTs (total N=1092 patients) that compared endoscopic to open discectomy for lumbar disc herniation. (18) Endoscopic discectomy was found to result in similar clinical outcomes to open discectomy, but had significantly greater patient satisfaction, lower intraoperative blood loss, and shorter hospital lengths of stay. Some of the larger trials included in the systematic review, along with larger trials on cervical disc herniation, are described in greater detail next.
**Randomized Controlled Trials**

A 1999 RCT by Hermantin et al. was rated with a low risk of bias in the 2014 Cochrane review. (19) Sixty patients who had objective evidence of a single intracranialcular herniation of a lumbar disc were randomized into 2 groups: endoscopic microdiscectomy or open laminotomy and discectomy. A similar percentage of patients were considered to have a satisfactory outcome (97% of the microendoscopic group, 93% of the open group). The mean duration of use of narcotics (7 vs. 25 days) and return to work (27 vs. 49 days) were significantly less in the microendoscopic group. This study is limited by the lack of validated outcome measures.

In 2008 and 2009, Ruetten et al. published 4 RCTs comparing outcomes from full-endoscopic discectomy with conventional techniques in the lumbar and cervical spine. (20-23) All of the studies were randomized or quasi-randomized, with assignment described as either the order of presentation or by balanced block randomization. Follow-up examinations were conducted at day 1 and at months 3, 6, 12, and 24 by doctors who were not involved in the operations. The studies were not blinded due to observable differences in the surgical approaches.

In one study, 200 patients with clinically-symptomatic lateral cervical disc herniation were assigned to decompression via endoscopic posterior cervical foraminotomy or conventional microsurgical anterior cervical discectomy and fusion (ACDF). (20) Patients with medial localization of the disc herniation were excluded. At 24 months after surgery, 175 patients (88%) were available for follow-up. Fifteen patients were lost to follow-up, and 10 patients had a revision with conventional ACDF due to persistent arm pain, recurrences, or failure of the implant (6 endoscopic patients, 4 ACDF). Postoperative pain was significantly reduced in the endoscopic group (data not reported), and the postoperative work disability was shorter (19 vs. 34 days). Other clinical outcomes (VAS for neck and arm pain, a German version of the North American Spine Society (NASS) Instrument (Hilibrand criteria) were similar in the 2 groups throughout the 24-month follow-up.

A 2009 report compared anterior endoscopic discectomy with ACDF in 120 patients with mediolateral cervical disc herniations. (23) The duration of pain ranged from 4 to 128 days. The mean operating time was 32 minutes for endoscopic discectomy compared with 62 minutes for ACDF. In the endoscopic discectomy group, bone resection was required to reach the epidural space or the foramen in 55% of cases. At 24 months, 103 patients (86%) were available for follow-up examinations. The revision rate was 6.1% for ACDF and 7.4% for endoscopic discectomy; these were not significantly different. Excluding 4 patients who were revised by ACDF, 85 patients (85.9%) had no arm pain; there were no significant differences in clinical outcomes between the 2 groups. Advantages and disadvantages of the anterior endoscopic approach were discussed, including a difficult learning curve.

Another study compared full-endoscopic interlaminar or transforaminal lumbar discectomy versus conventional microdiscectomy for clinically-symptomatic lumbar disc herniation in 200 patients. (21) The duration of pain ranged from 1 day to 16 months (mean, 82 days), and all forms of disc herniation were included in the study (random assignment to the treatment group). The particular endoscopic approach (interlaminar or transforaminal) was determined by the location of the herniation. The mean operating time for endoscopic discectomy was approximately half that of conventional microdiscectomy (22 vs. 43 minutes). Access-related osseous resection was required in 91 cases (91%) of the microdiscectomy group and 13 cases (13%) of the endoscopic group. The complication rate was significantly greater in the microdiscectomy group, with 1 delayed wound-healing, 1 soft tissue infection, and 3 cases of transient urinary retention. Postoperative pain and pain medication were significantly reduced in the endoscopic group (data not reported), and the postoperative work disability was shorter (25 vs. 49 days). At 24 months after surgery, 178 patients (89%) were available for follow-up. The 2 groups had similar improvement in leg pain; 79% of microdiscectomy and 85% of endoscopic discectomy patients reported being pain-free. More patients in the microdiscectomy group (5% vs. 1%) underwent revision spinal canal expansion and fusion.

A fourth study by Ruetten et al. compared revision endoscopic interlaminar or transforaminal lumbar discectomy versus conventional microdiscectomy in 100 patients who had recurrent lumbar disc herniation after conventional discectomy. (22) Patients were enrolled who had undergone previous conventional discectomy, presented with acute occurrence of radicular leg symptoms on the same side after a pain-free interval, and who showed a recurrent disc herniation in the same level by magnetic resonance imaging. The duration of pain ranged from 1 day to 13 months. Seventy-nine patients (79%) had received a mean of 9 weeks of conservative treatment. Due to limited technical mobility, criteria for the endoscopic transfaraminal approach included sequestering of material between the cranial and caudal pedicle. Operating time was significantly shorter with the endoscopic approach (24 vs. 58 minutes), and access-related osseous resection was required in 3 cases (6%) of the endoscopic group.
compared with 47 cases (94%) of the microdiscectomy group. There were 4 cases of dura injury (3 microdiscectomy and 1 endoscopic discectomy) and an overall serious complication rate that was significantly greater (21% vs. 6%) for the microdiscectomy group. Post-operative pain and pain medication were significantly reduced in the endoscopic group, as was postoperative work disability (28 vs. 52 days). At 24 months, 87 patients (87%) were available for follow-up. Seventy-nine percent had no leg pain at follow-up; there was no significant difference between the groups for any of the clinical outcomes (VAS, NASS Instrument, ODI).

In 2010, Teli et al. reported an RCT of micro-endoscopic interlaminar lumbar discectomy compared with microdiscectomy or open discectomy in 240 patients with posterior lumbar disc herniation. (16) Most herniations (60%) were extrusions. Group assignment was randomized but was revealed to the patients before the surgery due to a requirement of the local ethics committee. Laminotomy, medial facetectomy when needed, and nerve root retraction followed by discectomy were performed identically in the three groups. Surgeons had at least 5 years of experience in all of the operative techniques. The average surgical time was longer in the endoscopic group (56 minutes) compared with micro- or open discectomy (43 and 36 minutes, respectively). Follow-up assessments were performed at 6, 12, and 24 months by an independent investigator; 212 patients (91%) completed the 24-month evaluation. Intention-to-treat analysis showed no significant difference in the outcome variables (VAS, ODI, SF-36). The endoscopic procedure resulted in an increase in dural tears (8.7% vs. 2.7% or 3%), root injuries (3% vs. 0% or 0%), and recurrent herniations (11.4% vs. 4.2% or 3%) compared with the microdiscectomy or open approach, although these were not statistically different.

Garg et al. reported a randomized trial of microendoscopic lumbar discectomy versus open discectomy in 112 patients with a single-level disc herniation. (17) The report did not describe the method of randomization or whether patients or assessors were blinded. Surgical time was significantly greater in the endoscopic group (84 vs. 56 minutes) while blood loss (41 vs. 306 mL) and hospital stay (3 vs. 12 days) were reduced. Outcomes on the ODI were similar at baseline (25.78 endoscopic and 21.02 open discectomy) and all follow-up visits through 1 year postoperatively (1.75 endoscopic and 2.14 open discectomy).

Eight-year follow-up from a quasi-randomized controlled trial of endoscopic lumbar discectomy versus open discectomy was reported by Hussein et al. in 2014. (24) The study included 185 patients with a large uncontained lumbar disc herniation. Operative time was similar in the 2 groups. After surgery, the mean length of stay was 10.4 hours for the endoscopic group and 82.38 hours (3.5 days, p<0.05) for the open group. The mean time to return to work/normal activities after endoscopic surgery (8.5 days) was significantly shorter than after open surgery (31.4 days, p<0.05). The percentage of adverse events was similar between the 2 groups, and 8.1% of patients in each group required reoperation during the follow-up. Leg pain, back pain, and ODI scores (1.05, 1.43, 21.5%, respectively) remained improved over the 8 years of follow-up in the endoscopic group, while the open group had a deterioration of back pain (7.53) and ODI scores (59.6%) over the same time period.

**Observational Studies**
A number of observational studies have been reported, including studies of the learning curve, (25-27) and longer-term follow-up. (28-30) The largest and longest follow-up to date is from Choi et al, who reported their experience with 10,228 patients at their institution who had undergone percutaneous endoscopic lumbar discectomy over a 12-year period. (30) They found that 4.3% of cases required reoperation in the first 6 weeks due to incomplete removal of herniated discs (2.8%), recurrence (0.8%), persistent pain (0.4%), and approach-related pain (0.2%).

**Ongoing and Unpublished Clinical Trials**
Some currently unpublished trials that might influence this review are listed in Table 1.

**Table 1. Summary of Key Trials**

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
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<tr>
<td>Ongoing</td>
<td></td>
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<tr>
<td>NCT02358291</td>
<td>Microendoscopic Discectomy Vs Transforaminal Endoscopic Lumbar Discectomy</td>
<td>240</td>
<td>Mar 2017</td>
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<td>NCT02441959</td>
<td>Full-Endoscopic vs Open Discectomy for the Treatment of Symptomatic Lumbar</td>
<td>200</td>
<td>Jul 2017</td>
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<tr>
<td></td>
<td>Herniated Disc: A Prospective Multi-Center Randomized Study</td>
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</table>
Summary of Evidence
The evidence for automated percutaneous discectomy in individuals who have herniated intervertebral discs includes randomized controlled trials (RCTs) and systematic reviews of RCTs. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment related morbidity. The published evidence is insufficient to evaluate the impact of automated percutaneous discectomy on the net health outcome. Well-designed and executed RCTs are needed to determine the benefits and risks of this procedure. In addition, evidence from small RCTs does not support the use of these procedures. The evidence is insufficient to determine the effects of the technology on health outcomes.

The evidence for endoscopic discectomy in individuals who have herniated intervertebral discs includes a number of RCTs and systematic reviews of RCTs. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment related morbidity. Many of the RCTs were conducted at a single center in Europe. While some trials reported outcomes at least as good as traditional approaches, an RCT from a different center in Europe reported a trend toward increased complications and reherniations with an endoscopic approach. There are few reports from the United States. It is notable that there are a number of moderately large RCTs that will be completed in the next couple of years. The evidence is insufficient to determine the effects of the technology on health outcomes.

Clinical Input Received From Physician Specialty Societies and Academic Medical Centers
While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests, input was received from 4 physician specialty societies and 3 academic medical centers while this policy was under review in 2013. Overall, the input agreed that percutaneous and endoscopic discectomy are investigational. Most reviewers considered discectomy with tubular retractors to be a variant of open discectomy, with the only difference being the type of retraction used.

Practice Guidelines and Position Statements
National Institute for Health and Clinical Excellence
The National Institute for Health and Clinical Excellence published guidance in 2005 on automated percutaneous mechanical lumber discectomy, indicating that there is limited evidence of efficacy based on uncontrolled case series of heterogeneous groups of patients, and evidence from small RCTs shows conflicting results. (31) The guidance states that in view of uncertainty about the efficacy of the procedure, it should not be done without special arrangements for consent and for audit or research.

A NICE guideline on percutaneous transforaminal endoscopic lumbar discectomy for sciatica went in development (GID-IP1223) in March 2016.

American Society of Interventional Pain Physicians
The 2013 guideline update from the American Society of Interventional Pain Physicians states that the evidence for percutaneous disc decompression with Dekompressor is limited. (13) There were no recommended indications
for DeKompressor.

**American Pain Society**
The 2009 clinical practice guidelines from the American Pain Society found insufficient evidence to evaluate alternative surgical methods to standard open discectomy and microdiscectomy, including laser or endoscopic-assisted techniques, various percutaneous techniques, Coblation nucleoplasty, or the Disc Dekompressor. (32)

**U.S. Preventive Services Task Force Recommendations**
Not applicable.

**Medicare National Coverage**
There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.

**References**


Appendix

N/A
### History

<table>
<thead>
<tr>
<th>Date</th>
<th>Reason</th>
</tr>
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<tr>
<td>01/97</td>
<td>Add to Surgery Section - New Policy</td>
</tr>
<tr>
<td>08/13/02</td>
<td>Replace Policy - Policy reviewed without literature review; new review date only</td>
</tr>
<tr>
<td>07/13/04</td>
<td>Replace Policy - Policy reviewed with literature review; new review date only</td>
</tr>
<tr>
<td>06/14/05</td>
<td>Replace Policy - Policy revised with literature review; now considered investigational; references provided. Status changed to BC. Title changed by removing Lumbar. Hold for notification; publish 11/1/05.</td>
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<tr>
<td>06/16/06</td>
<td>Replace Policy - Policy reviewed with literature search; no change in policy statement; Scope and Disclaimer updated.</td>
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<td>Cross Reference Update - No other changes</td>
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<td>10/14/08</td>
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<td>Replace Policy - Policy updated with literature search; no change to the policy statement. References added.</td>
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<td>05/10/11</td>
<td>Replace Policy - Policy updated with literature review, rationale section extensively revised, no change in policy statement. Title changed to “Automated Percutaneous Discectomy”. ICD-10 codes added to policy.</td>
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<td>04/10/12</td>
<td>Replace policy. Endoscopic discectomy added to policy with literature review through October 2011; Rationale revised; references added and reordered; 1 reference removed; title changed to “Automated Percutaneous and Endoscopic Discectomy”. Endoscopic discectomy is considered investigational.</td>
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<tr>
<td>09/26/12</td>
<td>Update Related Policies – Add 7.01.126; ICD-10 codes are now effective 10/01/2014.</td>
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<tr>
<td>06/10/13</td>
<td>Replace policy. Policy updated with literature review through January 9, 2013; references added and reordered; clinical input reviewed; policy statement clarified to read “back pain and/or radiculopathy”.</td>
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<tr>
<td>09/30/13</td>
<td>Update Related Policies. Change title to 7.01.72 and 7.01.93.</td>
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<tr>
<td>01/21/14</td>
<td>Update Related Policies. Add 7.01.551.</td>
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<tr>
<td>03/11/14</td>
<td>Coding Update. Code 80.59 was removed per ICD-10 mapping project; this code is not utilized for adjudication of policy.</td>
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<td>06/19/14</td>
<td>Annual Review. Policy updated with literature review through March 27, 2014; references 13-14 and 18 added; policy statements unchanged. Diagnosis and procedure codes removed (ICD-9 and ICD-10) – performed outpatient.</td>
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<tr>
<td>06/17/15</td>
<td>Annual Review. Policy updated with literature review through March 23, 2015; references 17-18, 27, and 34 added; policy statements unchanged. CPT codes 0274T and 0275T added to the policy Coding section.</td>
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<tr>
<td>08/25/15</td>
<td>Update Related Policies. Remove deleted policy 7.01.537.</td>
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<tr>
<td>06/14/16</td>
<td>Annual Review. Policy updated with literature review through February 23, 2016; references 10 and 18 added. Policy statements unchanged.</td>
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U.S. Department of Health and Human Services
200 Independence Avenue SW, Room S9FF, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at:

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost.
Call 800-722-1471 (TTY: 800-842-5357).

Arabic (Amharic):
لا يوجد هذا الإشعار ملاحظات. قد يكون هذا الإشعار معلومات مهمة يوصى بك الحصول عليه من خلال Premera Blue Cross. في هذا الإشعار، قد تحتاج لإجراءات في ترميم حساباتك على حساباتك المصرفية أو التأمين 
قريبك. لا يوجد هذا الإشعار معلومات مهمة يوصى بك الحصول عليها من خلال Premera Blue Cross.
Call 800-722-1471 (TTY: 800-842-5357).

中文 (Chinese):
本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross 提交的 申請或保單的重要訊息。本通知可能有重要的日期，您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 800-842-5357).

Oromoo (Cushite):

Français (French):

Kreyòl ayisyen (Creole):

Deutsche (German):

Hmoob (Hmong):

Iloko (Ilocano):
Daytoy a Pakdaak ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaak mabal marga nga adda ket naglaon iti napateg nga impormasion maipanggep iti aksiyonono wynno coverage babaen iti Premera Blue Cross. Daytoy ket mabal mrag importante a petau iti daytoy a pakdaak. Mabal marga nga adda rumbenga nga aramintendo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapatgalainedyo ti coverage ti salun-atyo wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong ti bukodyo a pagasasao nga awan ti bayadanyo. Tumawagi ti numero nga 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian):