UnitedHealthcare Community Plan

Minimally Invasive Spine Surgery Procedures (for North Carolina Only)

Policy Number: CSNCT0364.02
Effective Date: June 1, 2024

➲ Instructions for Use

Table of Contents **Page**

Application ... 1
Coverage Rationale ... 1
Applicable Codes ... 1
U.S. Food and Drug Administration ... 2
References ... 2
Policy History/Revision Information ... 2
Instructions for Use ... 2

Related Policies

- Discogenic Pain Treatment
- Epidural Steroid Injections for Spinal Pain (for North Carolina Only)
- Facet Joint and Medial Branch Block Injections for Spinal Pain (for North Carolina Only)
- Spinal Fusion and Bone Healing Enhancement Products
- Total Artificial Disc Replacement for the Cervical Spine (for North Carolina Only)
- Vertebral Body Tethering for Scoliosis

Application

This Medical Policy only applies to the State of North Carolina.

Coverage Rationale

For medical necessity clinical coverage criteria, refer to the North Carolina Medicaid (Division of Health Benefits) Clinical Coverage Policy, Physician: 1A-30, Spinal Surgeries.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed
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., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar

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CPT Code	Description
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar
22899	Unlisted procedure, spine
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
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar

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HCPCS Code	Description
G0276	Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (PILD) or placebo-control, performed in an approved coverage with evidence development (CED) clinical trial

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

A variety of endoscopes and associated surgical instruments and devices have received marketing clearance through the FDA's 510(k) process. Refer to the following website for more information and search by product name in device name section: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpmn/pmn.cfm.

References

North Carolina Medicaid, Division of Health Benefits, Clinical Coverage Policies, Spinal Surgeries, No: 1A-30. https://medicaid.ncdhhs.gov/1a-30-spinal-surgeries/download?attachment. Accessed January 24, 2023.

Policy History/Revision Information

Date	Summary of Changes
06/01/2024	**Coverage Rationale** • Removed coverage statement **Supporting Information** • Added *FDA* section • Archived previous policy version CSNCT0364.01

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

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