Automated Percutaneous and Percutaneous Endoscopic Discectomy

Policy Number: 7.01.18
Origination: 8/1989
Last Review: 6/2017
Next Review: 6/2018

Policy
Blue Cross and Blue Shield of Kansas City (Blue KC) will not provide coverage for automated percutaneous or endoscopic discectomy. This is considered investigational.

When Policy Topic is covered
Not Applicable

When Policy Topic is not covered
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.

Percutaneous 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.

Considerations
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 discectomies are performed on lumbar vertebrae, Food and Drug Administration labeling of the Stryker Dekompressor Percutaneous Discectomy Probe and the Nucleotome includes the thoracic and cervical vertebrae.

Effective in 2017, there is a specific CPT code for endoscopic decompression:

62380 Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, I interspace, lumbar.
Percutaneous discectomy is also a component of the following CPT codes:

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 (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic

0275T lumbar.

### Description of Procedure or Service

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Surgical management of herniated intervertebral discs most commonly involves discectomy or microdiscectomy, performed manually through an open incision. Automated percutaneous discectomy involves placement of a probe within the intervertebral disc under image guidance with 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, and aspiration of disc material.

For individuals who have herniated intervertebral disc(s) who receive automated percutaneous discectomy, the evidence 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 net health outcomes. Evidence from small RCTs does not support the use of this procedure. Well-designed and executed RCTs are needed to determine the benefits and risks of this procedure. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have herniated intervertebral disc(s) who receive endoscopic percutaneous discectomy, the evidence 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. Some trials have reported outcomes at least as good as traditional approaches with an open incision, while 1 RCT from a different center in Europe reported a trend toward increased complications and reherniations using an endoscopic approach. There are few reports from the United States. Results from a number of moderately large ongoing RCTs are anticipated in the next 2 to 3 years. The evidence is insufficient to determine the effects of the technology on health outcomes.

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 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 some sort 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 (RF) decompression (see separate policy). In addition, intradiscal electrothermal annuloplasty is another minimally invasive approach to low back pain. In this technique, RF energy is used to treat the surrounding disc annulus (see separate policy).

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 transforaminal approach. Following insertion of the endoscope, the decompression is performed under visual control.

Regulatory Status
The DeKompressor Percutaneous Discectomy Probe (Stryker), Herniatome Percutaneous Discectomy Device (Gallini Medical Devices), and the Nucleotome (Clarus Medical) are examples of percutaneous discectomy devices that received clearance from the U.S. Food and Drug Administration (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.”

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

**Rationale**

This evidence review was originally created in December 1995 and has been updated regularly with searches of the MEDLINE database. The review was initially informed by a 1990 TEC Assessment. The most recent literature review was performed through March 6, 2017.

Assessment of efficacy for therapeutic intervention involves a determination of whether an intervention improves health outcomes. The optimal study design for this purpose is a randomized controlled trial (RCT) that includes clinically relevant measures of health outcomes. Intermediate outcome measures, also known as surrogate outcome measures, may also be adequate if there is an established link between the intermediate outcome and true health outcomes. Nonrandomized comparative studies and uncontrolled studies can sometimes provide useful information on health outcomes, but are prone to biases such as noncomparability of treatment groups, placebo effect, and variable natural history of the condition.

A 2014 Cochrane review of literature through November 2013 evaluated 11 studies of minimally invasive discectomy (MID) and compared with microdiscectomy/open discectomy.(1) Included in the MID category: 8 RCTs or quasi-RCTs on percutaneous endoscopic lumbar discectomy, 2 studies on transmuscular tubular microdiscectomy and 1 study on automated percutaneous lumbar discectomy. Seven of the studies had a high risk of bias. For the analysis, the reviewers combined all MID procedures. The authors reported that MID may be inferior in terms of relief of leg pain, low back pain, and re-hospitalization; however, differences in pain relief appeared to be small and may not be clinically important. Potential advantages of minimally invasive discectomy included lower risk of surgical site infection and shorter LOS.

**AUTOMATED PERCUTANEOUS DISCECTOMY**

**Systematic Reviews**

A 2015 systematic review and network meta-analysis by Lewis et al compared trials of 21 different treatment strategies for sciatica.(2) Examples of the 21 treatment strategies included in the analysis are conservative care, disc surgery, intraoperative interventions, epidural injections, biologic agents, and percutaneous discectomy. Under the category name of “percutaneous discectomy,” reviewers combined automated percutaneous discectomy, percutaneous automated nucleotomy, nucleoplasty, and laser discectomy. They searched 28 databases and trial registries through December 2009. Ninety studies were included and 10 involved the percutaneous discectomy category as an intervention. Of the 10, 4 are relevant to this evidence review: 2 case-control studies of percutaneous
endoscopic discectomy (2006, 2007), 1 RCT of percutaneous endoscopic discectomy (1993), and 1 RCT of automated percutaneous discectomy (1995). The remaining studies were published in a foreign language or involved the comparators nucleolysis and chemonucleolysis, rather than open discectomy or microdiscectomy. The global effects odds ratio for the category of percutaneous discectomy compared with inactive control was 0.82 (95% confidence interval [CI], 0.39 to 1.72), which was inferior to disc surgery, epidural injections, and intraoperative interventions. The pain intensity weighted mean difference for the category of percutaneous discectomy compared with inactive control was 11.5 (95% CI, -18.6 to 41.6). Reviewers concluded that there was no support for the effectiveness of percutaneous discectomy for the treatment of sciatica. Due to the inclusion of additional interventions into the broad category of percutaneous discectomy in this review, the relevance of these results for the evidence review is limited.

Two systematic reviews by Manchikanti et al were published in 2013. One review investigated the effectiveness of automated percutaneous lumbar discectomy (APLD), with a search of databases from 1966 to September 2012. (3) Studies were included if the following criteria were met: for RCTs, greater than 50% of the criteria adapted from the Cochrane Back Review Group; for cohort studies, 7 of 10 criteria from the Newcastle-Ottawa Scale (NOS) for assessing quality for cohort studies; and for case-control studies, 5 of 10 criteria from the NOS for case-control studies. No RCTs met the inclusion criteria. Nineteen observational studies met the criteria and were identified for this review. With no RCTs meeting the criteria, meta-analysis could not be performed. Within the 19 observational studies, 5515 patients underwent automated percutaneous discectomy, with 4412 reporting positive results. The range of positive results reported in the studies was 45% to 88%. Despite the large number of studies, the reviewers concluded that the literature was limited, because no RCTs met quality criteria for inclusion and because the most recent study, published in 2010, reported results from a study conducted in 2000-2002. The second review by Manchikanti focused specifically on disc decompression using the Dekompressor. (4) This review used the same criteria described above. No RCTs met the study inclusion criteria, while 3 observational studies met the criteria and were included. Reviewers acknowledged that the Dekompressor appeared to decrease pain, but because meta-analysis could not be conducted, the 3 trials were relatively small (total N=164 patients), and none provided follow-up data beyond 8 years, they concluded that the evidence was limited for use of the Dekompressor device for the treatment of lumbar disc herniation.

Vorobeychik et al (2012) (5) and Singh (2009) (6) also conducted reviews on the Dekompressor. Vorobeychik identified the same 3 observational studies as Manchikanti plus a case series while Singh identified the same observational studies as Manchikanti. The authors of these reviews also concluded that pain relief was achieved, but the evidence lacked sufficient rigor to support conclusions.

In 2009, Hirsch et al published a systematic review on APLD, searching databases from 1966 to April 2009. Cochrane review criteria were used to assess quality of
RCTs (50 of 100 points were needed for inclusion) and Agency for Healthcare Research and Quality criteria (50 of 100 points were needed for inclusion) were used to assess observational studies. Reviewers assessed 4 RCTs and 76 observational studies evaluating APLD.(7) One RCT (by Revel et al [1993]) met inclusion criteria and is detailed in the next section on RCTs.(8) The other 3 RCTs failed to meet study quality criteria. In discussing the results of the Revel trial, which showed a lower success rate than the observational studies, the reviewers noted that APLD might not have been successful in this trial due to inappropriate patient selection, failure to recruit the number of patients indicated by the sample size calculations, and provided follow-up of only 6 months. Ten observational studies met methodologic quality criteria for inclusion. Results were consistent among the observational studies, showing APLD effective among approximately 75% of patients. APLD appears to compare favorably compared with open discectomy, microdiscectomy, and chymopapain injection, though evidence lacked RCTs. The evidence for the use of APLD for short- and long-term pain relief is considered level II-2 (well-designed cohort or case-control studies), using the U.S. Preventive Services Task Force criteria.

Freeman and Mehdian assessed the evidence for 3 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.(9) They reported that trials of automated percutaneous discectomy suggested clinical outcomes are at best fair and often worse than with microdiscectomy.

In 2007, Gibson and Waddell published an updated Cochrane review of surgical interventions for lumbar disc prolapse, concluding that there was insufficient evidence on percutaneous discectomy techniques to draw firm conclusions.(10) In the same year, a task force of the American Society of Interventional Pain Physicians (ASIPP) reported that percutaneous disc decompression remains controversial. Although all observational studies were positive, the evidence from 4 randomized trials was negative.(11) Questions also remain about appropriate patient selection criteria for this procedure, particularly related to the size and migration of the disc herniation.

RCTs are described next. The trials are considered poor quality and, in general, did not meet most inclusion criteria of the above systematic reviews.

**Randomized Controlled Trials**

The 2002 LAPDOG study compared automated percutaneous discectomy with open discectomy in patients with lumbar disc herniation.(12) Enrolled patients had no prior lumbar spinal surgery, no coexistent lumbar spinal disease, and radiographic evidence of disc herniation. The trial was designed to recruit 330 patients but enrolled 36 patients for reasons that were not readily apparent. Twenty-seven patients were available at follow-up, with efficacy reported by 41% of the patients undergoing automated percutaneous discectomy and by 40% of the patients undergoing open discectomy. The authors concluded that “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.”

In 1995, Chatterjee et al reported on 71 patients with lumbar disc herniation randomly assigned to undergo percutaneous discectomy or lumbar microdiscectomy.(13) A satisfactory outcome was reported in 29% of patients undergoing percutaneous discectomy compared with 80% in the microdiscectomy group. The trial was terminated early due to the inferior outcome.

Revel et al compared percutaneous discectomy with chymopapain injection in 141 patients with disc herniation and sciatica in a 1993 randomized trial.(8) Treatment was considered successful in 61% of patients in the chymopapain group and 44% of patients in the percutaneous discectomy group. Thirty-two patients withdrew from the trial, citing therapeutic failure. Within 6 months of the trial, 20% of the patients underwent open laminectomy.

No additional RCTs have been identified since the 2002 LAPDOG study. All trials have focused on lumbar disc herniation. There were no RCTs of percutaneous discectomy for cervical or thoracic disc herniation. A 2013 review of the evidence from ASIPP 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.”(14)

**Section Summary: Automated Percutaneous Discectomy**

The evidence for automated percutaneous discectomy in individuals who have herniated intervertebral disc(s) includes small randomized controlled trials (RCTs) and systematic reviews of RCTs. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment related morbidity. Evidence from small RCTs does not support the use of this procedure. Well-designed and executed RCTs are needed to determine the benefits and risks of this procedure. The evidence is insufficient to determine the effects of the technology on health outcomes.

**PERCUTANEOUS ENDOSCOPIC DISCECTOMY**

**Systematic Reviews**

In 2017, Phan et al published a systematic review and meta-analysis comparing full endoscopic discectomy (FED) and micro-endoscopic discectomy (MED) with open discectomy for the treatment of lumbar disc herniation.(15) A database search through February 2016 identified 23 studies for inclusion. FED was favorable compared with open discectomy in surgery duration, hospital length of stay (LOS), and blood loss. MED was favorable compared with open discectomy in LOS and blood loss. Both endoscopic procedures were comparable to open discectomy as measured on a visual analog scale (VAS) for leg pain and Oswestry Disability Index (ODI) score. In terms of patient satisfaction, FED was more favorable than open discectomy and MED was comparable to open discectomy.
A 2016 systematic review and meta-analysis published by Li et al compared FED with traditional discectomy surgery. (16) The search was conducted in January 2015 and resulted in the inclusion of 4 RCTs and 2 non-RCTs. FED for herniation (both cervical and lumbar) was favorable compared with traditional discectomy in operative duration, blood loss, LOS, and return to work days. Clinical outcomes were comparable between FED and traditional discectomy.

A 2016 meta-analysis identified 9 RCTs (total N=1092 patients) through August 2014 that compared endoscopic to open discectomy for lumbar disc herniation. (17) Endoscopic discectomy resulted in clinical outcomes similar to open discectomy, but had significantly greater patient satisfaction, lower intraoperative blood loss, and shorter LOS.

In 2013, Smith et al published a systematic review of endoscopic discectomy for lumbar disc herniation. (18) A search for controlled trials published through September 2012 identified 4 RCTs. None found a significant difference in ODI scores for endoscopic discectomy compared to open discectomy or microdiscectomy. The largest study (Teli et al [2010], described below; N=240) reported an increase in the number of severe complications in the microendoscopic discectomy group. (19) Another study (Garg et al [2011], also described below; N=112) found a shorter hospital stay with no significant changes in ODI scores or complication rates but recommended that microendoscopic discectomy not be attempted without appropriate training. (20) The 2 other trials included in the review were small with 22 and 40 patients.

Several of the larger trials included in the systematic reviews above, larger trials on cervical disc herniation, and trials published subsequent to the systematic review literature searches are described in the next section.

**Randomized Controlled Trials**

In 2017, Gibson et al published an RCT comparing transforaminal endoscopic discectomy (TED) with microdiscectomy. (21) Patients with single-level lumbar prolapse and radiculopathy were randomized to TED under conscious sedation (n=70) or to microdiscectomy under general anesthesia (n=70). Both procedures resulted in comparable improvements in outcomes (ODI scores, VAS back pain, VAS leg pain, SF-36 scores) at 3 months, 1 year, and 2 years compared with baseline.

Eight-year follow-up from a quasi-RCT assessing endoscopic lumbar discectomy and open discectomy was reported by Hussein et al in 2014. (22) The trial included 185 patients with a large uncontained lumbar disc herniation. Surgery times were similar for both groups. After surgery, mean LOS was 10.4 hours for the endoscopic group and 82.38 hours (p<0.05) for the open group. 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 percentages of adverse events were similar between groups, and 8.1% of patients in each group required reoperation during the follow-up. Improvements in leg pain, back pain, and ODI scores (1.05, 1.43, 21.5%, respectively) persisted at 8 years in the
endoscopic group, but deteriorated for back pain (7.53) and ODI scores (59.6%) in the open group.

Garg et al (2011) reported a trial randomizing 112 patients with a single-level disc herniation to microendoscopic lumbar discectomy or open discectomy.(20) The method of randomization and whether patients and assessors were blinded were not reported. Surgical time was significantly longer in the endoscopic group (84 minutes vs 56 minutes) while blood loss (41 mL vs 306 mL) and hospital LOS (3 days vs 12 days) were reduced. ODI scores were similar at baseline (endoscopic, 25.78; open discectomy, 21.02) and all follow-up visits through 1 year postoperatively (endoscopic; 1.75; open discectomy 2.14).

In 2010, Teli et al reported an RCT comparing endoscopic discectomy to microdiscectomy or open discectomy in 240 patients with posterior lumbar disc herniation.(19) Most herniations (60%) were extrusions. The average surgical time was longer in the endoscopic group (56 minutes) than in the micro- or open discectomy groups (43 minutes and 36 minutes, respectively). Follow-up assessments were performed at 6, 12, and 24 months by an independent investigator; 212 (91%) patients completed the 24-month evaluation. Intention-to-treat analysis showed no significant difference in the outcome variables (VAS, ODI, and SF-36 scores). The endoscopic procedure led to more 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%) than the microdiscectomy or open approaches, although differences were not statistically significant.

In 2008 and 2009, Ruetten et al published 4 RCTs comparing full endoscopic discectomy with conventional techniques in the lumbar and cervical spine.(23-26) All studies were randomized or quasi-randomized, with assignment described as either order of presentation or balanced block. Follow-up examinations were conducted at day 1 and at months 3, 6, 12, and 24 by physicians not involved in the surgeries. The studies were not blinded due to observable differences in the surgical approaches. The four trials are described below:

- Patients with mediolateral cervical disc herniations (N=120) were randomized to full endoscopic anterior decompression (FACD) or to conventional anterior cervical decompression with fusion (ACDF). Mean surgery time was 32 minutes for FACD and 62 minutes for ACDF. At 24 months, 103 (86%) patients were available for follow-up examinations. Revision rates for ACDF (6.1%) and FACD (7.4%) did not differ significantly. There were no significant differences in clinical outcomes (pain, VAS arm, VAS neck) between groups.
Patients with clinically symptomatic lateral cervical disc herniation (N=200) were assigned to full endoscopic posterior cervical foraminotomy (FPCF) or conventional microsurgical anterior cervical discectomy and fusion (ACDF). At 24 months postsurgery, 175 (88%) patients were available for follow-up. Ten patients had a revision due to persistent arm pain, recurrences of herniation, or failure of the implant (6 endoscopic patients, 4 ACDF). Postoperative pain was significantly reduced in the endoscopic group (data not reported), and postoperative work disability was shorter (19 days vs 34 days). Other clinical outcomes (VAS scores for neck and arm pain, a German version of the North American Spine Society [NASS] Instrument [Hilibrand criteria]) were similar between groups throughout the 24-month follow-up.

Patients with clinically symptomatic lumbar disc herniation (N=200) were randomized to full endoscopic discectomy or to conventional microdiscectomy. Mean surgery time for endoscopic discectomy (22 minutes) was nearly 50% faster than for conventional microdiscectomy (43 minutes), and the complication rate was significantly lower. Postoperative pain and pain medication were significantly reduced in the endoscopic group (data not reported), and the postoperative work disability was shorter (25 days vs 49 days). At 24 months after surgery, 178 (89%) patients were available for follow-up. The 2 groups had similar improvements in leg pain, with 85% of endoscopic discectomy and 79% of microdiscectomy patients reporting being pain-free. More patients in the microdiscectomy group (5% vs 1%) underwent revision spinal canal expansion and fusion.

Patients with recurrent lumbar disc herniation following conventional discectomy who were in need of a revision (N=100) were randomized to full endoscopic discectomy or to conventional microdiscectomy. Surgery time was significantly shorter with the endoscopic approach (24 minutes vs 58 minutes), and access-related osseous resection was much less frequent in the endoscopic group (3 [6%] cases vs 47 [94%] cases). There were 4 cases of dura injury (1 endoscopic discectomy, 3 microdiscectomy). Overall serious complication rates were significantly greater in the microdiscectomy group (21% vs 6%). Postoperative pain and pain medication were significantly reduced in the endoscopic group, as was postoperative work disability (28 days vs 52 days). At 24 months, 87 (87%) patients were available for follow-up. Seventy-nine percent had no leg pain at follow-up, and there were no significant differences between groups in clinical outcomes (VAS, NASS Instrument, ODI scores).

A 1999 RCT by Hermantin et al(27) was rated as having a low risk of bias in the 2014 Cochrane review. Sixty patients who had objective evidence of a single intracanalicular 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 vs 93% of the open group). The mean duration of narcotic pain-relief use (7 days vs 25 days) and return to work (27 days vs 49 days) were significantly lower in the microendoscopic group. This study did not use validated outcome measures.
**Observational Studies**

In 2016, Gotecha et al published a prospective study on the use of transforaminal percutaneous endoscopic lumbar discectomy (TPELD) for the treatment of lumbar disc herniation.(28) Efficacy and limitations of the procedure were studied on 120 patients with lumbar disc herniation. Using McNab criteria, 89% achieved excellent (no pain or restrictions) or good (occasional back/leg pain) status at 6 months of follow-up. The authors noted that a limitation of the procedure is that in operating on patients with L5-S1 lumbar disc herniation, the iliac crest may interfere with the angle necessary to perform the discectomy successfully.

A number of observational studies have assessed the learning curve(29-31) and the need for longer follow-up of endoscopic discectomy.(32-34) The largest and longest follow-up to date has been reported by Choi et al (2015), who examined 10,228 patients at their institution who had had endoscopic lumbar discectomy over a 12-year period.(34) 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%).

**Section Summary: Percutaneous Endoscopic Discectomy**

The evidence for percutaneous endoscopic discectomy in individuals who have herniated intervertebral disc(s) 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. Some trials have reported outcomes at least as good as traditional approaches with an open incision, while an RCT from a different center in Europe reported a trend toward increased complications and reherniations using an endoscopic approach. There are few reports from the United States. Reporting from a number of moderately large ongoing RCTs is anticipated in the next 2 to 3 years. The evidence is insufficient to determine the effects of the technology on health outcomes.

**SUMMARY OF EVIDENCE**

For individuals who have herniated intervertebral disc(s) who receive automated percutaneous discectomy, the evidence 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 net health outcomes. Evidence from small RCTs does not support the use of this procedure. Well-designed and executed RCTs are needed to determine the benefits and risks of this procedure. The evidence is insufficient to determine the effects of the technology on health outcomes.

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Europe reported a trend toward increased complications and reherniations using an endoscopic approach. There are few reports from the United States. Results from a number of moderately large ongoing RCTs are anticipated in the next 2 to 3 years. The evidence is insufficient to determine the effects of the technology on health outcomes.

**CLINICAL INPUT 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 Care Excellence**

The National Institute for Health and Care Excellence (NICE) published guidance in 2005 on automated percutaneous mechanical lumbar discectomy, indicating that there was limited evidence of efficacy based on uncontrolled case series of heterogeneous groups of patients, and evidence from small RCTs showed conflicting results. The guidance indicated 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. The guidance was considered for review in 2009, but did not meet the review criteria; the 2005 guidance is therefore considered current.

A NICE guidance on percutaneous transforaminal endoscopic lumbar discectomy for sciatica was published in 2016. The guidance has stated that current evidence is adequate to support the use of percutaneous transforaminal endoscopic lumbar discectomy for sciatica. Choice of operative procedure (open discectomy, microdiscectomy, or percutaneous endoscopic approaches) may be influenced by symptoms, and location and size of prolapsed disc.

A NICE guidance on percutaneous interlaminar endoscopic lumbar discectomy for sciatica was published in 2016. The guidance stated that current evidence is adequate to support the use of percutaneous interlaminar endoscopic lumbar discectomy for sciatica. Choice of operative procedure (open discectomy, microdiscectomy, or percutaneous endoscopic approaches) may be influenced by symptoms, and location and size of prolapsed disc.
American Society of Interventional Pain Physicians
The 2013 guidelines from the American Society of Interventional Pain Physicians indicated that the evidence for percutaneous disc decompression with Dekompressor was limited. (14) There were no recommended indications for Dekompressor.

North American Spine Society
In 2014, the North American Spine Society published clinical guidelines on the diagnosis and treatment of lumbar disc herniation. (38) Table 1 summarizes recommendations specific to endoscopic percutaneous discectomy and automated percutaneous discectomy.

Table 1. NASS Recommendations for Lumbar Disc Herniation With Radiculopathy

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<td>Endoscopic percutaneous discectomy is suggested for carefully selected patients to reduce early postoperative disability and reduce opioid use compared with open discectomy.</td>
<td>B</td>
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<tr>
<td>There is insufficient evidence to make a recommendation for or against the use of automated percutaneous discectomy compared with open discectomy.</td>
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<tr>
<td>Endoscopic percutaneous discectomy may be considered for treatment.</td>
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</tr>
<tr>
<td>Automated percutaneous discectomy may be considered for treatment.</td>
<td>C</td>
</tr>
<tr>
<td>Patients undergoing percutaneous endoscopic discectomy experience better outcomes if &lt;40 years and symptom duration &lt;3 months.</td>
<td>II</td>
</tr>
</tbody>
</table>

a Grade B: fair evidence (level II or III studies with consistent findings; grade C: poor quality evidence (level IV or V studies).
b Level of evidence II: lesser quality randomized controlled trial (eg, <80% follow-up, no blinding, or improper randomization), prospective comparative study, systematic review of level II studies or level I studies with inconsistent results; level of evidence III: case control, retrospective, systematic review of level III studies; level of evidence IV: case series; level of evidence V: expert opinion.

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 Dekompressor. (39)

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.

ONGOING AND UNPUBLISHED CLINICAL TRIALS
Currently unpublished trials that might influence this review are listed in Table 2.
<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT02441959</td>
<td>Full-Endoscopic vs Open Discectomy for the Treatment of Symptomatic Lumbar Herniated Disc: A Prospective Multi-Center Randomized Study</td>
<td>200</td>
<td>Jul 2017</td>
</tr>
<tr>
<td>NCT01622413a</td>
<td>Transforaminal Endoscopic Surgery Cost Outcome Research Trial (TESCORT)</td>
<td>200</td>
<td>Sep 2018</td>
</tr>
<tr>
<td>NCT02742311</td>
<td>EuroPainClinics® Study V Prospective Observational Study (EPCSV)</td>
<td>500</td>
<td>Jan 2019</td>
</tr>
<tr>
<td>NCT02602093</td>
<td>(Cost) Effectiveness of Percutaneous Transforaminal Endoscopic Discectomy vs. Open Microdiscectomy for Patients With Symptomatic Lumbar Disc Herniation</td>
<td>682</td>
<td>Dec 2019</td>
</tr>
<tr>
<td>NCT01997086</td>
<td>Percutaneous Transforaminal Endoscopic Discectomy (PTED) Versus Microendoscopic Discectomy (MED) for the Treatment of Lumbar Disc Herniation: A Prospective Randomized Controlled Study</td>
<td>345</td>
<td>Aug 2023</td>
</tr>
<tr>
<td><strong>Unpublished</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT02358291</td>
<td>Microendoscopic Discectomy Vs Transforaminal Endoscopic Lumbar Discectomy Vs Open Discectomy for the Treatment of Lumbar Disc Herniation</td>
<td>240</td>
<td>Mar 2017 (unknown)</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.
a Denotes industry-sponsored or cosponsored trial.

References:


Billing Coding/Physician Documentation Information

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>62287</td>
<td>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</td>
</tr>
<tr>
<td>62380</td>
<td>Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar</td>
</tr>
<tr>
<td>63056</td>
<td>Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc</td>
</tr>
<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 (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic</td>
</tr>
<tr>
<td>0275T</td>
<td>Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous</td>
</tr>
</tbody>
</table>
resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar

C2614 Probe, percutaneous lumbar discectomy

**ICD-10 Codes**

- **M51.06** Intervertebral disc disorder with myelopathy, lumbar region
- **M51.07** Intervertebral disc disorder with myelopathy, lumbosacral region
- **M51.36** Other intervertebral disc degeneration, lumbar region
- **M51.37** Other intervertebral disc degeneration, lumbosacral region

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 discectomies are performed on lumbar vertebrae, Food and Drug Administration labeling of the Stryker Dekompressor Percutaneous Discectomy Probe and the Nucleotome includes the thoracic and cervical vertebrae.

Effective in 2017, there is a specific CPT code for endoscopic decompression: 62380 Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, I interspace, lumbar.

Percutaneous discectomy is also a component of the following CPT codes:

- **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 (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic 0275T lumbar.

**Additional Policy Key Words**

N/A

**Policy Implementation/Update Information**

- **8/1/89** New policy added to Surgery section as a medically necessary procedure to a single lumbar disc.
- **8/1/00** No policy statement changes.
- **8/1/01** No policy statement changes.
- **8/1/02** No policy statement changes.
- **8/1/03** Policy placed in Archives.
- **1/1/05** Policy removed from Archives. Policy statement updated to remove single level lumbar criteria.
- **7/1/05** Policy statement updated to indicate this procedure is considered investigational.
- **1/1/06** No policy statement changes.
1/1/07  No policy statement changes. Title changed to: Percutaneous Discectomy (formerly: Percutaneous Lumbar Discectomy).

1/1/08  No policy statement changes.

1/1/09  No policy statement changes.

1/1/10  No policy statement changes. Title changed to: Automated Percutaneous Discectomy (formerly: Percutaneous Discectomy).

1/1/11  No policy statement changes.

1/1/12  No policy statement changes. Coding updated.

2/1/12  Endoscopic discectomy added to policy; title changed to “Automated Percutaneous and Endoscopic Discectomy”. Endoscopic discectomy is considered investigational.

1/1/13  No policy statement changes.

3/1/13  No policy statement changes.

3/1/14  No policy statement changes.

6/1/14  Added "and/or radiculopathy" to investigational policy statement. Added codes 0274T, 0275T, C2614.

6/1/15  No policy statement changes.

6/1/16  No policy statement changes.


State and Federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The medical policies contained herein are for informational purposes. The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents Blue KC and are solely responsible for diagnosis, treatment and medical advice. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, photocopying, or otherwise, without permission from Blue KC.