ND

Medical Policies

Print

Policy Number:	S-159		
Policy Name:	Nucleoplasty and Biacuplasty		
Policy Type:	Medical	**Policy Subtype:**	Surgery
Effective Date:	09-15-2025	**End Date:**	11-02-2025

Description

Nucleoplasty is a minimally invasive percutaneous procedure performed under local anesthesia that was developed as an alternative to open discectomy for treatment of chronic back pain related to disc herniation. Nucleoplasty may also be referred to as decompression nucleoplasty or plasma disc decompression.

Biacuplasty is a minimally invasive percutaneous procedure performed under local anesthesia for the treatment of chronic discogenic pain originating from annular fissures or contained disc herniation.

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of processing, regardless of service date; or

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

Nucleoplasty

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of processing, regardless of service date.

Nucleoplasty is considered experimental/investigational and therefore non-covered because the safety and/or effectiveness of this service cannot be established by the available peer-reviewed literature.

Procedure Code

S2348

Biacuplasty

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

Biacuplasty is considered experimental/investigational and therefore non-covered because the safety and/or effectiveness of this service cannot be established by the available peer-reviewed literature.

Procedure Code

64999

Criteria

Coverage is subject to the specific terms of the member's benefit plan.

Professional Statements and Societal Positions Guidelines

Not Applicable

Diagnosis Codes

Not Applicable for this policy

CURRENT CODING

CPT:

64999	UNLISTED PROCEDURE NERVOUS SYSTEM	Medicaid Expansion
64999	UNLISTED PROCEDURE NERVOUS SYSTEM	Commercial

HCPCS:

S2348	Decompress disc rf lumbar	Medicaid Expansion
S2348	Decompress disc rf lumbar	Commercial

References

1. National Institute for Health and Care Excellence (NICE). Percutaneous coblation of the intervertebral disc for low back pain and sciatica. 2016. Accessed January 16, 2018.
2. Cincu R, Lorente F de A, Gomez J, Eiras J, Agrawal A. One decade follow up after nucleoplasty in the management of degenerative disc disease causing low back pain and radiculopathy. *Asian Journal of Neurosurgery.* 2015;10(1):21-25.
3. Ren D-J, Liu X-M, Du S-Y, Sun T-S, Zhang Z-C, Li F. Percutaneous Nucleoplasty Using Coblation Technique for the Treatment of Chronic Nonspecific Low Back Pain: 5-year Follow-up Results. *Chinese Medical Journal.* 2015;128(14):1893-1897.
4. Eichen PM, Achilles N, Kirchner R, et al. Nucleoplasty, a minimally invasive procedure for disc decompression: a systematic review and meta-analysis of published clinical studies. *Pain Physician [serial online]*. 2014;17(2):E149-E173.
5. Yang B, Xie J, Yin B, Wang L, Fang S, et al. Treatment of cervical disc herniation through percutaneous minimally invasive techniques. *Eur Spine J*. 2014;23(2):382-388.
6. Desai MJ, Kapural L, Petersohn JD, Vallejo R, Menzies R, et al. Twelve-month follow-up of a randomized clinical trial comparing intradiscal biacuplasty to conventional medical management for discogenic lumbar back pain. *Pain Med.* 2017;18(4):751-763.

ND Committee Review

Internal Medical Policy Committee 1-22-2020 annual review ***Effective March 2, 2020***

Internal Medical Policy Committee 7-22-2020 No change in criteria ***Effective September 7,2020***

Internal Medical Policy Committee 7-22-2021 Annual Review - No changes in criteria ***Effective September 6, 2021***

Internal Medical Policy Committee 7-21-2022 Annual Review - No changes in criteria ***Effective September 5, 2022***

Internal Medical Policy Committee 7-26-2023 Annual Review - No changes in criteria ***Effective September 4, 2023***

Internal Medical Policy Committee 7-16-2024 Annual Review - No changes in criteria ***Effective September 2,2024***

- *Added* coverage statement; and
- *Added* Policy Application

Disclaimer

Current medical policy is to be used in determining a Member's contract benefits on the date that services are rendered. Contract language, including definitions and specific inclusions/exclusions, as well as state and federal law, must be considered in determining eligibility for coverage. Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information. Likewise, medical policy, which addresses the issue(s) in any specific case, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and the Company reserves the right to review and update medical policy periodically.