



ND

Medical Policies



Print

Policy Number: S-5146

Policy Name: Discectomy

Policy Type: Medical

Effective Date: 09-15-2025

Policy Subtype: Surgery

End Date: 11-02-2025

Description

Disc Herniation

Extrusion of an intervertebral disc beyond the intervertebral space can compress the spinal nerves and result in symptoms of pain, numbness, and weakness.

Surgical Treatment

Discectomy is a surgical procedure in which one or more intervertebral discs are removed. The primary indication for discectomy is herniation (extrusion) of an intervertebral disc. Discectomy is intended to treat symptoms by relieving pressure on the affected nerve(s).

Lumbar Discectomy

Lumbar discectomy can be performed by a variety of surgical approaches. Open discectomy is the traditional approach. In open discectomy, a 2- to 3-cm incision is made over the area to be repaired. The spinal muscles are dissected, and a portion of the lamina may be removed to allow access to the vertebral space. The extruded disc is removed either entirely or partially using direct visualization. Osteophytes that are protruding into the vertebral space can also be removed if deemed necessary.

The main alternative to open discectomy is microdiscectomy, which has gained popularity. Microdiscectomy is a minimally invasive procedure that involves a smaller incision, visualization of the disc through a special camera, and removal of disc fragments using special instruments. Because less resection can be performed in a microdiscectomy, it is usually reserved for smaller herniations, in which a smaller amount of tissue needs to be removed. A few controlled trials comparing open discectomy with microdiscectomy have been published and reported that neither procedure is clearly superior to the other, but that microdiscectomy is associated with more rapid recovery. Systematic reviews and meta-analyses have also concluded that the evidence does not support the superiority of one (1) procedure over another.

Cervical Discectomy

The most common procedure for cervical discectomy is anterior cervical discectomy. This is an open procedure in which the cervical spine is approached through an incision in the anterior neck. Soft tissues and muscles are separated to expose the spine. The disc is removed using direct visualization. This procedure can be done with or without spinal fusion, but most commonly it is performed with fusion.

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.

Criteria

Lumbar discectomy may be considered **medically necessary** for the treatment of lumbar herniated disc when the following criteria are met:

- Signs and symptoms of radiculopathy on history and physical exam
- One of the following clinical presentations is present:
 - Rapidly progressing neurologic deficits; **or**
 - Persistent debilitating back or leg pain that is refractory to at least 6 weeks of conservative therapy
- Documentation of nerve root compression on imaging (magnetic resonance imaging or computed tomography) at a level that corresponds with the individual's symptoms.

Lumbar discectomy is **investigational** for the treatment of lumbar herniated disc when the above criteria are not met

Cervical discectomy may be considered **medically necessary** for the treatment of cervical herniated disc when the following criteria are present:

Signs and symptoms of radiculopathy and/or myelopathy on history and physical exam

- One of the following clinical presentations is present:
 - Rapidly progressing neurologic deficits; **or**
 - Persistent debilitating neck, back, or arm pain that is refractory to at least 6 weeks of conservative therapy; **or**
 - Persistent or progressive symptoms of myelopathy that are refractory to at least 6 weeks of conservative therapy.

Documentation of nerve root compression on imaging (magnetic resonance imaging or computed tomography) at a level that corresponds with the individual's symptoms (see Policy Guidelines section)

Cervical discectomy is **investigational** for the treatment of cervical herniated disc when the above criteria are not met.

Discectomy is considered **investigational** for all other indications.

The use of an annular closure device following discectomy is investigational.

Procedure Codes

63020	63030	63035	63040	63042	63043	63044
63056	63057	63075	63076	C2614	C9757	

Summary of Evidence

For individuals who have lumbar herniated disc(s) and symptoms of radiculopathy rapidly progressing or refractory to conservative care who receive lumbar discectomy, the evidence includes randomized controlled trials (RCTs) and systematic reviews. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. In individuals with lumbar radiculopathy with disc herniation who receive discectomy, there is sufficient evidence to support the use of discectomy in individuals who have not responded to 'usual care' for six (6) weeks. The evidence is limited by a lack of high-quality trials. In most trials, a high percentage of individuals in the conservative care group crossed over to surgery. This high degree of crossover reduced the power to detect differences when assessed by intention-to-treat analysis. Analysis by treatment received was also flawed because of the potential noncomparability of groups resulting from the high crossover rate. Despite the methodologic limitations, the evidence has consistently demonstrated a probable short-term benefit for surgery and a more rapid resolution of pain and disability. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have cervical herniated disc(s) and symptoms of radiculopathy rapidly progressing or refractory to conservative care who receive cervical discectomy, the evidence includes two (2) RCTs, a long-term observational study, and a systematic review. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. There is considerably less evidence on cervical discectomy than on lumbar discectomy. The best evidence on the efficacy of cervical discectomy consists of two (2) small RCTs comparing discectomy with conservative care, and a systematic review of these trials. Although there is less evidence for this indication, it does not differ substantially from lumbar herniated disc, showing that individual-reported symptoms and disability favor surgery in the short-term, and that long-term outcomes do not differ. Because cervical discectomy closely parallels lumbar discectomy, with close similarities in anatomy and surgical procedure, it can be inferred that the benefit reported for lumbar discectomy supports a benefit for cervical discectomy. Based on the available evidence and extrapolation from studies of lumbar herniated disc, it is likely that use of discectomy for cervical herniated disc improves short-term symptoms and disability. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have a lumbar herniated disc and undergo discectomy, use of a bone-anchored annular closure device has been evaluated as a means to reduce reherniation and reoperation in a systematic review and RCTs. Relevant outcomes are symptoms, functional outcomes, health status measures, quality of life, and treatment-related mortality and morbidity. Although a key RCT found beneficial effects in terms of reoperation and reherniation, the evidence is limited by a lack of blinding. In patients with lumbar radiculopathy with disc herniation who receive discectomy and an annular closure device, The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Professional Statements and Societal Positions Guidelines

Practice Guidelines and Position Statements

North American Spine Society

In 2014, the North American Spine Society published evidence-based clinical guidelines on the diagnosis and treatment of lumbar disc herniation with radiculopathy. The table below summarizes the recommendations specific to open discectomy or microdiscectomy.

Recommendations for Treating Lumbar Disc Herniation With Radiculopathy

Recommendations	GOR ^a
Endoscopic percutaneous discectomy is suggested for carefully selected individuals to reduce early postoperative disability and reduce opioid use compared with open discectomy.	B
There is insufficient evidence to make a recommendation for or against the use of automated percutaneous discectomy compared with open discectomy.	I
Discectomy is suggested to provide more effective symptom relief than medical/interventional care for individuals whose symptoms warrant surgical care. In individuals with less severe symptoms, both surgery and medical/interventional care appear to be effective in short and long term relief.	B
Use of an operative microscope is suggested to obtain comparable outcomes to open discectomy for individuals whose symptoms warrant surgery.	B
There is insufficient evidence to make a recommendation for or against the use of tubular discectomy compared with open discectomy.	I

ACD: anterior cervical discectomy; ACDF: anterior cervical discectomy with fusion; GOR: grade of recommendation; PLF: posterior laminoforaminotomy.

^aGrade B: fair evidence (level II or III studies with consistent findings); grade C: poor quality evidence (level IV or V studies).

In 2011, the North American Spine Society published evidence-based clinical guidelines on the diagnosis and treatment of cervical radiculopathy from degenerative disorders. The guidelines included evaluations of anterior cervical discectomy (ACD), ACD with fusion, ACD with instrumented fusion, ACD with fusion plus plate, and posterior laminoforaminotomy. Recommendations are listed in the table below.

Recommendations Treating Cervical Radiculopathy from Degenerative Disorders

Recommendations	GOR ^a
Surgical intervention is suggested for the rapid relief of symptoms when compared to medical/interventional treatment.	B

Surgery is an option to produce and maintain favorable long-term (>4 years) outcomes.	C
Both ACD and ACDF are suggested as comparable treatment strategies, producing similar clinical outcomes.	B
ACDF and total disc arthroplasty are suggested as comparable treatments, resulting in similarly successful short-term outcomes.	B
Both ACDF with and without a plate are suggested as comparable treatments, resulting in similar clinical outcomes and fusion rates.	B
Either ACDF or PLF are suggested for treatment of single level degenerative cervical radiculopathy secondary to foraminal soft disc herniation to achieve comparably successful clinical outcomes.	B

ACD: anterior cervical discectomy; ACDF: anterior cervical discectomy with fusion; GOR: grade of recommendation; PLF: posterior laminoforaminotomy.

^aGrade B: fair evidence (level II or III studies with consistent findings); grade C: poor quality evidence (level IV or V studies).

International Society for the Advancement of Spine Surgery

In 2019, the International Society for the Advancement of Spine Surgery published a policy on the surgical treatment of lumbar disc herniation with radiculopathy. This policy contained a review of available clinical evidence and concluded that discectomy (open, microtubular, or endoscopic) is a medically necessary procedure for the treatment of individuals who do not respond to nonsurgical care or have severe and deteriorating symptoms. Per the policy, documentation requirements include confirmation of radiculopathy based on history/physical examination AND either the presence of disabling leg or back pain refractory to 6 weeks of conservative care or progressive neurologic deficit AND level appropriate documentation of nerve root compression on imaging and/or nerve conduction velocity/electromyogram.

Diagnosis Codes

M50.00	M50.01	M50.020	M50.021	M50.022	M50.023	M50.10
M50.11	M50.12	M50.120	M50.121	M50.122	M50.123	M50.13
M50.20	M50.21	M50.22	M50.220	M50.221	M50.222	M50.223
M50.23	M50.03	M51.05	M51.06	M51.15	M51.16	M51.17
M51.25	M51.26	M51.27	M51.A0	M51.A1		

CURRENT CODING

CPT:

63020	LAMINOTOMY DCMPRN NRV ROOT 1 NTRSPC CERVICAL	Medicaid Expansion
63030	LAMINOTOMY DCMPRN NRV ROOT 1 NTRSPC LUMBAR	Medicaid Expansion
63035	LAMOT W/DCMPRN NRV RT EA ADDL NTRSPC CRV/LMBR	Medicaid Expansion
63040	LAMOT PRTL FFD EXC DISC REEXPL 1 NTRSPC CERVICAL	Medicaid Expansion
63042	LAMOT PRTL FFD EXC DISC REEXPL 1 NTRSPC LUMBAR	Medicaid Expansion
63043	LAMOT PRTL FFD EXC DISC REEXPL 1 NTRSPC EA CRV	Medicaid Expansion
63044	LAMOT W/PRTL FFD HRNA8 REEXPL 1 NTRSPC EA LMBR	Medicaid Expansion
63056	TRANSPEDICULAR DCMPRN SPINAL CORD 1 SEG LUMBAR	Medicaid Expansion
63057	TRANSPEDICULAR DCMPRN 1 SEG EA THORACIC/LUMBAR	Medicaid Expansion
63075	DISCECTOMY ANT DCMPRN CORD CERVICAL 1 NTRSPC	Medicaid Expansion
63076	DISCECTOMY ANT DCMPRN CORD CERVICAL EA NTRSPC	Medicaid Expansion
63020	LAMINOTOMY DCMPRN NRV ROOT 1 NTRSPC CERVICAL	Commercial
63030	LAMINOTOMY DCMPRN NRV ROOT 1 NTRSPC LUMBAR	Commercial
63035	LAMOT W/DCMPRN NRV RT EA ADDL NTRSPC CRV/LMBR	Commercial
63040	LAMOT PRTL FFD EXC DISC REEXPL 1 NTRSPC CERVICAL	Commercial
63042	LAMOT PRTL FFD EXC DISC REEXPL 1 NTRSPC LUMBAR	Commercial
63043	LAMOT PRTL FFD EXC DISC REEXPL 1 NTRSPC EA CRV	Commercial
63044	LAMOT W/PRTL FFD HRNA8 REEXPL 1 NTRSPC EA LMBR	Commercial
63056	TRANSPEDICULAR DCMPRN SPINAL CORD 1 SEG LUMBAR	Commercial

63057	TRANSPEDICULAR DCMRN 1 SEG EA THORACIC/LUMBAR	Commercial
63075	DISCECTOMY ANT DCMRN CORD CERVICAL 1 NTRSPC	Commercial
63076	DISCECTOMY ANT DCMRN CORD CERVICAL EA NTRSPC	Commercial

HCPCS:

C2614	Probe, perc lumb disc	Medicaid Expansion
C9757	Spine device implant surgery	Medicaid Expansion
C2614	Probe, perc lumb disc	Commercial
C9757	Spine device implant surgery	Commercial

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ND Committee Review

Internal Medical Policy Committee 7-22-2020 Adopt policy *Effective September 7, 2020*

Internal Medical Policy Committee 7-22-2021 Annual Review *Effective September 6, 2021*

Internal Medical Policy Committee 7-21-2022 Revision *Effective September 5, 2022*

- **Added** Summary of Evidence section

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

Internal Medical Policy Committee 7-16-2024 Coding update - *Effective September 02, 2024*

- **Added** Diagnosis Codes M50.03; M51.A0; and M51.A1; and
- **Added** Policy Application; and
- **Changed** not medically necessary statements to investigational.

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.