Policy Statement

Image-guided minimally invasive spinal decompression is considered investigational.

Policy Guidelines

The following category III CPT codes are applicable to this procedure:

- **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 (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic
- **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

The procedure uses an epidurogram. The following CPT code may also be reported:

- **72275**: Epidurography, radiological supervision and interpretation

The following HCPCS “G” code is specific to percutaneous image-guided lumbar decompression:

- **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

*Please note that codes 0275T and G0276 may be allowable for Medicare recipients participating in a Coverage with Evidence Development (CED) program.

Description

Image-guided minimally invasive lumbar decompression (IG-MLD) describes a percutaneous procedure for decompression of the central spinal canal in patients with spinal stenosis and hypertrophy of the ligamentum flavum. In this procedure, a specialized cannula and surgical tools (mild®) are used under fluoroscopic guidance for bone and tissue sculpting near the spinal canal. IG-MLD is proposed as an alternative to existing posterior decompression procedures.

Related Policies

- Interspinous and Interlaminar Stabilization/Distraction Devices (Spacers)

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these
instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

### Regulatory Status

In 2006, the X-Sten MILD Tool Kit now the mild® device kit (X-Sten Corp. renamed Vertos Medical) was cleared for marketing by the U.S. Food and Drug Administration through the 510(k) process for treatment of various spinal conditions. This set of specialized surgical instruments is used to perform percutaneous lumbar decompressive procedures.

Vertos’s mild® instructions state that the device is not intended for disc procedures but rather for tissue resection at the perilaminar space, within the interlaminar space, and at the ventral aspect of the lamina. The device is not intended for use near the lateral neural elements and remains dorsal to the dura using image guidance and anatomic landmarks.

Food and Drug Administration product code: HRX.

### Rationale

#### Background

**Spinal Stenosis**

In spinal stenosis, the space around the spinal cord narrows, compressing the spinal cord and its nerve roots. The goal of surgical treatment is to “decompress” the spinal cord and/or nerve roots.

The most common symptoms of lumbar spinal stenosis (LSS) are back pain with neurogenic claudication (i.e., pain, numbness, weakness) in the legs that worsens with standing or walking and is alleviated by sitting or leaning forward. Compression of neural elements generally occurs from a combination of degenerative changes, including ligamentum flavum hypertrophy, bulging of the intervertebral disc, and facet thickening with arthropathy. Spinal stenosis is often linked to age-related changes in disc height and arthritis of the facet joints. LSS is among the most common reasons for back surgery and the most common reason for lumbar spine surgery in adults over the age of 65.

The most common symptoms of cervical/thoracic spinal stenosis are neck pain and radiculopathy of the shoulder and arm. The most common cause of cervical radiculopathy is degenerative changes, including disc herniation.

#### Treatment

**Conventional Posterior Decompression Surgery**

For patients with LSS, surgical laminectomy has established benefits in reducing pain and improving quality of life.

For patients with cervical or thoracic stenosis, surgical treatment includes discectomy or foramin decompression.

A systematic review by Chou et al (2009) assessed surgery for back pain; it was commissioned by the American Pain Society and conducted by an evidence-based center. Four higher quality randomized trials were reviewed; they compared surgery with nonsurgical therapy for spinal stenosis, including two studies from the multicenter Spine Patient Outcomes Research Trial that evaluated laminectomy for spinal stenosis (specifically with or without degenerative spondylolisthesis). All 4 studies found that initial decompressive surgery (laminectomy) was slightly to moderately superior to initial nonsurgical therapy (e.g., average 8- to 18-point differences on the 36-Item Short-Form Health Survey and Oswestry Disability Index). However, there was insufficient evidence to determine the optimal adjunctive surgical methods for
laminectomy (i.e., with or without fusion, instrumented vs noninstrumented fusion) in patients with or without degenerative spondylolisthesis. Spine Patient Outcomes Research Trial continues to be referenced as the highest quality evidence published on decompressive surgery.

Less invasive surgical procedures include open laminotomy and microendoscopic laminotomy. In general, the literature comparing surgical procedures is limited. The literature has suggested that less invasive surgical decompression may reduce perioperative morbidity without impairing long-term outcomes when performed in appropriately selected patients. Posterior decompressive surgical procedures include: decompressive laminectomy, hemilaminotomy and laminotomy, and microendoscopic decompressive laminotomy.

Decompressive laminectomy, the classic treatment for LSS, unroofs the spinal canal by extensive resection of posterior spinal elements, including the lamina, spinous processes, portions of the facet joints, ligamentum flavum, and the interspinous ligaments. Wide muscular dissection and retraction is needed to achieve adequate surgical visualization. The extensive resection and injury to the posterior spine and supporting musculature can lead to instability with significant morbidity, both postoperatively and longer term. Spinal fusion, performed at the same time as laminectomy or after symptoms have developed, may be required to reduce resultant instability. Laminectomy may also be used for extensive multilevel decompression.

Hemilaminotomy and laminotomy, sometimes termed laminoforaminotomy, are less invasive than laminectomy. These procedures focus on the interlaminar space, where most of the pathologic changes are concentrated, minimizing resection of the stabilizing posterior spine. A laminotomy typically removes the inferior aspect of the cranial lamina, superior aspect of the subjacent lamina, ligamentum flavum, and the medial aspect of the facet joint. Unlike laminectomy, laminotomy does not disrupt the facet joints, supra- and interspinous ligaments, a major portion of the lamina, or the muscular attachments. Muscular dissection and retraction are required to achieve adequate surgical visualization.

Microendoscopic decompressive laminotomy, similar to laminotomy, uses endoscopic visualization. The position of the tubular working channel is confirmed by fluoroscopic guidance, and serial dilators are used to dilate the musculature and expand the fascia. For microendoscopic decompressive laminotomy, an endoscopic curette, rongeur, and drill are used for the laminotomy, facetectomy, and foraminotomy. The working channel may be repositioned from a single incision for multilevel and bilateral dissections.

Image-Guided Minimally Invasive Lumbar Decompression

Posterior decompression for LSS has been evolving toward increasingly minimally invasive procedures in an attempt to reduce postoperative morbidity and spinal instability. Unlike conventional surgical decompression, the percutaneous mild® decompressive procedure is performed solely under fluoroscopic guidance (e.g., without endoscopic or microscopic visualization of the work area). This procedure is indicated for central stenosis only, without the capability of addressing nerve root compression or disc herniation, should either be required.

Percutaneous image-guided minimally invasive lumbar decompression using a specially designed tool kit (mild®) has been proposed as an ultra-minimally invasive treatment of central LSS. In this procedure, the epidural space is filled with contrast medium under fluoroscopic guidance. Using a 6-gauge cannula clamped in place with a back plate, single-use tools (portal cannula, surgical guide, bone rongeur, tissue sculpter, trocar) are used to resect thickened ligamentum flavum and small pieces of lamina. The tissue and bone sculpting is conducted entirely under fluoroscopic guidance, with contrast media added throughout the procedure to aid visualization of the decompression. The process is repeated on the opposite side for bilateral decompression of the central canal. The devices are not intended for use near the lateral neural elements and are contraindicated for disc procedures.
Literature Review

Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life, and ability to function, including benefits and harms. Every clinical condition has specific outcomes that are important to patients and managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, two domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Image-Guided Minimally Invasive Lumbar Decompression

This evidence review addresses posterior decompression of LSS with percutaneous treatment performed under fluoroscopic guidance. The primary literature on IG-MLD includes a large RCT (n=302) that is ongoing, a small RCT (n=38), and a number of prospective and retrospective cohort studies and case series.

Review of Evidence

Randomized Controlled Trials

The protocol for the MiDAS ENCORE (Evidence-based Neurogenic Claudication Outcomes Research) trial (NCT02093520) was approved by the Centers for Medicare & Medicaid Services under coverage with evidence development. This nonblinded study, conducted at 26 interventional pain management centers in the U.S., randomized 302 patients in a 1:1 ratio to IG-MLD or epidural steroid injections (ESIs). Patients who withdrew from the trial after treatment but before the 1-year follow-up (22 IG-MLD, 32 ESI) were considered treatment failures.

Baseline scores were similar in both groups (see Table 1). However, more patients in the ESI group withdrew prior to trial treatment (22 patients vs 6 patients) due to dissatisfaction with randomization results and decisions to have surgery or other nonstudy therapy. This unequal dropout rate would suggest risk of bias due to nonblinding of patients and assessors and patient expectations. Patients who withdrew from the trial after treatment but before the 1-year follow-up (22 IG-MLD, 32 ESI) were considered treatment failures.

Six-month and 1-year results were published in 2016 (see Table 1). Patients in the ESI group were allowed up to four ESI treatments and received a mean of 2 injections over one year. The primary endpoint the proportion of responders achieving the minimally important difference of at least a 10-point improvement on the Oswestry Disability Index (ODI) score was significantly higher in the IG-MLD group than in the ESI group at both 6 months and 1 year. Secondary
efficacy endpoints were the proportion of responders achieving the minimally important difference on the numeric rating scale for pain and the Zurich Claudication Questionnaire. Adverse events were low (1.3% for both groups). Responder rates in patients with spinal comorbidities were reported to be similar to overall responder rates. However, it may be difficult to separate out the effect of comorbidities, because over 80% of patients had 1 or more spinal stenosis comorbidities.

Two-year follow-up data for patients treated with IG-MLD in the MiDAS ENCORE trial was published in 2018. Follow-up data was available for 69% of study participants and is summarized in Table 1. Comparative data for the ESI cohort was not reported.

Study relevance, design, and conduct limitations are summarized in Table 2 and 3.

### Table 1. MiDAS ENCORE Results

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Baseline Score, Mean (SD)</th>
<th>Percent Response at 6 Months, %</th>
<th>Percent Response at 1 Year, %</th>
<th>Percent Response (%) and Mean Improvement at 2 Years (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pain (NRS)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IG-MLD</td>
<td>7.7 (1.4)</td>
<td>55.9**</td>
<td>57.3**</td>
<td>71.73.6 (3.1 to 4.2)</td>
</tr>
<tr>
<td>ESI</td>
<td>7.8 (1.3)</td>
<td>33.3</td>
<td>27.1</td>
<td>NR</td>
</tr>
<tr>
<td><strong>Disability (ODI)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IG-MLD</td>
<td>53.0 (12.9)</td>
<td>62.2**</td>
<td>58.0**</td>
<td>72.422.7 (18.5 to 26.9)</td>
</tr>
<tr>
<td>ESI</td>
<td>51.7 (12.0)</td>
<td>35.7</td>
<td>27.1</td>
<td>NR</td>
</tr>
<tr>
<td><strong>ZCQ: Symptom Severity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IG-MLD</td>
<td>Pain: 3.8 (0.5) Neuroischemic: 3.2 (0.9)</td>
<td>52.8**</td>
<td>51.7*</td>
<td>73.51.0 (0.8 to 1.2)</td>
</tr>
<tr>
<td>ESI</td>
<td>Pain: 3.8 (0.5) Neuroischemic: 3.2 (0.8)</td>
<td>28.7</td>
<td>31.8</td>
<td>NR</td>
</tr>
<tr>
<td><strong>ZCQ: Physical Function</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IG-MLD</td>
<td>2.9 (0.5)</td>
<td>52.4**</td>
<td>44.1**</td>
<td>59.60.8 (0.6 to 0.9)</td>
</tr>
<tr>
<td>ESI</td>
<td>2.8 (0.4)</td>
<td>14.0</td>
<td>17.8</td>
<td>NR</td>
</tr>
<tr>
<td><strong>ZCQ: Patient Satisfaction</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NA</td>
<td>64.8**</td>
<td>61.5**</td>
<td>76.82.0 (1.8 to 2.2)</td>
<td></td>
</tr>
</tbody>
</table>


1 Pain score as determined with the Numerical Rating Scale, with 0 reflecting no pain and 10 reflecting worst possible pain. A positive response was defined by a ≥2-point improvement in score.
2 Disability score as determined with the Oswestry Disability Index (0-100), with a score of 0-20 reflecting minimal disability, a score of 21-40 reflecting moderate disability, and a score of 41-60 reflecting severe disability. A positive response was defined with an improvement (decrease) of 10 or more points as determined by the Minimally Important Change (MIC).
3 Pain symptom severity, physical function, and patient satisfaction with the procedure was assessed with relevant subdomains of the Zurich Claudication Questionnaire. Lower scores indicate better health status or higher patient satisfaction with treatment. A ≥0.5-point improvement in ZCQ subdomain scores denotes a MIC and defines a positive response. Patient satisfaction scores are only assessed post-treatment. ** p < 0.001
* p = 0.001
### Table 2. Study Relevance Limitations

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Intervention</th>
<th>Comparator</th>
<th>Outcomes</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>MiDAS ENCORE (2016, 2018)⁶⁷</td>
<td>4. Study population had a significantly high proportion of patients with comorbidities that the intervention was not designed to address.</td>
<td>3. Delivery not similar intensity as intervention.</td>
<td></td>
<td></td>
<td>1-2. Follow-up data at two years not reported for comparator.</td>
</tr>
</tbody>
</table>

The study limitations stated in this table are those notable in the current review; this is not a comprehensive limitations assessment.

- **Population key:** 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.
- **Intervention key:** 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest.
- **Comparator key:** 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively.
- **Outcomes key:** 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not established and validated measurements; 5. Clinical significant difference not prespecified; 6. Clinical significant difference not supported.
- **Follow-Up key:** 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms.

### Table 3. Study Design and Conduct Limitations

<table>
<thead>
<tr>
<th>Study</th>
<th>Allocation</th>
<th>Blinding</th>
<th>Selective Reporting</th>
<th>Data Completeness</th>
<th>Power</th>
<th>Statistical</th>
</tr>
</thead>
<tbody>
<tr>
<td>MiDAS ENCORE (2016, 2018)⁶⁷</td>
<td>3. Allocation concealment unclear.</td>
<td>1. Not blinded to treatment assignment.</td>
<td></td>
<td>1. High loss to follow-up or missing data.</td>
<td>1. Power calculations not clearly reported.</td>
<td>3. Confidence intervals and/or p values not reported for all outcome measures.</td>
</tr>
</tbody>
</table>

The study limitations stated in this table are those notable in the current review; this is not a comprehensive limitations assessment.

- **Allocation key:** 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.
- **Blinding key:** 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.
- **Selective Reporting key:** 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.
- **Data Completeness key:** 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. No intent to treat analysis (per protocol for noninferiority trials).
- **Power key:** 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference(s).
- **Statistical key:** 1. Analysis is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Analysis is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated.
Systematic Reviews
Prior to publication of MiDAS ENCORE trial results, the International Spine Intervention Society published a systematic review of the IG-MLD literature. Included were an RCT with 38 patients and 12 cohort studies or series. Pain measurements, using a visual analog score (VAS) or the Zurich Claudication Questionnaire, showed a weighted mean improvement of 41% in the short term (4-6 weeks), 46% at 3 months, 42% at 6 months, and 49% at 1 year. However, mean VAS scores exceeded 3 at all times posttreatment. Ten studies assessed function, nine using the ODI or one using the Roland-Morris Disability Questionnaire. ODI scores improved by a weighted mean of 16.5 at 6 weeks, 16.2 at 12 weeks, 15.4 at 6 months, and 14.0 at 1 year, a weighted cumulative decline to 33 from 47 at baseline. The study by Chopko (2013), reporting 2-year outcomes, was of questionable validity, and data were not included. Mean final ODI scores exceeded 30 for most studies, which would not be considered in the normal range. No direct procedure-related complications were identified in the selected studies, although the possibility of damage to dura and nerve roots with this procedure was noted. Overall, the body of evidence addressing the IG-MLD procedure was of low quality.

Case Series
One potential indication for IG-MLD is patients with symptomatic LSS primarily caused by a hypertrophic ligamentum flavum who are considered poor candidates for traditional decompressive surgery.

Chopko (2011) also reported on IG-MLD in 14 patients considered at high-risk for complications from open spine surgery and general anesthesia. Comorbidities included obesity, diabetes, hypertension, chronic obstructive pulmonary disease, chemotherapy, and coronary artery disease. Postoperatively, 9 (64%) of the 14 patients reported improvement in VAS pain scores of at least 3 points. ODI scores did not change significantly. A retrospective review by Lingreen and Grider (2010) reported on outcomes of a consecutive series of 42 patients who underwent IG-MLD by an interventional pain specialist. Most patients had not been considered surgical candidates by a spine surgeon. VAS pain scores averaged 9.6 at baseline and 5.8 at 30 days postprocedure, with 34 (80%) of patients reporting changes in VAS score of 3 or more points. Thirty (71%) patients reported improvements in function following IG-MLD. No major adverse events were identified.

Section Summary: Image-Guided Minimally Invasive Lumbar Decompression
The evidence on the use of IG-MLD to treat LSS or cervical/thoracic spinal stenosis consists of a large, ongoing RCT (n=302), a systematic review of a small RCT (n=38), and a number of prospective and retrospective cohort studies and case series. The largest RCT compared IG-MLD with ESIs (control) in patients with ligamentum flavum hypertrophy and who failed conservative therapy. Early results have suggested reductions in pain and improvements in function scores in the IG-MLD group vs the control group. The trial was unblinded and there is evidence of differing expectations and follow-up in both groups, suggesting a high-risk of bias. The available evidence is insufficient to determine the efficacy of mild® compared with placebo or to determine the efficacy of IG-MLD compared with open decompression. Trials with relevant control groups could provide greater certainty on the risks and benefits of this procedure.

Image-Guided Minimally Invasive Cervical or Thoracic Decompression
No evidence assessing use of image-guided minimally invasive cervical or thoracic decompression for treatment of patients with cervical or thoracic spinal stenosis was found.

Section Summary: Image-Guided Minimally Invasive Cervical or Thoracic Decompression
There is no evidence to inform conclusions about use of image-guided minimally invasive cervical or thoracic decompression to treat cervical or thoracic spinal stenosis.

Summary of Evidence
For individuals who have LSS, or cervical or thoracic spinal stenosis who receive IG-MLD, the evidence includes a large, ongoing RCT (n=302), a systematic review of a small RCT (n=38), and
a number of prospective and retrospective cohort studies and case series. Relevant outcomes are symptoms, functional outcomes, health status measures, and treatment-related morbidity. The largest RCT compared IG-MLD with ESIs (control) in patients who had ligamentum flavum hypertrophy and who failed conservative therapy. Early results have suggested reductions in pain and improvements in function scores in the IG-MLD group vs the control group. The trial was unblinded and there is evidence of differing expectations and follow-up in the 2 groups, suggesting a high-risk of bias. The available evidence is insufficient to determine the efficacy of mild® compared with placebo or to determine the efficacy of IG-MLD compared with open decompression. Trials with relevant control groups could provide greater certainty on the risks and benefits of this procedure. The evidence is insufficient to determine the effects of the technology on health outcomes.

Supplemental Information
Practice Guidelines and Position Statements

North American Spine Society
In 2011, the North American Spine Society revised clinical practice guidelines on the diagnosis and treatment of degenerative LSS. Treatment recommendations included:
• Interlaminar ESI for short-term (two weeks to six months) symptom relief in patients with neurogenic claudication or radiculopathy; however, there is conflicting evidence regarding long-term efficacy. (Grade of Recommendation: B)
• A multiple injection regimen of radiographically-guided transforaminal ESI or caudal injection for medium-term relief of pain. (Grade of Recommendation: C)
• Decompressive surgery to improve outcomes in patients with moderate to severe symptoms of LSS. (Grade of Recommendation: B)

No specific recommendations on percutaneous image-guided lumbar decompression were provided.

Lumbar Spinal Stenosis Consensus Group MIST Guidelines
In 2018, the Lumbar Spinal Stenosis Consensus Group, composed of a panel of nationally recognized spine experts, convened to evaluate the available literature and develop guidelines for minimally invasive spine treatment. Based on a systematic review of the available literature on percutaneous image-guided lumbar decompression, the consensus committee determined there is sufficient support to warrant Level I evidence (Grade A, Level I, Consensus strong). Grade A evidence is defined as "extremely recommendable (good evidence that the measure is effective and that benefits outweigh the harms."

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

Medicare National Coverage
Effective for services performed on or after January 9, 2014, the Centers for Medicare & Medicaid Services has determined that percutaneous image-guided lumbar decompression for LSS is not reasonable and necessary. The Centers for Medicare & Medicaid Services determined that percutaneous image-guided lumbar decompression would be covered by Medicare when provided in a clinical study through coverage with evidence development for beneficiaries with LSS enrolled in an approved clinical study meeting criteria in the decision memo.

According to the national coverage decision, percutaneous image-guided lumbar decompression is a posterior decompression of the lumbar spine performed under indirect image guidance without any direct visualization of the surgical area. This procedure is proposed as a treatment for symptomatic LSS unresponsive to conservative therapy. This procedure is generally described as a noninvasive procedure using specially designed instruments to
percutaneously remove a portion of the lamina and debulk the ligamentum flavum. The procedure is performed under x-ray guidance (e.g., fluoroscopic, computed tomography) with contrast media to identify and monitor the compressed area via epidurogram.

**Ongoing and Unpublished Clinical Trials**

Some currently unpublished trials that might influence this review are listed in Table 4.

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCT03072927</td>
<td>MILD® Percutaneous Image-Guided Lumbar Decompression: A Medicare Claims Study</td>
<td>4000</td>
<td>Dec 2020 (recruiting)</td>
</tr>
<tr>
<td>NCT03610737</td>
<td>A Multi-center, Randomized Controlled Study of the VertosMILD Procedure With Conventional Medical Management Versus Conventional Medical Management Alone in the Treatment of Lumbar Spinal Stenosis (MOTION)</td>
<td>150</td>
<td>Feb 2022 (ongoing)</td>
</tr>
</tbody>
</table>

| NCT01129921 | Comparative Study of Sham Versus Mild® (Minimally Invasive Lumbar Decompression) Procedure in Patients Diagnosed With Symptomatic Moderate to Severe Lumbar Central Canal Stenosis | 40 | Oct 2011 (completed) |

NCT: national clinical trial.

*a Denotes industry-sponsored or cosponsored trial.

**References**


### Documentation for Clinical Review

- No records required

### Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.

**IE**

The following services may be considered investigational.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT®</td>
<td>0274T</td>
<td>Percutaneous laminotomy/laminection (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; cervical or thoracic</td>
</tr>
<tr>
<td>CPT®</td>
<td>0275T</td>
<td>Percutaneous laminotomy/laminection (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</td>
</tr>
<tr>
<td>HCPCS</td>
<td>72275</td>
<td>Epidurography, radiological supervision and interpretation</td>
</tr>
<tr>
<td>HCPCS</td>
<td>G0276</td>
<td>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</td>
</tr>
</tbody>
</table>

### Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.
Definitions of Decision Determinations

**Medically Necessary:** Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member’s illness, injury, or disease.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

**Prior Authorization Requirements (as applicable to your plan)**

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.