MEDICAL POLICY

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Medical Policy Title	**Lumbar Microdiscectomy**
Policy Number	**7.01.98**
Current Effective Date	**October 15, 2026**
Next Review Date	**June 2027**

Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service. (Link to Product Disclaimer)

POLICY STATEMENT(S)

Initial Procedures

I. Initial primary lumbar microdiscectomy (laminotomy, laminectomy or hemilaminectomy) is considered **medically appropriate** when performed for the following conditions and **ALL** the associated criteria have been met:

   A. Neurogenic Claudication:

      1. Symptoms include **BOTH** of the following:

         a. Significant functional limitations have resulted in diminished quality of life and impaired age-appropriate activities of daily living; **and**

         b. Pain, cramping, weakness, or tingling in the lower back, buttock(s), and legs brought about by walking or positions that cause thecal sac or nerve root compression (e.g., standing, extension) and **EITHER** of the following:

            i. symptoms worsen with standing and/or walking; **or**

            ii. symptoms are alleviated with sitting and/or forward flexion;

      2. Less than clinically meaningful improvement with at least **TWO** (2) of the following (unless contraindicated):

         a. Prescription strength analgesics, steroids, gabapentinoids, or NSAIDS for six (6) weeks;

         b. Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for six (6) weeks;

         c. Epidural steroid injections or selective nerve root block(s) performed at the same level(s) as the requested surgery;

      3. MRI/CT shows neural structure compression at the requested level(s) that is concordant with patient symptoms and physical exam findings and is caused by **ANY** of the following:

         a. Herniated disc(s) (retained disc material or recurrent disc herniation);

b. Synovial cyst/arachnoid cyst;

c. Central/lateral/foraminal stenosis; **or**

d. Osteophytes;

4. Absence of unmanaged significant mental and/or behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, opioid or alcohol use disorders).

B. Radiculopathy:

1. Symptoms include **BOTH** of the following:

a. Significant level of pain on a daily basis, defined as clinically significant functional impairment (e.g., inability to perform household chores, prolonged standing, etc.); **and**

b. Persistent radiating pain into the buttock(s) and/or lower extremity(ies) resulting in clinically significant functional impairment;

2. Physical exam findings include **ANY**of the following:

a. Positive straight leg raises;

b. Positive crossed straight leg raise;

c. Positive femoral stretch test;

d. Dermatomal sensory deficit;

e. Functionally limiting motor weakness (e.g., foot drop, quadriceps weakness);

f. Reflex changes; **or**

g. Unremitting radicular pain into the lower extremity(ies) without concordant objective exam findings;

3. Less than clinically meaningful improvement with at least **TWO** (2) of the following (unless contraindicated):

a. Prescription strength analgesics, steroids, gabapentinoids, or NSAIDS for six (6) weeks;

b. Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for six (6) weeks;

c. Epidural steroid injections or selective nerve root block(s) performed at the same level(s) as the requested surgery;

4. MRI/CT shows neural structure compression at the requested level(s) that is concordant with patient symptoms and physical exam findings and is caused by **ANY** of the following:

a. Herniated disc(s) (retained disc material or recurrent disc herniation);

b. Synovial cyst/arachnoid cyst;

c. Central/lateral/foraminal stenosis; **or**

d. Osteophytes**;**

5. Absence of unmanaged significant mental and/or behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, opioid or alcohol use disorders).

Repeat Procedures

II. Repeat lumbar microdiscectomy (laminotomy or laminectomy) at the same level is considered **medically appropriate** when performed for **EITHER** of the following conditions when **ALL** of the associated criteria have been met:

A. Neurogenic Claudication:

1. Greater than 12 weeks have elapsed since the prior lumbar microdiscectomy;
2. Symptoms include **BOTH** of the following:
   a. Significant functional limitations have resulted in diminished quality of life and impaired, age-appropriate activities of daily living; **and**
   b. Pain, cramping, weakness, or tingling in the lower back, buttock(s), and legs brought about by walking or positions that cause thecal sac or nerve root compression (e.g., standing, extension) and **EITHER** of the following:
      i. symptoms worsen with standing and/or walking; **or**
      ii. symptoms are alleviated with sitting and/or forward flexion;
3. Less than clinically meaningful improvement with at least **TWO** (2) of the following (unless contraindicated):
   a. Prescription strength analgesics, steroids, gabapentinoids, or NSAIDS for six (6) weeks;
   b. Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for six (6) weeks;
   c. Epidural steroid injections or selective nerve root block(s) performed at the same level(s) as the requested surgery;
4. Post-operative MRI /CT shows neural structure compression at the requested level(s) that is concordant with the patient's symptoms and physical exam findings and that is caused by **ANY** of the following:
   a. Herniated disc(s) (retained disc material or a recurrent disc herniation);
   b. Synovial cyst or arachnoid cyst;
   c. Central/lateral/foraminal stenosis; **or**

d. Osteophytes;

5. Absence of unmanaged significant mental and/or behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, opioid or alcohol use disorders).

B. Radiculopathy:

1. Greater than 12 weeks since the prior lumbar microdiscectomy;
2. Symptoms include **BOTH** of the following:
   a. Significant level of pain on a daily basis, defined as clinically significant functional impairment (e.g., inability to perform household chores, prolonged standing, etc.); **and**
   b. Persistent radiating pain into the buttock(s) and/or lower extremity(ies) resulting in clinically significant functional impairment;
3. Physical exam findings including **ANY** of the following:
   a. Positive straight leg raises;
   b. Positive crossed straight leg raise;
   c. Positive femoral stretch test;
   d. Dermatomal sensory deficit;
   e. Functionally limiting motor weakness (e.g., foot drop, quadriceps weakness); **or**
   f. Reflex changes;
   g. Unremitting radicular pain into the lower extremity(ies) without concordant objective exam findings
4. Less than clinically meaningful improvement with at least **TWO** (2) of the following (unless contraindicated):
   a. Prescription strength analgesics, steroids, gabapentinoids, or NSAIDS for six (6) weeks;
   b. Provider-directed exercise program prescribed by a physical therapist, chiropractic provider, osteopathic or allopathic physician for six (6) weeks;
   c. Epidural steroid injections or selective nerve root block(s) performed at the same level(s) as the requested surgery;
5. Post-operative MRI /CT shows neural structure compression at the requested level(s) that is concordant with the patient's symptoms and physical exam findings, and that is caused by **ANY** of the following:
   a. Herniated disc(s) (retained disc material or a recurrent disc herniation);
   b. Synovial cyst or arachnoid cyst;

c. Central/lateral/foraminal stenosis; **or**

d. Osteophytes;

6. Absence of unmanaged significant mental and/or behavioral health disorders (e.g., major depressive disorder, chronic pain syndrome, secondary gain, opioid or alcohol use disorders).

III. Lumbar microdiscectomy (laminotomy, laminectomy or hemilaminectomy) with laser technique is considered **not medically necessary**.

IV. Initial and repeat lumbar microdiscectomy (laminotomy, laminectomy or hemilaminectomy) performed for **ANY** of the following sole indications is considered **not medically necessary**:

A. Annular tears;

B. Concordant discography;

C. Magnetic resonance (MR) spectroscopy results;

D. Degenerative disc disease.

V. Devices for disc annular repair (e.g., Barricaid Annular Closure Device [ACD]) are considered **investigational**.

VI. Percutaneous lumbar discectomy (i.e., performed with indirect visualization of the spine) is considered **investigational**.

RELATED POLICIES

Corporate Medical Policy

7.01.112 Intradiscal Procedures

7.01.113 Lumbar Decompression

11.01.03 Experimental or Investigational Services

POLICY GUIDELINE(S)

I. Minimum documentation requirements needed to complete a spinal surgery prior authorization request include **ALL** of the following:

A. CPT codes, ICD-10 codes, and disc levels or motion segments involved for planned surgery must be provided;

B. Detailed documentation of the type, duration, and frequency of provider-directed non-surgical treatment (e.g., interventional pain management, physical therapy, chiropractic care, or provider-directed active exercise program, etc.) that includes response to each treatment:

C. Detailed documentation explaining why a sufficient trial of non-surgical treatment was contraindicated (in applicable);

D. Detailed documentation of less than clinically meaningful improvement for each treatment;

E. Written reports/interpretations of the most recent advanced diagnostic imaging reports (e.g., computed tomography [CT] scan, magnetic resonance imaging [MRI], or Myelography) performed, read, and interpreted by an independent radiologist. Clinically significant discrepancies in interpretation between the surgeon and the radiologist need to be reconciled prior to the documentation submission;

F. The documentation for spinal fusion surgery requests must include flexion-extension plain x-rays based upon indications for instability and/or other plain x-rays that document failure of instrumentation, fusion, etc.

II. URGENT/EMERGENT CONDITIONS: All individuals being evaluated for spine surgery should be screened for the presence of urgent/emergent indications/conditions that warrant definitive surgical treatment. Imaging findings noted in the applicable procedure section(s) (e.g., CT scan or MRI) are required.

A. The following criteria are **NOT** required for confirmed urgent/emergent conditions:

1. Provider-directed, non-surgical management;
2. Proof of smoking cessation;
3. Absence of unmanaged significant mental or behavioral health disorder (e.g., major depressive disorder, chronic pain syndrome, secondary gain, opioid or alcohol use disorder);
4. Timeframe for repeat procedure.

B. Urgent/emergent conditions for lumbar microdiscectomy and/or excision of extradural lesion other than neoplasm include **ANY** of the following:

1. Cauda equina syndrome (CES);
2. Documentation of progressive neurological deficit on two (2) separate physical examinations;
3. Neurocompressive pathology with **ANY** of the following;
    a. motor weakness of grade 3/5 or less of specified muscle(s);
    b. rapidly progressive symptoms of motor loss;
    c. bowel incontinence;
    d. bladder incontinence/retention
4. Epidural hematoma;
5. Infection (e.g., discitis, epidural abscess, osteomyelitis);
6. Primary or metastatic neoplastic disease-causing pathologic fractures, cord compression or instability;

7. A condition otherwise meeting criteria listed in the applicable procedure section(s) with documentation of severe debilitating pain or dysfunction to the point of being incapacitated.

III. An urgent/emergent request is based on the 2019 NCQA standard for utilization management as is as follows:

A. A request for medical care or services where application of the time for making routine or non-life-threatening care determinations:

1. Could seriously jeopardize the life or health of the individual or the individual's ability to regain maximum function, based on a prudent layperson's judgment; or
2. Could seriously jeopardize the life, health, or safety of the individual or others, due to the individual's psychological state, or
3. In the opinion of a practitioner with knowledge of the individual's medical or behavior condition, would subject the individual to adverse health consequences without the care or treatment that is the subject of the request.

DESCRIPTION

Discectomy is a surgical procedure in which one (1) or more intervertebral discs are removed. Extrusion of an intervertebral disc beyond the intervertebral space can compress the spinal nerves and result in pain, numbness, and weakness. Discectomy is intended to treat symptoms by relieving pressure on the affected nerve root(s). Discectomy can be performed by a variety of surgical approaches, with either open surgery or minimally invasive techniques.

The main alternative to open discectomy is microdiscectomy, which 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. Removal of the disc itself must be done under direct visualization to be considered microdiscectomy.

The Barricaid ACD (Intrinsic Therapeutics, Woburn, MA) is implanted during a lumbar discectomy procedure, to act as a barrier to block the annular defect and reduce reherniation and reoperation. The device is a permanent implant, consisting of titanium and a flexible woven polymer fabric component intended to close an annular defect with a bone anchor to affix the device in place.

SUPPORTIVE LITERATURE

Overall, the literature suggests that lumbar discectomy provides effective clinical benefit in carefully selected patients with sciatica. There is strong evidence in favor of microdiscectomy surgery over conservative treatment at short-term follow-up. The comparative evidence on lumbar discectomy versus conservative care consists of a small number of randomized, controlled trials (RCTs) and non-randomized comparative studies. The RCT evidence is limited by a lack of high-quality trials. In most, a high percentage of patients in the conservative care group crossed over to receive surgery. This

high degree of contamination reduced the ability to detect a difference when assessed by intention-to-treat (ITT) analysis. Analysis by treatment received was also flawed because of the potential noncomparability of groups, resulting from the high volume of crossover. Despite the methodologic limitations of the evidence, the RCTs are consistent in demonstrating a probable short-term benefit for surgery and a more rapid resolution of pain and disability. For the ITT analyses, there were small differences in favor of surgery, which sometimes were statistically significant and at other times, were not. In contrast, on analysis by treatment received and in the non-randomized comparative studies, there were larger differences in favor of surgery that exceeded the threshold for clinical significance. At one year or longer, outcomes from surgery and conservative care appear to be equivalent.

In 2015, Lewis and colleagues published a network meta-analysis comparing 21 different strategies for treatment of sciatica. Reviewers included a total of 122 comparative studies, 90 of which were RCTs. For disc surgery, eight studies compared surgery with conservative care (three RCTs, one quasi-RCT, four cohort studies), and 34 studies compared discectomy with alternative treatments, including other surgical variations. For the main outcome (overall recovery), surgery was better than exercise therapy, traction, and percutaneous discectomy. However, for the outcome of pain, disc surgery was not found to be better than alternative treatments.

A systematic review based on a Cochrane review was published by Jacobs et al in 2011. Reviewers evaluated surgery and conservative management of sciatica due to lumbar herniated disc. They included five (5) RCTs, four (4) of which are discussed below, with the additional trial being a 1983 trial which was excluded from this review. Reviewers assigned a low risk of bias to two of the four trials: the randomized Spine Patient Outcomes Research Trial (SPORT) and the Leiden-The Hague Spine Intervention Prognostic Study. They determined that pooling of the results was not appropriate, due to differences in study methodologies, so a qualitative synthesis of the data was performed. Reviewers concluded that surgery was likely to lead to better short-term control of leg pain, but that the overall quality of the body of evidence for this outcome was low. No differences were demonstrated between surgical and conservative care outcomes at one year and beyond.

Chou et al (2009) published a systematic review of the evidence for efficacy of different surgical procedures for back pain, in conjunction with development of clinical guidelines for the American Pain Society. For the comparison of discectomy with nonsurgical care, four (4) studies were included, three (3) of which are reviewed below. Studies were not pooled. Reviewers found that discectomy, performed either by open surgery or microdiscectomy, had superior outcomes for pain and disability at up to three months, but no definite benefits at longer time points.

Weinstein et al (2006) reported on SPORT, a moderately-large trial that compared discectomy to non-operative care in patients with lumbar disc herniation and included both a randomized and a non-randomized component. The RCT included 501 patients randomized to discectomy or to usual care. Discectomy was performed by the open technique, and, in some cases, the medial border of the superior facet joint was removed. Crossover was allowed during the trial; 107 of the 245 patients assigned to usual care underwent surgery, and 140 of the 245 patients assigned to surgery underwent surgery. The main outcomes were changes from baseline in the bodily pain and physical function subscales of the SF-36, and the modified Oswestry Disability Index (ODI) measured at time

points up to two years. Secondary outcomes included self-reported improvement, work status, satisfaction with care, and a symptom severity measure (Sciatica Bothersomeness Index). For the primary outcomes evaluated using ITT analysis, improvements in ODI scores were superior for the surgery group at three months, but, at the one- and two-year follow-ups, there were no significant group differences on either primary outcome. For secondary outcomes, there were significant improvements for the surgery group on the Sciatica Bothersomeness Index at all time points, and satisfaction with care was superior for the surgery group at three (3) months, but not at longer time points. A secondary analysis was performed on a treatment-received basis, and this analysis showed significantly greater improvements for the surgery group at all time points. The estimated treatment effects for the SF-36 bodily pain and physical function subscales were 15.0 and 17.5, respectively, on a 0-to-100 scale. The estimated change in the ODI score was -15.0 on a 0 to 100 scale.

Devices for Annular Repair Following Spinal Surgery

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. 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.

Thome and colleagues (2018) conducted a randomized, controlled trial at 21 European centers, to determine whether use of a bone-anchored ACD, in addition to lumbar microdiscectomy, resulted in lower reherniation and reoperation rates and increased overall success, compared to lumbar microdiscectomy alone. A total of 554 patients were randomized to the ACD group (n=267) and the control (N=283). Enrolled patients were 21 to 75 years of age, with imaging confirmation of single-level disc herniation between L1 and S1, disc height 5mm or greater, who had attempted nonsurgical treatment for six (6) weeks or more. Results at 2 years showed symptomatic reherniation was lower in the ACD group (12% versus 25%, ($p<.001$). Reoperation was also lower in the ACD group (5% versus 13%; $p=.0001$). There were no differences in all-cause serious adverse events when ACD was compared to controls.

Three-year findings were published by Kienzler et al (2019). Results demonstrated that lumbar discectomies using ACD resulted in fewer symptomatic reherniations than discectomies without ACD implantation (15% vs. 30%), as well as fewer reoperations (11% versus 19%). Disability and quality of life scores demonstrated modest improvement in the ACD group over the control group at the three-year mark. Four-year reoperation rates were 14.4% with ACD and 21.1% with controls (Nanda et al. 2019). The study was funded by Intrinsic Therapeutics.

Five-year follow-up outcomes remained lower in patients receiving an annular closure device, with the risk of symptomatic reherniation (18.8% vs. 31.6%; $p<.001$) and reoperation (16.0% vs. 22.6%; $p=.03$) (Thome et al., 2021). None of the investigators were blind to treatment assignment, and only patients at specific sites were blind.

Cho et al (2019) published a smaller (n=60) RCT conducted solely in Korea. Patients were randomized (n=30 ACD and n=30 conventional lumbar discectomy and were followed for 24 months.

The primary endpoint of the trial was disc height. Patients treated with an annular closure device had maintained disc height at 24-months to a greater extent than those with discectomy alone (86.3% vs. 79.2%; p=.04). Back pain and leg pain were similarly improved in both treatment groups, without a statistical difference between the two groups. Recurrent herniation was more common with discectomy alone. The study is limited by a small sample size, large loss to follow-up (≤70% at 2-year follow-up), and unclear blinding limit the validity of this trial.

Miller et al. (2020) published a systematic review and meta-analysis of the Barricaid annular device in patients at high risk for lumbar disc reherniation. Four trials (2 RCTs) were included in the meta-analysis (Cho et al 2019; Thome et al 2018; Barth et al 2016; Vukas et al 2013). The 2018 trial by Thome, summarized above, was the only trial to find a significant decrease in symptomatic reherniation or reoperation at 2 years. The other 3 trials all indicated nonsignificant reduction for both outcomes. The authors reported that overall results of the meta-analysis favored the use of an annular device for post-discectomy patients with large annular defects.

PROFESSIONAL GUIDELINE(S)

The International Society for the Advancement of Spine Surgery (ISASS) policy states:

- For the surgical treatment of lumbar disc herniation with radiculopathy, the current level 1 evidence demonstrates that, in appropriately selected patient populations, implantation of a bone-anchored ACD reduces the risk of symptom recurrence and revision surgery compared to discectomy alone (Lorio et al 2020).

North American Spine Society (NASS) Coverage Policy 2019 Lumbar Discectomy Recommendations

Primary or recurrent lumbar disc herniation with radiculopathy indicated when both criteria are met:

- Lumbar radiculopathy is present, and a correlative lesion is present on advanced imaging.
- Presence of symptoms for at least 6 weeks and inability to tolerate or failure to respond to 4 weeks of nonsurgical care, including but not limited to physical therapy, chiropractic treatment, and/or fluoroscopic-guided epidural steroid injections

REGULATORY STATUS

The U.S. Food and Drug Administration (FDA) regulates annular repair devices as medical devices. All annular repair devices including related components require FDA approval before marketing and use in the United States to ensure they are safe and effective for human use. Refer to the FDA Medical Device website. Available from: https://www.fda.gov/medical-devices [accessed 2026 May 19]

The FDA lists the most serious type of medical device recalls as well as early alert communications about corrective actions being taken by companies that the FDA believes are likely to be the most serious type of recalls. Available from: Medical Device Recalls | FDA [accessed2026 May 19]

Barricaid received FDA pre-market approval in February 2019. FDA indicated use is for reducing the incidence of reherniation, and reoperation in skeletally mature patients with radiculopathy (with or without back pain) attributed to a posterior or posterolateral herniation, and confirmed by history, physical examination and imaging studies which demonstrate neural compression using MRI to treat

a large annular defect (between 4-6 mm tall and between 6-10 mm wide) following a primary discectomy procedure (excision of herniated intervertebral disc) at a single level between L4 and S1.

Other FDA approved closure devices Xclose Tissue Repair System (Anulex Technologies, Inc. Minnetonka, MN) approved in August 2006, and the Inclose Surgical Mesh Ssytem, approved in August 2005.

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy, and/or excision of herniated intervertebral disc, 1 interspace, lumbar
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar
63032 (E/I)	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; with repair of annular defect by implantation of bone-anchored annular closure device, including all imaging guidance, 1 interspace, lumbar (List separately in addition to code for primary procedure) (Effective 01/01/26)
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, re-exploration, single interspace; lumbar
63044	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, re-exploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)

Code	Description
63056	Transpedicular approach with decompression of spinal cord, equine and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (e.g., far lateral herniated intervertebral disc)
63057	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)
63267	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar
63272	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar
63277	Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, lumbar

HCPCS Codes

Code	Description
C9757 (E/I)	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar
S2350	Discectomy, anterior with decompression of spinal cord and/or nerve root(s); including osteophytectomy; lumbar, single interspace
S2351	Discectomy, anterior with decompression of spinal cord and/or nerve root(s); including osteophytectomy; lumbar, each additional interspace (List separately in addition to code for primary procedure)

ICD10 Codes

Code	Description
D16.6	Benign neoplasm of vertebral column
D32.1	Benign neoplasm of spinal meninges
D33.4	Benign neoplasm of spinal cord
M51.06	Intervertebral disc disorders with myelopathy, lumbar region

Code	Description
M51.16-M51.17	Intervertebral disc disorders with radiculopathy, lumbar/lumbosacral regions
M51.26-M51.27	Other intervertebral disc displacement, lumbar/lumbosacral regions
M51.36-M51.37	Other intervertebral disc degeneration, lumbar/lumbosacral regions
M51.46-M51.47	Schmorl's nodes, lumbar/lumbosacral regions
M51.86-M51.87	Other intervertebral disc disorders, lumbar/lumbosacral regions
M54.16-M54.17	Radiculopathy, lumbar/lumbosacral regions

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SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Lumbar microdiscectomy is not specifically addressed in a National or Regional Medicare coverage determinations or policies.

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a

specific service, medical policy criteria apply to the benefit.

- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION	
Committee Approval Dates	
06/18/18, 12/20/18, 07/18/19, 01/16/20, 08/20/20, 06/17/21, 06/16/22, 07/20/23, 10/17/24, 06/26/25, 06/18/26	
Date	**Summary of Changes**
06/18/26	• Annual review; policy statement added for unremitting radicular pain into the lower extremity(ies) without concordant objective exam findings.
12/31/25	• Code edit, added 63032. Policy intent unchanged
06/26/25	• Off-cycle review; moved CPT codes 63267, 63272, 63277 to Lumbar Decompression CMP 7.01.113. Clarifying verbiage for provider directed exercise program.
01/01/25	• Summary of changes tracking implemented.
06/18/18	• Original effective date