Minimally Invasive Spine Surgery Procedures (for Ohio Only)

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Instructions for Use

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Application

This Medical Policy only applies to the state of Ohio. Any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity using Ohio Administrative Code 5160-1-01.

Coverage Rationale

For medical necessity clinical coverage criteria for minimally invasive spine surgeries, refer to the InterQual® CP: Procedures:

- Decompression +/- Fusion, Lumbar
- Fusion, Lumbar Spine

Click here to view the InterQual® criteria.

The following spinal procedures are unproven and not medically necessary due to insufficient evidence of efficacy:

- Axial Lumbar Interbody Fusion (AxiaLIF®), a percutaneous Presacral access route to the L5 to S1 vertebral bodies
- Percutaneous Image-Guided Lumbar Decompression (PILD)
- Percutaneous sacral augmentation (Sacroplasty), with or without a balloon or bone cement
- Minimally Invasive Lumbar Decompression (MILD®)
- Laparoscopic Anterior Lumbar Interbody Fusion (LALIF)

Definitions

Axial Lumbar Interbody Fusion (AxiaLIF): Also called trans-sacral, transaxial, or paracoccygeal interbody fusion and is a minimally invasive technique that is used in L5 to S1 (Presacral) spinal fusions. The technique provides access to the spine along the long axis of the spine, as opposed to anterior, posterior, or lateral approaches. The surgeon enters the back through a very small incision next to the tailbone, and the abnormal disc is taken out. Then, a bone graft is placed

where the abnormal disc was and is supplemented with a large metal screw. Sometimes, additional, smaller screws are placed through another small incision higher on the back for extra stability (Cragg et al., 2004).

Endoscope: An Endoscope is a diagnostic instrument that is equipped with illumination and designed for direct visualization of internal anatomical structures (Animated Dissection of Anatomy for Medicine, 2025).

Endoscopic Discectomy: A minimally invasive surgical procedure that removes herniated disc material from the spine using an Endoscope (NASS, 2025).

Fluoroscopy: The use of radiological imaging to position instruments during diagnostic and surgical procedures (NASS, 2025).

Image-Guided Minimally Invasive Lumbar Decompression (MILD®): Minimally Invasive Lumbar Decompression is a minimally invasive, image-guided procedure that is used to decompress the lumbar spine in cases in which central canal stenosis is caused by a thickened ligamentum flavum (Zhang et al., 2025).

Laparoscopic Anterior Lumbar Interbody Fusion (LALIF): Laparoscopic Anterior Lumbar Interbody Fusion is a minimally invasive surgical procedure that is used to fuse painful or unstable vertebrae together in the lumbar region. The procedure uses several small incisions in the abdomen to provide endoscopic access to the anterior spine [Decker et al., 2025; American Academy of Orthopaedic Surgeons (AAOS), 2025].

Open Spine Surgery: Open Spine Surgery involves making a long incision to expose the surgical area, providing the surgeon with direct visualization and access to the underlying anatomy (AAOS, 2025).

Percutaneous Image-Guided Lumbar Decompression (PILD): Percutaneous Image-Guided Lumbar Decompression is a minimally invasive surgical procedure that is used to treat individuals with symptomatic posterior lumbar spinal stenosis. This technique involves the removal of thickened tissue to enlarge the spinal canal, thereby relieving nerve compression. The procedure uses imaging guidance rather than direct visualization of the surgical area and is performed through a percutaneous (through the skin) approach (Hayes, 2025).

Posterior Lumbar Spine Surgery: Posterior Lumbar Spine Surgery is the surgical approach to access an individual's lumbar spine through the back of the body (AAOS, 2025).

Presacral: Anterior to the sacrum (Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, 2023).

Sacroplasty: Sacroplasty is a minimally invasive procedure that involves the placement of polymethyl methacrylate cement into the site of a sacral insufficiency fracture to provide mechanical stabilization and pain relief. The procedure can be performed via multiple approaches, including bilateral short axis, bilateral long axis, coaxial vision, transiliac, interpedicular, and balloon assisted (Singh et al., 2024).

Spinal Decompression: Spinal stenosis, which is a narrowing of the vertebral canal, is a common condition that can result in compression of the nerves. This can produce a variety of symptoms, including pain, numbness, and muscle weakness. If surgery is recommended, it may be possible to remove the bone and soft tissues causing the nerve compression through a minimally invasive surgery approach using tubular dilators and a microscope or Endoscope. The more common decompressive procedures include laminectomy and foraminotomy [American Association of Neurological Surgeons (AANS), 2022; updated 2024].

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar
22899	Unlisted procedure, spine
62287	Decompression, 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
62330	Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (i.e., CT or fluoroscopy), bilateral; one interspace, lumbar
62331	Decompression, percutaneous, with partial removal of the ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (i.e., CT or fluoroscopy), bilateral; additional interspace(s), lumbar (List separately in addition to code for primary procedure)
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

HCPCS Code	Description
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

Description of Services

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 and radiculopathy 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 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 is removed or ablated, although these techniques are not precisely targeted at the offending extruding disc material.

To alleviate many of the limitations of previous techniques, a Presacral approach to the lumbosacral junction has been investigated. Transaxial anterior lumbar interbody fusion is an emerging minimally invasive spinal fusion procedure that is used to treat individuals with chronic lower back pain. This procedure is an alternative to traditional fusion techniques that use anterior or posterior approaches to directly expose the lumbosacral spine. In the case of transaxial anterior lumbar interbody fusion, the spine is accessed percutaneously via the anterior surface of the sacrum (Ollendorf et al., 2011).

Clinical Evidence

Axial Lumbar Interbody Fusion

Although this method may be considered an emerging, minimally invasive surgical approach, no RCTs that evaluate axial lumbar interbody fusion (AxiaLIF) as a minimally invasive or percutaneous surgical procedure for the treatment of L5 to S1 conditions were found in the peer-reviewed, published scientific literature that supported safety and efficacy. Improvement in net health outcomes has not been clearly demonstrated compared with standard surgical methods, and it remains unclear whether this surgical technique results in clinical benefits that are as good as or superior to standard surgical

techniques. The evidence is insufficient to allow any conclusions regarding short- and long-term clinical benefits, possible complications, failure rates, relief of symptoms, and improvement in functional levels, and the need for further surgery is as beneficial as other surgical approaches to lumbosacral interbody fusion.

An ECRI report for the AxiaLIF Plus System indicated that the evidence from a case series in one systematic review and one additional case series (not in the systematic review) is at too high of a risk of bias to support conclusions on the safety and effectiveness of one-level lumbar interbody fusion or L5 to S1 spondylolisthesis or spondylosis with AxiaLIF. RCTs that compare individual-oriented outcomes (e.g., pain, functional status, reoperation rates) of AxiaLIF with other interbody fusion surgical approaches are needed to assess AxiaLIF's comparative effectiveness (ECRI, 2020).

Balsano et al. (2020) conducted a retrospective analysis to evaluate the radiographic and clinical results for patients treated with the AxiaLIF Technique (AxiaLIF, AMS Group) using a minimally invasive presacral approach. From 2013 to 2018, a total of 52 patients had been treated (12 male, 40 female; mean age, 46.3 years). The diagnosis included L5 isthmic spondylolisthesis low-grade dysplasia and primary and secondary degenerative disc disease. Overall, 43 patients had been followed up for at least 2 years. Fusion assessment was based on plain radiographs and Brantigan fusion criteria at 1, 6, 12, and 24 months after surgery. All patients completed the visual analog scale (VAS) and Oswestry Disability Index (ODI) at baseline through the last follow-up. Clinical results showed good pain resolution. VAS back demonstrated an average reduction over baseline of 50%, 57%, 71%, and 77% at 3, 6, 12, and 24 months, respectively ($p < 0.001$). The ODI demonstrated an average reduction over baseline of 38%, 51%, 67%, and 72% at the same time points ($p < 0.001$). Complete fusion was demonstrated in 65% of cases and partial fusion in 30%; 5% were in the absence of bony bridges that were visible radiographically. Two major complications were noted, one retroperitoneal hematoma and one spondylodiscitis, with one minor complication, which was a superficial infection of the surgical wound. The authors concluded that the surgical treatment of degenerative disc disease at L5 to S1 with the minimally invasive technique AxiaLIF showed good radiographic and clinical outcomes, with an acceptable rate of complications. Moreover, shorter hospitalization and faster functional recovery are additional factors that support the choice of this technique. This study is limited by its small sample size and retrospective observations. Although the results are promising, the small sample size and lack of a comparison group limit the generalizability of the findings.

Anand et al. (2018) conducted a single-center retrospective study to compare the fate of the lumbosacral junction in anterior lumbar interbody fusion (ALIF) patients vs AxiaLIF patients in terms of clinical and radiographic outcomes. Adult patients who (1) had spinal deformity; (2) were treated with circumferential minimally invasive surgery (MIS) techniques, with at least a 2-year follow-up; and (3) underwent AxiaLIF or ALIF at the lumbosacral junction were included. Patients were separated into two groups: AxiaLIF (56 patients) and ALIF (38 patients). Outcome measures included segmental lordosis, sagittal vertical alignment, lumbar lordosis (LL), and pelvic incidence–LL mismatch as well as pseudarthrosis, major complication, and revision surgery rates. The ALIF group achieved greater postoperative and delta segmental lordosis, higher delta sagittal vertical alignment, higher delta LL, and lower postoperative pelvic incidence–LL mismatch. The pseudarthrosis, major complication, and revision surgery rates were higher in the AxiaLIF group. Five cases of pseudarthrosis at L5 to S1 were seen, all in the AxiaLIF group. The authors concluded that ALIF patients had more favorable radiographic correction parameters and lower rates of pseudarthrosis, major complications, and revision surgeries. ALIF is the preferred strategy for L5 to S1 arthrodesis at the bottom of a long construct. This study is limited by its small sample size and retrospective observations. In addition, the ALIF vs AxiaLIF surgeries were not randomized. Further research, with RCTs, is needed to validate these findings.

The National Institute for Health and Care Excellence guidance states that the evidence on the safety of transaxial interbody lumbosacral fusion for severe chronic low back pain shows that there are serious but well-recognized complications. Therefore, this procedure should only be used with special arrangements for clinical governance, consent and audit, or research. The National Institute for Health and Care Excellence encourages further research into transaxial interbody lumbosacral fusion (NICE, 2018).

Zeilstra et al. (2013) reported their 6-year, single-center experience with L5 to S1 AxiaLIF. Overall, 131 individuals with symptomatic degenerative disc disease that was refractory to nonsurgical treatment were treated with AxiaLIF at L5 to S1 and followed up for a minimum of 1 year. Main outcomes included back and leg pain severity, ODI score, working status, analgesic medication use, individual satisfaction, and complications. Back and leg pain severity decreased by 51% and 42%, respectively, during the follow-up period. Back function scores improved 50% compared with baseline. The authors concluded that single-level AxiaLIF is a safe and effective means to achieve lumbosacral fusion in individuals with symptomatic degenerative disc disease. Moreover, they noted, "Our study is limited by the retrospective nature of the analysis. Additionally, all patients underwent fusion at L5 to S1 and, therefore, no conclusions can be drawn regarding the effectiveness or safety of 2-level AxiaLIF from this report. Lastly, mean patient follow-up was 21 months. Although this represents one of the longest follow-up reports following AxiaLIF surgery, long-term clinical and radiographic outcomes are unknown."

In a 5-year postmarketing surveillance study, Gundanna et al. (2011) reported complications associated with axial presacral lumbar interbody fusion in 9,152 individuals. A single-level L5 to S1 fusion was performed in 8,034 individuals (88%), and a two-level L4 to S1 fusion was performed in 1,118 individuals (12%). Complications were reported in 1.3% of individuals, with the most commonly reported complications being bowel injury (0.6%) and transient intraoperative hypotension (0.2%). Other complications that were noted included superficial wound and systemic infections, migration, subsidence, presacral hematoma, sacral fracture, vascular injury, nerve injury, and ureter injury. The overall complication rate was similar between the single-level (1.3%) and two-level (1.6%) fusion procedures, with no significant differences noted for any single complication. The authors concluded that the overall complication rates compared favorably with those reported in trials of open and minimally invasive lumbar fusion surgery.

Clinical Practice Guidelines

American Association of Neurological Surgeons (AANS)/Congress of Neurological Surgeons (CNS)

The AANS and CNS have jointly published a series of guidelines that address fusion for degenerative disease of the lumbar spine (2014). Surgical decompression is recommended for patients with symptomatic neurogenic claudication due to lumbar stenosis without spondylolisthesis who elect to undergo surgical intervention. In the absence of deformity or instability, lumbar fusion has not been shown to improve outcomes in patients with isolated stenosis; therefore, it is not recommended.

North American Spine Society (NASS)

NASS (2014b) published guidelines on the treatment of degenerative spondylolisthesis. NASS has stated that there is insufficient evidence to make a recommendation for or against the cost-effectiveness of minimal access-based surgical treatments compared with traditional open surgical treatments for degenerative lumbar spondylolisthesis. This guideline did not specifically address AxiaLIF.

Laparoscopic Anterior Lumbar Interbody Fusion

Evidence in the peer-reviewed scientific literature that evaluates laparoscopic anterior lumbar interbody fusion (LALIF) is primarily in the form of prospective and retrospective case series, comparative trials, and nonrandomized trials. The average sample size of these studies varies but range, on average, from 40 to more than 200 individuals. Many studies are outdated, with the average being over 20 years ago. Currently, the published, peer-reviewed scientific literature does not allow strong conclusions regarding the overall benefit and long-term efficacy of the laparoscopic approach compared with open spinal fusion.

Minimally invasive alternatives to the mini-open ALIF approach include LALIF and robotic-assisted anterior lumbar interbody fusion (R-ALIF). In a 2025 systematic review, Decker et al. summarized the existing literature on both L- and R-ALIF, focusing on current practices as well as future objectives. In total, 48 studies met the criteria for inclusion; 42 focused on LALIF (37 of these were published prior to 2004), while six assessed R-ALIF. Compared with mini-open ALIF procedures, LALIF produced similar outcomes; however, LALIF had longer operative times, higher technical demands, and a potentially higher rate of complications. The researchers indicated that based on the evidence identified in the review, LALIF is now rarely used. Evidence specific to R-ALIF, although limited, revealed potential reductions in complications, such as nerve injury and retrograde ejaculation, as well as shorter recovery times, but additional training requirements, logistical challenges due to the large robotic operating systems, and higher cost present potential barriers. Although these data are encouraging, several limitations were noted. These include the high volume of retrospective studies in the analysis, exclusion of studies that were not published in English, and significant level of heterogeneity among the studies reviewed, limiting data interpretation. In addition, only six studies that focused on R-ALIF were identified for the review, most of which had been published in the past 2 years. Lastly, because of the limitations noted above, no quantitative analysis of the publications was carried out. Further high-quality clinical studies that substantiate the utility of R-ALIF in spinal surgery are required before this technology can be incorporated into standard models of care.

Minimally Invasive Lumbar Decompression

Available studies have limitations that include noncontrolled trials, case series, nonblinded studies, and a small number of individuals. Well-designed studies that include a larger number of individuals at multicenters, use of clear participant selection criteria, measures of outcomes using standardized tools, comparison with conservative management, comparison with and without an anesthetic agent, and longer-term outcomes are needed to validate the use, safety, and effectiveness of this technology.

Zhang et al. (2025) conducted a systematic review and meta-analysis to evaluate the efficacy of the Minimally Invasive Lumbar Decompression (MILD®) procedure for the treatment of lumbar spinal stenosis due to a hypertrophied ligamentum flavum. Pain relief, measured via the VAS or ODI, was the primary outcome of this analysis; scores were measured at baseline, less than 6 months post treatment, 6 months or less post treatment, less than 1 year post treatment, and greater than 1 year post treatment. Postoperative complications were assessed as a secondary outcome. Information from 500 individuals, enrolled in 12 clinical trials, was examined. The analysis revealed a significant decrease in mean pain score after MILD® treatment compared with baseline ($p < 0.01$). In addition, the rate of adverse events was low (8.2%) compared with those of other surgical decompression techniques. The authors concluded that based on these findings, MILD® appears to be a safe and effective surgical technique for individuals with stenosis that is secondary to a hypertrophied ligamentum flavum. However, the review has several notable limitations. The clinical trials that were evaluated in this study (some of which were retrospective) did not have consistent exclusion and inclusion criteria. Heterogeneity across the included trials was high, and publication bias was likely. While all clinical trials that were included in the analysis incorporated conservative treatments prior to MILD®, neither treatment modalities nor duration of treatment were standardized. VAS and ODI scores were used; these are subjective and may have introduced bias. Additional large, well-designed, prospective studies are needed to confirm the findings of this review and analysis. (Publications by Mekhail et al., 2021, and Chopko et al., 2013, which were previously cited in this policy, are included in this systematic review.)

ECRI (2021a) performed a literature review of the Vertos mild® Device Kit. Evidence from studies synthesized in systematic reviews showed that the mild® procedure is safe and relieves lumbar spinal stenosis symptoms at up to 1 year of follow-up. Evidence from additional studies suggests that the mild® procedure may be as effective as but safer than laminectomy (three nonrandomized studies) and may be more effective than epidural steroid injections (ESIs; one RCT), but these findings need validation in additional RCTs to permit conclusions. Despite the large amount of available data, some evidence gaps remain. Additional RCTs are needed to verify findings and assess mild®'s effectiveness compared with that of other decompression procedures. Large, multicenter studies that assess the mild® procedure's long-term effectiveness (i.e., 5 years or longer) are also needed.

Merkow et al. (2020) published the results of a systematic review that evaluated outcomes with both MILD® and Superion (intraspinous process device), separately, as treatments for lumbar spinal stenosis. Regarding MILD®, the authors' review included eight studies: two RCTs, three prospective observational trials, and three retrospective observational trials. The authors concluded that MILD® is modestly safe and effective for the treatment of lumbar spinal stenosis, based primarily on the study by Staats et al. (2018), which showed 2-year outcomes. (This study is included in the 2025 Hayes Health Technology Assessment discussed below.)

Aldahshory et al. (2020) evaluated and compared the clinical outcomes with two different treatment modalities for degenerative lumbar canal stenosis (LCS): the classic laminectomy with posterolateral transpedicular screw fixation and MILD. This was a randomized study in 50 participants with degenerative LCS. The study compared two cohorts; in group A, 25 participants underwent classic lumbar laminectomy with posterolateral transpedicular fixation, and in group B, 25 participants underwent MILD. There were no statistically significant differences between both treatment modalities in the VAS for leg pain and back pain, Patient Satisfaction Index, and ODI after 1 year. The fusion operations were associated with higher estimates of blood loss and longer hospital stay. The authors concluded that MILD has the same satisfactory results as classic laminectomy with posterolateral fixation for the treatment of degenerative LCS, with less bleeding loss and shorter hospitalization. The study limitations include a 1-year follow-up, which is not sufficient to assess the reoperation rate in case of adding fusion. Other limitations include a small sample size and lack of information about the body mass index of each participant and the associated comorbidities.

In 2019, Deer et al. published consensus guidelines for minimally invasive spine treatment for lumbar spinal stenosis. The U.S. Preventive Services Task Force criteria for evidence level and degree of recommendation were used, along with strength of consensus for development of the guidelines. In this guideline regarding percutaneous image-guided lumbar decompression (PILD), the authors concluded that the available evidence is level 1 and is supportive of PILD. In addition to retrospective and prospective studies that were reviewed by the consensus group, there were two comparative prospective trials that led to reimbursement approval by the Centers for Medicare and Medicaid Services, both being noted as level 1 (Brown, 2012; Staats et al., 2018, detailed below); both compared PILD with lumbar ESIs and not with open decompression. The recommendation by the authors is grade A (good evidence that the measure is effective and that benefits outweigh harms), level 1 (at least one controlled and randomized trial, properly designed), and a strong consensus (> 80% consensus).

Staats et al. (2018, included in the 2021a ECRI literature review and the 2025 Hayes Health Technology Assessment discussed elsewhere in this policy) reported the results of a prospective multicenter RCT. This study evaluated the long-term durability of the MILD procedure in terms of functional improvement and pain reduction in participants with lumbar

spinal stenosis and neurogenic claudication due to a hypertrophic ligamentum flavum. Follow-up occurred at 6 months and 1 year for the randomized phase and at 2 years for MILD participants only. The ODI, Numeric Pain Rating Scale, and Zurich Claudication Questionnaire were used to evaluate function and pain. Safety was evaluated by assessing incidence of device-/procedure-related adverse events. The authors concluded that MILD showed excellent long-term durability, and there was no evidence of spinal instability through the 2-year follow-up. Given the minimally invasive nature of this procedure, its robust success rate, and durability of outcomes, MILD is an excellent choice for first-line therapy for select individuals with central spinal stenosis, neurogenic claudication symptoms, and a hypertrophic ligamentum flavum. Despite the above findings, the study has limitations, including the lack of a control group at the 2-year follow-up. The randomized controlled portion of the study concluded at the primary end point of 1 year, and supplementary follow-up through 2 years was conducted for the MILD participant group only. This study did not compare efficacy directly with open surgical approaches, including lumbar decompression, fusion, and spacers.

Brown (2012) reported the results of a double-blinded, randomized, prospective study of ESIs and the mild® procedure at a single pain management center. A total of 38 participants with symptomatic lumbar spinal stenosis participated in the study and were randomized into two treatment groups: 21 participants in the mild® arm and 17 participants in the ESI arm. Outcome measures were reported using the VAS, ODI, and Zurich Claudication Questionnaire patient satisfaction score. The authors reported that at 6 weeks, the mild® participants improved from an average VAS baseline of 6.3 to a mean of 3.8. The ESI group had a mean VAS score of 6 at baseline compared with 6.3 at 6 weeks of follow-up. Using the ODI, at 6 weeks of follow-up, participants in the mild® group had a decrease from a baseline mean ODI from 38.8 to 27.4. In the ESI group, the initial ODI was 40.5, and at 6 weeks of follow-up, the ODI was 34.8. In the mild® group, there was no significant change in the VAS and ODI scores from weeks 6 to 12. Participants in the ESI group were not measured at week 12. Participants were allowed to cross over from the ESI group to the mild® group before 12 weeks, and eventually, all the participants in the ESI group had the mild® procedure. A total of 14 of the 17 participants in the crossover ESI group experienced an improvement in their VAS scores after the mild® procedure. Limitations of the study include its small size and short follow-up. (This study is included in the Hayes 2025 Health Technology Assessment and the systematic review by Zhang et al., 2025, discussed above.)

Clinical Practice Guidelines

International Society for the Advancement of Spine Surgery (ISASS)

In 2016, the ISASS published recommendations for decompression with interlaminar stabilization. The ISASS concluded, based in part on a conference presentation of a study, that an interlaminar spacer in combination with decompression can provide stabilization in patients who do not present with greater than grade 1 instability. Recommended indications and limitations are described in the article. The document did not address interspinous and interlaminar distraction devices without decompression (Guyer et al., 2016).

North American Spine Society (NASS)

The 2011 NASS clinical guideline on interspinous process spacing devices concluded that there is insufficient evidence to make a recommendation for or against the placement of an interspinous process spacing device in patients with lumbar spinal stenosis.

Percutaneous Image-Guided Lumbar Decompression

This evidence review addresses posterior decompression of lumbar spinal stenosis with percutaneous treatment performed under fluoroscopic guidance. The primary literature on image-guided MILD includes a large RCT, a small RCT, 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 trial was unblinded, and there is evidence of differing expectations and follow-up in the two groups, suggesting a high risk of bias. The available evidence is insufficient to determine the efficacy of MILD compared with that of placebo or to determine the efficacy of image-guided MILD compared with that of 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 that the technology results in an improvement in the net health outcome.

A Hayes Health Technology Assessment (2025) evaluated the effectiveness and safety of the PILD procedure in adults (≥ 18 years old) with posterior lumbar spinal stenosis. The evidence in the assessment included 11 relevant studies and focused on individuals with lumbar spinal stenosis that was primarily due to hypertrophy of the ligamentum flavum. PILD was performed via the mild® procedure using a proprietary surgical kit (mild®; Vertos Medical, Inc.) in most of the published literature. Overall, Hayes determined that the body of evidence was low quality, and while statistically and clinically significant improvements in symptoms of pain, disability, and function that lasted for up to 1 to 2 years were observed, substantial uncertainty remains regarding long-term durability of benefit and effectiveness compared with other minimally invasive procedures.

In a Health Technology Assessment, a small body of very limited low-quality evidence is considered insufficient to determine the safety and efficacy of percutaneous laser disc decompression for lower back disc herniation (Hayes, 2018; updated 2021). The assessment also suggests uncertainty regarding the comparative and long-term effectiveness of percutaneous laser disc decompression and the need for subsequent surgeries.

Brouwer et al. (2015, included in the Hayes report above) conducted an RCT with a noninferiority study design (n = 115) to evaluate percutaneous laser disc decompression compared with conventional surgery for the treatment of low back pain. The noninferiority analysis showed that percutaneous laser disc decompression resulted in noninferior outcomes compared with conventional surgery; however, the number of reoperations that were required was significantly higher in the percutaneous laser disc decompression group (38%) than the conventional surgery group (16%). At the 2-year follow-up, Brouwer et al. (2017) demonstrated that although the rate of reoperation in the percutaneous laser disc decompression group was higher than expected, surgery could be avoided in 48% of those participants who were original candidates for surgery. The authors concluded that the results justify the need for additional studies into the value of percutaneous laser disc decompression as an alternative to conservative treatment.

In a retrospective observational study, Klessinger (2018) reported on the resurgery frequency in 73 patients who received percutaneous lumbar disc decompression (PLDD) using the Dekompressor. Patient data were drawn from an electronic medical record system for patients who were receiving PLDD between January 2005 and December 2007. A history of pain for a minimum of 3 months was mandatory. Patients had either low back pain or radicular pain, with or without a sensory loss. Patients with lumbar spine surgery in their history were excluded. All patients were seen in the practice 1 month after the operation for follow-up, and subsequent follow-up was according to the needs of the patient. In 22 patients (30.1%), the follow-up was longer than 5 years, and in five patients (6.8%), it was longer than 10 years. The mean follow-up time was 35.6 months. The results showed that 1 month after the intervention, excellent results were achieved in 17 patients, and good results were achieved in 32 patients, giving a short-term success rate of 67.1%; however, subsequent open surgery at the index level was necessary in 19 patients (26.0%). Most reoperations (15 patients) had to be performed during the first year after PLDD (20.5% of all patients; 78.9% of all resurgeries). These patients had a statistically significant worse outcome (26.7% vs 75.0% satisfied patients). Radicular pain was present in all patients with early subsequent surgery but was present in only 50% of patients with late surgery. The mean time between PLDD and the additional surgery was 10.8 ±17.9 months. The author concluded that despite an initial success rate of 67%, the resurgery rate of 26% offsets that, suggesting that PLDD is not a replacement for open discectomy. Further studies are needed to compare the outcome with and rate of subsequent surgery in populations of individuals with or without radicular symptoms to find the ideal indications for PLDD.

In a prospective cohort study, McCormick et al. (2016) determined long-term outcomes with Dekompressor PLDD for discogenic radicular pain. Consecutive participants (n = 70) with discogenic lumbosacral radicular pain who underwent PLDD with Dekompressor were included in the study. The Numeric Rating Scale leg pain score and ODI score data were collected at 6 months and 1 year. These two measures, 5-point Likert scale participant satisfaction, and surgical rate data were also collected at 8 years when possible. Overall, 40 and 25 participants were successfully contacted at the 1-year and 8-year follow-ups, respectively. At 1 year and 8 years, Numeric Rating Scale leg pain scores were reduced greater than 50% in 47% and 29% of participants, respectively; ODI score improved greater than 30% in 43% and 26% of participants, respectively. Of the participants who were followed-up at 8 years, 36% had undergone surgery, and the median satisfaction was 4 (IQR, 2-5). The authors concluded that while limited by loss to follow-up, the findings of this study suggested that treatment of discogenic lumbosacral radicular pain with Dekompressor resulted in decreased leg pain and disability and favorable satisfaction at the long-term follow-up. They stated that further study, with adequate follow-up retention, is needed to confirm that Dekompressor spares open spinal surgery. The findings are limited by the lack of a comparison group and large loss to follow-up.

Cong et al. (2016) conducted a systematic review to compare the effectiveness and safety of endoscopic discectomy with those of open discectomy for the treatment of symptomatic lumbar disc herniation. A search was used to identify all published RCTs up to August 2014. Cochrane methodology was used for the results of this meta-analysis. Nine relevant RCTs, involving 1,092 individuals, were identified. Compared with open discectomy, endoscopic discectomy resulted in slightly better clinical outcomes, which were evaluated by the Macnab criteria without clinical significance (endoscopic discectomy group: 95.76%; open discectomy group: 80%; p = 0.10), a significantly greater individual satisfaction rate (endoscopic discectomy group: 93.21%; open discectomy group: 86.57%; p = 0.03), lower intraoperative blood loss volume, and shorter length of hospital stay. The authors concluded that from the existing outcomes, endoscopic discectomy surgery could be viewed as a sufficient and safe supplementation and alternative to standard open discectomy. The cost-effectiveness analyses still remain unproved from the existing data. More independent, high-quality RCTs that include sufficiently large sample sizes are needed.

Manchikanti et al. (2013b) conducted a systematic review in individuals with radicular pain to determine the effectiveness of mechanical lumbar disc decompression with nucleoplasty. Fifteen studies met the inclusion criteria, but only one was an RCT; therefore, no meta-analysis could be performed. A total of 2,429 individuals were evaluated, with at least 50 individuals in each study and a follow-up period of 1 year. Individuals had an average improvement of 62% in pain relief. In this limited-to-fair evidence, the authors concluded that nucleoplasty may provide relief in individuals with disc herniation. Limitations include the lack of RCTs, patient loss, publication bias, and large number of placebo-control groups in which a local anesthetic injection was performed, thus mimicking a facet joint injection.

Percutaneous Sacroplasty

There is insufficient and low-quality evidence demonstrating the safety and clinical efficacy of percutaneous sacral augmentation or percutaneous sacroplasty for sacral insufficiency fractures from causes other than osteoporosis or malignancy. Further research is necessary to establish the value of this procedure, with recommended larger RCTs that are geared to establish the safety and long-term effectiveness of this procedure for unilateral or bilateral sacral insufficiency fractures.

A 2023 (updated November 2024) Hayes Evolving Evidence Report for percutaneous sacroplasty for the treatment of sacral insufficiency fractures (SIFs) due to causes other than malignancy indicates that there is minimal support for using percutaneous sacroplasty for the treatment of SIFs. In addition, based on a review of full-text clinical practice guidelines and position statements, guidance appears to confer no/unclear support for sacroplasty for the treatment of SIFs. In the report, Hayes concluded that the overall body of evidence is poor and additional research is needed to establish the value and role of sacroplasty for the treatment of SIFs.

Andresen et al. (2022) conducted a retrospective study to compare the outcomes of conservative, interventional, and surgical treatment of fragility fractures of the sacrum (FFS). The study spanned 2 years and contained 292 patients who had confirmed FFS. The individual treatment concepts were determined by using fracture morphology, pain, concomitant diseases, and the will of the patient. Patients who had a pain level of ≤ 5 benefited from the conventional treatment measures; patients with pain levels of > 5 notably delayed the development of mobility. Post sacroplasty, patients' pain levels were found to be reduced significantly, which produced a swift improvement in mobility without any noteworthy difference between vertebro-, balloon, radiofrequency, and cement sacroplasty. The study also found that the patients who benefited from osteosynthesis took longer in pain reduction and mobilization due to compound fracture types with lumbopelvic stabilization. Mortality rates were at 21.7% after 12 months in patients who underwent conservative treatment, while the rate in those who sought interventional treatment was 8.4%; patients who underwent surgical therapy were found to be at 13.6%. The mortality rate increased to 24.3% in the group of patients who underwent conservative therapy and were problematic to mobilize due to pain. Over the course of 2 years, patients attained the greatest independence after sacroplasty. Patients who chose sacroplasty followed by osteosynthesis and conservative treatment achieved subjective satisfaction during 12 and 24 months. Vitamin D deficiency was noted in all patients. The authors concluded that patients with FFS and low pain levels could be treated conservatively, whereas patients with interminable, immobilizing pain had a notable increase in complications and mortality. In patients with nondislocated fractures and an unacceptable level of pain, sacroplasty was significantly beneficial. Surgically treated patients with sacroplasty or osteosynthesis benefited in independence and lower mortality. The treatment of different fracture types and bias due to the selection of the type of treatment (surgical vs interventional) are limitations, in addition to the retrospective study design.

Chandra et al. (2019) conducted a systematic review and meta-analysis that evaluated the safety and effectiveness of sacroplasty for the treatment of osteoporotic and malignant sacral fractures. Overall, 19 studies (n = 861) met the inclusion criteria and were used in this analysis. The main outcome measures that were extracted included technical success rate, clinical success rate, complication rate, and pain score, as measured by the VAS. The study identified that 98.9% of individuals achieved technical success with sacroplasty and clinical success of 95.7%. The primary complication was cement leakage at 0.3%, which required surgical decompression. The VAS pain level prior to the procedure and at 24 to 48 hours, 6 months, and 12 months was demonstrated by cumulative pain scores of 8.32 ±0.01, 3.55 ±0.01, 1.48 ±0.01, and 0.923 ±0.01, respectively. The authors concluded that sacroplasty appears safe and effective for pain relief in individuals with osteoporotic or malignant sacral fractures, with statistically significant, sustained improvement in VAS pain scores up to 12 months. Limitations of this study are those intrinsic to systematic reviews. Techniques, selection of individuals, and follow-up were not standardized across the studies. In addition, the bulk of studies that were involved in this meta-analysis were retrospective and prospective case series, and there were no RCTs that met the inclusion criteria. Additionally, other metrics of clinical benefit were not analyzed, including individuals' mobility after the procedure, individuals' satisfaction, and individuals' use of narcotics. To summarize, the meta-analysis supported that sacroplasty seems safe and effective for the treatment of osteoporotic or malignant sacral fractures, with statistically considerable experienced improvement in VAS pain scores up to 12 months. The results of the study may be used as an incentive for

upcoming RCTs that compare sacroplasty with conservative management or sham procedures. (Frey et al., 2017, which was previously cited in this policy, is included in this systematic review.)

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

A variety of endoscopes and associated surgical instruments and devices have received marketing clearance through the FDA's 510(k) process. Refer to the following website for more information and search by product name in the device name section: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed October 22, 2025)

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Policy History/Revision Information

Date	Summary of Changes

04/01/2026	**Definitions**
	• Removed definition of:
	  ○ Automated Percutaneous Lumbar Discectomy (APLD)
	  ○ Interlaminar Lumbar Instrumented Fusion (ILIF)
	  ○ Nucleoplasty
	  ○ Percutaneous or Endoscopic Lumbar Fusion
	  ○ Transforaminal (TESSYS®) and Interlaminar Endoscopic Surgical Systems
	  ○ Tubular Retractor
	• Updated definition of:
	  ○ Axial Lumbar Interbody Fusion (AxiaLIF)
	  ○ Endoscope
	  ○ Endoscopic Discectomy
	  ○ Fluoroscopy
	  ○ Image-Guided Minimally Invasive Lumbar Decompression (MILD®)
	  ○ Laparoscopic Anterior Lumbar Interbody Fusion (LALIF)
	  ○ Open Spine Surgery
	  ○ Percutaneous Image-Guided Lumbar Decompression (PILD)
	  ○ Posterior Lumbar Spine Surgery
	  ○ Sacroplasty
	Applicable Codes
	• Added CPT codes 62330 and 62331
	• Removed CPT code 0275T
	• Revised description for CPT code 62287
	Supporting Information
	• Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information
	• Archived previous policy version CS364OH.C

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state (Ohio Administrative Code [OAC]) or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state (OAC) or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state (OAC) or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state (OAC) or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare uses InterQual® for the primary medical/surgical criteria, and the American Society of Addiction Medicine (ASAM) for substance use, in administering health benefits. If InterQual® does not have applicable criteria, UnitedHealthcare may also use UnitedHealthcare Medical Policies, Coverage Determination Guidelines, and/or Utilization Review Guidelines that have been approved by the Ohio Department for Medicaid Services. The UnitedHealthcare Medical Policies, Coverage Determination Guidelines, and Utilization Review Guidelines are intended to be used in

connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.