

Clinical Policy: Discography

Reference Number: WNC.CP.264

Last Review Date: 08/24

Coding Implications

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description¹

Discography is an invasive, intradiscal diagnostic technique that uses imaging and pain to diagnose discogenic pain. In lumbar discography, contrast medium is injected into a lumbar intervertebral disc that is thought to be the cause of low back pain. This procedure is a screening tool used to reproduce a patient's pain, visualize the disc morphology, and determine if surgical intervention would be appropriate. Injection pressures are also taken into account when considering whether the test suggests symptomatic disc degeneration.¹

Policy/Criteria¹

- I. It is the policy of WellCare of North Carolina® that lumbar discography is **not medically necessary**.
- II. It is the policy of WellCare of North Carolina® that there is insufficient evidence in the published peer-reviewed literature to support the use of cervical and thoracic discography.

Background¹

Lumbar Discography

Lumbar Discography is a controversial diagnostic test for chronic discogenic low back pain after other possible sources of lumbar pain have been excluded, and surgery is being considered.¹⁻² Proponents argue that recreating the patient's pain makes the test more sensitive and specific than imaging such as radiographs, myelography, and MRI, which identify both symptomatic and asymptomatic abnormalities.² The North American Spine Society (NASS) supports the use of lumbar discography citing evidence that it associates pain with moderate to severe disc degeneration and endplate abnormalities on imaging. However, NASS indicates there is insufficient evidence to support the use of discography to predict successful outcomes in patients after lumbar surgery.³ Critics argue that discography lacks reliability, given the absence of a clearly defined gold-standard reference test and the ability of the test to produce pain in patients without any prior history of back pain.^{2,4} Additionally, studies have come to conflicting conclusions regarding the accuracy of lumbar discography in identifying the source of discogenic pain and in guiding treatment decisions.^{1,5-8} Further, in a review of published studies since 2017,

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Hayes, Inc. identified five position statements or guidelines that confer weak support of lumbar provocative discography.¹⁷

Recent guidelines upheld prior statements regarding the unsuitability of discography as a standalone test. Moreover, there is evidence from a prospective cohort study that discography may lead to accelerated disk degeneration such as occurrence of new herniations, loss of disc height, and loss of disc signal intensity.²

Cervical/Thoracic Discography

Cervical discography and thoracic discography remain controversial procedures due to the absence of validation and controlled outcome studies. Further limitations include a paucity of literature and few studies of poor quality.⁹⁻¹¹ For cervical and thoracic pain, discography is not an appropriate diagnostic or screening tool.¹⁰⁻¹¹

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
62290	Injection procedure for discography, each level; lumbar
62291	Injection procedure for discography, each level; cervical or thoracic
62292	Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar
72285	Discography, cervical or thoracic, radiological supervision and interpretation
72295	Discography, lumbar, radiological supervision and interpretation

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	08/21	01/22
Annual review. Description and background updated with no impact to criteria. References reviewed and updated.	08/22	08/22
NCHC verbiage removed from NC Guidance Verbiage.	04/23	04/23
Annual Review. CPT codes & references reviewed.	08/23	08/23

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Annual Review. Updated background with no clinical significance. References reviewed and updated. ICD-10/HCPCS code tables removed.	08/24	08/24

References

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12. Wang H, Li Z, Zhang C, et al. Correlation between high-intensity zone on MRI and discography in patients with low back pain. *Medicine (Baltimore)*. 2017;96(30):e7222. doi:10.1097/MD.00000000000007222.
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16. Manchikanti L, Soin A, Benyamin RM, et al. An Update of the Systematic Appraisal of the Accuracy and Utility of Discography in Chronic Spinal Pain. *Pain Physician*. 2018;21(2):91 to 110.
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North Carolina Guidance

Eligibility Requirements

- a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
- b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

- a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.

2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>

Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information

Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

- a. Claim Type - as applicable to the service provided:

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

- b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
- c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

- d. Modifiers - Providers shall follow applicable modifier guidelines.
- e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
- f. Co-payments -
For Medicaid refer to Medicaid State Plan:
<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>
- g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in

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This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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