Clinical Policy: Discography
Reference Number: CP.MP.115
Date of Last Revision: 06/23

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

Description
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.

Policy/Criteria
I. It is the policy of health plans affiliated with Centene Corporation® that lumbar discography is not medically necessary.

II. It is the policy of health plans affiliated with Centene Corporation that there is insufficient evidence in the published peer-reviewed literature to support the use of cervical and thoracic discography.

Background
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. Proponents argue that recreating the patient’s pain makes the test more sensitive and specific than imaging such as radiographs, myelography, and magnetic resonance imaging (MRI), which identify both symptomatic and asymptomatic abnormalities. 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. 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. 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. Discography after lumbar discectomy in particular has been noted to produce pain in patients who are otherwise asymptomatic.

Recent guidelines upheld prior statements regarding the unsuitability of discography as a stand-alone 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.

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.\textsuperscript{10-12} For cervical and thoracic pain, discography is not an appropriate diagnostic or screening tool.\textsuperscript{11-12}

**Coding Implications**

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<tr>
<th>CPT\textsuperscript{®} Codes</th>
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<tr>
<td>62290</td>
<td>Injection procedure for discography, each level; lumbar</td>
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<tr>
<td>62291</td>
<td>Injection procedure for discography, each level; cervical or thoracic</td>
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<tr>
<td>62292</td>
<td>Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar</td>
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<tr>
<td>72285</td>
<td>Discography, cervical or thoracic, radiological supervision and interpretation</td>
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<tr>
<td>72295</td>
<td>Discography, lumbar, radiological supervision and interpretation</td>
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**Reviews, Revisions, and Approvals**

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References


Clinical Policy

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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 developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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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**Note: For Medicaid members/enrollees**, 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.

**Note: For Medicare members/enrollees**, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at [http://www.cms.gov](http://www.cms.gov) for additional information.

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