SPINE EVOLUTIONS

Spine Evolutions 2026: Audience Questions

Update to MBT Reimbursement Section of 2025 Spine Evo Questions

What is the updated reimbursement for medial branch nerve transection (MBT)?
If you're performing MBT (64772), you can now complete 6 nerve transections per surgery (previously 2 nerves). Medicare made this change effective January 1, 2026. There are 12 Medicare Administrative Contractors (MACs). *Answered by Wade Jensen, MD (Star Valley, WY)*

The key nuance surgeons should understand is that CMS has approved 6 units nationally for CPT® 64772 starting January 1, 2026, but actual reimbursement is still set regionally by each Part B MAC. Every MAC must update its own systems to reflect this change, and the timing of those updates is not yet known.

Until that occurs, coverage and payment levels may vary by region. In short, the national policy now supports 6 units, but consistent reimbursement won't be guaranteed until all MACs complete their updates. During this transition, awareness, clear documentation, and ongoing communication with local MACs remain essential. *Answered by Paul J. Houle, MD (Hyannis, MA)*

› Becker's Spine Review. CMS approves 6 units for CPT 64772: Why this is a major step for endoscopic spine surgery. Accessed February 4, 2026. https://www.beckersspine.com/spine/cms-approves-6-units-for-cpt-64772-why-this-is-a-major-step-for-endoscopic-spine-surgery/

Summary of Change
CMS has increased the Medically Unlikely Edit (MUE) for CPT 64772 from 2 units to up to 6 units per operative session. This update is now active at the federal level.

Adoption Status
Most MACs have updated their systems to reflect the expanded MUE, though timing varies by region. Private payer adoption typically follows but may not occur uniformly.

Key Points
Surgeons may now bill up to 6 units of 64772 per operative session through Medicare and Medicaid.

Reimbursement depends on payer policy, modifier usage, and documentation; this should not be represented as automatically reimbursed at 100% for all 6 nerves, and the amount of reimbursement varies by area.

Each nerve must be documented as a distinct procedure. Current clinical technique involves a separate skin incision for each nerve, which supports the appropriate use of the -59 modifier.

When multiple nerves are accessed through the same skin incision, reimbursement for additional nerves may be reduced.

Relevant modifiers include:
› -59: Distinct procedural service

› -50: Bilateral procedure

For questions related to coding, billing, or prior authorizations, please contact the Arthrex Market Access and Reimbursement team at 844-604-6359.

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General Spine Endoscopy Questions

What duration of nerve retraction is considered excessive?
This is dynamic. In awake patients, they will tell you or at least squirm and react with pain. In anesthetized patients, this is when neuromonitoring starts to show changes. It will be different for each patient. *Answered by Paul J. Houle, MD (Hyannis, MA)*

Are you delivering a steroid (Decadron, etc) locally prior to and/or following your endoscopic decompression?
No. *Answered by Paul J. Houle, MD (Hyannis, MA)*

Did you get postoperative MRIs on every patient when first starting out with endoscopic cases to assess appropriate decompression?
No. I always continue to evaluate the patient clinically. Do you get MRI on every patient when you first started practice? This is a similar situation. If the patient's symptoms have resolved and they are doing well, no need to look. If they are doing poorly or not as well as expected, then yes I would get an MRI. *Answered by Paul J. Houle, MD (Hyannis, MA)*

I struggle with weighing that decrease in invasiveness with the increase in anesthesia time for endoscopic ULBD. A ULBD with METRx with 18 mm tube for me takes 30 minutes. Honestly, how long do these cases take you, and is that extra time worth it?
That is a great point, one I struggle with as well. Not all tubular surgery is the same. If you are one of those surgeons who still uses the bovie to dissect muscle during tubular surgery, you are going to notice a huge difference. In my tubular surgeries, I use almost no electrocautery, so there is minimal pain. With the new Arthrex drills, I think the time it takes to do a ULBD will significantly decrease and a realistic time for a single level should be under an hour. *Answered by Paul J. Houle, MD (Hyannis, MA)*

What is your technique to make sure the entire disc has been removed and there is no residual stenosis at the end of the case?
I know I am done with discectomy when I see a pulsatile nerve and I can see black space underneath the nerve.

For decompression, exactly the same way doing any other decompression. *Answered by Paul J. Houle, MD (Hyannis, MA)*

I have performed about 100 endoscopic cases and have observed more reherniations after endoscopic vs tubular microdiscectomies. Any recommendations you can offer to reduce this rate? Is it my technique?
More likely that the patients are more active early. The literature supports that the reherniation rate is about the same. It is possible that you are dealing with residual disc material rather than reherniation and that could be related to technique. For transforaminal cases, it is easy to leave disc behind, especially with a large fragment. It's tempting to call it a day when you remove a large fragment but go back and inspect. Is the nerve pulsatile? Can I see underneath the nerve? Does the bipolar slide underneath the nerve without resistance? *Answered by Paul J. Houle, MD (Hyannis, MA)*

- Ahn Y, Lee SH, Park WM, Lee HY, Shin SW, Kang HY. Percutaneous endoscopic lumbar discectomy for recurrent disc herniation: surgical technique, outcome, and prognostic factors of 43 consecutive cases. *Spine (Phila Pa 1976).* 2004;29(16):E326-332. doi:10.1097/01.brs.0000134591.32462.98
- Ruetten S, Komp M, Merk H, Godolias G. Full-endoscopic interlaminar and transforaminal lumbar discectomy versus conventional microsurgical technique: a prospective, randomized, controlled study. *Spine (Phila Pa 1976).* 2008;33(9):931-939. doi:10.1097/BRS.0b013e31816c8af7
- Gibson JNA, Waddell G. Surgical interventions for lumbar disc prolapse: updated Cochrane Review. *Spine (Phila Pa 1976).* 2007;32(16):1735-1747. doi:10.1097/BRS.0b013e3180bc2431

Does removing the SAP cause further collapse and compression?
No. Because reaming and drilling remove only the nonarticulating surfaces of the SAP/IAP, these steps have no impact on stability. *Answered by Paul J. Houle, MD (Hyannis, MA)*

- Hagel V, Calek AK, Meisterhans M, Suter M, Fasser MR, Widmer J, Farshad M. Biomechanical effects of incremental resection of the lumbar superior articular process using an endoscopic approach. *Eur Spine J.* 2025;34(12):5773-5779. doi:10.1007/s00586-025-09470-z

What is the dose of TXA we use?
Almost all of the faculty are using TXA intravenously. Most use 1 g pre-op and some use a higher dosage of 20 mg/kg pre-op. No provider is adding TXA locally. Some providers are using epinephrine in the endoscopic fluid, just like one would do with a shoulder scope. *Answered by Wade K. Jensen, MD (Star Valley, WY)*

- Goldstein K, Jones C, Kay J, Shin J, de Sa D. Tranexamic acid administration in arthroscopic surgery is a safe adjunct to decrease postoperative pain and swelling: a systematic review and meta-analysis. *Arthroscopy.* 2022;38(4):1366-1377.e9. doi:10.1016/j.arthro.2021.10.001

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In a highly degenerated foramen with a lot of inflammatory/fibrotic tissue obscuring the anatomy, what strategies do you use to safely identify the exiting nerve?
The bone is home. Find Wagner's arch. As you follow this rostrally, the tip of the SAP points to the exiting nerve. *Answered by Paul J. Houle, MD (Hyannis, MA)*

Honestly, how long did it take to get to 100 cases?
About 18 months. *Answered by Paul J. Houle, MD (Hyannis, MA)*

How do you see AI shaping the future of endoscopic surgery and its clinical integration?
Awesome question. I think AI will help stratify risk and identify patients who would benefit from decompression alone vs fusion, leading to more endoscopic foraminoplasty as an alternative to fusion. *Answered by Paul J. Houle, MD (Hyannis, MA)*

Why use an ESP block for such a minimally invasive procedure?
It helps tremendously with pain during reaming, and minimizes or eliminates the need for post-op pain medication. *Answered by Paul J. Houle, MD (Hyannis, MA)*

How did you overcome the administrative obstacles?
I presented a compelling argument. I demonstrated how it would benefit my patients and the community. *Answered by Paul J. Houle, MD (Hyannis, MA)*

Do you have any recommendations for bed position, like use of reverse Trendelenburg for mitigating ICP increases?
I perform my cases in the lateral position; this provides airway access for anesthesia and completely decompresses the abdomen. You should not see ICP increases unless you have a dural tear. For more information, you can refer to the OrthoPedia presentations below. *Answered by Paul J. Houle, MD (Hyannis, MA)*

- Farshad M, Stauffer A, Zipser CM, et al. An experimental model for fluid dynamics and pressures during endoscopic lumbar discectomy. *Neurospine*. 2024;21(3):745-752. doi:10.14245/ns.2448350.175
- Farshad M, Schader JF, Stauffer A, et al. Intra-, epidural and intracranial pressure changes during interlaminar endoscopy, with and without dural tear. *Neurospine*. 2025;22(2):583-591. doi:10.14245/ns.2550456.228

Resources

- Dural Tears: Prevention and Repair
  https://clinician.orthopedia.com/student/path/2129567/activity/3631926
- Importance of Pump Pressure During Spinal Endoscopy
  https://clinician.orthopedia.com/student/path/2129567/activity/3950566
- Endoscopic Spine Surgery: Irrigation Insights
  https://clinician.orthopedia.com/student/path/2129567/activity/4842175

Reimbursement

In the ASC setting, what is required for reimbursement under the new CMS update?
I, unfortunately, do not work in an ASC. Prior authorization is not required for Medicare. However, I would give your coders and billers a heads-up and make sure they are aware of the MUE changes, and that they should expect denials, and that they should be on top of appeals and resubmissions. *Answered by Paul J. Houle, MD (Hyannis, MA)*

- For more information, refer to the question "What is the updated reimbursement for MBT?" at the beginning of this document.

Are any of the faculty billing for the 64772 nerve transection code along with a decompression or discectomy code?
I am not. *Answered by Paul J. Houle, MD (Hyannis, MA)*

How do you code endoscopic debridement?
Options include 63047 or 62380. However, many insurers do not cover 62380, and there are no RVUs assigned to this code. *Answered by Peter Derman, MD (Dallas, TX)*

How do you code pars fracture repair?
For the lumbar spine:

- 22325: Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; lumbar.
- 22328: Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; each additional fractured vertebra or dislocated segment.

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Endoscopic Decompressions

What landmarks are you using to ensure that that you have adequately decompressed?
For the lateral extent, I use the pedicles. My starting point is on the medial pedicular line, so I know that when my scope is straight up in the air that I have decompressed the ipsilateral side (this saves time from taking a lot of x-ray). For the contralateral side, I generally go until the flavum detaches from the undersurface of the SAP. I then check an x-ray to ensure my probe is at the contralateral pedicle or foramen. The cranial and caudal limits are generally the detachment of the ligamentum from the lamina. I also compare intra-op x-rays, while marking the cranial and caudal extent with a probe, to my pre-op MRI to ensure I am above and below any compressive pathology. *Answered by Chad E. Campion, MD (Memphis, TN)*

What are your thoughts and what does literature say on indirect decompression fusion techniques (OLIF/LLIF) vs endoscopic decompression alone?
I am unaware of any literature comparing endoscopic decompression to indirect decompression through interbody fusion. My personal thoughts would be why fuse a segment, unless frankly unstable, and hasten adjacent segment disease, if a limited decompression alone can achieve symptomatic relief? *Answered by Chad E. Campion, MD (Memphis, TN)*

How do you determine the amount of ipsilateral facet to resect for ULBD? Do you identify the pars?
I use the ipsilateral pedicle and ligamentum detachment as my intraoperative guide. I then take an intra-op x-ray and compare to preoperative imaging to ensure I resected any compressive pathology. I do not identify the pars. While this could be easily done, I feel it takes additional time and tissue disruption and adds very little to the case. *Answered by Chad E. Campion, MD (Memphis, TN)*

Can you give tips or technique on your transition to en bloc flavectomy?
This technique requires a lot of drilling. Early on, you will feel as though you are drilling forever. I generally drill the cranial and caudal lamina until the ligamentum is nearly detached. I then drill off the ipsilateral medial facet until the flavum is detached. A Kerrison or curette can then be used to detach from the lamina above and below. If possible, I drill the contralateral side prior to ipsilateral detachment, but occasionally the flavum will become “floppy” and obscure the view. It’s important to drill until nearly completely detached circumferentially because once the ligamentum is disrupted, there will generally be epidural bleeding that obscures the view and adds significant additional time and headache. *Answered by Chad E. Campion, MD (Memphis, TN)*

The most efficient way to drill is to press the bur head into the ligamentum and the ligament-bone interface. These are side-cutting burs, so the tip does very little to remove bone. *Answered by Chad E. Campion, MD (Memphis, TN)*

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Dural Tears in Endoscopic Surgery

What are the implications of pump irrigation on intraoperative dural tears (ie, risk of overinflation of the CSF space)?

Prof. Dr. med. Mazda Farshad has published several well-designed studies on this. The key takeaways are that with the dura intact, even very high pressures cause little increase in intracranial pressure. With a durotomy, the pump pressure should be monitored more closely. The biggest increase in intracranial pressure occurs when the outflow is blocked. Once a durotomy is identified, I try to maintain constant outflow and move the case along as quickly as it can safely and effectively be done. *Answered by Chad E. Campion, MD (Memphis, TN)*

- Farshad M, Stauffer A, Zipser CM, et al. An experimental model for fluid dynamics and pressures during endoscopic lumbar discectomy. *Neurospine*. 2024;21(3):745-752. doi:10.14245/ns.2448350.175
- Farshad M, Schader JF, Stauffer A, et al. Intra-, epidural and intracranial pressure changes during interlaminar endoscopy, with and without dural tear. *Neurospine*. 2025;22(2):583-591. doi:10.14245/ns.2550456.228
- Vargas RAA, Hagel V, Xifeng Z, et al. Durotomy- and irrigation-related serious adverse events during spinal endoscopy: illustrative case series and international surgeon survey. Int J Spine Surg. 2023;17(3):387-398. doi:10.14444/8454
- Farshad M, Schader JF, Stauffer A, et al. Irrigation during lumbar spinal endoscopy: important considerations. *Orthop Procs*. 2025;107-B(SUPP_8):55. doi:10.1302/1358-992X.2025.8.055
- Liu D, Mobbs RJ. Risk analysis of neurological deterioration associated with fluid insufflation in uniportal spine endoscopy: a case series and literature review. Int J Spine Surg. 2025;19(3):279-287. doi:10.14444/8730
- Ozturk M, Dolas I, Yorukoglu AG, et al. Pressure changes at spinal epidural and intracranial regions in fresh cadavers during full endoscopic lumbar spine surgery with continuous irrigation. *J Orthop Surg Res*. 2025;20(1):618. doi:10.1186/s13018-025-06023-4

Resources

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How do you place fibrin glue with the irrigation?

I turn off irrigation and gently suction through the accessory port to remove fluid. I then inject each component of the fibrin glue separately while removing the scope. It is important to pull the scope back away from the durotomy and only lightly suction fluid to avoid nerve root herniation.

Alternatively, a switching stick can be placed down the tube to express fluid through the switching sticks cannulation. The fibrin glue can then be injected down the tube. *Answered by Chad E. Campion, MD (Memphis, TN)*

What is your post-op protocol for CSF leak precautions based on tear size and repair type?

My general thinking is that if the hole is big enough to pass a small grasper, I place a dural patch into the defect as a plug and spray with fibrin. If too small to pass an instrument, I spray fibrin glue.

If it is a very large hole, I attempt to reduce all nerve roots into the dura. I then attempt a patch/plug. If the hole is big enough that a patch will not stay, or there is significant CSF leakage, I have opened for repair one time. Hopefully, instrumentation will soon be available to make endoscopic dural repair/suture much easier and more reliable. *Answered by Chad E. Campion, MD (Memphis, TN)*

Resources

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Specifically, what material is used for plug-and-patch dural repair?

I use a collagen-based dural substitute matrix. Only a very small portion of the patch from the box is needed, so a small piece is cut off. Keep the remainder safe and dry incase the first patch is spit out. *Answered by Chad E. Campion, MD (Memphis, TN)*

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Do you recommend fixing the dural tear immediately, or soon after it happens, to try to avoid worsening nerve root extrusion, or finishing the case first and repairing it at the end?

Luckily, if these occur, they are generally very small. In that case, I usually continue on and repair/plug at the end. If nerve roots are herniated, I will reduce them into the thecal sac and plug to hopefully avoid further issues. *Answered by Chad E. Campion, MD (Memphis, TN)*

Resources

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Irrigation in Endoscopic Spine Surgery

What is an ideal pump pressure for endoscopic spine surgery?
I no longer use a pump, but when I did, I tried to keep the pressure as low as I could while still being able to see and control bleeding. I used to keep pressure below diastolic. *Answered by Chad E. Campion, MD (Memphis, TN)*

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Arthrex, Inc. does not offer a fluid pump that is cleared for use in spine endoscopy.

Does this pressure change based on the endoscopic procedure?
In my experience, no. Something to keep in mind is that while the bed and anatomic location you are working on may be higher or lower from the ground, the pump stays at the same level. For accurate assessment of pressure, the pump should be raised or lowered to be at the same height as the working area. *Answered by Chad E. Campion, MD (Memphis, TN)*

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How do you maintain such a clear field during the procedure without it filling with bloody fluid?
Constant outflow through the working channel and accessory port allow for blood and debris to egress, while irrigation pressure helps tamponade small bleeding vessels and bone. Increasing pressure safely can help control bleeding, but the most effective way is to coagulate vessels and tissue prior to removal to prevent bleeding. Diamond burs can also help control bony bleeding. They do not cut the bone, but rather grind the bone away, which can tamponade boney bleeders. By taking partial bites with a Kerrison, some bony bleeders can be almost crimped closed as well. *Answered by Chad E. Campion, MD (Memphis, TN)*

Endoscopic Cervical Techniques

Which anatomic landmark guides how far lateral you take your cervical foraminotomy?
I measure the facet width on pre-op MRI/CT. Intraoperatively, I use the known diameter of my drill (usually 3.5-4.5 mm) to assess how much I have removed and ensure it is no more than 50%. I also palpate for the pedicles to make sure I am at least to midpedicle. *Answered by Chad E. Campion, MD (Memphis, TN)*

- Choi JU, Hwang CJ, Cho JH, Park S, Lee HR, Lee DH. Reevaluating the 50% facetectomy threshold in posterior cervical foraminotomy: a comparative clinical and radiographic analysis. *Spine J.* 2026;26(4):674-684. doi:10.1016/j.spinee.2025.11.003

Any tips and tricks for identifying anatomy with fluoroscopy at lower cervical levels in patients with large body habitus? Do you consider using navigation?
I do not use navigation, but this would make level confirmation and evaluating the extent of decompression much easier. For lower levels and larger patients, much of my cervical work is done on AP imaging with a C-arm. *Answered by Chad E. Campion, MD (Memphis, TN)*

Which camera/cannula are you using for posterior cervical decompression?
The 15° 7 mm endoscope is commonly used for cervical cases. The 10 mm endoscope can also be used. *Answered by Peter Derman, MD (Dallas, TX)*

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Endoscopic Far Lateral Discectomy

For far lateral L1-L2 discs, what steps do you take to avoid injuring the kidney during the approach?
I always draw out my approach on pre-op MRI to ensure there is no anatomy at risk, or at least know its proximity to my approach. I have not yet seen a kidney be in a location that I have had to alter an approach. For a far lateral, the kidney should be less of a risk than in a lateral recess or central disk. This is due to the "steeper" angle and more medial approach for the far lateral compared to the more midline pathologies. *Answered by Chad E. Campion, MD (Memphis, TN)*

- Inokuchi T, Tezuka F, Yamashita K, et al. Approach-related safety considerations for transforaminal full-endoscopic lumbar spine surgery. *Eur Spine J.* 2025;34:5765-5772. doi:10.1007/s00586-025-09295-w

Percutaneous Pars Fracture Repair

The point of preventing a spondylolisthesis is interesting. What are your thoughts about offering surgery for acute fractures for quicker return to play and prevention of future problems?
While there is not a significant body of literature to forego a period of conservative treatment, this is potentially an area deserving more thought and investigation. Especially in high-level athletes, the repetitive rest and play back-and-forth accounts for significant time away from sport and even reduced level of play while active. *Answered by Chad E. Campion, MD (Memphis, TN)*

- Garg S, Wang Y, Lehman N, Gallizzi M. Robotic-assisted bilateral lumbar pars fracture endoscopic debridement and direct repair as treatment for lumbar radiculopathy: a case report. *N Am Spine Soc J.* 2025;24:100823. doi:10.1016/j.xnsj.2025.100823
- Jin M, Zhang J, Shao H, Liu J, Zhao T, Huang Y. Percutaneous endoscopic-assisted direct repair of pars defect without general anesthesia could be a satisfying treatment alternative for young patient with symptomatic lumbar spondylolysis: a technique note with case series. *BMC Musculoskelet Disord.* 2020;21(1):340. doi:10.1186/s12891-020-03365-4
- Sutton JH, Guin PD, Theiss SM. Acute lumbar spondylolysis in intercollegiate athletes. *J Spinal Disord Tech.* 2012;25(8):422-425. doi:10.1097/BSD.0b013e318236ba6c
- Christman T, Li Y. Pediatric Return to Sports After Spinal Surgery. *Sports Health.* 2016;8(4):331-335. doi:10.1177/1941738116634685.

Do you see pars repair/fixation becoming indicated at an earlier time point and if so, when do the faculty pull the trigger for early operative intervention?
I do think with more minimally invasive techniques and better instrumentation, early direct repair is likely to become more common, especially in high-level athletes. Personally, I still recommend a period of conservative treatment. *Answered by Chad E. Campion, MD (Memphis, TN)*

How do you code pars fracture repair?
For the lumbar spine:

- 22325: Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; lumbar.
- 22328: Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; each additional fractured vertebra or dislocated segment.

This description of technique is provided as an educational tool and clinical aid to assist properly licensed medical professionals in the usage of specific Arthrex products. As part of this professional usage, the medical professional must use their professional judgment in making any final determinations in product usage and technique. In doing so, the medical professional should rely on their own training and experience and should conduct a thorough review of pertinent medical literature and the product's directions for use. Postoperative management is patient-specific and dependent on the treating professional's assessment. Individual results will vary and not all patients will experience the same postoperative activity level or outcomes.

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