



Thermal Intradiscal Procedures – JA6291

Related CR Release Date: December 9, 2008

Date Job Aid Revised: December 17, 2008

Effective Date: September 29, 2008

Implementation Date: January 5, 2009

Key Words MM6291, CR6291, R1646CP, R97NCD, Thermal, Intradiscal, TIP

Contractors Affected

- Fiscal Intermediaries (FIs)
- Part A/B Medicare Administrative Contractors (A/B MACs)
- Medicare Carriers

Provider Types Affected Physicians and other providers who bill Medicare Carriers, FIs, or A/B MACs for providing thermal intradiscal procedures (TIPs) to Medicare beneficiaries



- Change Request (CR) 6291 communicates the findings of a new national coverage determination (NCD) regarding TIPs, including billing requirements.
- Effective for services performed on or after September 29, 2008, the Centers for Medicare & Medicaid Services (CMS) has concluded that the evidence does not demonstrate that TIPs improve health outcomes. **Therefore, CMS has determined that TIPs are not reasonable and necessary for the treatment of low back pain.**
- Effective September 29, 2008, TIPs are non-covered for Medicare beneficiaries.

CR6291 Summary

Provider Needs to Know...

- Announces the relevant Current Procedural Terminology (CPT) codes that (effective September 29, 2008) will be denied when submitted, and also the codes that will be denied **when identified as a TIP**;
- Instructs Medicare contractors to deny claims for radiologic or fluoroscopic guidance when performed in conjunction with a TIP; and

- Urges physicians, ambulatory surgical centers and hospitals to provide appropriate liability notices to beneficiaries.

Note: Percutaneous disc compression or nucleoplasty procedures that do not utilize a radiofrequency energy source or electrothermal energy (such as the disc decompressor procedure or laser procedure) are not within the scope of this NCD.

TIPs NCD Requirements

- The following table displays the CPT/ Healthcare Common Procedure Coding System (HCPCS) codes that are identified for TIPs performed within the annulus of the intervertebral disc.
- **Effective September 29, 2008, Medicare contractors will deny claims submitted for TIPs with any of these non-covered codes.**

CPT/HCPCS Code	Description
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; one or more additional levels
0062T	Percutaneous intradiscal annuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; single level
0063T	Percutaneous intradiscal annuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; one or more additional levels

- The change to add the non-covered indicator for these codes will be part of the January 2009 Medicare Physician Fee Schedule update. The change to the status indicator to non-covered for the above HCPCS codes is part of the Integrated Outpatient Code Editor update for January 2009.
- The following CPT codes, which can be used for TIPs performed within the nucleus of the disc (e.g., Percutaneous (or plasma) disc compression (PDD) or Targeted disc compression (TDD) procedures), can also be used for procedures that are not within the scope of this NCD:
 - **62287** (Aspiration procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar);
 - **22899** (Unlisted procedure, spine); and
 - **64999** (Unlisted procedure, nervous system).
- Providers should note that since codes 22899 or 64999 do suspend for review, when

they are submitted for TIPs performed within the nucleus, they should submit a clear description of the procedure in the narrative section of the claim.

- Contractors may also be advising providers to submit intervertebral disc nucleus procedures that are considered TIPs under codes 22899 or 64999 in order to avoid improper payment for a TIP under code 62287.
- Providers are also advised to submit the biacuplasty procedure under code 0062T (currently some providers are submitting this procedure under code 64999).
- As all TIPs are performed with radiologic or fluoroscopic guidance, this ancillary service would be directly related to a non-covered service and would also be non-covered.
- When denying TIPs claims, Medicare contractors will use:
 - Medicare Summary Notice 21.11 - "This service was not covered by Medicare at the time you received it;"
 - Claim Adjustment Reason Code 96 - "Non-covered charge(s)", and
 - Remittance Advise Remark Code N386 - "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.hhs.gov/mcd/search.asp>. If you do not have access, you may contact the contractor to request a copy of the NCD."
- Physicians and hospitals are advised to give beneficiaries, who choose to have this procedure, an Advance Beneficiary Notice (ABN), consistent with the *Medicare Claims Processing Manual*, Chapter 30, (Financial Liability Protections).
- This ABN, which must be issued prior to the procedure, should indicate that after a National Coverage Analysis (NCA) Medicare issued a NCD (*Medicare National Coverage Determinations (NCD) Manual*, Section 150.11 (Thermal Intradiscal Procedures (TIPs)) (Effective September 29, 2008)), which states that TIPs are not reasonable and necessary for Medicare beneficiaries. **Therefore, Medicare never pays for this service and the beneficiary would be held financially responsible if they decide to have this procedure.**

Note: Unless the beneficiary was informed via the ABN prior to performance of the procedure that he/she would be financially responsible, the provider is liable for charges for TIPs. In addition, beginning March 1, 2009, the ABN-G will no longer be valid and the revised ABN (CMS-R-131) must be issued.

Background

- Percutaneous TIPs involve the insertion of a catheter(s)/probe(s) into the spinal disc under fluoroscopic guidance in order to produce (or apply) heat and/or disruption within the disc to relieve low back pain.
 - On January 15, 2008, CMS initiated a NCA on TIPs. CR6291 communicates the findings of this NCA, and the resultant NCD. This is the first NCD to address TIPs.
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- The NCA addressed the use of TIPs to:
 - Treat symptomatic patients with annular disruption of a contained herniated disc;
 - To seal annular tears or fissures; or
 - To destroy nociceptors for the purpose of relieving pain.
- The scope of the NCA included the use of percutaneous intradiscal techniques that utilize devices employing a radiofrequency energy source or electrothermal energy to apply or create heat and/or disruption within the disc for coagulation and/or decompression of disc material.
- It also included techniques that use single or multiple probes/catheters which:
 - Utilize a resistance coil or other thermal intradiscal technology;
 - Are flexible or rigid; and
 - Are placed within the nucleus, the nuclear-annular junction, or the annulus.
- Although not meant to be a complete list, TIPs are commonly identified as:
 - Intradiscal electrothermal therapy;
 - Intradiscal thermal annuloplasty;
 - Percutaneous intradiscal radiofrequency thermocoagulation;
 - Radiofrequency annuloplasty;
 - Intradiscal biacuplasty;
 - PDD or ablation; or
 - TDD.
- At times, TIPs are identified or labeled based on the name of the catheter(s)/probe(s) that are used (e.g., SpineCath, discTRODE, SpineWand, Accuterm, or TransDiscal electrodes), and each technique or device has its own protocol for application of the therapy.

**Operational
Impact**

Carriers, FIs, and A/B MACs do not need to search their files to recoup payment for claims already paid. However, they will adjust claims that are brought to their attention.

**Reference
Materials**

The related MLN Matters article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6291.pdf> on the CMS website.

The official instruction (CR6291) was issued in two transmittals. The revised *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, Part 2 (Sections 90 – 160.26) (Coverage Determinations), Section 150.11 (Thermal Intradiscal Procedures (TIPs) (Effective September 29, 2008) can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R97NCD.pdf> on the CMS website.

The transmittal that revises Chapter 32 of the *Medicare Claims Processing Manual* is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1646CP.pdf> on the CMS website.

The following sections are revised in Chapter 32 (Billing Requirements for Special Services):

- Section 220 (Billing Requirements for Thermal Intradiscal Procedures (TIPs) Claims),
 - Section 220.1 (General),
 - Section 220.2 (Contractor A/B MAC),
 - Section 220.3 (Medicare Summary Notice (MSN), Claim Adjustment Reason Code (CARC), and Remittance Advise Remark Code (RARC), and
 - Section 220.4 (Advance Beneficiary Notice (ABN)).
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