DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

REVISED products from the Medicare Learning Network® (MLN)

- "Improving Quality of Care for Medicare Patients: Accountable Care Organizations", Fact Sheet, ICN 907407, downloadable

MLN Matters® Number: MM8757	**Related Change Request (CR) #: CR 8757**
Related CR Release Date: May 16, 2014	**Effective Date: January 9, 2014**
Related CR Transmittal #: R167NCD and R2959CP	**Implementation Date: October 6, 2014**

Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)

Provider Types Affected

This MLN Matters® Article is intended for providers submitting claims to Medicare Administrative Contractors (MACs) for services furnished to Medicare beneficiaries.

Provider Action Needed

Effective for claims with dates of service on and after January 9, 2014, Medicare will only allow coverage with evidence development (CED) for percutaneous image-guided lumbar decompression (PILD) for lumbar spinal stenosis (LSS) for beneficiaries enrolled in an approved clinical trial.

Background

PILD is a procedure that was proposed as a treatment for symptomatic LSS unresponsive to conservative therapy. PILD is a posterior decompression of the lumbar spine performed under indirect image guidance without any direct visualization of the surgical area. It is generally

described as a non-invasive procedure using specially designed instruments to percutaneously remove a portion of the lamina and debulk the ligamentum flavum. The procedure is performed under x-ray guidance (e.g., fluoroscopic, CT) with the assistance of contrast media to identify and monitor the compressed area via epiduragram.

The Centers for Medicare & Medicaid Services (CMS) currently does not cover PILD; and moreover, after careful consideration, determines that PILD for lumbar spinal stenosis LSS is not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act (the Act).

However, CMS has determined that effective for claims with dates of service on or after January 9, 2014, Medicare will cover PILD only when it is provided in a clinical study under section 1862(a)(1)(E) of the Act, through CED, for beneficiaries with LSS who are enrolled in an approved clinical study that meets the criteria described in the National Coverage Determinations (NCD) Manual at NCD150.13.

Specific Payment Actions

- On or after January 9, 2014, effective for hospital outpatient procedures on type of bill (TOB) 13X or 85X, and for professional claims billed with a place of service (POS) 22 (outpatient) or 24 (ambulatory surgical center), Medicare will allow CED for PILD (procedure code 0275T) for LSS, ICD-9 diagnosis range 724.01-724.03, or ICD-10 diagnosis range M48.05-M48.07, only when billed with:
    a) Diagnosis code ICD-9 V70.7 (ICD-10 Z00.6) and condition code 30 either in the primary or secondary positions; and
    b) Modifier Q0; and
    c) An 8-digit clinical trial number listed at **http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/PILD.html** on the CMS CED website.
- On or after January 9, 2014, effective for hospital outpatient procedures on type of bill (TOB) 13X or 85X, your MAC will reject claims for PILD, procedure code 0275T for LSS, ICD-9 diagnosis range 724.01-724.03, or ICD-10 diagnosis range M48.05-M48.07, when billed without:
    a) Diagnosis code ICD-9 V70.7 (ICD-10 Z00.6) in either the primary/secondary positions;
    b) Modifier Q0, condition code 30 (institutional claims only); and,
    c) An 8-digit clinical trial number listed on the CMS website.

  When rejecting these claims, they will use:
    a) Claims Adjustment Reason Code (CARC): 50 -These are non-covered services because this is not deemed a “medical necessity” by the payer;
    b) Remittance Advice Remarks Code (RARC) 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 web access, you may contact the contractor to request a copy of the NCD; and

c) Group Code – Contractual Obligation (CO).

- MACs will return the professional PILD claim as unprocessable when billed with a diagnosis code other than 724.01-724.03 (ICD-9) or M48.05-M48.07 (ICD-10), using:
  a) CARC B22: "This payment is adjusted based on the diagnosis;"
  b) RARC N704: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."; and
  c) Group Code-Contractual Obligation (CO).
- MACs will return the professional PILD claim as unprocessable when billed in a place of service other than 22 (outpatient) or 24 (ambulatory surgical center), using:
  a) CARC 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service;"
  b) RARC N704: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."; and
  c) Group Code-Contractual Obligation (CO).

4. MACs will return the professional PILD claim as unprocessable if it does not contain the required clinical trial diagnosis code V70.7 (ICD-9) or Z00.6 (ICD-10) in either the primary/secondary positions, using:
   a) CARC B22: "This payment is adjusted based on the diagnosis;"
   b) RARC M76: "Missing/incomplete/invalid diagnosis or condition;"
   c) RARC N704: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."; and
   d) Group Code-Contractual Obligation (CO).

- MACs will return the professional PILD claim as unprocessable when billed without Modifier Q0, using:
  a) CARC 4: "The procedure code is inconsistent with the modifier used or a required modifier is missing;"
  b) RARC N657: "This should be billed with the apporpriate code for these services.";
  c) RARC N704: "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information;" and
  d) Group Code-Contractual Obligation (CO).

- MACs will accept the numeric, 8-digit clinical trial identifier number preceded by the two alpha characters of "CT" when placed in Field 19 of paper Form CMS-1500, or when entered WITHOUT the "CT" prefix in the electronic 837P in Loop 2300 REF02 (REF01=P4). **NOTE: The "CT" prefix is required on a paper claim, but it is not required on an electronic claim**.
- For PILD claims submitted without a clinical trial identifier number, they will follow the requirements outlined in CR8401, Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims, released on October 30, 2013. You can find the associated MLN Matters® article at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8401.pdf** on the CMS website.

MACs will not search their files to adjust claims already processed, but will adjust claims that you bring to their attention.

Finally, you should note that endoscopically assisted laminotomy/laminectomy, which requires open and direct visualization, as well as other open lumbar decompression procedures for LSS, are not within the scope of this NCD.

Additional Information

The official instruction, CR8757, issued to your MAC, consists of two transmittals. The first updates the "Medicare National Coverage Determinations Manual" and it is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R167NCD.pdf** on the CMS website. The second transmittal updates the "Medicare Claims Processing Manual" and it is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2959CP.pdf** on the same site.