MLN Matters
Information for Medicare Fee-for-Service Health Care Professionals

MLN Matters Number: MM6291 Revised **Related Change Request (CR) #: 6291**

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Related CR Transmittal #: R1646CP and **Implementation Date: January 5, 2009**

Thermal Intradiscal Procedures

Note: This article was revised on April 12, 2018, to update Web addresses. All other information remains the same.

Provider Types Affected

Physicians and other providers who bill Medicare carriers, fiscal intermediaries (FI), or Medicare Administrative Contractors (MAC) for providing thermal intradiscal procedures (TIP) to Medicare beneficiaries

What You Need to Know

CR 6291, from which this article is taken, communicates the findings of a new national coverage determination (NCD) regarding thermal intradiscal procedures (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; and has therefore 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.

Specifically, CR 6291:

- 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 (ASC), and hospitals to provide appropriate liability notices to beneficiaries.

You should make sure that your billing staffs are aware of this NCD regarding TIPs, the details of which can be found in the Background section that follows.

Background

Percutaneous thermal intradiscal procedures (TIPs) involve the insertion 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, the CMS initiated a national coverage analysis (NCA) on TIPs. CR 6291 communicates the findings of this NCA, and the resultant NCD. Please note that this is the first NCD to address thermal intradiscal procedures (TIPs).

The NCA addressed the use of TIPs to: 1) treat symptomatic patients with annular disruption of a contained herniated disc, 2) to seal annular tears or fissures, or 3) to destroy nociceptors for the purpose of relieving pain. It 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. Further, it included techniques that use single or multiple probes/catheters which: 1) utilize a resistance coil or other thermal intradiscal technology; 2) are flexible or rigid; and 3) 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 (IDET);
- Intradiscal thermal annuloplasty (IDTA);
- Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT);
- Radiofrequency annuloplasty (RA);
- Intradiscal biacuplasty (IDB);
- Percutaneous (or plasma) disc decompression (PDD) or ablation; or
- Targeted disc decompression (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, Accutherm, or TransDiscal electrodes); and each technique or device has its own protocol for application of the therapy.

Note: Percutaneous disc decompression 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 this NCD's scope.

TIPs NCD Requirements

CR 6291 announces that CMS has concluded that the evidence does not demonstrate that TIPs improve health outcomes; and has therefore determined that TIPs are not reasonable and necessary for the treatment of low back pain.

Therefore, effective September 29, 2008, TIPs are non-covered for Medicare beneficiaries; and for services on and after that date, your carriers, FIs, and MACs will deny any claims that you submit for TIPs.

The following table displays the CPT/HCPCS codes that are identified for TIPs procedures performed within the annulus of the intervertebral disc. **On, or after, September 29, 2008, your Medicare contractors will deny claims that you submit for TIPs procedures 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

CPT Codes Identified For TIPs Procedures Performed Within the Annulus of the Intervertebral Disc*

*The change to add the non-covered indicator for these codes will be part of the January 2009 Medicare Physician Fee Schedule Update and the change to the status indicator to non-covered for the above HCPCS is part of the integrated Outpatient Code Editor (IOCE) update for January 2009 .

Note that the following CPT codes, which can be used for TIPs procedures performed within the nucleus of the disc (e.g., PDD or 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)

Please note that since codes 22899 or 64999 do suspend for review, when you submit them for TIPs procedures performed within the nucleus, you 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).

In addition, as all TIPs procedures are performed with radiologic or fluoroscopic guidance, this ancillary service would be directly related to a noncovered service and would itself, therefore, also be noncovered. CR 6291 instructs your carrier, FI, or A/B MAC to deny claims for the radiologic or fluorosocpic guidance when performed in conjunction with a TIP.

When denying your TIPs claims, Medicare contractors will use:

- Medicare Summary Notice (MSN) 21.11 - "This service was not covered by Medicare at the time you received it;"
- Claim Adjustment Reason Code (CARC) 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.gov/medicare-coverage-database/overview-and-quick-search.aspx.** If you do not have access, you may contact the contractor to request a copy of the NCD."

Note: 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.

CR 6291 further advises physicians and hospitals 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 you must issue prior to the procedure, should indicate that, after an NCA, Medicare issued a national coverage determination (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.

You should be aware that unless the beneficiary was informed via the ABN prior to performance of the procedure that he/she would be financially responsible, you are liable for charges for TIPs.

You should also be aware that beginning March 1, 2009, the ABN-G will no longer be valid and you must issue the revised ABN (CMS-R-131).

Additional Information

You can find the official instruction, CR 6291, was issued to your carrier, FI or MAC in two transmittals. You will find 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) is a national coverage determination (NCD)) at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R97NCD.pdf**. The transmittal that revises the *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Sections 220 (Billing Requirements for Thermal Intradiscal Procedures (TIPs) Claims), 220.1 (General), 220.2 (Contractor A/B MAC), 220.3 (Medicare Summary Notice (MSN), Claim Adjustment Reason Code (CARC), and Remittance Advise Remark Code (RARC)), and 220.4 (Advance Beneficiary Notice (ABN)) is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1646CP.pdf**.

If you have any questions, please contact your carrier, FI, or MAC at their toll-free number, which is at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html**.

Document History

- December 11, 2008 – Initial article released.
- April 12, 2018 – The article is revised to update Web addresses. All other information remains the same.