CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1646	**Date: December 9, 2008**
	Change Request 6291

Subject: Thermal Intradiscal Procedures (TIPs)

I. SUMMARY OF CHANGES: Upon completion of a national coverage analysis for TIPs, the decision was made that TIPs are non-covered for Medicare beneficiaries. This instruction includes the billing requirements for TIPs.

New / Revised Material
Effective Date: September 29, 2008
Implementation Date: January 5, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
N	32/220/Billing Requirements for Thermal Intradiscal Procedures (TIPs) Claims
N	32/220/220.1/General
N	32/220/220.2/Contractor A/B MAC
N	32/220/220.3/Medicare Summary Notice (MSN), Claim Adjustment Reason Code (CARA), and Remittance Advise Remark Code (RARC)
N	32/220/220.4/Advanced Beneficiary Notice (ABN)

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1646	Date: December 9, 2008	Change Request: 6291

SUBJECT: Thermal Intradiscal Procedures (TIPs)

Effective Date: September 29, 2008

Implementation Date: January 5, 2009

I. GENERAL INFORMATION

A. Background: This is a new national coverage determination (NCD). There is no existing NCD on thermal intradiscal procedures (TIPs).

On January 15, 2008, the Centers for Medicare and Medicaid Services (CMS) initiated a national coverage analysis (NCA) on (TIPs). The scope of this NCA on TIPs included percutaneous intradiscal techniques utilizing devices that employ the use of 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 to treat symptomatic patients with annular disruption of a contained herniated disc, to seal annular tears or fissures, or destroy nociceptors for the purpose of relieving pain. This includes 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 (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 is used (e.g. SpineCath, discTRODE, SpineWand, Accutherm, or TransDiscal electrodes). This change request (CR) communicates the findings and the NCD of this NCA.

While four CPT codes are identified for TIPs procedures performed within the annulus of the intervertebral disc (22526, 22527, 0062T and 0063T), the codes (codes 62287, 22899 and 64999) used for TIPs procedures performed within the nucleus of the disc (eg., PDD or TDD procedures) may also be used for procedures that are not within the scope of the TIPs NCD. The contractors may advise providers through a MLN Matters article to submit TIPs procedures performed within the nucleus under code 22899 or 64999 with a clear description of the procedure in the narrative section of the claim since these codes suspend for review. Contractors may also advise providers to submit the biacuplasty procedure under code 0062T (currently some providers are submitting this procedure under code 64999). This CR provides instructions on codes that shall be denied when submitted and for codes that shall be denied when identified as a TIP.

All TIPs procedures are performed with radiologic or fluoroscopic guidance. This service would be directly related to a noncovered service and, therefore, noncovered. This CR provides an instruction to deny claims for the radiologic or fluorosocpic guidance when performed in conjunction with a TIP.

This CR includes requirements for physicians, ASCs, and hospitals to provide appropriate liability notices to beneficiaries. Any provider who performs the service described in this instruction that is expected to be non-covered on the basis of this coverage decision should provide the beneficiary with the appropriate liability notice in advance of the procedure consistent with chapter 30, Pub 100-04, the Medicare Claims Processing.

B. Policy: Effective for services performed on or after September 29, 2008, CMS has concluded that the evidence does not demonstrate that TIPs improve health outcomes. Thus, CMS has determined that TIPs are

not reasonable and necessary for the treatment of low back pain. Therefore, TIPs are noncovered as identified in section 150.11 of Pub.100-03, the NCD Manual.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
6291.1	Effective for dates of service on and after September 29, 2008, contractors shall deny claims submitted for TIPs.	X		X	X							
6291.1.1	Contractors shall deny claims for TIPs when billed with *any* of the following codes: 22526 22527 0062T 0063T	X		X	X							IOCE
6291.1.2	Contractors shall deny claims submitted under the following codes when the narrative identifies the service provided as a TIP: 62287 22899 64999 **Note:** Contractors may advise providers to submit intervertebral disc nucleus decompression procedures that are considered TIPs under code 22899 or 64999 since these codes suspend for review. Contractors are not required to suspend code 62287 for review to identify whether it is a TIP.	X		X	X							
6291.1.3	Contractors shall deny claims for radiologic or fluoroscopic guidance when this service is identified as performed in conjunction with a TIP.	X		X	X							
6291.1.4	Contractors shall use Medicare Summary Notice (MSN) 21.11, "This service was not covered by Medicare at the time you received it."	X		X	X							
6291.1.5	Contractors shall use Claim Adjustment Reason Code 96, "Non-covered charge(s)" when denying the claim.	X		X	X							
6291.1.6	Contractors shall use 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	X		X	X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	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."											
6291.1.7	Contractors need not search their files to recoup payment for claims already paid. However, contractors shall adjust claims brought to their attention.	X		X	X							
6291.2	Contractors shall be aware that providers shall issue the appropriate liability notice to a beneficiary for TIPs.	X		X	X							
6291.2.1	Contractors shall be aware that providers shall issue an Advanced Beneficiary Notice (ABN) to beneficiaries who choose to have this procedure. The ABN shall indicate that after an NCA Medicare issued a national coverage determination (NCD) (section 150.11 of the Medicare NCD Manual) stating 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**: Beginning March 1, 2009, the ABN-G will no longer be valid and providers must issue the revised ABN (CMS-R-131).	X		X	X							
6291.2.2	Contractors shall include the Group Code, CO (Contractor Obligation) or PR (Provider Responsibility) depending on liability.	X		X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
6291.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this	X		X	X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Deirdre O'Connor, (410) 786-3263, Deirdre.oconnor@cms.hhs.gov, (coverage); Pat Brocato-Simons, (410) 465-4790, Patricia.brocatosimons@cms.hhs.gov, (coverage), Cynthia Glover, (410) 786-6289, Cynthia.glover@cms.hhs.gov, (carrier claims), Melissa E. Dehn, (410) 786-5721, Melissa.dehn@cms.hhs.gov (institutional claims), Valeri Ritter, (410) 786-8652, Valeri.ritter@cms.hhs.gov, (institutional claims)

Post-Implementation Contact(s):
Appropriate Regional Office or MAC Project Officer

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers:*
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs):*

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and

immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

Table of Contents
(Rev. 1646, 12-09-08)

220 - Billing Requirements for Thermal Intradiscal Procedures (TIPs)

(Rev. 1646, Issued: 12-09-08, Effective: 09-29-08, Implementation: 01-05-09)

220.1 – General

(Rev. 1646, Issued: 12-09-08, Effective: 09-29-08, Implementation: 01-05-09)

Effective for services on or after September 29, 2008, the Center for Medicare & Medicaid Services (CMS) made the decision that Thermal Intradiscal Procedures (TIPS) are not reasonable and necessary for the treatment of low back pain. Therefore, TIPs are non-covered. Refer to Pub.100-03, Medicare National Coverage Determination (NCD) Manual Chapter 1, Part 2, Section 150.11, for further information on the NCD.

220.2 - Contractors, A/B Medicare Administrative Contractors (MACs)

(Rev. 1646, Issued: 12-09-08, Effective: 09-29-08, Implementation: 01-05-09)

The following Healthcare Common Procedure Coding System (HCPCS) codes will be nationally non-covered by Medicare effective for dates of service on and after September 29, 2008:

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

NOTE: The change to add the non-covered indicator for the above HCPCS codes will be part of the January 2009 Medicare Physician Fee Schedule Update. The change to the status indicator to non-cover the above HCPCS will be part of the January Integrated Outpatient Code Editor (IOCE) update.

Claims submitted with the non-covered HCPCS codes on or after September 29, 2008, will be denied by Medicare contractors.

220.3 - Medicare Summary Notice (MSN), Claim Adjustment Reason Code (CARC), and Remittance Advice Remark Code (RARC)

(Rev. 1646, Issued: 12-09-08, Effective: 09-29-08, Implementation: 01-05-09)

The following messages are used by Medicare contractors when denying non-covered TIP services:

- *MSN: 21.11 "This service was not covered by Medicare at the time you received it."*

- *CARC: 96 "Non-covered charge(s)"*

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/med/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD."

220.4- Advance Beneficiary Notice (ABN)

(Rev. 1646, Issued: 12-09-08, Effective: 09-29-08, Implementation: 01-05-09)

Providers are liable for charges if TIPS is used in surgery, unless the beneficiary was informed that he/she would be financially responsible prior to performance of the procedure. To avoid this liability the provider should have the beneficiary sign an ABN.