2020 BILLING GUIDANCE
for the mild® Procedure (NCT03072927)

The Centers for Medicare & Medicaid Services (CMS) established national coverage for the mild® procedure under the national coverage determination (NCD) for percutaneous image-guided lumbar decompression (PILD) for lumbar spinal stenosis (LSS). The mild procedure is now covered for Medicare patients nationwide, effective for procedures performed on or after February 16, 2017, under a CMS-approved claims analysis study that will passively collect and analyze real-world data to demonstrate the role of the therapy in the continuum of care for LSS. View the NCD: Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis (150.13)

PATIENT ELIGIBILITY

<table>
<thead>
<tr>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medicare beneficiary</td>
<td>Patients who have received a laminectomy, laminotomy, fusion, interspinous process decompression, or mild in the lumbar region during the 12 months prior to the index date.</td>
</tr>
<tr>
<td>• Diagnosis of LSS with neurogenic claudication (NC)</td>
<td></td>
</tr>
</tbody>
</table>

PHYSICIAN PAYMENT

Category III CPT codes do not have assigned relative value units (RVUs) for calculation of physician payment; the physician payment will be contractor-adjusted by each MAC. It is recommended that you contact your local MAC to determine specific payment levels in your area.

<table>
<thead>
<tr>
<th>Category III CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ø275T (APC 5114)</td>
<td>Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method under indirect image guidance (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar</td>
</tr>
</tbody>
</table>

AMBULATORY SURGERY CENTER

<table>
<thead>
<tr>
<th>Category III CPT Code</th>
<th>Description</th>
<th>2020 Rate (National Average—Subject to Wage Indexing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ø275T (APC 5114)</td>
<td>Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method under indirect image guidance (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar</td>
<td>$2,803.36*</td>
</tr>
</tbody>
</table>

Some ASC claims to non-Medicare payers may require the inclusion of HCPCS device code C1889 to report the mild insertable device. ASCs should review their provider contracts for guidance on non-Medicare payers.

**Status Indicator for APC with a (J1) “Comprehensive APC.”

**C Codes are required by hospitals for reimbursement and data collection purposes for insertable devices. Federal Register / Vol. 83, No. 225 / Wednesday, November 21, 2018 / Rules and Regulations; page 58950.


### Claims Identifying Information to Signify Patient is Participating in a Study

<table>
<thead>
<tr>
<th>CED Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Clinical Trial (NCT) Number</td>
</tr>
<tr>
<td>Modifier to Category III CPT Code</td>
</tr>
<tr>
<td>Primary Diagnosis Code</td>
</tr>
<tr>
<td>Secondary Diagnosis Code*</td>
</tr>
<tr>
<td>Condition Code (UB-Ø4 Facility Claims Only)</td>
</tr>
</tbody>
</table>

*CMS allows for the ZØØ.6 to be coded in the primary or secondary position.

### BILLING SPECIFICS

For hospital outpatient procedures on type of bill (TOB) 13x or 85x, and for professional claims billed with a place of service (POS) 22 (“Hospital” Outpatient) or 24 (ASC), Medicare will allow for the mild procedure, known as PILD, (procedure code Ø275T) for LSS, only when billed with:

<table>
<thead>
<tr>
<th>Category III CPT Code</th>
<th>Description</th>
<th>Required C Code **</th>
<th>2020 Rate (National Average—Subject to Wage Indexing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ø275T (APC 5114)</td>
<td>Percutaneous laminotomy/laminecctomy (interlaminar approach) for decompression of neural elements (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method under indirect image guidance (e.g., fluoroscopic, CT), <strong>single or multiple levels, unilateral or bilateral; lumbar</strong></td>
<td>C1889 (Implantable/insertable device, not otherwise classified)</td>
<td>$5,981.28***</td>
</tr>
</tbody>
</table>

*Status Indicator for APC with a (J1) “Comprehensive APC.”

**C Codes are required by hospitals for reimbursement and data collection purposes for insertable devices. Federal Register / Vol. 83, No. 225 / Wednesday, November 21, 2018 / Rules and Regulations; page 58950.


### CLAIM FORM INSTRUCTIONS

#### Claims Identifying Information to Signify Patient Is Participating in a Study

<table>
<thead>
<tr>
<th>CMS 15ØØ Physician Claim</th>
<th>UB-Ø4 Hospital Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Claim</td>
<td></td>
</tr>
<tr>
<td>Paper Claim</td>
<td></td>
</tr>
<tr>
<td><strong>See examples on next page</strong></td>
<td></td>
</tr>
</tbody>
</table>

*Please check with your local MAC to confirm placement of condition code and NCT number.

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**Note:**

- **CED Study:**
  - National Clinical Trial (NCT) Number
  - Modifier to Category III CPT Code
  - Primary Diagnosis Code
  - Secondary Diagnosis Code
  - Condition Code (UB-Ø4 Facility Claims Only)

- **CMS 15ØØ Physician Claim**
  - Loop 23ØØ
  - REFØ2= Ø3Ø72927
  - REFØ1= P4
  - (do not use “CT” on electronic claim)

- **UB-Ø4 Hospital Claim**
  - Loop 23ØØ
  - REFØ2= Ø3Ø72927
  - REFØ1= P4
  - (do not use “CT” on electronic claim)

- **Form Locator 19**
  - (preceded by “CT”)
  - Example: CTØ3Ø72927

- **Form Locator 39 Value Codes**
  - D4 is reported in Code Field
  - The NCT number is reported in the Amount field

- **Form Locator 18**
  - Not reported on physician claim
CMS 1500 PHYSICIAN CLAIM

8-DIGIT CLINICAL TRIAL NUMBER
- Form Locator 19
- Preceded by “CT” if sending paper claim (CT03072927)
- NOTE: Only report 8 digits if electronic submission (03072927); see electronic claim submission instructions

DIAGNOSIS CODES
- M48.062 – Spinal stenosis, lumbar region with neurogenic claudication
- Z03.6 – Encounter for examination for normal comparison and control in clinical research program
- NOTE: “A” and “B” should be reported in Box 24E to point both M48.062 and Z03.6 to the procedure code

REPORT QØ MODIFIER
- Investigational clinical service provided in a clinical research study that is in an approved clinical research study
- NOTE: If the letter “O” is reported rather than the number “Ø” the claim will be denied by Medicare

CATEGORY III CPT CODE
- Ø275T – Percutaneous Image-Guided Lumbar Decompression
- NOTE: The procedure description includes “single or multiple levels” and should be reported as X1 unit

PLACE OF SERVICE (POS)
- Medicare allows for the mild procedure on professional claims when billed with a POS 22 (Hospital Outpatient) or 24 (ASC)

UB-04 HOSPITAL CLAIM

CONDITION CODE 3Ø
- Form Locator 18
- Enter the condition “3Ø” Qualifying Clinical Trials Non-research services provided to all patients, including managed care enrollees enrolled in a Qualified Clinical Trial

CATEGORY III CPT CODE
- Form Locator 44
- Enter CPT for procedure and modifier Ø275T – mild procedure
- QØ – Investigational clinical service provided in a clinical research study in an approved clinical research study

8-DIGITAL CLINICAL TRIAL NUMBER
- Form Locator 39-41
- Enter code D4 & Clinical Trial Number 03072927
- If paper claim include CT (CT03072927)
- If electronic, do NOT use ‘CT.’ See electronic claim submission instructions.

REQUIRED C CODE
- Form Locator 44
- Enter HCPCS “C1889” implantable/insertable device, not otherwise classified with Revenue Code 272
- NOTE: C1889 is required on hospital claims only – DO NOT REPORT ON PHYSICIAN OR ASC CLAIMS
**MEDICARE ADVANTAGE PAYERS**

Medicare Advantage (MA) plans are responsible for payment of items and services in CMS-approved NCD CED studies. [Medicare Managed Care Manual–Chapter 4 Section 10.7.3–Benefits and Beneficiary Protections](#)

Some MA payers will require prior authorization for *mild*. Please provide ALL the information below to the MA payer when requesting prior authorization in order for the payer to be aware the procedure is being performed as part of the CMS-approved CED study.

- Ø275T – Minimally Invasive Lumbar Decompression
- M48.Ø62 – Spinal stenosis with neurogenic claudication, lumbar region
- ZØØ.6 – Encounter for examination for normal comparison and control in clinical research program
- QØ Modifier – Investigational clinical service provided in an approved clinical research study
- **Condition Code 3Ø (Institutional claims only)** – Non-research services provided to all patients, including managed care enrollees, enrolled in a Qualified Clinical Trial
- **National Clinical Trial Number** – Ø3Ø72927
- **National Coverage Determination 150.13**

**MEDICARE SUPPLEMENT / MEDIGAP PAYERS**

Supplement payers are covering *mild* except Medicaid, TRICARE and BCBS Federal. Please check with the payer prior to performing the procedure to confirm coverage and payment.

**COMMERCIAL (PRIVATE) PAYERS**

Coverage for *mild* varies by payer policy.

We encourage providers to contact non-Medicare payers to confirm coverage prior to performing the procedure.

**OTHER GOVERNMENT PAYERS**

- **Veterans Affairs** – Covers *mild* when prior authorization is obtained and performed by VA-approved provider
- **TRICARE** – Does not currently cover *mild* per [TRICARE Policy Manual 6010.57-M Chapter 1 Section 12.1](#)
- **Medicaid** – Coverage varies by state; please confirm coverage and payment for your specific state
- **Workers’ Compensation** – Coverage depends on WC Carrier and authorization status

**ADDITIONAL RESOURCES:**

- [MLN Matters® Number: MM1ØØ89](#)  
  (Previous issues referenced in MM10089: MM84Ø1-January 6, 2014 & MM8757-October 6, 2014)
- [CMS PILD CED Overview](#)
- [CMS Manual System Transmittal 3811](#)
- [Clinicaltrials.gov Study Record Detail](#)

**ASSISTANCE**

If you have any questions please contact our reimbursement support team: [reimbursement@vertosmed.com](mailto:reimbursement@vertosmed.com) | (855) 848-MILD (6453)

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