2020 BILLING GUIDANCE

for the *mild* Procedure (NCTØ3Ø72927)

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 (15Ø.13)

PATIENT ELIGIBILITY

Inclusion Criteria	Exclusion Criteria
• Medicare beneficiary • Diagnosis of LSS with neurogenic claudication (NC)	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.

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.

Category III CPT Code	Description
Ø275T (APC 5114)	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

AMBULATORY SURGERY CENTER

Category III CPT Code	Description	2020 Rate (National Average—Subject to Wage Indexing)
Ø275T (APC 5114)	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	$2,803.36*

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.*

*Addendum AA-Final ASC Covered Surgical Procedures for CY 2020. Released 11/2019.

HOSPITAL OUTPATIENT

Category III CPT Code	Description	Required C Code **	2020 Rate (National Average—Subject to Wage Indexing)
Ø275T (APC 5114) Status Indicator (J1*)	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	C1889 (Implantable/insertable device, not otherwise classified)	$5,981.28***

*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.
***Addendum B–Final OPPS Payment by HCPCS Code for CY 2020. Released 11/2019.

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:

Claims Identifying Information to Signify Patient is Participating in a Study	CED Study
National Clinical Trial (NCT) Number	Ø3Ø72927
Modifier to Category III CPT Code	QØ Investigational clinical service provided in a clinical research study that is in an approved clinical research study
Primary Diagnosis Code	M48.Ø62 Spinal stenosis, lumbar region with neurogenic claudication
Secondary Diagnosis Code*	ZØØ.6* Encounter for examination for normal comparison and control in clinical research program
Condition Code (UB-Ø4 Facility Claims Only)	3Ø Qualifying clinical trial

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

CLAIM FORM INSTRUCTIONS

Claims Identifying Information to Signify Patient Is Participating in a Study	CMS 15ØØ Physician Claim	UB-Ø4* Hospital Claim
National Clinical Trial (NCT) Number		
<u>Electronic Claim</u>	Loop 23ØØ REFØ2= Ø3Ø72927 REFØ1= P4 (do not use "CT" on electronic claim)	Loop 23ØØ REFØ2= Ø3Ø72927 REFØ1= P4 (do not use "CT" on electronic claim)
<u>Paper Claim</u> *See examples on next page*	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
Condition Code 3Ø–Qualifying Clinical Trial	Not reported on physician claim	Form Locator 18

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

CMS 1500 PHYSICIAN CLAIM

8-DIGIT CLINICAL TRIAL NUMBER

- Form Locator 19
- Preceded by "CT" if sending paper claim (CTØ3Ø72927)
- NOTE: Only report 8 digits if electronic submission (Ø3Ø72927); see electronic claim submission instructions

DIAGNOSIS CODES

- M48.Ø62 – Spinal stenosis, lumbar region with neurogenic claudication
- ZØØ.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.Ø62 and ZØØ.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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
CT03072927

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. M48.062 B. Z00.6 C. D.
E. F. G. H.
I. J. K. L.

22. CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	
1 01	03	19	01	03	19	24		0275T	Q0	AB	3600	00	1		NPI	XXXX
2															NPI	

PLACE OF SERVICE (POS)

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

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

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*

1 HOSPITAL NAME
HOSPITAL ADDRESS
CITY, STATE ZIP
PHONE NUMBER

3a PAT. CNTL # XXXXXXXXX
b. MED. REC. #
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH

8 PATIENT NAME a PATIENT NAME
9 PATIENT ADDRESS a PATIENT ADDRESS

10 BIRTHDATE 07/06/1941 | 11 SEX M | 12 ADMISSION DATE 01/03/2019 | 13 HR 06 | 14 TYPE 3 | 15 SRC 2 | 16 DHR | 17 STAT 01 | 18 30 | 19 | 20 | 21

31 OCCURRENCE CODE / DATE: 01/03/2019
32 OCCURRENCE CODE / DATE
33 OCCURRENCE CODE / DATE
34 OCCURRENCE CODE / DATE
35 CODE

8-DIGIT CLINICAL TRIAL NUMBER

- Form Locator 39-41
- Enter code D4 & Clinical Trial Number Ø3Ø72927
- If paper claim include CT (CTØ3Ø72927)
- If electronic, do NOT use 'CT.' See electronic claim submission instructions.

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39 VALUE CODES CODE / AMOUNT
a D4 CT03072927
b
c
d

40 VALUE CODES CODE / AMOUNT
41 CODE

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

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON
1	0250	PHARMACY GENERAL		010319	9	17265	
2	0258	PHARMACY IV SOLUTIONS		010319	1	1000	
3	0271	MED/SRG SUPP/DEVICE NONSTERILE		010319	1	6700	
4	0272	MED/SRG SUPP/DEVICE STERILE					
5	0360	OR SVCS GENERAL	0275T Q0				
6	0272	MED/SRG SUPP/DEVICE-STERILE	C1889				
7	0370	ANESTHESIA GENERAL					
8	0710	RECOVERY ROOM GENERAL					
9							
10							

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 | (855) 848-MILD (6453)

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