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)

### PHYSICIAN

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>2021 Medicare Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ø275T*</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 (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar</td>
<td>$600-$1,100</td>
</tr>
</tbody>
</table>

*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 Medicare Administrative Contractor (MAC). It is recommended that you contact your local MAC to determine specific payment levels in your area.

*The Global Surgery Indicator for Ø275T is “YYY.” Codes designated as “YYY” are contractor-priced codes, for which MACs determine the global period. MACs generally specify 90 days for this procedure. It is recommended that you contact your local MAC to confirm. Medicare Physician Fee Schedule 2021.

### ASC

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>2021 Medicare Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ø275T (APC 5114) Status Indicator (J8) Device-Intensive</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 (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar</td>
<td>$3,941.14*</td>
</tr>
</tbody>
</table>


### HOSPITAL

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Required C Code**</th>
<th>2021 Medicare Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ø275T (APC 5114) Status Indicator (J1)*</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 (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar</td>
<td>C1889 (Implantable/insertable device, not otherwise classified)</td>
<td>$6,264.95***</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.

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>

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 0275T) for LSS, only when billed with:

<table>
<thead>
<tr>
<th>Claims Identifying Information to Signify Patient Is Participating in a Study</th>
<th>CED Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Clinical Trial (NCT) Number</td>
<td>Ø3072927</td>
</tr>
<tr>
<td>Modifier to Category III CPT Code</td>
<td>QØ</td>
</tr>
<tr>
<td>Investigational clinical service provided in a clinical research study that is in an approved clinical research study</td>
<td></td>
</tr>
<tr>
<td>Primary Diagnosis Code</td>
<td>M48.062</td>
</tr>
<tr>
<td>Spinal stenosis, lumbar region with neurogenic claudication</td>
<td></td>
</tr>
<tr>
<td>Secondary Diagnosis Code*</td>
<td>Z00.6*</td>
</tr>
<tr>
<td>Encounter for examination for normal comparison and control in clinical research program</td>
<td></td>
</tr>
<tr>
<td>Condition Code (UB-Ø4 Facility Claims Only)</td>
<td>3Ø</td>
</tr>
<tr>
<td>Qualifying Clinical Trial</td>
<td></td>
</tr>
</tbody>
</table>

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

CLAIM FORM INSTRUCTIONS

<table>
<thead>
<tr>
<th>Claims Identifying Information to Signify Patient Is Participating in a Study</th>
<th>CMS 15ØØ</th>
<th>UB-Ø4*</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Clinical Trial (NCT) Number</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Electronic Claim**

| Loop 23ØØ | REFØ2= Ø3072927 | REFØ1= P4 |
| (do not use "CT" on electronic claim) |

**Paper Claim**

See examples on next page

| Form Locator 19 (preceded by "CT") | Form Locator 39 Value Codes |
| Example: CTØ3072927 | • D4 is reported in the 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.*
2021 BILLING GUIDANCE

CMS 1500 PAPER 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
  - Z00.6 – 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 Z00.6 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 "Q" the claim will be denied by Medicare

- **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**
  - Q0275T – Percutaneous Image-Guided Lumbar Decompression
  - NOTE: The procedure description includes "single or multiple levels" and should be reported as X1 unit

- **DIAGNOSIS CODES**
  - M48.062 – Spinal stenosis, lumbar region with neurogenic claudication
  - Z00.6 – Encounter for examination for normal comparison and control in clinical research program

- **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 "Q" the claim will be denied by Medicare

- **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**
  - Q0275T – Percutaneous Image-Guided Lumbar Decompression
  - NOTE: The procedure description includes "single or multiple levels" and should be reported as X1 unit

UB-04 PAPER 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

- **STATEMENT COVERED PERIOD FROM THROUGH**

- **HOSPITAL NAME**

- **HOSPITAL ADDRESS**

- **CITY, STATE ZIP**

- **PHONE NUMBER**

- **PATIENT NAME**

- **PATIENT ADDRESS**

- **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

- **CATEGORY III CPT CODE**
  - Form Locator 44
  - Enter CPT for procedure and modifier Q0275T – mild Procedure
  - Q0 – Investigational clinical service provided in a clinical research study in an approved clinical research study

- **REQUIRED C CODE**
  - Form Locator 44
  - Enter HCPCS “C1889” implantable/insertable device, not otherwise classified
  - 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
Q6 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 15Ø.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 6Ø1Ø.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 MM1ØØ89: MM84Ø1-January 6, 2014 & MM8757-October 6, 2014)
- CMS PILO 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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