



2024 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. This is 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 LSS **(15Ø.13)**.

PHYSICIAN

CPT Code	Description	2024 Medicare Rate
Ø275T*	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), <u>single or multiple levels, unilateral or bilateral</u> ; lumbar	\$560-\$1,100 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 9Ø days for this procedure. It is recommended that you contact your local MAC to confirm. Medicare Physician Fee Schedule 2024.

ASC

CPT Code	Description	2024 Medicare Rate (National Average-Subject to Wage Indexing)
Ø275T (APC 5114) Status Indicator (J8) Device-Intensive	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), <u>single or multiple levels, unilateral or bilateral</u> ; lumbar	\$5,060.31*

*Addendum AA-Final ASC Covered Surgical Procedures for CY 2024. Released 02/2024.

HOSPITAL

CPT Code	Description	Required C Code**	2024 Medicare 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 (eg, fluoroscopic, CT), <u>single or multiple levels, unilateral or bilateral</u> ; lumbar	C1889 (Implantable/ insertable device, not otherwise classified)	\$6,816.33***

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

Effective January 1, 2005, hospitals paid under the OPPTS that report procedure codes that require the use of devices must also report the applicable HCPCS codes and charges for all devices that are used to perform the procedures. Source: **Medicare Claims Processing Manual Chapter 4 Section 61.1.

***Addendum B Final OPPTS Payment by HCPCS Code for CY 2024. Released 02/2024.

PATIENT ELIGIBILITY

Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none"> Medicare and Medicare Advantage beneficiaries: NO age restriction 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.

BILLING SPECIFICS – MEDICARE AND MEDICARE ADVANTAGE

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.

For non-Medicare claims (commercial, W/C, Medicaid, VA, TRICARE, etc.) only report CPT Ø275T and Primary Diagnosis Code M48.Ø62.

CLAIM FORM INSTRUCTIONS

Claims Identifying Information to Signify Patient Is Participating in a Study	CMS 15ØØ	UB-Ø4*
National Clinical Trial (NCT) Number		
Electronic Claim	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)
Paper Claim <i>See examples on next page</i>	Form Locator 19 (preceded by "CT") Example: CTØ3Ø72927	Form Locator 39 Value Codes <ul style="list-style-type: none"> D4 is reported in the Code field The NCT number is reported in the Amount field (preceded by "CT")
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 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 Q0 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 "0" the claim will be denied by Medicare

The image shows a portion of a CMS 1500 Paper Claim form. Callouts point to the following fields:

- 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):** CT03072927
- 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:** A: M48.062, B: Z00.6
- 24. A. DATE(S) OF SERVICE:** 01 03 19 to 01 03 19
- 24. B. PLACE OF SERVICE:** 24
- 24. D. PROCEDURES, SERVICES, OR SUPPLIES:** 0275T Q0
- 24. E. DIAGNOSIS POINTER:** AB
- 24. F. CHARGES:** 3600
- 24. G. DAYS OR UNITS:** 00
- 24. H. REPORT TYPE:** 1
- 24. I. QUAL:** NN
- 24. J. QUAL:** NN
- 24. K. QUAL:** XXXX

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

- 0275T – 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 30

- Form Locator 18
- Enter the condition "30" Qualifying Clinical Trials Non-research services provided to all patients, including managed care enrollees enrolled in a Qualified Clinical Trial

8-DIGIT 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.

CATEGORY III CPT CODE

- Form Locator 44
- Enter CPT for procedure and modifier 0275T – 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

The image shows a portion of a UB-04 Paper Claim form. Callouts point to the following fields:

- 1. HOSPITAL NAME:** XXXXXXXXXXXX
- 3. PATIENT NAME:** [Redacted]
- 10. BRNTHDATE:** 07/06/1941
- 11. SEX:** M
- 12. DATE:** 01/03/2019
- 13. HP:** 06
- 14. TYPE:** 3
- 15. SRC:** 2
- 16. DRG:** 01
- 17. SRT:** 30
- 31. OCCURRENCE DATE:** 01/03/2019
- 39. VALUE CODES AMOUNT:** D4
- 40. CODES:** CT03072927
- 46. HCPCS / RATE / HPCS CODE:** 0275T Q0
- 46. HCPCS / RATE / HPCS CODE:** C1889
- 46. HCPCS / RATE / HPCS CODE:** 0250 PHARMACY GENERAL
- 46. HCPCS / RATE / HPCS CODE:** 0258 PHARMACY IV SOLUTIONS
- 46. HCPCS / RATE / HPCS CODE:** 0271 MED/SRG SUPP/DEVICE NONSTERILE
- 46. HCPCS / RATE / HPCS CODE:** 0272 MED/SRG SUPP/DEVICE STERILE
- 46. HCPCS / RATE / HPCS CODE:** 0360 OR SVCS GENERAL
- 46. HCPCS / RATE / HPCS CODE:** 0272 MED/SRG SUPP/DEVICE-STERILE
- 46. HCPCS / RATE / HPCS CODE:** 0370 ANESTHESIA GENERAL
- 46. HCPCS / RATE / HPCS CODE:** 0710 RECOVERY ROOM GENERAL

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 that 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 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® in VA facility
- **TRICARE** – Does not currently cover mild® per **TRICARE Policy Manual 6Ø1Ø.6Ø-M Chapter 1 Section 11.1**
- **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: 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 | www.mildReimbursement.com | (855) 848-MILD (6453)

Disclaimer: Reimbursement and health economics information provided by Vertos Medical Inc. is gathered from third-party sources and is subject to change without notice. This information is provided for illustrative purposes only and does not constitute reimbursement or legal advice. Vertos Medical encourages providers to submit accurate and appropriate claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services, and to submit appropriate codes, charges, and modifiers for services that are rendered. Vertos Medical recommends that you consult with your payers, reimbursement specialists, and/or legal counsel regarding coding, coverage, and reimbursement matters. Vertos Medical does not promote the use of its products outside their FDA-cleared label.