2022 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	2022 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), **single or multiple levels, unilateral or bilateral**; lumbar	$600-$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 2022.

ASC

CPT Code	Description	2022 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), **single or multiple levels, unilateral or bilateral**; lumbar	$4,020.32*

*Addendum AA-Final ASC Covered Surgical Procedures for CY 2022. Released 11/2021.

HOSPITAL

CPT Code	Description	Required C Code**	2022 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), **single or multiple levels, unilateral or bilateral**; lumbar	C1889 (Implantable/ insertable device, not otherwise classified)	$6,397.05***

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

**Effective January 1, 2005, hospitals paid under the OPPS 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 OPPS Payment by HCPCS Code for CY 2022. Released 11/2021.

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PATIENT ELIGIBILITY

Inclusion Criteria	Exclusion Criteria
• 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 *See examples on next page*	Form Locator 19 (preceded by “CT”) Example: CTØ3Ø72927	Form Locator 39 Value Codes • 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.

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CMS 15ØØ PAPER 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.

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-Ø4 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*

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 | ADMISSION 12 DATE 01/03/2019 | 13 HR 06 | 14 TYPE 3 | 15 SRC 2 | 16 DHR | 17 STAT 01 | 18 30

31 OCCURRENCE CODE DATE 01/03/2019

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.

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

39 VALUE CODES CODE / AMOUNT: a D4 CT03072927

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
0250	PHARMACY GENERAL		010319	9	17265
0258	PHARMACY IV SOLUTIONS		010319	1	1000
0271	MED/SRG SUPP/DEVICE NONSTERILE				00
0272	MED/SRG SUPP/DEVICE STERILE				00
0360	OR SVCS GENERAL	0275T Q0			00
0272	MED/SRG SUPP/DEVICE-STERILE	C1889			00
0370	ANESTHESIA GENERAL				00
0710	RECOVERY ROOM GENERAL		010319	49	3136 00

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**

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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 1Ø.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 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 or when performed by VA Community Care Network Provider when prior authorization/referral is obtained
- **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 | (855) 848-MILD (6453)

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