Thermal Intradiscal Procedures (TIPs) (NCD 150.11)

Guideline Number: MPG304.06
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Terms and Conditions

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Related Medicare Advantage Policy Guideline

- Vertebral Augmentation Procedure (VAP)/ Percutaneous Vertebroplasty

Related Medicare Advantage Coverage Summaries

- Pain Management and Pain Rehabilitation
- Spine Procedures

Policy Summary

See Purpose

Overview

Percutaneous thermal intradiscal procedures (TIPs) involve the insertion of a catheter(s)/probe(s) in the spinal disc under fluoroscopic guidance for the purpose of producing or applying heat and/or disruption within the disc to relieve low back pain.

Although not intended to be an all - inclusive list, TIPs are commonly identified as intradiscal electro thermal therapy (IDET), intradiscal thermal annuloplasty (IDTA), percutaneous intradiscal radiofrequency thermocoagulation (PIRFT), radiofrequency annuloplasty (RA), intradiscal biacuplasty (IDB), percutaneous (or plasma) disc decompression (PDD) or coblation, or targeted disc decompression (TDD). At times, TIPs are identified or labeled based on the name of the catheter/probe that is used (e.g., SpineCath, discTRODE, SpineWand, Accutherm, or TransDiscal electrodes). Each technique or device has its own protocol for application of the therapy. Percutaneous disc decompression or nucleoplasty procedures that do not utilize a radiofrequency energy source or electro thermal energy (such as the disc decompressor procedure or laser procedure) are not within the scope of this NCD.

Guidelines

CMS has determined that TIPs are not reasonable and necessary for the treatment of low back pain. Therefore, TIPs, which include procedures that employ the use of a radiofrequency energy source or electro thermal energy to apply or create heat and/or disruption within the disc for the treatment of low back pain, are non - covered.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
22526	Percutaneous intradiscal electro thermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level (Not covered by Medicare)

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CPT Code	Description
22527	Percutaneous intradiscal electro thermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure) (Not covered by Medicare)
22899	Unlisted procedure, spine
64999	Unlisted procedure, nervous system

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References

CMS National Coverage Determinations (NCDs)

NCD 150.11 Thermal Intradiscal Procedures (TIPs)

CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	Medicare Part A	Medicare Part B
L36954 Non-Covered Services other than CPT® Category III Non-Covered Services Retired 03/23/2020	A56506 Billing and Coding: Non-Covered Services other than CPT® Category III Non-Covered Services Retired 03/23/2020	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
N/A	A57743 Billing and Coding: Non-Covered Services Retired 07/01/2020	First Coast	FL, PR, VI	FL, PR, VI
L36219 Non-Covered Services Retired 06/30/2020	A57641 Billing and Coding: Non-Covered Services Retired 06/30/2020	Noridian	AS, CA (Northern), CA (Southern), GU, HI, MP, NV	AS, CA (Entire State) GU, HI, MP, NV
L35008 Non-Covered Services Retired 06/30/2020	A57642 Billing and Coding: Non-Covered Services Retired 06/30/2020	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY

CMS Benefit Policy Manual

Chapter 15; § 260 Ambulatory Surgical Center Services

CMS Claims Processing Manual

Chapter 12; § 90.3 Physicians' Services Performed in Ambulatory Surgical Centers (ASC)
Chapter 14; § 10 - 70 Ambulatory Surgical Centers
Chapter 32; § 220 Billing Requirements for Thermal Intradiscal Procedures (TIPs)

CMS Transmittal(s)

Transmittal 97, Change Request 6291, Dated 12/09/2008 (Thermal Intradiscal Procedures (TIPs))

MLN Matters

Article MM6291, Thermal Intradiscal Procedures

UnitedHealthcare Commercial Policies

Discogenic Pain Treatment
Surgical Treatment for Spine Pain

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Others

Decision Memo for Thermal Intradiscal Procedures (CAG - 00387N), CMS Website

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
04/01/2021	**Template Update** • Reformatted policy; transferred content to new template
11/11/2020	**Applicable Codes** • Removed CPT code 62287 **Supporting Information** • Updated *References* section to reflect the most current information • Archived previous policy version MPG304.05

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS"

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basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

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*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.

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