Thermal Intradiscal Procedures (Includes IDET and Nucleoplasty)

MPM 20.7

Disclaimer

Refer to the member’s specific benefit plan and Schedule of Benefits to determine coverage. This may not be a benefit on all plans or the plan may have broader or more limited benefits than those listed in these criteria.

Description

Percutaneous thermal intradiscal procedures (TIPs) involve the insertion of a catheter or probe 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 meant to be a complete list, TIPs are commonly identified as:

- Intradiscal electrothermal therapy (IDET);
- Intradiscal thermal annuloplasty (IDTA);
- Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT);
- Radiofrequency annuloplasty (RA);
- Intradiscal biacuplasty (IDB);
- Percutaneous (or plasma) disc decompression (PDD) or ablation; or
- Targeted disc decompression (TDD).

Coverage Determination

Inconclusive or Non-Supportive Evidence: For cervical, lumbar and nonspecific back pain, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended.

For Commercial members:

Presbyterian uses MCG Criteria # A-0217. MCG clinical indication current role remains uncertain. Due to contractual restrictions providers may not access the MCG website but may obtain a copy of the criteria from the Prior Authorization

For Medicare and Medicaid members:

CMS, National Coverage Determination (NCD), for Thermal Intradiscal Procedures (TIPs) (NCD 150.11). Effective for services performed on or after September 29, 2008, the 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 electrothermal energy to apply or create heat and/or disruption within the disc for the treatment of low back pain.
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back pain, are noncovered.

Coding

The coding listed in this Medical Policy is for reference only. Covered and non-covered codes are within this list.


<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description (non-covered CPT)</th>
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</thead>
<tbody>
<tr>
<td>22526</td>
<td>Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level</td>
</tr>
<tr>
<td>22527</td>
<td>Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels</td>
</tr>
</tbody>
</table>

References


2. CMS, National Coverage Determination (NCD), for Thermal Intradiscal Procedures (TIPs) (NCD 150.11), Version #1, Date 01/05/209. [Cited 01/22/2020]

3. CMS, MLN Matters # MM6291, Thermal Intradiscal Procedures, article revised on April 12, 2018. [Cited 01/22/2020]

Approval Signatures

Clinical Quality & Utilization Mgmt. Committee: Howard Epstein MD

Medical Director: Norman White MD

Approval Date

March 25, 2020

Publication History

IDET – Intradiscal Electrothermal Therapy

Dec 2001 PHP Medical Affairs Criteria, original effective date; archived Feb. 2004

01-26-04 PHP Benefit Alert on IDET, original effective date

02-05-05 PHP Benefit Alert on IDET, update

07-03-08 PHP Benefit Alert transitioned to Medical Policy, annual review/revision

Nucleoplasty

08-01-03 PHP Benefit Alert, original effective date

09-05-07 PHP Benefit Alert, update

07-03-08 PHP Benefit Alert transitioned to Medical Policy, annual review/revision
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<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
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<tbody>
<tr>
<td>09-23-09</td>
<td>IDET and Nucleoplasty combined into one Medical Policy, entitled Thermal Intradiscal Procedures, MPM 20.7</td>
</tr>
<tr>
<td>11-30-11</td>
<td>Annual Review.</td>
</tr>
<tr>
<td>01-29-14</td>
<td>Presbyterian Policy Retired. 01-29-14 Presbyterian now uses MCG Criteria A-0217</td>
</tr>
<tr>
<td>01-24-18</td>
<td>Annual review. Accessed MCG criteria A-0217. Last updated 2-2-17. No change. Current role remains uncertain. There are currently no clinical indications for this technology</td>
</tr>
<tr>
<td>03-25-20</td>
<td>Annual review. MCG criteria A-0217 unchanged and remains uncertain. Added non-coverage determination by CMS, (NCD 150.11) for the usage TIPs. Policy has been reviewed by PHP Medical Policy Committee on 01/26/2020.</td>
</tr>
</tbody>
</table>

This Medical Policy is intended to represent clinical guidelines describing medical appropriateness and is developed to assist Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) Health Services staff and Presbyterian medical directors in determination of coverage. The Medical Policy is not a treatment guide and should not be used as such.

For those instances where a member does not meet the criteria described in these guidelines, additional information supporting medical necessity is welcome and may be utilized by the medical director in reviewing the case. Please note that all Presbyterian Medical Policies are available online at: [Click here for Medical Policies](#)