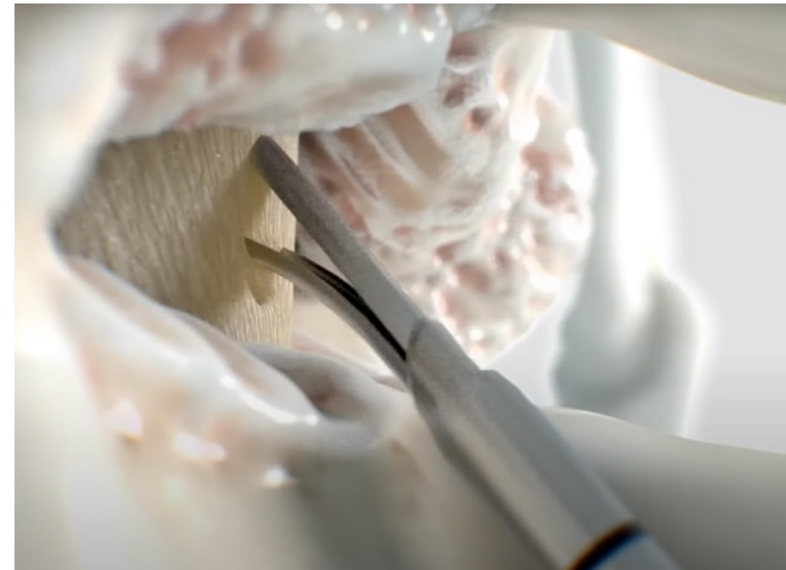
# 2025 billing and coding guide

# mild® procedure

(NCT03072927)



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 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 **(150.13).**

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# mild® procedure

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**Questions?** Contact IVS Reimbursement Hot Line | **954 302 4591** | **IVS-reimbursement@stryker.com**

# Payment

## Physician

| CPT codes[1] | Description | 2025 Medicare rate[2] |
|---|---|---|
| **0275T*** | 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 (e.g., fluoroscopic, CT), **single or multiple levels, unilateral or bilateral;** lumbar | **$550-$1,050**<br>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 0275T 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 2025.

## ASC

| CPT codes[1] | Description | 2025 Medicare rate[3] (National Average-Subject to Wage Indexing) |
|---|---|---|
| **0275T (APC 5114)**<br>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 (e.g., fluoroscopic, CT), **single or multiple levels, unilateral or bilateral;** lumbar | **$5,283** |

## Hospital

| CPT codes[1] | Description | Required C Code** | 2025 Medicare rate[3] (National Average-Subject to Wage Indexing) |
|---|---|---|---|
| **0275T (APC 5114)**<br>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 (e.g., fluoroscopic, CT), **single or multiple levels, unilateral or bilateral;** lumbar | **C1889[4]**<br>(Implantable/ insertable device, not otherwise classified) | **$7,144** |

*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.**

# Patient eligibility[5]

| Inclusion criteria | Exclusion criteria |
| --- | --- |
| • Medicare and Medicare Advantage beneficiaries: **no** age restriction<br>• Diagnosis of LSS with neurogenic claudication (NC) | Patients who have received a laminectomy, laminotomy, fusion, interspinous process decompression or mild procedure in the lumbar region during the 12 months prior to the index date. |

# Billing/claim instructions

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:

## Billing specifics—Medicare and Medicare advantage

| Claims identifying information to signify patient is participating in a study | CED study |
|---|---|
| National clinical trial (NCT) number | 03072927 |
| Modifier to category III CPT code | Q0<br>Investigational clinical service provided in a clinical research study that is in an approved clinical research study |
| Primary diagnosis code | M48.062<br>Spinal stenosis, lumbar region with neurogenic claudication |
| Secondary diagnosis code* | Z00.6*<br>Encounter for examination for normal comparison and control in clinical research program |
| Condition code (UB-04 facility claims only) | 30<br>Qualifying clinical trial |

*CMS allows for the Z00.6 to be coded in the primary or secondary position.

**For non-Medicare claims (commercial, W/C, Medicaid, VA, TRICARE, etc.) only report CPT 0275T and primary diagnosis code M48.062.**

## Claim form instructions

| Claims identifying information to signify patient is participating in a study | CMS 1500 | UB-04* |
|---|---|---|
| National clinical trial (NCT) number | | |
| Electronic claim | Loop 2300<br>REF02 = 03072927<br>REF01 = P4<br>(Do not use “CT” on electronic claim) | Loop 2300<br>REF02 = 03072927<br>REF01 = P4<br>(Do not use “CT” on electronic claim) |
| Paper claim<br>See examples on next page | Form locator 19<br>(Preceded by “CT”)<br>Example: CT03072927 | Form locator 39 value codes<br>• D4 is reported in the code field<br>• The NCT number is reported in the amount field (preceded by “CT”) |
| Condition code 30–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.

# Billing/claim instructions (continued)

## CMS 1500 paper claim

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
CT03072927

20. OUTSIDE LAB? YES NO $ CHARGES

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.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 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 (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 12 | 06 | 24 | 12 | 06 | 24 | 24 | | 0275T | Q0 | AB | 4600 00 | 1 | | NPI | XXXXXXXXXX |
| 2 | | | | | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | | | | | NPI | |

SUPPLIER INFORMATION

**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

**Place of services (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

**Report Q0 modifier**

- Investigational clinical service provided 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

# Billing/claim instructions (continued)

## UB-04 paper claim

1 HOSPITAL NAME
HOSPITAL ADDRESS
CITY, STATE ZIP
PHONE NUMBER

3a PAT. CNTL # XXXXXXXXX
b. MED. REC. #
4 TYPE OF BILL 131
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7

8 PATIENT NAME a PATIENT NAME
9 PATIENT ADDRESS a PATIENT ADDRESS

| 10 BIRTHDATE | 11 SEX | 12 ADMISSION DATE | 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | 18 CONDITION CODES |
|---|---|---|---|---|---|---|---|---|
| 07/06/1941 | M | 12/06/2024 | 06 | 3 | 2 | | 01 | 30 |

31 OCCURRENCE CODE / DATE: 12/06/2024

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 | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|
| 0250 | PHARMACY GENERAL | | 120624 | 9 | 172 65 | | |
| 0258 | PHARMACY IV SOLUTIONS | | 120624 | 1 | 10 00 | | |
| 0271 | MED/SRG SUPP/DEVICE NONSTERILE | | 120624 | 1 | 67 00 | | |
| 0272 | MED/SRG SUPP/DEVICE STERILE | | 120624 | 13 | 4336 00 | | |
| 0360 | OR SVCS GENERAL | 0275T Q0 | 120624 | 1 | 15344 00 | | |
| 0272 | MED/SRG SUPP/DEVICE-STERILE | C1889 | 120624 | 1 | 4275 00 | | |
| 0370 | ANESTHESIA GENERAL | | 120624 | 86 | 774 00 | | |
| 0710 | RECOVERY ROOM GENERAL | | 120624 | 49 | 3136 00 | | |

### Condition code 30

- Form locator 18
- Enter the condition "30" qualifying clinical trials on-research services provided to all patients, including managed care enrollees enrolled in a qualified clinical trial

### Category III CPT code

- Form locator 44
- Enter CPT for procedure and modifier 0275T mild procedure
- Q0—Investigational clinical service provided 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

### 8-digit clinical trial number

- Form locator 39-41
- Enter code D4 and clinical trial number 03072927
- If **paper** claim, include CT (CT03072927)
- If **electronic**, do **not** use CT; see electronic claim submission instructions

# Payor coverage

## Medicare Advantage payors

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 payors will require prior authorization for mild procedures. Please provide **all** the information below to the MA payor when requesting prior authorization in order for the payor to be aware that the procedure is being performed as part of the CMS-approved CED study.

**0275T** Minimally invasive lumbar decompression
**M48.062** Spinal stenosis with neurogenic claudication, lumbar region
**Z00.6** Encounter for examination for normal comparison and control in clinical research program
**Q0 modifier** Investigational clinical service provided in an approved clinical research study
**Condition code 30 (institutional claims only)** Non-research services provided to all patients, including managed care enrollees enrolled in a qualified clinical trial
**National clinical trial number** 03072927
**National Coverage Determination** 150.13

## Medicare supplement/Medigap payors

Supplement payors are covering mild procedures except Medicaid, TRICARE and BCBS Federal.
Please check with the payor prior to performing the procedure to confirm coverage and payment.

## Commercial (private) payors

Coverage for mild procedures varies by payor policy.
We encourage providers to contact non-Medicare payors to confirm coverage prior to performing the procedure.

## Other government payors

- **Veterans Affairs**—Covers mild procedures in VA facility
- **TRICARE**—Does not currently cover mild procedures per **TRICARE Policy Manual 6010.60-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

# Resources and references

## Resources and support

- **MLN Matters number: MM10089**
  Previous issues referenced in MM10089: MM8757–October 6, 2014
- **CMS PILD CED Overview**
- **CMS Manual System Transmittal 3811**
- **Clinicaltrials.gov Study Record Detail**

## References


1. Current Procedural Terminology 2024, American Medical Association. Chicago, IL 2024. CPT is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®) is copyright 2024 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
2. 2025 CMS PFS Final Rule, Addendum B (published November 1, 2024). Medicare national average physician payment rates listed in this document are based on the November 2024 release of the relative value file and conversion factor of 32.3465. https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1807-f.
3. 2025 CMS OPPS/ASC Final Rule, Addendum AA, B and J (published November 1, 2024). https://www.cms.gov/medicare/regulations-guidance/fee-for-service-payment-regulations.
4. Healthcare Common Procedure Coding System (HCPCS) Level II codes are maintained by the Centers for Medicare & Medicaid Services.
5. mild Percutaneous Image-Guided Lumbar Decompression: a Medicare Claims Study. https://www.clinicaltrials.gov/study/NCT03072927.


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## Interventional Spine

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Stryker does not assume any responsibility for coding decisions, nor does it recommend codes for specific patients' procedures. The provider is solely responsible for reporting the codes that accurately describe the services furnished to a particular patient as well as the patient's medical condition. It is the provider's responsibility to determine and document that the services provided are medically necessary and that the site of service is appropriate. It is the health care provider's responsibility to report the patient diagnosis, the procedures performed and the products used, consistent with the specific payor's guidelines.

Stryker defers to specialty society guidelines, payor policies and guidelines, Medicare and the AMA regarding the submission of claims and the appropriate coding for procedures and products.

Reimbursement has three components, coding, coverage and payment. All three must be aligned for providers to receive reimbursement for the services they furnish. Payment rates are calculated and represent the national unadjusted payment rates. Payment to individual providers will vary based on a number of variables, including geographic location.

This information in this document is accurate as of November 18, 2024, and all coding and reimbursement information is subject to change without notice. Please contact your Medicare Administrative Contractor or Private Payor for billing, payment and coverage information.


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