Policy: MP030
Section: Medical Benefit Policy
Subject: Intradiscal Electrothermal Therapy IDET

I. Policy: Intradiscal Electrothermal Therapy (IDET™)

II. Purpose/Objective:
To provide a policy of coverage regarding Intradiscal Electrothermal Therapy (IDET™)

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) The service or benefit will assist the Member to achieve or maintain maximum functional
capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

DESCRIPTION:
Intradiscal Electrothermal Therapy (IDET™), also known as Intradiscal electrothermal annuloplasty, is an invasive procedure reported in the medical literature to treat lumbar disc pain. The procedure is performed under local anesthesia with intravenous sedation using an intradiscal catheter and an electrothermal generator. The procedure is usually administered in the outpatient setting. A catheter is inserted percutaneously and is positioned in the disc using fluoroscopic guidance. The tip of the catheter delivers heat to the tissue it comes in contact with. IDET is theorized to work by treating the protein wall of the disc and reducing the volume of the disc material that causes nerve irritation.

EXCLUSIONS: The Plan does NOT provide coverage for Intradiscal Electrothermal Therapy as a treatment for any indication because it is considered experimental, investigational or unproven. The Geisinger Technology Assessment Committee evaluated this technology and concluded that there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this test on health outcomes when compared to established tests or technologies.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

CODING ASSOCIATED WITH: Intradiscal Electrothermal Therapy (IDET™)
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

22526 Percutaneous intradiscal annuloplasty, any method, unilateral or bilateral including fluoroscopic guidance; single level
22527 Percutaneous intradiscal annuloplasty, any method, unilateral or bilateral including fluoroscopic guidance; one or more additional levels

LINE OF BUSINESS:
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD’s and NCD’s will supersede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:


Geisinger Clinic Technology Assessment Committee, re-review, IDET for Treatment of Low Back Pain, January 2003.


Centers for Medicare & Medicaid Services. National Coverage Determination (NCD) for Thermal Intradiscal Procedures (TIPs) (150.11)

This policy will be revised as necessary and reviewed no less than annually.

Devised: 9/01

Revised: 7/02, 7/2/03; 7/04; 7/05 (Reference); 7/06 (references/coding/exclusions); 7/07 (references/coding)

Reviewed: 7/08, 7/09, 6/10, 6/11, 6/12, 6/13, 6/14; 6/15, 6/16, 5/17, 8/18; 9/19