Policy: MP222  
Section: Medical Benefit Policy  
Subject: Intradiscal Biacuplasty

I. Policy: Intradiscal Biacuplasty

II. Purpose/Objective:  
To provide a policy of coverage regarding Intradiscal Biacuplasty

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 biacuplasty involves the use of two cooled radiofrequency electrodes placed on the posterolateral sides of the intervertebral annulus fibrosus. It is proposed that by cooling the probes a larger area may be treated than with a regular needle probe.

EXCLUSIONS:
The Plan does NOT provide coverage for the use Intradiscal biacuplasty 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 technology 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 Biacuplasty
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 electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level
22527 Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional level
22899 Unlisted procedure, spine


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 supercede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:


Proposed Decision Memo for Thermal Intradiscal Procedures (CAG-00387N)

Baylis Medical Inc. website. TransDiscal™ System. Accessed Jul 13, 2008. Available at URL address:
http://www.baylismedical.com/PMProdList8.html


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

Devised: 11/19/08

Revised:

Reviewed: 01/10, 1/11, 1/12, 1/13, 1/14, 1/15, 1/16, 1/17, 1/18, 1/19, 1/20