Intradiscal Electro Thermal Annuloplasty

I write in support of covering Intradiscal Electro Thermal Annuloplasty 22526, 22527.

By now you have been provided extensive literature on this subject. The best of thesupport comes from a prospective 2 cohort series comparing IDET (aka ITA, IDTA, IDTT) to radiofrequency annular ablation (aka RFA). The results were dramatically favorable for IDET but unfavorable to RFA. (Kapural et al. Itradiscal thermal annuloplasty versus intradiscal radiofrequency ablatin for the treatment of dicogenicpain: a prospective matched control trial. Pain Med 2005 6;6:425-31.)

I have been employing the technique since shortly after its release. I have only been performing a few per year due to non-coverage. I have no financial interest in any of the products and am not a consultant. In carefully selected patients who have severe lumbar pain with activities such as sitting and who have concordant provocation discography, my results have been about 80% positive results; that means greater than 50% relief, improved function and reduced medication. Here are just two vignettes:

A 911 dispatcher in her mid 50s presented with severe back pain particularly with sitting.

Her job required her to sit for up to 10 hours per day. She had reduced her hours to and average of 2 per day. She had multilevel degenerative disk disease but only one disc that provoked concordantly on provocation discography. IDET provided gradual but dramatic improvement. By three months she had returned to 10 hour per day work in comfort with no narcotic use.

A 34 year old delivery truck driver presented with severe back pain, intermittent sciatica and addiction to opioids. He had taken medical leave of work and found himself out of control with medication use trying to control his pain. He had severe concordant pain at L5-S1 and severe discordant pain at L4-5 and L3-4. He was treated with IDET. At 6 weeks he was able to go camping with his son's Boy Scout troop. At 3 months his pain was almost completely gone and had stopped using opioids. At 3 months I released him to light duty with a 40# weight restriction, but the employer did not accept him until I returned him without restrictions at 6 months.

To be successful, an interventional pain physician must have available a variety of tools, including IDET. One tool will not treat all patients. Individual patients must be properly diagnosed and treatment fitted to the individual. IDET will not be the right treatment for every patient with back pain. When appropriate, as exemplified above, proper IDET can dramatically improve symptoms, restore patients to work, family and recreation, restore financial independence, and reduce opioid consumption.

Coverage should provide improved access to care by many deserving patients and give them a better chance of returning to wellness. Reimbursement should be adequate to cover the physician fees, facility costs and permit pass through of the device cost. Please, find favorably in the coverage decision for IDET.

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