Abbott

CHRONIC PAIN THERAPIES

National Medicare Reimbursement Guide

Effective January 1, 2024

NEUROMODULATION MEDICARE REIMBURSEMENT GUIDE

Introduction

This content is intended to provide reference material related to general guidelines for reimbursement when used consistently with the product's labeling. This content includes information regarding coverage, coding and reimbursement. Additional resources can be found at:

https://www.neuromodulation.abbott/us/en/hcp/provider-resources/reimbursement-guides.html

Reimbursement Hotline

Abbott offers a reimbursement hotline, which provides live coding and reimbursement information from dedicated reimbursement specialists. Coding and reimbursement support is available from 8 a.m. to 5 p.m. Central Time, Monday through Friday at (855) 569-6430 or ptahotline@abbott.com. Coding and reimbursement assistance is provided subject to the disclaimers set forth in this guide.

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SPINAL CORD STIMULATION

MEDICARE NATIONAL COVERAGE DETERMINATION[12]

CMS provides coverage for Spinal cord stimulation (SCS) & Dorsal root ganglion stimulation (DRG) under a longstanding National Coverage Determination (NCD) for Electrical Nerve Stimulators (160.7) that includes specific criteria for coverage, which are as follows:

- The implantation of the stimulator is used only as a late resort (if not a last resort) for patients with chronic intractable pain;
- With respect to item a, other treatment modalities (pharmacological, surgical, physical, or psychological therapies) have been tried and did not prove satisfactory, or are judged to be unsuitable or contraindicated for the given patient;
- Patients have undergone careful screening, evaluation and diagnosis by a multidisciplinary team prior to implantation. (Such screening must include psychological, as well as physical evaluation);
- All the facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment training, and follow up of the patient (including that required to satisfy item c) must be available; and
- Demonstration of pain relief with a temporarily implanted electrode precedes permanent implantation.

PRIVATE PAYERS

- Private payer plans vary significantly in coverage and compliance requirement for SCS and DRG.
- Private payers should be consulted in advance of the procedure to verify terms and conditions of coverage.
- Please check with your payer regarding appropriate coding and payment information.
- Commercial payer policies vary on details such as:
  - prior authorization requirements

Please consult the private payer directly to ensure complete understanding of any relevant coverage polices and billing requirements.

SPINAL CORD STIMULATION

MEDICARE LOCAL COVERAGE DETERMINATIONS

- Noridian JE (CA, NV, HI)[13]
  - LCD #L35136 LCA #A57791
- Noridian JF (AK, ID, OR, WA, AZ, MT, ND, SD, UT, WY)[14]
  - LCD #L36204 LCA #A57792
- Palmetto GBA JM (AL, GA, TN, SC, VA, WV, NC)[15]
  - LCD #L37632 LCA #A56876

For Medicare, in the absence of a Local Coverage Determination (LCD), the MAC's defer to the NCD.[12]

- CGS – J15
  - NCD:160.7
- WPS – J5 & J8
  - NCD:160.7
- NGS – JK
  - NCD: 160.7
- Novitas – JL
  - NCD: 160.7
- Novitas – JH
  - NCD: 160.7
- First Coast Service Options (FCSO) – JN
  - NCD: 160.7

SPINAL CORD STIMULATION

CPT‡ CODE	DESCRIPTION	WORK RVU	NATIONAL MEDICARE RATE	
			FACILITY	NON-FACILITY
	TRIAL PROCEDURE			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	7.15	$407	$2,236
	PERMANENT PROCEDURES			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	7.15	$407	$2,236
63655	Laminectomy implant of neurostimulator electrodes, plate/paddle, epidural	10.92	$838	NA
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	5.19	$337	NA

Rates effective Jan 1, 2024 - Dec 31, 2024

• NA: There are no Medicare valuations for these codes and these procedures are not typically performed in an in-office setting.Check with your carrier to determine reimbursement rates.

SPINAL CORD STIMULATION

CPT‡ CODE	DESCRIPTION	WORK RVU	NATIONAL MEDICARE RATE	
			FACILITY	NON-FACILITY
	REVISION AND REMOVAL PROCEDURES			
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	5.08	$326	$675
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	11.00	$851	NA
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	7.75	$444	$889
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	11.52	$886	NA
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array	4.35	$298	NA

Rates effective Jan 1, 2024 - Dec 31, 2024
• NA: There are no Medicare valuations for these codes and these procedures are not typically performed in an in-office setting.Check with your carrier to determine reimbursement rates.

SPINAL CORD STIMULATION

CPT‡ CODE	DESCRIPTION	WORK RVU	NATIONAL MEDICARE RATE	
			FACILITY	NON-FACILITY
	ANALYSIS AND PROGRAMMING			
95970*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	0.35	$18	$18
95971*	…; simple spinal cord or peripheral nerve (e.g., sacral nerve) device is tested. A simple device affects only three or fewer of the following: interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, algorithm detection, closed loop parameters, and passive parameters. Programming of the device by the physician or other qualified health care professional is included in this service.	0.78	$38	$47
95972*	…; complex spinal cord or peripheral nerve (e.g., sacral nerve) device is tested. A complex device affects more than three of the following: interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, algorithm detection, closed loop parameters, and passive parameters. Programming of the device by the physician or other qualified health care professional is included in this service.	0.80	$39	$56

Rates effective Jan 1, 2024 - Dec 31, 2024

- Programming of the device by the physician or other qualified health care professional is included in this service. A physician or other qualified health care professional is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. A patient or his payer should not be billed for analysis and programing services performed at the discretion of the physician by a manufacturer's representative.
- *CPT‡ codes 95970-95972 were added to Medicare's list of telehealth services for the duration of the public health emergency (CMS, Interim Final Rule).

SPINAL CORD STIMULATION

CPT‡ CODE	DESCRIPTION	STATUS INDICATOR	C-APC	NATIONAL MEDICARE FACILITY RATE
	TRIAL PROCEDURE			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	J1	5462	$6,523
	PERMANENT PROCEDURES			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	J1	5462	$6,523
63655	Laminectomy implant of neurostimulator electrodes, plate/paddle, epidural	J1	5464	$20,865
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	J1	5465	$29,617

Rates effective Jan 1, 2024 - Dec 31, 2024

- J1 = Hospital Part B services paid through a comprehensive APC

SPINAL CORD STIMULATION

CPT‡ CODE	DESCRIPTION	STATUS INDICATOR	C-APC	NATIONAL MEDICARE FACILITY RATE
	REVISION AND REMOVAL PROCEDURES			
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	Q2	5431	$1,842
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	J1	5461	$3,245
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	J1	5462	$6,523
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	J1	5463	$12,992
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array	J1	5461	$3,245

Rates effective Jan 1, 2024 - Dec 31, 2024

- J1 = Hospital Part B services paid through a comprehensive APC
- Q2 = T-packaged codes

SPINAL CORD STIMULATION

CPT‡ CODE	DESCRIPTION	STATUS INDICATOR	C-APC	NATIONAL MEDICARE FACILITY RATE
	ANALYSIS AND PROGRAMMING			
95970*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	Q1	5734	$122
95971*	…; simple spinal cord or peripheral nerve (e.g., sacral nerve) device is tested. A simple device affects only three or fewer of the following: interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, algorithm detection, closed loop parameters, and passive parameters. Programming of the device by the physician or other qualified health care professional is included in this service.	S	5742	$92
95972*	…; complex spinal cord or peripheral nerve (e.g., sacral nerve) device is tested. A complex device affects more than three of the following: interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, algorithm detection, closed loop parameters, and passive parameters. Programming of the device by the physician or other qualified health care professional is included in this service.	S	5742	$92

Rates effective Jan 1, 2024 - Dec 31, 2024

- Q1 = Packaged APC payment if billed on same date of service as HCPCS assigned status indicator S, T, V or X
- S = Procedure or service, not discounted when multiple
- Programming of the device by the physician or other qualified health care professional is included in this service. A physician or other qualified health care professional is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. A patient or his payer should not be billed for analysis and programing services performed at the discretion of the physician by a manufacturer's representative.
- *CPT‡ codes 95970-95972 were added to Medicare's list of telehealth services for the duration of the public health emergency (CMS, Interim Final Rule).

SPINAL CORD STIMULATION

CPT‡ CODE	DESCRIPTION	PAYMENT INDICATOR	MULTI-PROCEDURE DISCOUNT	NATIONAL MEDICARE FACILITY RATE
	TRIAL PROCEDURE			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	J8	N	$4,952
	PERMANENT PROCEDURES			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	J8	N	$4,952
63655	Laminectomy implant of neurostimulator electrodes, plate/paddle, epidural	J8	N	$17,993
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	J8	N	$25,298

Rates effective Jan 1, 2024 - Dec 31, 2024

- J8 = Device-intensive procedure; paid at adjusted rate.

SPINAL CORD STIMULATION

CPT‡ CODE	DESCRIPTION	PAYMENT INDICATOR	MULTI-PROCEDURE DISCOUNT	NATIONAL MEDICARE FACILITY RATE
	REVISION AND REMOVAL PROCEDURES			
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	G2	N	$898
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	G2	Y	$1,898
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	J8	N	$4,864
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	J8	N	$10,317
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array	A2	Y	$1,898

Rates effective Jan 1, 2024 - Dec 31, 2024

- A2 = Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.
- G2 = Non office-based surgical procedure added in CY2008 or later; payment base on OPPS relative payment rate.
- J8 = Device-intensive procedure; paid at adjusted rate.

SPINAL CORD STIMULATION

PROCEDURE	SCENARIO	TYPICAL MS-DRG ASSIGNMENT	MS-DRG TITLE	NATIONAL MEDICARE FACILITY RATE
Implant or replace SCS system; generator and lead(s)	Pain disorder or due to causalgia or RSD, and other nervous system disorders	028	Spinal procedures with MCC	$42,192
		029	Spinal procedures with CC or spinal neurostimulators	$24,003
	Pain due to musculoskeletal disorders	518	Back and neck procedure except spinal fusion with MCC or disc device/neurostim	$25,568
Implant or replace generator only	Pain disorder or due to causalgia or RSD, and other nervous system disorders	040	Peripheral/cranial nerve and other nervous system procedure with MCC	$26,960
		041	Peripheral/cranial nerve and other nervous system procedure with CC or peripheral neurostim	$15,618
		042	Peripheral/cranial nerve and other nervous system procedure without CC/ MCC	$12,181
	Pain due to musculoskeletal disorders	981	Extensive O.R. procedure unrelated to principal diagnosis with MCC	$33,190
		982	Extensive O.R. procedure unrelated to principal diagnosis with CC	$17,406
		983	Extensive O.R. procedure unrelated to principal diagnosis without CC/ MCC	$11,449

Rates effective Oct 1, 2023 - Sept 30, 2024

SPINAL CORD STIMULATION

PROCEDURE	SCENARIO	TYPICAL MS-DRG ASSIGNMENT	MS-DRG TITLE	NATIONAL MEDICARE FACILITY RATE
Implant or replace lead(s) only	Pain disorder or due to causalgia or RSD, and other nervous system disorders	028	Spinal procedures with MCC	$42,192
		029	Spinal procedures with CC or spinal neurostimulators	$24,003
		030	Spinal procedures without CC/MCC	$16,237
	Pain due to musculoskeletal disorders	518	Back and neck procedure except spinal fusion with MCC or disc device/neurostim	$25,568
		519	Back and neck procedure except spinal fusion with CC	$13,783
		520	Back and neck procedure except spinal fusion without CC/MCC	$10,023

Rates effective Oct 1, 2023 - Sept 30, 2024

SPINAL CORD STIMULATION

PROCEDURE	TYPICAL MS-DRG ASSIGNMENT	MS-DRG TITLE	NATIONAL MEDICARE FACILITY RATE
Remove SCS system; generator and lead(s) Remove or revise lead(s) only	028	Spinal procedures with MCC	$42,192
	029	Spinal procedures with CC or spinal neurostimulators	$24,003
	030	Spinal procedures without CC/MCC	$16,237

PROCEDURE	TYPICAL MS-DRG ASSIGNMENT
Remove, generator only	These codes are not considered "significant procedures" for the purpose of MS-DRG assignment. A non-surgical (i.e., medical) MS-DRG is assigned to the inpatient hospital admission according to the principal diagnosis

SPINAL CORD STIMULATION

HOSPITAL INPATIENT PROCEDURE CODES		
Procedure	Possible ICD-10 PCS Code	Description
Lead Insertion	00HU0MZ	Insertion of neurostimulator lead into spinal canal, open approach
	00HU3MZ	Insertion of neurostimulator lead into spinal canal, percutaneous approach
	00HV0MZ	Insertion of neurostimulator lead into spinal cord, open approach
	00HV3MZ	Insertion of neurostimulator lead into spinal cord, percutaneous approach
Lead Removal	00PU0MZ	Removal of neurostimulator lead from spinal canal, open approach
	00PU3MZ	Removal of neurostimulator lead from spinal canal, percutaneous approach
	00PV0MZ	Removal of neurostimulator lead from spinal cord, open approach
	00PV3MZ	Removal of neurostimulator lead from spinal cord, percutaneous approach
Lead Revision	00WU0MZ	Revision of neurostimulator lead in spinal canal, open approach
	00WU3MZ	Revision of neurostimulator lead in spinal canal, percutaneous approach
	00WV0MZ	Revision of neurostimulator lead in spinal cord, open approach
	00WV3MZ	Revision of neurostimulator lead in spinal cord, percutaneous approach
Lead Replacement		Two codes are required to identify a device replacement; one code for the removal of the existing device and one code for the implantation of a new device

SPINAL CORD STIMULATION

HOSPITAL INPATIENT PROCEDURE CODES		
Procedure	Possible ICD-10 PCS Code	Description
Generator Implant	0JH60BZ	Insertion of single array stimulator generator into chest subcutaneous tissue and fascia, open approach
	0JH63BZ	Insertion of single array stimulator generator into chest subcutaneous tissue and fascia, percutaneous approach
	0JH70BZ	Insertion of single array stimulator generator into back subcutaneous tissue and fascia, open approach
	07H73BZ	Insertion of single array stimulator generator into back subcutaneous tissue and fascia, percutaneous approach
	0JH80BZ	Insertion of single array stimulator generator into abdomen subcutaneous tissue and fascia, open approach
	0JH83BZ	Insertion of single array stimulator generator into abdomen subcutaneous tissue and fascia, percutaneous approach
Generator Removal	0JPT0MZ	Removal of stimulator generator from trunk subcutaneous tissue and fascia, open approach
	0JPT3MZ	Removal of stimulator generator from trunk subcutaneous tissue and fascia, percutaneous approach
Generator Revision	0JWT0MZ	Revision of stimulator generator from trunk subcutaneous tissue and fascia, open approach
	0JWT3MZ	Revision of stimulator generator from trunk subcutaneous tissue and fascia, percutaneous approach
Generator Replacement		Two codes are required to identify a device replacement: one code for the removal of the existing device and one code for the implantation of a new device.

SPINAL CORD STIMULATION

ADDITIONAL CODING AND REIMBURSEMENT FOR SPINAL CORD STIMULATION

HCPCS Device Category Codes	
C-CODE	DESCRIPTION
	CODES FOR MEDICARE HOSPITAL OUTPATIENT PROCEDURES
C1767	Generator
C1778	Neurostimulator lead (use for permanent procedure)
C1787	Patient programmer, neurostimulator
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system
C1883	Adapter or extension
C1897	Lead neurostimulator test kit, pacing lead (use for trial procedures)
	ADDITIONAL CODES
L8680	Implantable neurostimulator electrode, each
L8679	Implantable neurostimulator pulse generator, any type
L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only

SPINAL CORD STIMULATION

CODING AND REIMBURSEMENT FOR SPINAL CORD STIMULATION (SCS) AND DORSAL ROOT GANGLION (DRG) STIMULATON

Diagnosis codes are used by both hospitals and physicians to document the medical necessity and clinical rationale for the procedure. For chronic pain patients, there are many possible diagnosis code scenarios and a wide variety of possible combinations. This list is not exhaustive of all the diagnosis codes supporting chronic pain neuromodulation procedures and is meant to serve as an example for your review. The customer should check with their local carriers or intermediaries and should consult with legal counsel or a financial, coding or reimbursement specialist for coding, reimbursement or billing questions related to ICD-10-CM diagnosis codes.

ICD-10-CM-DIAGNOSIS CODES	
ICD-10-CM	DESCRIPTION
	Chronic Pain Disorders
G89.21	Chronic pain due to trauma
G89.28	Other chronic post-procedural pain
G89.29	Other chronic pain
G89.4	Chronic pain syndrome

ICD-10-CM-DIAGNOSIS CODES	
ICD-10-CM	DESCRIPTION
	Causalgia (Complex Regional Pain Syndrome II, CRPS II)
G57.70	Causalgia of unspecified lower limb
G57.71	Causalgia of right lower limb
G57.72	Causalgia of left lower limb
G57.73	Causalgia of bilateral lower limbs

ICD-10-CM-DIAGNOSIS CODES	
ICD-10-CM	DESCRIPTION
	Reflex Sympathetic Dystrophy (RSD) (Complex Regional Pain Syndrome I, CRPS I)
G90.521	Complex regional pain syndrome I of right_x000D_ lower limb
G90.522	Complex regional pain syndrome I of left_x000D_ lower limb
G90.523	Complex regional pain syndrome I of lower limb, bilateral
G90.529	Complex regional pain syndrome I of unspecified lower limb

ICD-10-CM-DIAGNOSIS CODES	
ICD-10-CM	DESCRIPTION
	Peripheral Neuropathy of the Extremities
G57.90	Unspecified mononeuropathy of unspecified lower limb
G57.91	Unspecified mononeuropathy of right lower limb
G57.92	Unspecified mononeuropathy of left lower limb
G57.93	Unspecified mononeuropathy of bilateral_x000D_ lower limbs

SPINAL CORD STIMULATION

CODING AND REIMBURSEMENT FOR SPINAL CORD STIMULATION (SCS) AND DORSAL ROOT GANGLION (DRG) STIMULATON

ICD-10-CM-DIAGNOSIS CODES	
ICD-10-CM	DESCRIPTION
	Device Complications
T85.112A	Breakdown (mechanical) of implanted electronic neurostimulator of spinal cord electrode (lead)
T85.113A	Breakdown (mechanical) of implanted electronic neurostimulator, generator
T85.122A	Displacement of implanted electronic neurostimulator of spinal cord electrode (lead)
T85.123A	Displacement of implanted electronic neurostimulator, generator
T85.192A	Other mechanical complication of implanted electronic neurostimulator of spinal cord
T85.193A	Other mechanical complication of implanted electronic neurostimulator, generator
T85.890A	Other specified complication of nervous system prosthetic devices, implants and grafts
Z45.42	Encounter for adjustment and management of neurostimulator

ICD-10-CM-DIAGNOSIS CODES	
ICD-10-CM	DESCRIPTION
	Post Laminectomy Syndrome
M96.1	Causalgia of unspecified lower limb

ICD-10-CM-DIAGNOSIS CODES	
ICD-10-CM	DESCRIPTION
	Diabetic Peripheral Neuropathy
E08.42	Diabetes mellitus due to underlying condition with diabetic polyneuropathy
E09.42	Drug or chemical induced diabetes mellitus with neurological complications with diabetic polyneuropathy
E10.42	Type 1 diabetes mellitus with diabetic polyneuropathy
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy
E13.42	Other specified diabetes mellitus with diabetic polyneuropathy

SPINAL CORD STIMULATION

CODING AND REIMBURSEMENT FOR SPINAL CORD STIMULATION (SCS) AND DORSAL ROOT GANGLION (DRG) STIMULATON

ICD-10-CM-DIAGNOSIS CODES	
ICD-10-CM	DESCRIPTION
	Radiculopathy
M54.12	Radiculopathy, cervical region
M54.13	Radiculopathy, cervicothoracic region
M54.14	Radiculopathy, thoracic region
M54.15	Radiculopathy, thoracolumbar region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M54.18	Sacral and sacrococcygeal radiculopathy

ICD-10-CM-DIAGNOSIS CODES	
ICD-10-CM	DESCRIPTION
	Arachnoiditis
G03.1	Chronic meningitis
G03.9	Meningitis, unspecified

SPINAL CORD STIMULATION

CODING AND REIMBURSEMENT FOR SCS & DRG

FOR IMPLANTING PHYSICIAN(S): This checklist is provided as a summary of the information used to process claims for SCS and DRG procedures per CMS's NCD 160.7. It is the responsibility of the hospital and/or physician to determine appropriate coding for a particular patient and / or procedure. Any claim should be coded appropriately and supported with adequate documentation in the medical record.[12]

- ICD Diagnosis and documentation supports a specific condition indicated for neurostimulator placement

Physician office notes including:

- Documentation that alternatives and non-surgical options were discussed with the beneficiary
- Medical records with relevant history, physical exam, and diagnostic studies
- Condition(s) requiring procedure
- Surgical consult with physician evaluation/order for the procedure/device
    - If the patient is not a surgical candidate, include notes supporting why surgical intervention is not appropriate or indicated for the patient
- Documentation of treatments tried/failed or contraindicated including but not limited to
    - Spine surgery
    - Physical therapy
    - Medications
    - Injections
    - Psychological therapy
- Documentation of psychological evaluation by appropriate qualified professional
- Documentation that patient was educated on procedure with discussion of risks and benefits

For permanent placement, include all of the above documentation, as well as documentation of pain relief with the temporary implanted electrode(s)

- A successful trial should be associated with at least a 50 percent reduction of target pain or 50 percent reduction of analgesic medications

RADIOFREQUENCY ABLATION

CPT‡ CODE	DESCRIPTION	WORK RVU	NATIONAL MEDICARE RATE	
			FACILITY	NON-FACILITY
	CERVICAL SPINE/THORACIC SPINE			
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	3.32	$188	$430
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint	1.32	$65	$251
	LUMBAR SPINE/ SACRAL SPINE			
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	3.32	$188	$434
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint	1.16	$57	$236
	GENICULAR NERVE			
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	2.5	$143	$382
	SACROILIAC JOINT			
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)	3.39	$191	$465
	OTHER PERIPHERAL NERVES			
64640*	Destruction by neurolytic agent; other peripheral nerve or branch	1.98	$117	$244
77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)	0.54	NA	$114

Rates effective Jan 1, 2024 - Dec 31, 2024

- *CPT‡ code 64640 may not be billed more than 5 times on a single date of service.
- Some services or procedures performed by HCP's may not have specific CPT‡ codes. When submitting claims for these services or procedures that are not otherwise specified please contact your HE&R representative.

RADIOFREQUENCY ABLATION

CPT‡ CODE	DESCRIPTION	STATUS INDICATOR	C-APC	NATIONAL MEDICARE FACILITY RATE
	CERVICAL SPINE/THORACIC SPINE			
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	J1	5431	$1,842
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint	N	NA	Packaged
	LUMBAR SPINE/ SACRAL SPINE			
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	J1	5431	$1,842
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint	N	NA	Packaged
	GENICULAR NERVE			
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	J1	5431	$1,842
	SACROILIAC JOINT			
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	J1	5431	$1,842
	OTHER PERIPHERAL NERVES			
64640	Destruction by neurolytic agent; other peripheral nerve or branch	T	5443	$869
77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)	N	NA	Packaged

Rates effective Jan 1, 2024 - Dec 31, 2024
- J1 = Hospital Part B services paid through a comprehensive APC
- N = Items and services packaged into APC rates
- T = Significant procedure, multiple reduction applies

RADIOFREQUENCY ABLATION

CPT‡ CODE	DESCRIPTION	PAYMENT INDICATOR	MULTI-PROCEDURE DISCOUNT	NATIONAL MEDICARE FACILITY RATE
	CERVICAL SPINE/ THORACIC SPINE			
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	G2	Y	$898
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint	N1	N	$0
	LUMBAR SPINE/ SACRAL SPINE			
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	G2	Y	$898
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint	N1	N	$0
	GENICULAR NERVE			
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	G2	Y	$898
	SACROILIAC JOINT			
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	G2	Y	$898
	OTHER PERIPHERAL NERVES			
64640	Destruction by neurolytic agent; other peripheral nerve or branch	P3	Y	$173
77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)	N1	NA	NA

Rates effective Jan 1, 2024 - Dec 31, 2024

- G2 = Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment rate.
- N1 = Package service/item; no separate payment made.
- P3 = Office-based surgical procedure added to ASC list in CY2008 or later with MPFS non-facility PE RVUs payment based on non-facility PE RVUs.

RADIOFREQUENCY ABLATION

CODING AND REIMBURSEMENT FOR RADIOFREQUENCY ABLATION (RFA)

Pre-Procedure Requirements

Most insurance providers require at least one diagnostic procedure for each treated site, with some requiring two. Please check with the payer before performing any radiofrequency (RF) procedure to be sure you have completed all required step therapies.

Appeals

There are numerous reasons that a facility or physician may face a denied, pended or underpaid claim.

Claims are typically denied or pended for four reasons:

- The claims processors have made an administrative error
- The claim forms contain clerical errors
- The payer has not deemed the procedure to be medically necessary
- The payer's requests for information have gone unanswered by the patient

Appealing Denied Claims

A denied claim can be appealed. When a claim has been denied, review the Explanation of Benefits (EOB) for an explanation of the denial.

Immediately contact the payer if the EOB does not explain the reason for the denial and request an explanation. In cases where the denial was a result of a clerical error on the claim form, confirm the correct code with the payer and resubmit the corrected claim form.

Other reasons for a denied claim may include:

- The technology is considered investigational
- The CPT‡ code does not meet the diagnosis code
- The medical necessity has not been determined

Should your claim have been denied for one of these reasons, it is best to contact the payer directly in order to offer additional information about the procedure. You should ask the claims processor to indicate which additional materials should be provided in order to potentially reverse the original coverage determination. If you feel that your claim has been underpaid, contact the claims office indicated on the patient's EOB and request a review of your claim.

Reasons for underpayment of a procedure include but are not limited to:

- The coding of the procedure performed is incorrect
- The lack or misuse of an appropriate modifier
- The lack of supporting documentation

You will find that each payer has its own unique review process. It is best to contact the payer for the exact guidelines. In most cases, however, you will be asked to submit your appeal request in writing. When contacting the payer, be sure to inquire as to where the request should be sent and to whose attention it should be directed.

If you have additional reimbursement questions, please call the Reimbursement Hotline at (855) 569-6430.

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5. CMS_2024 ICD-10-PCS [cited: September 2023]. https://www.cms.gov/medicare/coding-billing/icd-10-codes/2024-icd-10-pcs
6. CMS_2024 ICD-10-CM [cited: September 2023] https://www.cms.gov/medicare/coding-billing/icd-10-codes/2024-icd-10-cm
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8. Modifier 50 Fact Sheet [cited: September 2023] https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00144531
9. Modifier 59 Fact Sheet [cited: September 2023] https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?_adf.ctrl-state=86hvagjfk_4&contentId=00144545
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11. Modifier 95 for Telehealth. [cited: September 2023] https://www.aapc.com/blog/50505-using-modifier-95-for-telehealth-makes-cents/
12. NCD Electrical Nerve Stimulator 160.7 [cited: September 2023] https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=240
13. LCD - Spinal Cord Stimulators for Chronic Pain (L35136) [cited: September 2023] https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=35136&DocID=L35136
14. LCD - Spinal Cord Stimulators for Chronic Pain (L36204) [cited: September 2023] https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=36204&DocID=L36204
15. LCD - Spinal Cord Stimulators for Chronic Pain (L37632) [cited: September 2023] https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=37632

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