



RADIOFREQUENCY ABLATION

National Medicare Reimbursement Guide

Effective January 1, 2024

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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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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

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- *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

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- 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

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- G2 = Non office-based surgical procedure added in CY 2008 or later; payment based on OPSS 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, pending or underpaid claim.

Claims are typically denied or pending 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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<https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=240>
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