HEALTH ECONOMICS & REIMBURSEMENT

CHRONIC PAIN THERAPIES

National Medicare Reimbursement Guide

Effective January 1, 2023

TERMS AND CONDITIONS

All content herein may be based upon several sources, included but not limited to primary sources, scientific literature, commercially available data sets, customer supplied information, and external sources.

Estimates shown are for illustrative purposes only. This content is not intended for any other purpose.

It should be noted that there are usually differences between economic modelling actual results. Abbott does not take responsibility for any such discrepancies. There is no guarantee of any potential economic outcome, including payment, cost savings, or procedure volume. Economic outcomes are dependent on many factors and will vary.

Certain Maryland hospitals paid under Maryland Waiver provisions using All Patient Refined Diagnosis Related Group (APR-DRG) are excluded from payment under the Medicare Inpatient Prospective Payment System (IPPS).

Reimbursement Calculators should not be provided at no charge to actively licensed Healthcare Professionals (HCPs) who regularly practice in Vermont.

This information is not to be distributed to third parties.

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. This content and all supporting documents are available at:

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

Coding and reimbursement assistance is provided subject to the disclaimers set forth in this guide.

Disclaimer

This material and the information contained herein is for general information purposes only and is not intended, and does not constitute, legal, reimbursement, business, clinical, or other advice. Furthermore, it is not intended to and does not constitute a representation or guarantee of reimbursement, payment, or charge, or that reimbursement or other payment will be received. It is not intended to increase or maximize payment by any payer. Abbott makes no express or implied warranty or guarantee that the list of codes and narratives in this document is complete or error-free. Similarly, nothing in this document should be viewed as instructions for selecting any particular code, and Abbott does not advocate or warrant the appropriateness of the use of any particular code. The ultimate responsibility for coding and obtaining payment/reimbursement remains with the customer. This includes the responsibility for accuracy and veracity of all coding and claims submitted to third-party payers. In addition, the customer should note that laws, regulations, and coverage policies are complex and are updated frequently, and, therefore, the customer should check with its local carriers or intermediaries often and should consult with legal counsel or a financial, coding, or reimbursement specialist for any questions related to coding, billing, reimbursement, or any related issues. This material reproduces information for reference purposes only. It is not provided or authorized for marketing use.

			NATIONAL MEDICARE RATE	
CPT‡ CODE	DESCRIPTION	WORK RVU	FACILITY	NON-FACILITY
	TRIAL PROCEDURE			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	7.15	$416	$2,341
	PERMANENT PROCEDURES			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	7.15	$416	$2,341
63655	Laminectomy implant of neurostimulator electrodes, plate/paddle, epidural	10.92	$858	NA
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling (Do not report 63685 in conjunction with 63688 for the same pulse generator or receiver)	5.19	$367	NA

- 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.

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	$332	$696
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	11.00	$868	NA
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	7.75	$454	$916
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	11.52	$905	NA
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver	5.30	$380	NA

- 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.

CPT‡ CODE	DESCRIPTION	WORK RVU	NATIONAL MEDICARE RATE FACILITY	NATIONAL MEDICARE RATE 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	$19	$19
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	$39	$48
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	$41	$57

- 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)

CPT‡ CODE	DESCRIPTION	STATUS INDICATOR	APC	NATIONAL MEDICARE FACILITY RATE
	TRIAL PROCEDURE			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	J1	5462	$6,604
	PERMANENT PROCEDURES			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	J1	5462	$6,604
63655	Laminectomy implant of neurostimulator electrodes, plate/paddle, epidural	J1	5464	$21,515
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling (Do not report 63685 in conjunction with 63688 for the same pulse generator or receiver)	J1	5465	$29,358

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

CPT‡ CODE	DESCRIPTION	STATUS INDICATOR	APC	NATIONAL MEDICARE FACILITY RATE
	REVISION AND REMOVAL PROCEDURES			
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	Q2	5431	$1,798
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	J1	5461	$3,248
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	J1	5462	$6,604
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	J1	5463	$11,953
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver	J1	5461	$3,248

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

Rates effective Jan 1, 2023 - Dec 31, 2023

CPT‡ CODE	DESCRIPTION	STATUS INDICATOR	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	$116
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	$100
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	$100

- 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)

CPT‡ CODE	DESCRIPTION	PAYMENT INDICATOR	MULTI-PROCEDURE DISCOUNT	NATIONAL MEDICARE FACILITY RATE
	TRIAL PROCEDURE			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	J8	N	$4,913
	PERMANENT PROCEDURES			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	J8	N	$4,913
63655	Laminectomy implant of neurostimulator electrodes, plate/paddle, epidural	J8	N	$17,950
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling (Do not report 63685 in conjunction with 63688 for the same pulse generator or receiver)	J8	N	$24,716

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

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	$854
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	G2	Y	$1,816
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	J8	N	$5,090
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	J8	N	$9,791
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver	A2	Y	$1,816

- 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.

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	$40,317
		029	Spinal procedures with CC or spinal neurostimulators	$23,443
	Pain due to musculoskeletal disorders	518	Back and neck procedure except spinal fusion with MCC or disc device/neurostim	$25,570
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	$25,987
		041	Peripheral/cranial nerve and other nervous system procedure with CC or peripheral neurostim	$16,038
		042	Peripheral/cranial nerve and other nervous system procedure without CC/ MCC	$12,688
	Pain due to musculoskeletal disorders	981	Extensive O.R. procedure unrelated to principal diagnosis with MCC	$31,419
		982	Extensive O.R. procedure unrelated to principal diagnosis with CC	$17,205
		983	Extensive O.R. procedure unrelated to principal diagnosis without CC/ MCC	$11,457

Rates effective Oct 1, 2022 - Sept 30, 2023

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	$40,317
		029	Spinal procedures with CC or spinal neurostimulators	$23,443
		030	Spinal procedures without CC/MCC	$16,059
	Pain due to musculoskeletal disorders	518	Back and neck procedure except spinal fusion with MCC or disc device/neurostim	$25,570
		519	Back and neck procedure except spinal fusion with CC	$13,714
		520	Back and neck procedure except spinal fusion without CC/MCC	$10,151

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	$40,317
	029	Spinal procedures with CC or spinal neurostimulators	$23,443
	030	Spinal procedures without CC/MCC	$16,059

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

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

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.

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

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

ICD-10-CM-DIAGNOSIS CODES

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	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	DESCRIPTION
	Reflex Sympathetic Dystrophy (RSD) (Complex Regional Pain Syndrome I, CRPS I)
G90.521	Complex regional pain syndrome I of right lower limb
G90.522	Complex regional pain syndrome I of left 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	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	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 lower limbs

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	DESCRIPTION
	Post Laminectomy Syndrome
M96.1	Causalgia of unspecified lower limb

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

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	DESCRIPTION
	Arachnoiditis
G03.1	Chronic meningitis
G03.9	Meningitis, unspecified

CPT‡ CODE	DESCRIPTION	WORK RVU	FACILITY	NATIONAL MEDICARE NON-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	3.32	$191	$444
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	$67	$261
	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	$192	$448
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	$59	$246
	GENICULAR NERVE			
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	2.5	$146	$394
	SACROILIAC JOINT			
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)	3.39	$195	$479
	OTHER PERIPHERAL NERVES			
64640*	Destruction by neurolytic agent; other peripheral nerve or branch	1.98	$119	$250
77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)	0.54	NA	$119

- 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.

CPT‡ CODE	DESCRIPTION	STATUS INDICATOR	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	$1,798
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	$1,798
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	$1,798
	SACROILIAC JOINT			
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	J1	5431	$1,798
	OTHER PERIPHERAL NERVES			
64640	Destruction by neurolytic agent; other peripheral nerve or branch	T	5443	$852
77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)	N	NA	Packaged

- J1 = Hospital Part B services paid through a comprehensive APC
- N = Items and services packaged into APC rates
- T = Significant procedure, multiple reduction applies

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	$854
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	$854
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	$854
	SACROILIAC JOINT			
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	G2	Y	$854
	OTHER PERIPHERAL NERVES			
64640	Destruction by neurolytic agent; other peripheral nerve or branch	P3	Y	$172
77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)	N1	NA	NA

- 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.

Rates effective Jan 1, 2023 - Dec 31, 2023

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.

REFERENCES

1. FY2023 IPPS Final Rule Home Page. U.S. Centers for Medicare and Medicaid Services. [cited: August 2022]. https://www.cms.gov/medicare/acute-inpatient-pps/fy-2023-ipps-final-rule-home-page
2. CY2023 ASC Final Rule Home Page. U.S. Centers for Medicare and Medicaid Services. [cited: November 2022]. https://www.cms.gov/medicaremedicare-fee-service-paymentascpaymentasc-regulations-and-notices/cms-1772-fc
3. CY2023 MPFS Final Rule Home Page. U.S. Centers for Medicare and Medicaid Services. [cited: January 2023]. https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1770-f
4. CY2023 OPPS Final Rule Home Page. U.S. Centers for Medicare and Medicaid Services. [cited: November 2022]. https://www.cms.gov/httpswwwcmsgovmedicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient/cms-1772-fc
5. CMS_2023 ICD-10-PCS [cited: August 2022]. https://www.cms.gov/medicare/icd-10/2023-icd-10-pcs
6. FY2022 IPPS Final Rule & Correction Notice Home Page. U.S. Centers for Medicare and Medicaid Services. [cited: January 2022]. https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page
7. CMS 2023 ICD-10-CM [cited: March 2023]. https://www.cms.gov/medicare/icd-10/2023-icd-10-cm

Information contained herein for DISTRIBUTION in the US ONLY.

Abbott
One St. Jude Medical Dr., St. Paul, MN 55117, USA, Tel: 1 651 756 2000

™ Indicates a trademark of the Abbott Group of Companies
‡ Indicates a third party trademark, which is property of its respective owner.

www.neuromodulation.abbott
©2023 Abbott. All rights reserved. MAT-1901175 v14.0
HE&R, approved for non-promotional use only.

Abbott