
2016 HF10™ THERAPY HOSPITAL OUTPATIENT DEPARTMENT AND AMBULATORY SURGERY CENTER REIMBURSEMENT REFERENCE GUIDE

HF10 therapy, delivered by the Nevro® Senza® System, is a new high-frequency spinal cord stimulation technology designed to aid in the management of chronic intractable pain of the trunk/limbs, including unilateral or bilateral pain associated with the following: Failed Back Surgery Syndrome (FBSS), intractable low back and leg pain.

REIMBURSEMENT SUPPORT LINE 1-888-895-8104

Hospital Outpatient Department Coding and Payment

The following CPT codes are provided as a guide for hospital outpatient department (HOPD) reporting. Actual code(s) billed should reflect the services provided to each individual patient. The Medicare fee schedules listed are a national average and have not been geographically adjusted.

Historically, facilities report CPT codes which map to Ambulatory Payment Classifications (APCs) under Medicare. Effective January 1, 2015, CMS formed Comprehensive APCs (C-APCs) for hospital outpatient payment of some device-related procedures, including spinal cord stimulation therapy implant, revision and replacement procedures. The Agency has established status indicator “J1” which it has designated to CPT codes that are identified as primary services assigned to C-APCs. All other items and services reported on the same date of service are considered adjunctive services and included in the C-APC. If there are cases with multiple J1 status codes on a single claim, the CPT codes are assigned to a single C-APC based on the code with the highest cost. The result is a single C-APC payment for the comprehensive service based on all included charges on the claim.

Device removal procedures and programming services will continue to be paid under the traditional APC methodology whereby each reported CPT code will map to individual APCs and be distinctly paid.

In addition, the Centers for Medicare and Medicaid Services (CMS) has granted Transitional Pass-Through (TPT) payment status for the neurostimulator implant procedure using HF10 therapy.

Medicare will provide pass-through payment to outpatient hospitals and ambulatory surgery centers (ASCs) for the Senza System in addition to the payment for the neurostimulator implant procedure. In order to obtain this additional payment, hospitals must report a new HCPCS pass-through device code (C1822) on the same date of service with the CPT code for the implant procedure. Medicare claims without both codes will not be eligible for pass-through payment. A guide to Medicare’s calculation of the TPT payment can be obtained from the Federal Register <https://www.gpo.gov/fdsys/pkg/FR-2000-11-13/pdf/00-28475.pdf>

Disclaimer:

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Procedure	CPT Code¹	Description	SI*	APC²	Medicare National Average²
Implant	63650	Percutaneous implantation of neurostimulator electrode array, epidural	J1	5462	\$5,224
	63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	J1	5463	\$17,359
	63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	J1	5464	\$26,728
Revision	63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	J1	5462	\$5,244
	63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate-paddle(s) via laminotomy or laminectomy, including fluoroscopy, when performed	J1	5462	\$5,244
	63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver	Q2	5461	\$2,189

Procedure	CPT Code¹	Description	SI*	APC²	Medicare National Average²
Removal	63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	Q2	5431	\$1,393
	63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	Q2	5461	\$2,189
	63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver	Q2	5461	\$2,189
Analysis & Programming	95970	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming	Q1	5734	\$91
	95971	...simple spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming	S	5742	\$106
	95972	...complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming	S	5742	\$106

*OPPS Status Indicators:

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

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Q1 = STV-Packaged codes; packaged payment if billed on the same date of service as a HCPCS code assigned status indicator “S”, “T”, or “V”. In other circumstances, payment is made through a separate APC payment.

Q2 = T-Packaged codes; packaged payment if billed on the same date of service as a HCPCS code assigned status indicator “T”. In other circumstances, payment is made through a separate APC payment.

S = Procedure or service, not discounted when multiple.

Ambulatory Surgery Center Coding and Payment

Ambulatory Surgery Centers (ASCs) also report CPT codes, but they are assigned to individual fee schedules. Multiple procedures may be paid for each case. Unlike the HOPD, the C-APC payment methodology does not apply to procedures performed in an ASC.

As of 2008, ASCs have been subject to Medicare payment methodology following the Hospital Outpatient Payment system and therefore now eligible for **Transitional Pass-Through Payment (TPT)** as well. Under the TPT status, Medicare will make “carrier priced” decisions on a case-by case basis. ASCs should contact their MACs directly to determine device payment (note: C1822 carries the Procedure Indicator of “C” for “Carrier Priced.”)¹

Device programming is not eligible for Medicare reimbursement in an ASC.

Procedure	CPT Code ¹	Description	Procedure Indicator*	Medicare National Average ²
Implant	63650	Percutaneous implantation of neurostimulator electrode array, epidural	J8	\$3,994
	63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	J8	\$14,797
	63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	J8	\$21,259
Revision	63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	J8	\$3,994
	63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate-paddle(s) via laminotomy or laminectomy, including fluoroscopy, when performed	J8	\$3,994
	63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver	A2	\$1,224
Removal	63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	G2	\$779
	63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	G2	\$1,224
	63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver	A2	\$1,224

¹ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9484.pdf>

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*ASC Procedure Indicator:

A2 = Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight

G2 = Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight

J8 = Device-intensive procedure; paid at adjusted rate

Facility Modifiers

Modifiers are appended to CPT codes to indicate to a payer that a service or procedure has been altered by specific circumstances, but do not ensure payment. In all cases, documentation must support the use of any modifiers reported on claims, and facilities should be prepared to submit their documentation to the payers to justify any potential increases in payment.

Modifier ^{1,3}	Description	Notes ⁴
-52	Reduced services	Report this modifier when a service or procedure is partially reduced or eliminated at the physician's discretion.
-58	Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period	Report this modifier during the post-op period if a procedure or service was performed was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure.
-59	Distinct procedural service	Also append the appropriate subset modifier (XE, XP, XS, XU) below.
	-XE ⁵ Separate encounter, a service that is distinct because it occurred during a separate encounter	
	-XP ⁵ Separate practitioner, a service that is distinct because it was performed by a different practitioner	
	-XS ⁵ Separate structure, a service that is distinct because it was performed on a separate organ/structure	
	-XU ⁵ Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service	
-76	Repeat procedure or service by the same physician or other qualified health care professional	Report this modifier when a procedure or service was repeated subsequent to the original procedure or service.
-78	Unplanned return to the operating /procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period	Used when another procedure was performed during the post-op period of the initial procedure.
-PO	Services, procedures and/or surgeries provided at off campus provider-based outpatient departments	As of January 1, 2016 it is required for this service type.

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Device Codes: HCPCS Level II

The HCPCS codes are reported by facilities when they have purchased and supplied the device. Medicare will no longer implement procedure-to-device edits in their hospital claim's system but encourages facilities to continue to include the appropriate HCPCS C-codes on their claims for cost reporting purposes. Although other commercial payers may also accept C-codes, the device L-codes listed below are generally reported for non-Medicare plans. Please check with your payer or Nevro's Health Economics & Reimbursement department for specifics on HCPCS billing.

Device	HCPCS Code ³	Description
Commercial Payer Device HCPCS Codes		
Leads: 8-contact	L8680	Implantable neurostimulator electrode, each
Pulse Generator	L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
External Recharger	L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only
Remote Control (patient programmer)	L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
Medicare Device HCPC Codes		
Leads	C1778	Lead, neurostimulator (implantable)
	C1897	Lead, neurostimulator, test kit (implantable)
Extension	C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable)
Pulse Generator	C1822*	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system
Patient Programmer	C1787	Patient programmer, neurostimulator

*New for 2016, Senza Spinal Cord Stimulation System delivering HF10 therapy received approval from CMS for a new C-code, C1822.

Medicare Coverage Determinations

Medicare has a National Coverage Determination (NCD) which allows for coverage of spinal cord stimulation when the following criteria⁶ are met:

- 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 the previous criteria, 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;

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- 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 the previous criteria must be available; and,
- Demonstration of pain relief with a temporarily implanted electrode precedes permanent implantation.

In addition, some local Medicare Administrative Contractors (MACs) may require additional coverage criteria through their local policies (LCDs). It is advised the providers check with their individual MACs to confirm the coverage criteria in their state.

References:

- ¹ Current Procedural Terminology 2016, American Medical Association. Chicago, IL 2015. CPT is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®) is copyright 2015 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
- ² OPPS and ASC Final Rule, Federal Register (80 Fed Reg, No. 219) November 13, 2015, 42 CFR Parts 405, 410 and 412 et al.
- ³ HCPCS Level II, 2016 Expert. Ingenix, St. Anthony Publishing/Medicode. Salt Lake City, 2015.
- ⁴ Coding With Modifiers, A Guide to Correct CPT And HCPCS Level II Modifier Usage, Second Edition. American Medical Association. Chicago, IL 2010.
- ⁵ Specific Modifiers for Distinct Procedural Services. MLM Matters® Number MM8863, effective January 1, 2015. Related Change Request #8863, released August 15, 2014.
- ⁶ National Coverage Determination (NCD) for Electrical Nerve Stimulators (160.7). Centers for Medicare and Medicaid Services. Benefit Category: Prosthetic Devices. Effective August 7, 1995.

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