HF10™ THERAPY

2018 Hospital Outpatient Reimbursement and Coding Reference Guide

HF10™ therapy, delivered by the Nevro® Senza® System, is the high-frequency spinal cord stimulation technology operated at 10,000 Hz designed to aid in the management of chronic intractable pain of the trunk and limbs without paresthesia.

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CPT® Procedure Codes

The following CPT® codes are provided as a guide for hospital outpatient department (HOPD) reporting. Actual code(s) billed should reflect the documented services provided to each individual patient. The Medicare Outpatient Prospective Payment System (OPPS) payment rates listed are a national average and have not been geographically or wage adjusted.

Comprehensive APCs

Effective January 1, 2015, Centers for Medicare and Medicare Services (CMS) formed Comprehensive APCs (C-APCs) for hospital outpatient payment of device-intensive procedures, including spinal cord stimulation therapy implant, revision and replacement procedures. CMS established status indicator "J1" to designate CPT codes assigned to C-APCs. Note that generally, all other items and services reported on the same claim are considered adjunctive services and included in the single C-APC payment rate. Certain services, such as preventive services, pass-through drugs and devices, are not packaged into the C-APC payment and are evaluated for separate payment. If there are cases with multiple J1 status indicator CPT codes on a single claim, the C-APC payment is made for the primary CPT code which typically is the code with the highest cost per the OPPS Addendum J ranking. The result is a single C-APC payment for the comprehensive service based on all included charges on the claim.

The table below provides a brief description of the procedure and the CPT code plus the following:

- HCPCS short description
- Medically unlikely edit (MUE) date of service unit limit
- OPPS status indicator (SI)
- Applicable APC group number
- National average payment rate

C-APCs are denoted with a status indicator of J1. Codes with a status indicator of Q1 or Q2 are conditionally packaged. Codes with status indicator Q2 do not receive separate APC payment when included on a claim with another J1 or T status indicator code. Codes with status indicator of Q1 do not receive separate APC payment when included on a claim with another J1, S, T or V status indicator code. Codes with a status indicator of S do not receive separate payment when included on a claim with another J1 code. Regardless of whether a code

receives separate payment, all appropriate HCPCS and CPT codes should be billed which correctly describe the procedure performed and documented.

Procedure	CPT Code[1]	Short Descriptor[1]	MUE[2]	*SI[3]	APC[3]	Medicare National Average[3]
Trial: Perc Leads	63650	*Percutaneous implantation of neurostimulator electrode array, epidural*	2	J1	5462	$6,055
Implant: Perc Leads	63685	*Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling*	1	J1	5464	$27,890
	63650	*Percutaneous implantation of neurostimulator electrode array, epidural*	2	J1	5462	Inclusive*
Implant: Paddle Lead	63685	*Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling*	1	J1	5464	$27,890
	63655	*Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural*	1	J1	5463	Inclusive*
Revision	63663	*Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed*	1	J1	5462	$6,055
	63664	*Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed*	1	J1	5463	$18,368
	63688	*Revision or removal of implanted spinal neurostimulator pulse generator or receiver*	1	Q2	5461	$2,879

[1] *Current Procedural Terminology 2017*, American Medical Association. Chicago, IL 2017. CPT is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®) is copyright 2017 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] Outpatient Services - MUE Table - Effective 1/1/18. https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html. Accessed December 15, 2017.

[3] Addendum B.- OPPS Payment by HCPCS Code for CY 2018, Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Final Rule, Federal Register Volume 82, Number 217 (Monday, November 13, 2017) 42 CFR Parts 414, 416 and 419 et al.

Procedure	CPT Code	Short Descriptor	MUE	*SI	APC	Medicare National Average
Removal	63661	*Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed*	1	Q2	5431	$1,610
	63662	*Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed*	1	Q2	5461	$2,879
	63688	*Revision or removal of implanted spinal neurostimulator pulse generator or receiver*	1	Q2	5461	$2,879

Procedure	CPT Code	Short Descriptor	MUE	*SI	APC	Medicare National Average
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*	1	Q1	5734	$105
	95971	*…simple spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming*	1	S	5742	$115
	95972	*…complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming*	1	S	5742	$115

Note: Analysis and programming of spinal cord stimulator systems may be provided by the treating physician, practitioner, or axillary medical personnel (in accordance with the Medicare or relevant payer "incident-to" requirements) under the direct supervision of physician (or other practitioner), with or without support from a manufacturer's representative. A physician should not bill if the service is performed under the direction of, or entirely by, a

manufacturer representative without payer consent. Nevro recommends that the insurance carrier be contacted for interpretation of applicable coding and billing policies.

***OPPS Status Indicators[4]**

Status Indicator	OPPS Payment Status
J1	Hospital Part B services paid through a comprehensive APC.
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.

Medicare Reimbursement Examples

The below calculations represent the formula in which Medicare calculates the allowable after applying the packaging rules. These examples reflect rounded national averages and are not geographically or wage adjusted.

Trial

CPT 63650	+	CPT 63650	=	Medicare Allowable
$6,055 *Paid per C-APC 5462*	+	$0.00 *Inclusive of C-APC 5462*	=	**$6,055**

Implant: Perc Leads

CPT 63685	+	CPT 63650	+	CPT 63650	=	Medicare Allowable
$27,890 *Paid per C-APC 5464*	+	$0.00 *Inclusive of C-APC 5464*	+	$0.00 *Inclusive of C-APC 5464*	=	**$27,890**

Implant: Paddle Lead

CPT 63685	+	CPT 63655	=	Medicare Allowable
$27,890 *Paid per C-APC 5464*	+	$0.00 *Inclusive of APC C-5464*	=	**$27,890**

[4] Addendum D1.— OPPS Payment Status Indicators for CY 2018, Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Final Rule, Federal Register Volume 82, Number 217 (Monday, November 13, 2017) 42 CFR Parts 414, 416 and 419 et al.

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[5]	Description	Notes
-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	Report this modifier when billing the same CPT for two or more distinct procedural services.
-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	Excepted service provided at an off-campus, outpatient, provider-based department of a hospital	Do not report this modifier for services performed in remote locations of a hospital, satellite facilities of a hospital, or in an off-campus dedicated emergency department.
-PN	Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital	Do not report this modifier for services performed in remote locations of a hospital, satellite facilities of a hospital, or in an off-campus dedicated emergency department.

[5] Coding with Modifiers A Guide to Correct CPT And HCPCS Level II Modifier Usage, Second Edition. American Medical Association. Chicago, IL 2010.

Level II HCPCS: Devices

Level II 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 all appropriate HCPCS C-codes on their claims for correct coding and cost reporting purposes.

Effective January 1, 2016, CMS created a new device category (C1822) for HF10 therapy based on the clinical evidence that fulfills the substantial clinical improvement criteria. Medicare accepts this code, along with all other applicable C-codes on each outpatient hospital claim as appropriate.

Billing C1822

For Medicare claims, Nevro's IPG kit and charger kit should billed under revenue code 278 with HCPCS C1822 *(generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system)*. Nevro's system is the only device on the market that should be billed with C1822.

Product Code	Description	Revenue Code	HCPCS Code[6]
NIPG1500	IPG Kit	278	C1822
CHGR1000	Charger Kit	278	C1822

Charges associated with the IPG and charger kit should be combined and billed as one line item on the UB-04 claim form.

Most commercial plans provide guidance in their medical policies about which device HCPCS codes to report on claims. The table below contains the HCPCS Level II codes, as well as the L-codes that might be listed in a medical policy or commercial contract.

Please check with your payer or Nevro's Health Economics & Reimbursement department for specifics on HCPCS billing.

Device	HCPCS Code[7]	Description
Medicare Level II HCPCS Codes		
Pulse Generator	C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system
Leads (8-contact, paddle)	C1778	Lead, neurostimulator (implantable)

[6] HCPCS Level II, 2017 Expert, AAPC. Salt Lake City, UT. 2016.

[7] HCPCS Level II, 2017 Expert, AAPC. Salt Lake City, UT. 2016.

Trial Leads	C1897	Lead, neurostimulator, test kit (implantable)
Leads Extension	C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable)
Patient Programmer	C1787	Patient programmer, neurostimulator

Device	HCPCS Code	Description
Commercial Payer L-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

Nevro Device Crosswalk by Product Code

The following Nevro products have Level II HCPCS that can be billed on the UB-04 claim form. Medicare accepts the below C-codes. For commercial claims, please confirm device coding with payer prior to billing (see tables on page seven).

Product Code	Description	HCPCS Code	Revenue Code
Trial			
TLEAD1058-50B	Trial Lead, 50cm	C1897	278
TLEAD1058-70B	Trial Lead, 70cm	C1897	278
Implant			
NIPG1500	IPG Kit	C1822	278
NIPG2000	IPG Kit	C1822	278
CHGR1000	Charger Kit	C1822	278
PTRC100	Patient Remote Kit	C1787	271
LEAD1058-50B	Lead Kit, 50cm	C1778	278
LEAD1058-70B	Lead Kit, 70cm	C1778	278
LEAD1058-90B	Lead Kit, 90cm	C1778	278
LEAD3005-50B	Paddle Lead Kit	C1778	278
LEAD3005-70B	Paddle Lead Kit	C1778	278
Implant Accessories			
LEAD2008-25B	Lead Extension Kit, 25cm	C1883	278
LEAD2008-35B	Lead Extension Kit, 35cm	C1883	278
LEAD2008-60B	Lead Extension Kit, 60cm	C1883	278
SADP2008-25B	S8 Lead Adapter Kit, 25cm	C1883	278
MAPD2008-25B	M8 Lead Adapter Kit, 25cm	C1883	278
ACCK5000	Lead Anchor Kit	L8699	278
ACCK5300	Lead Anchor Kit (N300)	L8699	278
ACCK7000	IPG Port Plug Kit	L8699	278

Medicare National Coverage Determination

Medicare's National Coverage Determination (NCD) 160.7 allows for coverage of spinal cord stimulation when the criteria outlined below is met[8]. In addition, some local Medicare Administrative Contractors (MACs) may require additional coverage criteria through their local policies (LCDs) so please check with your MAC. Nevro recommends that the HOPD medical record contain documentation to support coverage of spinal cord stimulation per Medicare and other payers' requirements.

a) The implantation of the stimulator is used only as a **late resort (if not a last resort)** for patients with chronic intractable pain
b) 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
c) 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)
d) 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
e) Demonstration of pain relief with a temporarily implanted electrode precedes permanent implantation

Payer coverage and payment policies will vary and should be verified by the provider prior to treatment and billing.

[8] National Coverage Determination (NCD) for Electrical Nerve Stimulators (160.7). Centers for Medicare and Medicaid Services. Benefit Category: Prosthetic Devices. Effective August 7, 1995.