# HF10™ THERAPY
# 2019 Ambulatory Surgery Center 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.

**Nevro Reimbursement Support**

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## CPT® Procedure Codes

The following CPT® codes are provided as a guide for Ambulatory Surgery Center (ASC) 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 or wage adjusted. ASCs report CPT codes, but they are assigned to individual fee schedules. Multiple procedures may be paid for each case.

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
- Payment indicator
- National average payment rate

| Procedure | CPT Code[1] | Short Descriptor[1] | MUE[2] | *Payment Indicator[1] | Medicare National Average[3] |
|---|---|---|---|---|---|
| Trial | 63650 | *Percutaneous implantation of neurostimulator electrode array, epidural* | 2 | J8 | $4,450 |
| Implant: Perc Leads | 63685 | *Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling* | 1 | J8 | $22,581 |
| | 63650 | *Percutaneous implantation of neurostimulator electrode array, epidural* | 2 | J8 | $4,450 |

[1] Current Procedural Terminology 2019, American Medical Association. Chicago, IL 2016. CPT is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®) is copyright 2016 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

[2] Outpatient Services - MUE Table - Effective 1/1/2019. https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html. Accessed January 15 2019.

[3] Addendum AA --Final ASC Covered Surgical Procedures for CY 2019, Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Final Rule, Federal Register Volume 83, Number 248 (Friday, December 28, 2018), 42 CFR Parts 416 and 419

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| Procedure | CPT Code | Short Descriptor | MUE | *Payment Indicator | Medicare National Average |
|---|---|---|---|---|---|
| Implant: Paddle Lead | 63685 | *Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling* | 1 | J8 | $22,581 |
| | 63655 | *Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural* | 1 | J8 | $15,743 |

| Procedure | CPT Code | Short Descriptor | MUE | *Payment Indicator | Medicare National Average |
|---|---|---|---|---|---|
| Revision | 63663 | *Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed* | 1 | G2 | $4,092 |
| | 63664 | *Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed* | 1 | J8 | $14,144 |
| | 63688 | *Revision or removal of implanted spinal neurostimulator pulse generator or receiver* | 1 | A2 | $1,483 |
| Removal | 63661 | *Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed* | 1 | G2 | $782 |
| | 63662 | *Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed* | 1 | G2 | $1,483 |
| | 63688 | *Revision or removal of implanted spinal neurostimulator pulse generator or receiver* | 1 | A2 | $1,483 |

***ASC Payment Indicator[4]**

| Indicator | Description |
|---|---|
| **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 |
| **N1** | Packaged service/item; no separate payment made |

[4] Addendum DD1 -- Final ASC Payment Indicators for CY 2019, Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Final Rule, Federal Register Volume 83, Number 248 (Friday, December 28, 2018), 42 CFR Parts 416 and 419

## Medicare Reimbursement Examples

The below calculations represent the formula in which Medicare calculates the allowable when multiple procedures are billed. These examples reflect rounded national averages and are not geographically adjusted. No multiple procedure discounting should be applied to these codes.

**Trial**

| CPT 63650 | + | CPT 63650 | = | Medicare Allowable |
|---|---|---|---|---|
| $4,450 | + | $4,450 | = | $8,900 |

**Implant: Perc Leads**

| CPT 63685 | + | CPT 63650 | + | CPT 63650 | = | Medicare Allowable |
|---|---|---|---|---|---|---|
| $22,581 | + | $4,450 | + | $4,450 | = | $31,481 |

**Implant: Paddle Lead**

| CPT 63685 | + | CPT 63655 | = | Medicare Allowable |
|---|---|---|---|---|
| $22,581 | + | $15,743 | = | **$38,324** |

## Programming CPTs

Programming CPTs (95970-95972) are nonsurgical procedures that are not payable by Medicare in an ASC. The ASC should not report these codes to Medicare. If the physician does programming, they can report those codes on the physician claim. For more guidance, please see Nevro's 2019 Physician Reimbursement and Coding Guide.

## 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[5] |
|---|---|---|
| -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 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.

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## Level II HCPCS: Devices

### Medicare Claims

Under the ASC payment system, packaged services (indicated by Payment Indicator 'N1'), are bundled into the ASC payment for the covered surgical procedure. Pursuant to Medicare Claims Processing Manual (Chapter 14 - Ambulatory Surgical Centers)[6]:

> *ASCs must incorporate charges for packaged services into the charges reported for the separately payable services with which they are provided. Because contractors pay the lesser of 80 percent of actual charges or the ASC payment rate for the separately payable procedure, and because this comparison is made at the claim line-item level, facilities may not be paid appropriately if they unbundle charges and report those charges for packaged codes as separate line-item charges.*

### Commercial Claims

Most commercial plans provide guidance in their medical policies about which device HCPCS codes to report on claims. Nevro recommends reviewing commercial contracts and medical policies to determine if it is appropriate to bill implant codes.

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] | Payment Indicator[8] | Description |
|---|---|---|---|
| **Medicare Level II HCPCS Codes** | | | |
| Pulse Generator | C1822 | N1 | Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system |
| Leads (8-contact, paddle) | C1778 | N1 | Lead, neurostimulator (implantable) |
| Trial Leads | C1897 | N1 | Lead, neurostimulator, test kit (implantable) |
| Lead Extension | C1883 | N1 | Adaptor/extension, pacing lead or neurostimulator lead (implantable) |
| Patient Programmer | C1787 | N1 | Patient programmer, neurostimulator |

[6] Medicare Claims Processing Manual, Chapter 14 - Ambulatory Surgical Centers, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf. Accessed December 15, 2017

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

[8] Addendum AA --Final ASC Covered Surgical Procedures for CY 2019, Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Final Rule, Federal Register Volume 83, Number 248 (Friday, December 28, 2018), 42 CFR Parts 416 and 419

| Device | HCPCS Code[9] | Payment Indicator[10] | Description |
|---|---|---|---|
| **Commercial Payer L-Codes** | | | |
| Leads: 8-contact | L8680 | N/A | Implantable neurostimulator electrode, each |
| Pulse Generator | L8687 | N/A | Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension |
| External Recharger | L8689 | N/A | External recharging system for battery (internal) for use with implantable neurostimulator, replacement only |
| Remote Control (patient programmer) | L8681 | N/A | Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only |

## 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[11]. In addition, some local Medicare Administrative Contractors (MACs) may require additional coverage criteria through their local policies (LCDs) so please check with your MAC.

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.**

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

[10] Addendum AA --Final ASC Covered Surgical Procedures for CY 2019, Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Final Rule, Federal Register Volume 83, Number 248 (Friday, December 28, 2018), 42 CFR Parts 416 and 419

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