HF10™ THERAPY
2019 Physician 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 physician reporting. Actual code(s) billed should reflect the services provided to each individual patient in the office (non-facility) or hospital/ASC (facility) setting. The Medicare fee schedules listed are a national average and have not been geographically or wage adjusted. Some codes are subject to the multiple procedure discount rule.

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

- Description
- Medicare Non-Facility National Average
- Non-Facility Relative Value Unit (RVU)
- Medicare Facility National Average
- Facility Relative Value Unit (RVU)
- Global Period

Procedure	CPT Code[1]	Description	Medicare Non-Facility National Average[2]	Non-Facility RVU[2]	Medicare Facility National Average[2]	Facility RVU[2]	Global Period[2]
Trial	63650*	*Percutaneous implantation of neurostimulator electrode array, epidural*	$1,657	45.98	$426	11.82	10
** Standard multiple procedure rules apply: When two or more eligible procedures are performed together on the same date of service, the highest paid code is reimbursed at 100% of the fee schedule; each additional code is reimbursed at 50% of the fee schedule.*							

[1] *Current Procedural Terminology 2017*, 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] Medicare Physician Fee Schedule Final Rule, Federal Register Volume 82, Number 219 (November 15, 2017) 42 CFR Parts 405, 410 and 411 et al. All MPFS Fee Schedules calculated using CF of $35.9996.

Procedure	CPT Code[3]	Description	Medicare Non-Facility National Average[4]	Non-Facility RVU[4]	Medicare Facility National Average[4]	Facility RVU[4]	Global Period[4]
Implant: Perc Leads	63650*	*Percutaneous implantation of neurostimulator electrode array, epidural*	$1,657	45.98	$426	11.82	10
	63685*	*Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling*	N/A	N/A	$375	10.40	10
Implant: Paddle Lead	63655*	*Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural*	N/A	N/A	$869	24.10	90
	63685*	*Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling*	N/A	N/A	$375	10.40	10

** Standard multiple procedure rules apply: When two or more eligible procedures are performed together on the same date of service, the highest paid code is reimbursed at 100% of the fee schedule; each additional code is reimbursed at 50% of the fee schedule.*

[3] *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.

[4] Medicare Physician Fee Schedule Final Rule, Federal Register (82 Fed Reg, No. 219) November 15, 2017, 42 CFR Parts 405, 410 and 411 et al. All MPFS Fee Schedules calculated using CF of $35.9996.

Procedure	CPT Code[5]	Description	Medicare Non-Facility National Average[6]	Non-Facility RVU[6]	Medicare Facility National Average[6]	Facility RVU[6]	Global Period[6]
Revision	63663*	*Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed*	$845	23.44	$467	12.95	10
	63664*	*Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed*	N/A	N/A	$911	25.29	90
	63688*	*Revision or removal of implanted spinal neurostimulator pulse generator or receiver*	N/A	N/A	$387	10.73	10
Removal	63661*	*Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed*	$631	17.51	$336	9.32	10
	63662*	*Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed*	N/A	N/A	$879	24.40	90
	63688*	*Revision or removal of implanted spinal neurostimulator pulse generator or receiver*	N/A	N/A	$387	10.73	10

** Standard multiple procedure rules apply: When two or more eligible procedures are performed together on the same date of service, the highest paid code is reimbursed at 100% of the fee schedule; each additional code is reimbursed at 50% of the fee schedule.*

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[6] Medicare Physician Fee Schedule Final Rule, Federal Register Volume 83, Number 226 (Friday, November 23, 2018), 42 CFR Parts 405, 410 and 411 et al. All MPFS Fee Schedules calculated using CF of $36.0391

Information provided by Nevro is presented for illustrative purposes only and does not constitute coding, reimbursement, or legal advice. It is always the provider's responsibility to determine the medical necessity and proper site of service for the procedure, and to submit appropriate codes, charges and modifiers for services rendered.

Procedure	CPT Code[7]	Description	Medicare Non-Facility National Average[7]	Non-Facility RVU[8]	Medicare Facility National Average[8]	Facility RVU[8]
Analysis & Programming	95970	*Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., 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.*	$19	0.54	$19	0.53
	95971	*... with simple spinal cord or peripheral nerve (e.g., sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional.*	$52	1.44	$42	1.17
	95972	*… with complex spinal cord or peripheral nerve (e.g., sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional.*	$58	1.62	$43	1.19

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.

[7] Medicare Physician Fee Schedule Final Rule, Federal Register Volume 83, Number 226 (Friday, November 23, 2018), 42 CFR Parts 405, 410 and 411 et al. All MPFS Fee Schedules calculated using CF of $36.0391

Medicare Reimbursement Examples

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

Trial: Non-Facility (Office)

CPT 63650	+	CPT 63650	=	Medicare Allowable
$1,657	+	$829 *50% reduction applied to $1,353*	=	**$2,486**

Trial: Facility (ASC/Hospital)

CPT 63650	+	CPT 63650	=	Medicare Allowable
$426	+	$213 *50% reduction applied to $426*	=	**$639**

Implant: Two Percutaneous Leads

CPT 63650	+	CPT 63650	+	CPT 63685	Medicare Allowable
$426	+	$213 *50% reduction applied to $426*	+	$187 *50% reduction applied to $377*	= **$826**

Physician 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 providers should be prepared to submit their documentation to the payers to justify any potential increases in payment.

Modifier[8]	Description	Notes
- 22	Increased procedural services	Used to identify procedures where additional work, time and complexity was required.
-52	Reduced services	Report this modifier when a service or procedure is partially reduced or eliminated at the physician's discretion.
-53	Discontinued procedure	Use this modifier when a surgical or diagnostic procedure is terminated, prior to administration of anesthesia or surgical preparation, due to extenuating circumstances or those that threaten the well-being of the patient.

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

Modifier[9]	Description	Notes
-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.
-62	Two surgeons	Identifies the case where two primary surgeons perform distinct parts of a single procedure.
-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.
-80	Assistant surgeon	Used to identify a surgeon who actively assists in a procedure but does not perform distinct parts of the primary procedure.
-81	Minimum assistant surgeon	Reported when the services of an assistant surgeon are required for a relatively short period of time.
-82	Assistant surgeon (when qualified resident surgeon not available)	Report this modifier when a qualified surgeon is not readily available.

[9] *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

The HCPCS codes are reported by physicians when they have purchased and supplied the device. This is most common for trial leads placed in the office, or a replacement charger or remote control. Medicare considers the leads (L8680) inherent in the fee schedule of the trial implant, and therefore does not reimburse separately for these devices. Providers should check with their individual payers for their policy on distinct lead payment.

Device	HCPCS Code[10]	Description
Lead: 8-contact	L8680	Implantable neurostimulator electrode, each
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 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.

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

[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.