ReActiv8 US Reimbursement Coding & Payment

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ICD-10-CM Diagnosis Codes

General Description	ICD-10-CM Code	Diagnosis Description
Muscle wasting & atrophy	M62.5A2	Muscle wasting and atrophy, not elsewhere classified, back, lumbosacral
Other specified dorsopathies	M53.86	Lumbar region
Other specified dorsopathies	M53.87	Lumbosacral region
Lumbago with sciatica, right side	M54.41	Back pain when pain is felt going down the leg from the back
Lumbago with sciatica, left side	M54.42	Back pain when pain is felt going down the leg from the back
Vertebrogenic low back pain	M54.51	Low back vertebral endplate pain
Other low back pain	M54.59	Back pain
Other dorsalgia	M54.89	Back pain
Device Related Complications	T85.113A	Breakdown (mechanical) of implanted electronic neurostimulator, generator
	T85.123A	Displacement of implanted electronic neurostimulator, generator
	T85.193A	Other mechanical complication of implanted electronic neurostimulator, generator
	T85.734A	Infection and inflammatory reaction due to implanted electronic neurostimulator generator
	T85.734A	Infection and inflammatory reaction due to implanted electronic neurostimulator generator
	T85.820A	Fibrosis due to nervous system prosthetic devices, implants, and grafts
	T85.830A	Hemorrhage due to nervous system prosthetic devices, implants, and grafts
	T85.840A	Pain due to nervous system prosthetic devices, implants, and grafts
	T85.890A	Other specified complication of nervous system prosthetic devices, implants, and grafts
Attention toDevice	Z45.42	Encounter for adjustment and management of neurostimulator
NeurostimulatorStatus	Z96.82	Presence of neurostimulator

HCPCS II Device Codes (non-Medicare)

Device/Product	HCPCS Code	Description
Lead	L8680	Implantable neurostimulator electrode, each
Pulse Generator	L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
Patient Programmer	L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only

Device C-Codes (Medicare)

Device/Product	HCPCS Code	Description
Leads	C1778	Lead, neurostimulator (implantable)
Pulse Generator	C1767	Generator, neurostimulator (implantable) non-rechargeable
Patient Programmer	C1787	Patient programmer, neurostimulator
Lead Introducer	C1894	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, non-laser

Device Edits (Medicare)

CPT Procedure Code	CPT Code Description	HCPCS II Device Codes	HCPCS II Code Description
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	C1778	Lead, neurostimulator (implantable)
64590	Insertion or replacementof peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling	C1767	Generator, neurostimulator (implantable) non-rechargeable

Physician Coding & Payment - Possible CPT© Procedure Codes

Procedure	CPT Code & Description	Medicare RVUs		2023 Medicare National Physician Fee Schedule	
		Physician Office	Facility	Physician Office	Facility
		Work RVU/Total RVU	Total RVU		
Nervous system surgery, unspecified	64999 - Unlisted Procedure Code	No assigned RVUs; Payment is Carrier dependent			
Lead Implantation	64555-Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	5.76/64.83	9.65	$2,143	$319
Generator Implantationor Replacement	64590-Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling	2.45/7.87	4.79	$260	$158
Imaging Guidance	76000-26 Fluoroscopy, up to one hour - professional component	0.30/0.46	0.46	$15	$15
Revision or Removal of Lead	64585 Revision or removal of peripheral neurostimulator electrode array	2.11/7.25	4.26	$240	$141
Revision or Removal of Generator	64595 Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver	1.78/6.94	3.79	$229	$125
Analysis & Programming	95970 Analysis	0.35/0.56	0.55	$19	$18
	95971 Analysis w/Simple programming	0.78/1.42	1.15	$47	$38
	95972 Analysis w/Complex programming	0.80/1.68	1.20	$56	$40

*2023 CMS PFS Final Rule – Conversion Factor $33.06; CPT codes and descriptors only are copyright 2023 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

Medicare 2023 Hospital Outpatient Coding & Payment*

Hospitals use CPT codes for outpatient services. Under Medicare's APC methodology for hospital outpatient payment, each CPT code is assigned to one APC with an assigned relative weight that is then converted to a flat payment amount.

As shown on the tables below, peripheral nerve stimulation is subject to C-APCs specifically for implantation and revision/replacement of the leads, and implantation/replacement of the generator. C-APCs are identifiedby status indicator J1.

Procedure	CPT Code	APC	APC Title	SI	Relative Weight	National 2023 Medicare Unadjusted Payment
Nervous system surgery, unspecified	64999	5441	Level 1 Nerve Injections	T	3.1769	$272
Lead Implantation	64555	5462	Level 2 Neurostimulator and Related Procedures	J1	77.1613	$6,604
Generator Implantation or Replacement	64590	5464	Level 4 Neurostimulator and Related Procedures	J1	251.3917	$21,515
Revision or Removal of Lead	64585	5461	Level 1 Neurostimulator and Related Procedures	J1	37.9468	$3,248
Revision or Removal of Generator	64595	5461	Level 1 Neurostimulator and Related Procedures	J1	37.9468	$3,248
Imaging Guidance	76000	5523	Level 3 Imaging Without Contrast	S	2.7285	$234
Analysis & Programming	95970	5734	Level 4 Minor Procedures	S	1.3567	$116
	95971	5742	Level 2 Electronic Analysis of Devices	S	1.1662	$100
	95972	5742	Level 2 Electronic Analysis of Devices	S	1.1662	$100

Status Indicator: J1 Hospital Part B Services Paid Through a Comprehensive APC (C-APC) NOTE: Assignment of a CPT procedure code to a C-APCs is considered a primary procedure. All other services andprocedures reported on the claim would be considered adjunctive to the primary procedure. CMS will make a single APC payment for the entire hospital outpatient encounter. There is no additional payment for the adjunctive services or procedures. When procedures performed in an episode of care map to multiple C- APCs, the entire episode will map to the highest paying C-APC.

Status Indicator: Q1 STV-Packaged Codes

Status Indicator: S Significant Procedure Not Subject to Multiple Procedure

DiscountingStatus Indicator: T Procedure or Service, Multiple Procedure

Reduction Applies

*2023 CMS OPPS Final Rule Addendum A

Medicare 2023 ASC Coding & Payment*

ASCs use CPT codes for their services. Medicare payment for procedures performed in an ambulatory surgery center is generally based on Medicare's ambulatory patient classification (APC) methodology for hospital outpatient payment. However, C-APCs are used only to report hospital outpatient services and arenot applicable to ASC billing.

Each CPT code designated as a covered procedure in an ASC is assigned a comparable weight as under thehospital outpatient APC system. This is then converted to a flat payment amount using a conversion factor unique to ASCs. Multiple procedures can be paid for each claim. Certain ancillary services, such as imaging,are also covered when they are integral to covered surgical procedures, although they may not be separately payable. In general, there is no separate payment for devices; their payment is packaged into the payment for the procedure.

Procedure	CPT Code	Payment Indicator	Multiple Procedure Discounting	RelativeWeight	2023 Medicare NationalAverage
Nervous system surgery, unspecified	64999	NA	NA	NA	Not payable in ASC
Lead Implantation	64555	J8	No	107.9103	$5,596
Generator Implantation or Replacement	64590	J8	No	372.8441	$19,333
Revision or Removal of Lead	64585	A2	Yes	35.0215	$1,816
Revision or Removal of Generator	64595	J8	Yes	45.1346	$2,340
Imaging Guidance	76000	Z3	No	MPFS non-facility PE RVUs	$4
Analysis & Programming	95970	Not applicable			
	95971				
	95972				

Payment Indicator: J8 Device-intensive procedure; paid at adjusted rate

Payment Indicator: A2 Surgical procedure on ASC list in CY 2007; payment based on OPPS relative paymentweight.

Payment Indicator: Z3 Radiology or diagnostic service paid separately when provided integral to a surgicalprocedure on ASC list; payment based on MPFS non-facility PE RVUs

*2023 CMS OPPS Final Rule Addendum AA