ReActiv8®

ReActiv8® Implantable Neurostimulation System

2026 U.S. Reimbursement & Coding Guide

For Hospital Outpatient Departments | Ambulatory Surgery Centers | Physician Practices

ReActiv8® is reimbursed across hospital outpatient departments (HOPDs), ambulatory surgery centers (ASCs), and physician practices under established Medicare payment systems. In CY 2026, implantation procedures are primarily reimbursed under the Hospital Outpatient Prospective Payment System (OPPS), the Ambulatory Surgical Center (ASC) Payment System, and the Medicare Physician Fee Schedule (MPFS).

Payment varies by site of service, payer policy, geographic locality, and contractual terms. Successful reimbursement depends on accurate coding, appropriate device reporting, site-of-service eligibility, and complete clinical documentation supporting medical necessity.

PURPOSE OF THIS GUIDE

This document provides general coding, coverage, and reimbursement information for the ReActiv8® Implantable Neurostimulation System in the United States for Calendar Year (CY) 2026.

It is intended for revenue cycle leadership, coding professionals, compliance personnel, and healthcare providers seeking a structured overview of Medicare payment methodologies and common commercial payer considerations.

ReActiv8® implantation is performed in both Hospital Outpatient Departments (HOPDs) and Ambulatory Surgery Centers (ASCs). Each site is reimbursed under a different Medicare payment methodology and carries distinct billing responsibilities.

Diagnosis Codes (ICD-10-CM)

Diagnosis coding must support the clinical rationale for implantation and ongoing device management. Payor policy may vary regarding reimbursement by diagnosis and should be periodically reviewed to determine applicability.

ICD-10-CM	Description
M62.85	Dysfunction of multifidus muscles, lumbar region
M62.5A2	Muscle wasting and atrophy, back, lumbosacral
M53.86	Other specified dorsopathies, lumbar region
M53.87	Other specified dorsopathies, lumbosacral region
M54.51	Low back vertebrogenic pain
Z45.42	Encounter for adjustment and management of neurostimulator

2026 Physician Codes (CMS MPFS)[3]

Physicians use CPT®[4] codes to bill for outpatient services. When a physician performs multiple procedures in the same encounter, Medicare may not reimburse for each procedure fully. Instead, Medicare will apply a multiple procedure payment reduction (MPPR) for codes assigned status of "2", paying the highest valued code at 100% of assigned rate and the next code at 50% of the assigned rate. Review of all procedures performed by the same physician on the same date of service is recommended to understand if any adjustment to the assigned reimbursement rate may be applied. All primary surgical procedures have a 10-day global period.

Facility Based Reference Allowable
(Non-Qualifying APM CF $33.4009)

CPT	MPPR	Work RVU	Total RVU	National Payment Amount
64555	2	5.62	8.80	$293.93
64590	2	4.97	7.99	$266.87
64585	2	2.06	4.07	$135.94
64595	2	3.70	6.28	$209.76
76000-26	N/A	0.30	0.46	$15.36
95970	0	0.35	0.48	$16.03
95971	0	0.78	1.03	$34.40
95972	0	0.80	1.05	$35.07

**Actual payment will vary by locality and participation status.*

2026 Hospital Codes (CMS OPPS)[1]

Under OPPS, ReActiv8® primary implantation procedures are considered “device intensive” and are assigned to Comprehensive APCs (C-APCs). When a C-APC applies, all adjunctive services are packaged into the primary APC payment.

From a billing operations standpoint, the facility should treat the claim as a **single bundled episode of care**, with the primary CPT driving payment.

Additionally, the leads and/or generator must be reported with device codes C1778 and C1767 on the same claim; billing without the device HCPCS may result in denial.

CPT	REV CODE	APC	SI	National Payment Amount
Lead Implantation				
64555 Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excluding sacral nerve)	360	5462	J1	$6,511.03
C1778 Lead, neurostimulator	278	N/A	N/A	N/A
Generator Implant or Replacement				
64590 Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or indirect coupling	360	5464	J1	$19,820.31
C1767 Generator, neurostimulator (implantable), non-rechargeable	278	N/A	N/A	N/A
Revision or removal of lead				
64585 Revision or removal of peripheral neurostimulator electrode array	360	5461	J1	$3,571.83
Revision or removal of Generator				
64595 Revision or removal of peripheral or gastric neurostimulator pulse generator or receivable	360	5461	J1	$3,571.83
Imaging Guidance				
76000 Fluoroscopy, up to one hour	320	5523	S	$243.77

CPT	REV CODE	APC	SI	National Payment Amount
Analysis & Programming				
95970 Electronic analysis of implanted neurostimulator pulse generator/transmitter	N/A	5734	Q1	$135.93
95971 with simple spinal cord or peripheral nerve neurostimulator pulse generator/transmitter programming by physician	N/A	5742	S	$97.13
95972 with complex spinal cord or peripheral nerve neurostimulator pulse generator/transmitter programming by physician	N/A	5742	S	$97.13

Operational Guidance (OPPS):

- The facility should report the **primary CPT** under revenue code **0360**.
- Implant charges should be mapped to revenue code **0278**.
- Required device HCPCS codes (e.g., C1778, C1767) should appear on the same claim as the primary CPT.
- The facility should not expect separate reimbursement for packaged services when a J1 status indicator applies.
  Accurate HCPCS reporting supports CMS rate setting methodology

OPPS Status Indicators:

J1 — Hospital Part B Services Paid Through a Comprehensive APC

S — Paid under OPPS, separate APC payment.

Q1 — Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “S”, “T”, or “V".

2026 ASC Codes (CMS)[2]

ASC reimbursement is procedure-based. For Medicare beneficiaries, device costs associated with ReActiv8® implantation are packaged into the ASC facility payment.

From an operational perspective, the facility should confirm ASC eligibility and that codes are listed in fee schedules **prior to scheduling** to prevent avoidable denials.

CPT	Multiple Procedure Discounting	Payment Indicator	National Payment Amount
Lead Implantation			
64555 Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excluding sacral nerve)	No	J8	$5,774.91
Generator Implant or Replacement			
64590 Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or indirect coupling	No	J8	$16,224.24
Revision or Removal of Lead			
64585 Revision or removal of peripheral neurostimulator electrode array	Yes	A2	$2,003.41
Revision or Removal of Generator			
64595 Revision or removal of peripheral or gastric neurostimulator pulse generator or receivable	Yes	A2	$2,003.41
Imaging Guidance			
76000 Fluoroscopy, up to one hour	No	Z3	$28.53

ASC Payment Indicators:

J8— Device-intensive procedure; paid at adjusted rate.
A2— Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.
Z3—Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS non-facility PE RVUs.

2026 Other Device Codes (CMS)[1,2]

CMS requires hospitals to report device HCPCS reporting for tracking purposes; payment is packaged.

HCPCS Level I Code	Description	OPPS Status Indicator	ASC Payment Indicator
C1767	Generator, Neurostimulator (implantable), non-rechargeable	N	N1
C1778	Lead, Neurostimulator (implantable)	N	N1
C1787	Patient Programmer, Neurostimulator	N	N1
C1894	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, non-laser	N	N1

Status/Payment Indicators:

N — Items and Services Packaged into APC Rates
N1— Packaged service/item; no separate payment made.

2026 Other Device Codes (Non-Medicare)[4]

When billing to non-Medicare payors, they may require the use of HCPCS II codes for reporting and/or payment rather than the HCPCS Level I codes previously identified.

HCPCS Level II Code	Description
L8680	Implantable Neurostimulator electrode, each
L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
L8681	Patient Programmer, (external) for use with implantable programmable neurostimulator pulse generator, replacement only.

Documentation Considerations

Documentation should clearly establish: - Multifidus dysfunction - Failure of conservative care - Medical necessity for implantation - Device programming and management when applicable.

Commercial Payer Considerations

Commercial payer reimbursement may differ materially from Medicare methodology.

Coverage Policies

- Many commercial payers publish device- or therapy-specific medical policies.
- Coverage may require documentation of failed conservative management.
- Some plans may restrict site of service (e.g., HOPD vs ASC).

Payment Methodology

- May follow Medicare APC/ASC grouping logic.
- May use case rates or negotiated carve-outs.
- Device reimbursement may be packaged or separately reimbursed depending on contract.

Operational

- Verify prior authorization requirements.
- Confirm device reporting expectations (C-codes, L-codes, or none).
- Review contract terms for implant carve-outs.

Medicaid Considerations

Medicaid reimbursement policies vary by state and managed care organization (MCO).

Key Variables

- State-specific fee schedules
- Managed Medicaid plan policies
- Site-of-service restrictions
- Prior authorization requirements

Providers should consult state Medicaid fee schedules and individual MCO policies to confirm coverage and payment.

Prior Authorization Considerations

Prior authorization is commonly required for implantable neurostimulation procedures.

Typical Documentation Requirements

- Clinical diagnosis and duration
- Failed conservative treatment history
- Imaging or diagnostic support where required
- Procedure details and device description

Failure to obtain appropriate prior authorization may result in claim denial regardless of coding accuracy.

References:

1. 2026 OPPS Addendum B- December 29, 2025 https://www.cms.gov/apps/ama/license.asp?file=/files/zip/january-2026-opps-addendum-b.zip

2. January 2026 ASC Addenda- February 5, 2026
https://www.cms.gov/apps/ama/license.asp?file=/files/zip/january-2026-asc-approved-hcpcs-code-payment-rates.zip-0

3. 2026 MPFS Final Rule Addenda- November 18, 2025 (*3)
https://www.cms.gov/files/zip/cy-2026-pfs-final-rule-addenda-updated-11-18-2025.zip

4. CPT® codes are listed in accordance with the American Medical Association 2026 CPT® Professional Edition

Important Disclaimer

Reimbursement information contained herein is gathered from third-party sources, including the Centers for Medicare & Medicaid Services (CMS), and is presented for informational purposes only. This information does not constitute legal advice, reimbursement advice, or a guarantee of coverage or payment. Healthcare providers are solely responsible for determining appropriate coding, documentation, billing, and claim submission practices. Coverage policies and reimbursement methodologies vary by payer, plan, and geographic region and are subject to change without notice. Providers should consult applicable Medicare Administrative Contractors (MACs), commercial payers, Medicaid agencies, reimbursement specialists, and/or legal counsel to confirm coding, coverage, and payment requirements. Nothing in this guide is intended to promote off-label use of any medical device or to interfere with independent clinical judgment.

Indications for Use

The ReActiv8 System is indicated for bilateral stimulation of the L2 medial branch of the dorsal ramus as it crosses the transverse process at L3 as an aid in the management of intractable chronic low back pain associated with multifidus muscle dysfunction, as evidenced by imaging or physiological testing in adults who (i) have failed therapy including pain medications and physical therapy and (ii) are not candidates for spine surgery

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