Boston Scientific
Advancing science for life™

GUIDEPOINT
Reimbursement Resources

2018 Quick Reference Guide – Radio Frequency Ablation Intradiscal Joint

Reimbursement 2018

Coding and Payment Guide for Medicare Reimbursement: The following are the 2018 Medicare coding and national payment rates for Radio Frequency Ablation (Intradiscal Joint) procedures performed in an ambulatory surgical center, physician office, or outpatient hospital.

Therapeutic Procedures

		Physician			Ambulatory Surgery Center		Outpatient Hospital		
CPT®[1]	Description	National Average Payment [2] (Non-Facility)	National Average Payment [2] (Facility)	Global Period	Status Indicator[3]	ASC National Average Payment[2]	Status Indicator[4]	APC Code[5]	OPPS National Average Payment[2]
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance, single level	$2,397	$351	10	Not Covered		Not Covered		
(+)22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance, 1 or more additional levels. (List separately in addition to code for primary procedure).	$2,025	$166	ZZZ[6]	Not Covered		Not Covered		
62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar	NA	$595	90	A2	$2,033	J1	5432	$4,627
22899	Unlisted procedure, spine	Carrier Priced			Not Covered		T	5111	$215
64999	Unlisted procedure, nervous system	Carrier Priced			Carrier Priced		T	5441	$245

Diagnostic Procedures

Diagnostic Procedures below are often required prior to coverage for the therapeutic procedures above. The provider is responsible for verifying payer policy as to the appropriate code used for each procedure.

CPT[1]	Description
62290	Injection procedure for discography, each level; lumbar
62291	Injection procedure for discography, each level; cervical or thoracic
72285	Discography, cervical or thoracic, radiological supervision and interpretation
72285-26	
72295	Discography, lumbar, radiological supervision and interpretation
72295-26	

Medicare Local Coverage Determinations[7]

Please check with your local contractor. In the absence of an LCD, Medicare contractors will follow the NCD.

Palmetto GBA (AL, GA, NC, SC, TN, VA, WV)	LCD #L36471
Nordian JE (CA, NV, HI)	LCD #L34993
Nordian JF (AK, AZ, ID, MT, WY, ND, OR, SD, UT, and WA)	LCD #L34995
NGS (CT,NY, IL, MN, WI)	LCD #L35936
WPS (MI, IN, IA, KS, NE, MO, MN)	LCD #L35996
CGS (KY, OH)	LCD #L34832
First Coast (FL, Puerto Rico, Virgin Islands)	LCD #L33814

To locate the LCDs listed above: Go to: http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx ENTER LCD # in Document ID

(+) Add on code. Only reimbursed in combination with the appropriate primary code

*Payer coverage limitations exist for facet joint denervation/destruction in the thoracic spine. Check with payer prior to performing procedure.

Sequestration Disclaimer: Rates referenced in these guides do not reflect Sequestration; automatic reductions in federal spending that will result in a 2% across-the-board reduction to ALL Medicare rates as of January 1, 2018. (Budget Control Act of 2011)

1. CPT Copyright 2017 American Medical Association (AMA). All rights reserved. CPT® is a registered trademark of the AmericanMedical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.
2. "National Average Payment" is the amount Medicare determines to be the maximum allowance for any Medicare covered procedure. Actual payment will vary based on the maximum allowance less any applicable deductibles, co-insurance etc.
3. AASC Status indicators: A2: Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight. N1: Packaged service/item; no separate payment made. P3: Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs.
4. Outpatient Status Indicators: N: Items and Services Packaged into APC Rates. Payment is packaged into payment for other services. Therefore, there is no separate APC payment. T: Procedure or Service, Multiple Procedure Reduction applies J1: Hospital Part B services paid through a comprehensive APC.
5. APC Codes: 5432: Level 2 Nerve Procedures, 5111: Level 1 Musculoskeletal Procedures, 5441: Level 1 Nerve Injections
6. "ZZZ" are surgical codes, they are add-on codes that you must bill with another service. There is no post-operative work included in the MPFS payment
7. List of local Medicare carriers is not an exhaustive list. LCD Link . Please go to the appropriate Medicare contractor specific website to find the most updated state coverage jurisdiction.

Boston Scientific

Advancing science for life™

Neuromodulation
25155 Rye Canyon Loop
Valencia, CA 91355
www.bostonscientific.com

NM-455405-AB_MAR2018