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2019 Quick Reference Guide – Radio Frequency Ablation Peripheral Nerve

Reimbursement 2019

Coding and Payment Guide for Medicare Reimbursement: The following are the 2019 Medicare coding and national payment rates for Radio Frequency Ablation (Peripheral Nerves) 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]
64600	Destruction by neurolytic agent, trigeminal nerve; supraorbital, intraorbital, mental, or interior alveolar branch	$445	$240	10	A2	$394	T	5443	$765
64605	Desctruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale	$609	$364	10	A2	$781	J1	5431	$1,631
64610	Desctruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring	$796	$514	10	A2	$781	J1	5431	$1,631
64620	Destruction by neurolytic agent, intercostal nerve	$213	$180	10	A2	$394	T	5443	$765
64630	Destruction by neurolytic agent, pudendal nerve	$244	$197	10	A2	$394	T	5443	$765
64640	Destruction by neurolytic agent, other peripheral nerve or branch	$139	$97	10	P3	$91	T	5443	$765
64680	Destruction by neurolytic agent, with or without radiologic monitoring; celiac plexus	$327	$168	10	A2	$394	T	5443	$765
64681	Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus	$592	$284	10	A2	$394	T	5443	$765
64999	Unlisted procedure, nervous system	Carrier Priced			Not Covered		T	5441	$247
77002	Fluoroscopic guidance for needle placement (e.g. biopsy, aspiration, injection, localization device).	$103	NA	ZZZ[6]	N1	N/A Packaged	N1	N/A Packaged	
77002-26		$28	$28	ZZZ[6]					

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
64400	Injection, anesthetic agent; trigeminal nerve, any division or branch
64418	Injection, anesthetic agent; suprascapular nerve
64420	Injection, anesthetic agent; intercostal nerve, single
64421	Injection, anesthetic agent; intercostal nerves, multiple, regional block
64425	Injection, anesthetic agent, ilioinguinal, iliohypogastric nerves
64430	Injection, anesthetic agent, pudendal nerve
64447	Injection, anesthetic agent; femoral nerve, single
64450	Injection, anesthetic agent; other peripheral nerve or branch
64505	Injection, anesthetic agent; sphenopalatine ganglion
64510	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)
64517	Injection, anesthetic agent; superior hypogastric plexus
64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)
64530	Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring

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 (NC,SC, 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
Cahaba (AL, GA, TN)	LCD #L34293

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.

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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. ASC 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: 5443: Level 3 Nerve Injections, 5431: Level 1 Nerve 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.

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