2019 Quick Reference Guide – Radio Frequency Ablation Knee Joint

Reimbursement 2019

Coding and Payment Guide for Medicare Reimbursement: The following are the 2019 Medicare coding and national payment rates for Radio Frequency Ablation (Knee 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]
64640	Destruction by neurolytic agent; other peripheral nerve or branch	$139	$97	10	P3	$91	T	5443	$765
77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)	$103	NA	ZZZ[6]	N1	N/A Packaged	N	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
27370	Injection of contrast for knee arthrography
73580	Radiologic examination, knee, arthrography, radiological supervision and interpretation
73580-26	
64447	Injection, anesthetic agent; femoral nerve, single
64450	Injection, anesthetic agent; other peripheral nerve or branch

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: 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
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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