2022 Quick Reference Guide – Radio Frequency Ablation Sacroiliac Joint

Reimbursement 2022

Coding and Payment Guide for Medicare Reimbursement: The following are the 2022 Medicare coding and national payment rates for Radio Frequency Ablation (Sacroiliac Joint) procedures performed in an ambulatory surgical center, physician office, or outpatient hospital.

		Physician			Ambulatory Surgery Center		Outpatient Hospital		
Diagnostic Procedures									
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]**
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with imaging guidance (ie, fluoroscopy or computed tomography)	$240	$83	000	G2	$329	T	5442	$649
Therapeutic Procedures									
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	$496	$198	10	G2	$826	J1	5431	$1,793

The Boston Scientific Radiofrequency Generators, associated Radiofrequency Lesion Probes and RF Cannula are indicated for use in procedures to create radiofrequency lesions for the treatment of pain or for lesioning only peripheral nerve tissue for functional neurosurgical procedures. The Boston Scientific RF Injection Electrodes are used for percutaneous nerve blocks with local anesthetic solution for radiofrequency lesioning of peripheral nerve tissue only. The Boston Scientific LCED and Stereotactic TCD Electrodes are indicated for use in radiofrequency (RF) heat lesioning of nervous tissue including the Central Nervous System.

Warnings: The Boston Scientific RF devices may cause interference with active devices such as neurostimulators, cardiac pacemakers, and defibrillators. Interference may affect the action of these active devices or may damage them. For appropriate guidance, consult the instructions for use for these active devices.

Caution: U.S. Federal law restricts this device to sale by or on the order of a physician.

Diagnostic Procedures 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.

Disclaimer: Health economic and reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules and policies. This information is presented for illustrative purposes only and does not constitute reimbursement or legal advice. Boston Scientific encourages providers to submit accurate and appropriate claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services and to submit appropriate codes, charges, and modifiers for services that are rendered. Boston Scientific recommends that you consult with your payers, reimbursement specialists and/or legal counsel regarding coding, coverage and reimbursement matters. Boston Scientific does not promote the use of its products outside their FDA-approved label. Information included herein is current as of November 2021 but is subject to change without notice. Rates for services are effective January 1, 2022.

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, 2022. (Budget Control Act of 2011)

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2. "National Average Payment" is the amount Medicare determines to be the maximum allowance for any Medicare covered procedure. These are national average payment amounts, individual payments may vary based on locality and Medicare's geographic adjustments. 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. G2: Non office-based surgical procedure added in CY 2008 orlater; payment based on OPPS relative payment weight. 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 servicespaid through a comprehensive APC.
5. APC Codes: 5431: Level 1 Nerve Procedures, 5442: Level 2 Nerve Injections

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