2021 Quick Reference Guide – Radio Frequency Ablation Sacroiliac Joint

Reimbursement 2021

Coding and Payment Guide for Medicare Reimbursement: The following are the 2021 Medicare coding and national payment rates for Radio Frequency Ablation (Sacroiliac Joint) procedures performed in an ambulatory surgical center, physician office, or outpatient hospital.

Diagnostic 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]
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with imaging guidance (ie, fluoroscopy or computed tomography)	$230	$80	000	G2	$322	T	5442	$635
Therapeutic Procedures									
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	$517	$197	10	G2	$809	J1	5431	$1,754

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.

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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, 2021. (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 or later; 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 services paid through a comprehensive APC.
5. APC Codes: 5431: Level 1 Nerve Procedures, 5442: Level 2 Nerve Injections

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NM-455409-AE