Reimbursement Information for the Intracept® Procedure

Provider Diagnosis Codes – ICD-10-CM Diagnosis Coding

All providers (hospitals, physicians, ASCs, etc.) must report a diagnosis code(s) when submitting a claim for payment to an insurer whether it is Medicare, Medicaid, or a commercial plan, such as Aetna or United Healthcare. The diagnosis code supports the medical necessity for the service and lets the payer know why the service was performed.

The following diagnosis codes may apply to patients undergoing the Intracept Procedure:

M47.816	Spondylosis w/o myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis w/o myelopathy or radiculopathy, lumbosacral region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M54.5	Low back pain

Providers may wish to contact Medicare Administrative Contractors (MACs) or third-party payers to confirm coverage and verify appropriate ICD-10 diagnosis codes.

Physician Coding – CPT Code*

Intracept is a relatively new spine procedure. A specific CPT code has not been established. Therefore, consistent with AMA coding guidelines, physicians should report the following:

- **CPT code 22899** Unlisted procedure, spine

An unlisted procedure code is generally reported when a Category I or III code does not adequately describe the procedure performed.

It is the responsibility of the provider to ensure all information required to process unlisted procedure codes is included on the claim form when the claim is submitted:

- Obtain written prior authorization (different than precertification) for elective (non-Medicare) cases.
- Submit CMS 1500 claim form (include concise description of the service in item 19) with operative report and cover letter.
- Do not use modifiers on unlisted procedure codes.
- Do not report more than one unlisted procedure code per anatomic area per operative session.

With respect to payment, it will be necessary to negotiate payment as unlisted CPT codes are not assigned relative value units and there may be payment delays.

Physicians should contact their specialty society, the AMA, or the payer if they have questions related to CPT coding.

Unlisted Codes and Payment Considerations

Report an unlisted code if no CPT code describes the procedure. In the cover letter that is transmitted with the claim, you should:

1. Identify and describe a comparator procedure (and CPT code) that the surgeon performs that is similar to the Intracept Procedure. Keep in mind that the comparator/base code should represent surgery on the same anatomical area, involve the same or similar approach and exposure, and if possible, require the same amount of skill and time.
2. List 2-3 things that make the unlisted procedure MORE OR LESS difficult than the existing comparison code in CPT.
3. Assess the RVUs of the similar code, making sure you feel it represents a “fair value” for the work involved. Next you will:
    a. Convert this GREATER OR LESSER degree of difficulty to a percent INCREASE OR DECREASE in your fee for the existing comparison code.
    b. List your normal fee for the existing comparison code. Keep in mind that the percent difference is critically important. The payer will adjust up or down from their fee schedule, not your charge.

Medical Necessity and Prior Authorization Documentation

The patient’s medical record must contain documentation to support medical necessity of the procedure. Medical record documentation should include a detailed history and physical including any diagnostic studies and treatment to support the rationale for the Intracept Procedure. Appropriate documentation should demonstrate medical necessity and include additional information as noted below:

- Intracept is medically indicated in patients who have
    – A history of low back pain of at least 6 months duration; and
    – Failed to respond to at least 6 months of non-surgical management; and
    – MRI demonstrated Modic Type 1 or Type 2 changes* at one or more vertebrae from L3 to S1; and
    – Activities of daily living that are limited by persistent low back pain; and
    – All other reasonable sources of pain have been ruled out.
- Published literature and clinical information supporting the efficacy of the procedure.
- Cover letter that is concise and outlines the procedure, medical necessity, and requested fee.

*Documented by at least one of the following:
- Modic Type 1 and/or Modic Type 2
- Endplate changes, inflammation, edema, disruption, and/or fissuring
- Fibrovascular bone marrow changes (hypointensive signal for Modic Type 1)
- Fatty bone marrow replacement (hyperintensive signal for Modic Type 2)

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Hospital Outpatient Coding and 2020 Medicare Payment

Hospital Outpatient Departments (HOPDs) also report CPT codes, and in some instances, HCPCS C codes, when billing for procedures. As noted above, the Intracept Procedure is relatively new and a specific CPT code has not been established by the AMA. Effective January 1, 2019, the Centers for Medicare and Medicaid Services (CMS) established two new HCPCS C codes to report the Intracept Procedure. Depending on the procedures performed, for Medicare claims, hospital outpatient departments will report one or both of the following:

- **C9752** Destruction of intraosseous basivertebral nerve, first two vertebral bodies, including imaging guidance (e.g., fluoroscopy), lumbar/sacrum
- **C9753** Destruction of intraosseous basivertebral nerve, each additional vertebral body, including imaging guidance (e.g., fluoroscopy), lumbar/sacrum (list separately in addition to code for primary procedure)

C9752 is designated as device-intensive by CMS. CMS requires HOPDs to report C1889 for the device costs when there is no specific device C-code for a device-intensive procedure.

- **C1889** Implantable/insertable device, not otherwise classified

HOPDs should verify with the relevant commercial payer regarding whether they require them to bill the C codes for the Intracept Procedures or the following unlisted CPT code:

- Revenue codes are reported in addition to the CPT or HCPCS code. Hospitals may categorize the associated Intracept devices charge to either revenue code 0272 or 0279.
- **CPT code 22899** Unlisted procedure, spine

Medicare payment for hospital outpatient procedures is based on Ambulatory Payment Classifications (APCs). The Medicare Hospital Outpatient Payment for C9752 is listed below.

APC	Title	2020 Medicare APC Payment*
5115	Level 5 Musculoskeletal Procedures	$11,901**

*2020 CMS/OPPS/ASC Final Rule, Addenda AA and B (available on CMS website), 84 Fed. Reg. 218 (Nov. 12, 2019) and Correction Notice, 85 Fed. Reg. 2 (Jan 3, 2020) (Rounded to the nearest dollar).

**HCPCS code C9753 and C1889 are packaged into payment for C9752.

Private Payer Payment

HOPDs may negotiate with ***private payers*** regarding payment for procedures billed with the C codes or an unlisted CPT code. Confirm with the facility contract whether the appropriate negotiation provisions are included in the payer contract.

To learn more about the Intracept Procedure, please visit relievant.com

Relievant Medsystems Inc. is pleased to provide general information on coding, coverage, and payment. This information is not intended to be legal or financial advice. Nothing in this guide should be construed as a guarantee by Relievant of coverage or payment for Intracept Procedures. Nothing in the document should be viewed as an instruction to use a particular code or influence levels of payment. Providers are responsible for exercising their independent clinical judgement and reporting the codes that accurately reflect the patient's condition and the services rendered and submit bills consistent with the patient's insurer requirements. Reimbursement changes annually. This information is accurate as of January 3, 2020. Providers are advised to consult with the applicable payer or the Specialty Society or legal counsel for any coding, payment or billing related issues.

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Ambulatory Surgical Center – Coding and 2020 Medicare Payment

As with HOPDs, Ambulatory Surgical Centers (ASCs) also report CPT codes, and in some instances, HCPCS C codes, to bill for procedures.

When billing Medicare:

- ASCs should bill C9752 for the Intracept procedures
- ASCs should **not** bill separate line item HCPCS codes that are packaged into the payment for surgical procedures
- ASCs should **not** bill surgical add-on codes because the payment is packaged into payment for the primary procedure
- ASCs should **not** bill C9753
- ASCs should **not** bill C1889

The Medicare ASC payment rate is based on a percentage of the HOPD payment rate. The 2020 Medicare ASC payment rate is listed below.

HCPCS Code	Descriptor	2020 ASC Payment Rate*
C9752	Destruction of intraosseous basivertebral nerve, first two vertebral bodies, including imaging guidance (e.g., fluoroscopy), lumbar/sacrum	$7,465***

***HCPCS code C9753 is packaged into payment for C9752.

Private Payer Coding

For private/commercial payers, depending on the specific payer requirements, ASCs may report one or both of the HCPCS C codes or the unlisted CPT code:

- **C9752** Destruction of intraosseous basivertebral nerve, first two vertebral bodies, including imaging guidance (e.g., fluoroscopy), lumbar/sacrum
- **C9753** Destruction of intraosseous basivertebral nerve, each additional vertebral body, including imaging guidance (e.g., fluoroscopy), lumbar/sacrum (in addition to code for primary procedure)
- **CPT code 22899** Unlisted procedure, spine

Private Payer Payment

Most private insurers will negotiate with ASCs to establish payment for procedures billed with an unlisted CPT code such as CPT 22899. Commercial payers may also negotiate with ASCs to establish payment for HCPCS C codes. Providers may want to review their contracts with payers to see which ones provide payment for unlisted codes and/or HCPCS C codes. If a provision for payment does not exist, providers may want to check if there is an opportunity to negotiate for payment of the unlisted code or the HCPCS C codes.

Indications for Use

The Intracept Intraosseous Nerve Ablation System is intended to be used in conjunction with radiofrequency (RF) generators for the ablation of basivertebral nerves of the L3 through S1 vertebrae for the relief of chronic low back pain of at least six months duration that has not responded to at least six months of conservative care, and is also accompanied by features consistent with Type 1 or Type 2 Modic changes on an MRI such as inflammation, edema, vertebral endplate changes, disruption and fissuring of the endplate, vascularized fibrous tissues within the adjacent marrow, hypointensive signals (Type 1 Modic change), and changes to the vertebral body marrow including replacement of normal bone marrow by fat, and hyperintensive signals (Type 2 Modic change).