2024 PHYSICIAN REIMBURSEMENT
Intracept® Procedure

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, hypo intensive signals (Type1 Modic change), and changes to the vertebral body marrow including replacement of normal bone marrow by fat and hyper intensive signals (Type 2 Modic change).

ICD-10-CM DIAGNOSIS CODING

Diagnosis codes are used by both physicians and facilities to document the indication for the procedure. It is recommended providers contact their Medicare Administrative Contractors (MACs) and/or third-party payers to confirm coverage and verify appropriate ICD-10 diagnosis codes. 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
M54.50	Low back pain
M54.51	Vertebrogenic low back pain; low back pain vertebral endplate pain

MEDICARE PHYSICIAN CODING, RELATIVE VALUE UNIT (RVU) AND PAYMENT FOR SERVICES PERFORMED IN A FACILITY SETTING

CPT[1] Code	Description	Work RVUs[2]	Total RVUs[2]	Payment Rate[3]
64628[4]	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; **first two vertebral bodies** lumbar or sacral	7.15	12.37	$404.96
+64629[5]	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; **each additional vertebral body**, lumbar or sacral (list separately in addition to code for primary procedure)	3.77	5.85	$191.51

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[2] 2024 CMS/PFS Final Rule, Addenda B (available on CMS website).
[3] Medicare national average payment subject to geographic adjustment 2024 CMS/PFS Final Rule, Addenda B: work, practice expense, and malpractice RVUs multiplied by CY2024 conversion factor $32.4772 (available on CMS website). Physician payment amounts reflected are for services performed in a facility setting. There is no office payment assigned.
[4] CPT code 64628 has a global period of 10 days.
[5] CMS/Medicare has assigned a Medically Unlikely Edit (MUE) on CPT code 64629. If a 4th vertebral body is billed, it is likely to be denied due to the edit. Medically reasonable and necessary units more than the MUE may be considered for payment but may require an appeal. Each unit determined to be medically necessary should be paid at the full fee schedule value.

2024 FACILITY REIMBURSEMENT

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2024 HOSPITAL OUTPATIENT CODING AND PAYMENT

CPT[1] Code	Description	Status Indicator[5]	APC	Medicare	Private/Commercial
64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; **first two vertebral bodies** lumbar or sacral	J1	5115	$12,552[2,3]	Contractual
+64629	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; **each additional vertebral body**, lumbar or sacral (list separately in addition to code for primary procedure)	N	N/A	Bundled	Contractual
C1889[4]	Implantable/insertable device, not otherwise classified (CMS requires HOPDs to report C1889 for device costs when there is no specific device C-code for a device intensive procedure)	N/A	N/A	Report with Revenue Code 278 with device charges	Contractual Report with Revenue Code 278 with device charges

2024 AMBULATORY SURGICAL CENTER CODING AND PAYMENT

CPT[1] Code	Description	Status Indicator[5]	APC	Medicare	Private/Commercial
64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; **first two vertebral bodies** lumbar or sacral	J8	5115	$9,396[2]	Contractual
+64629	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; **each additional vertebral body**, lumbar or sacral (list separately in addition to code for primary procedure)	N	N/A	Bundled Note: ASCs do not report code to CMS	Contractual
C1889	Implantable/insertable device, not otherwise classified	N/A	N/A	Note: ASCs do not report C1889 to CMS	Contractual Report with Revenue Code 278 with device charges

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[2] Medicare national average payment subject to geographic adjustment, 2024 CMS/OPPS/ASC Final Rule, Addenda AA and B (available on CMS website).
[3] Medicare payment for hospital outpatient procedures is based on Ambulatory Payment Classifications (APCs). CPT codes 64628 and +64629 are assigned to APC 5115.
[4] CPT code 64628 is designated as device-intensive by CMS. CMS requires HOPDs to report C1889 with revenue code 0278 for the device cost. Medicare may deny claims without device associated charges (CMS Manual System, transmittal 11305).
[5] Status Indicator (SI) shows how a code is handled for payment purposes: J1= paid under comprehensive APC, single payment based on primary service without separate payment for other adjunctive services; J8= device intensive ASC procedures. N= ancillary HCPCS codes that are integral to the delivery of other procedures and services. Payment for this code type is "packaged" (bundled) into the payment for other services and therefore are not separately reimbursable.

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 1, 2024. Providers are advised to consult with the applicable payer or the Specialty Society or legal counsel for any coding, payment, or billing related issues.

Questions

If you have reimbursement questions regarding the Intracept Procedure, please contact us at: claimsreimbursement@relievant.com