Boston Scientific
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2021 Quick Reference Guide – Radio Frequency Ablation Knee 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 (Knee 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]
64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed	$218	$77	000	P3	$164	T	5442	$635

Therapeutic 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]
64624	Destruction by neurolytic agent, genicular nerve branches including guidance, when performed	$407	$140	10	P3	$809	J1	5431	$1,754

Medicare Local Coverage Determinations

In the absence of an LCD, Medicare determines medical necessity on a case by case basis.

First Coast Service Options (FL)	LCD #L33933	LCA #A57788
NGS (IL, MN, WI, CT, NY, ME, MA, RI, VT)	LCD #L36850	LCA #A57452

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

Indications for use: 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: For a patient with a cardiac pacemaker, contact the pacemaker company to determine whether the pacemaker needs to be converted to fixed rate pacing during the radiofrequency procedure. Refer to the Instructions for Use provided with Boston Scientific generators, electrodes and cannulas for potential adverse effects, additional warnings and precautions prior to using these products.

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

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, 2020 but is subject to change without notice. Rates for services are effective January 1, 2021.

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: 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: 5442: Level 2 Nerve Injections, 5431: Level 1 Nerve Procedures

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