This guide provides physician and hospital coding and payment information for radiofrequency ablation procedures. In addition, St. Jude Medical offers a reimbursement hotline, which provides live coding and billing information from dedicated reimbursement specialists. Hotline support is available from 8 a.m. to 5 p.m. Central Time, Monday through Friday at (800) 727-7846 or pta@sjm.com. Hotline reimbursement assistance is provided subject to the disclaimers set forth in this guide.

This document and the information contained herein is for general information purposes only and is not intended and does not constitute legal, reimbursement, coding, business or other advice. Furthermore, it is not intended to increase or maximize payment by any payer. Nothing in this document should be construed as a guarantee by St. Jude Medical regarding levels of reimbursement, payment or charge, or that reimbursement or other payment will be received. Similarly, nothing in this document should be viewed as instructions for selecting any particular code. The ultimate responsibility for coding and obtaining payment/reimbursement remains with the customer. This includes the responsibility for accuracy and veracity of all coding and claims submitted to third party payers. Also note that the information presented herein represents only one of many potential scenarios, based on the assumptions, variables and data presented. In addition, the customer should note that laws, regulations, coverage and coding policies are complex and updated frequently. Therefore, the customer should check with their local carriers or intermediaries often and should consult with legal counsel or a financial, coding or reimbursement specialist for any coding, reimbursement or billing questions or related issues. This information is for reference purposes only. It is not provided or authorized for marketing use.

### Ambulatory Surgery Center

**Effective Dates:** January 1, 2017 – December 31, 2017

<table>
<thead>
<tr>
<th>CPT™ Code</th>
<th>Description</th>
<th>Payment Indicator</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>64633</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint</td>
<td>G2</td>
<td>$788</td>
</tr>
<tr>
<td>64634</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint</td>
<td>N1</td>
<td>N/A</td>
</tr>
<tr>
<td>64635</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint</td>
<td>G2</td>
<td>$788</td>
</tr>
<tr>
<td>64636</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint</td>
<td>N1</td>
<td>N/A</td>
</tr>
<tr>
<td>64640</td>
<td>Destruction by neurolytic agent; other peripheral nerve or branch.</td>
<td>P3</td>
<td>$87</td>
</tr>
<tr>
<td>77002</td>
<td>Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)</td>
<td>N1</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Payment Indicators**
- G2 = Non-office base surgical procedure added in CY2008 or later. Payment based on OPPS relative value weight.
- N1 = Packaged service/item; no separate payment made.
- P3 = Office-based surgical procedure added to ASC list in CY2008 or later with MPFS nonfacility PE RVUs payment based on nonfacility PE RVUs.
Pre-Procedural Requirements

Most insurance providers require at least one diagnostic procedure for each treated site, with some requiring two. Please check with the payer before performing any radiofrequency (RF) procedure to be sure you have completed all required step therapies.

Appeals

There are numerous reasons that a facility or physician may face a denied, pended or underpaid claim.

Claims are typically denied or pended for four reasons:
- The claims processors have made an administrative error
- The claim forms contain clerical errors
- The payer has not deemed the procedure to be medically necessary
- The payer’s request for information have gone unanswered by the patient

Appealing Denied Claims

A denied claim can be appealed. When a claim has been denied, review the Explanation of Benefits (EOB) for an explanation of the denial. Immediately contact the payer if the EOB does not explain the reason for the denial and request an explanation. In cases where the denial was a result of a clerical error on the claim form, confirm the correct code with the payer and resubmit the corrected claim form.

Other reasons for a denied claim may include:
- The technology is considered investigational
- The CPT™ code does not meet the diagnosis code
- The medical necessity has not been determined

Should your claim have been denied for one of these reasons, it is best to contact the payer directly in order to offer additional information about the procedure. You should ask the claims processor to indicate which additional materials should be provided in order to potentially reverse the original coverage determination.

If you feel that your claim has been underpaid, contact the claims office indicated on the patient’s EOB and request a review of your claim. Possible reasons for underpayment of a procedure include but are not limited to:
- The coding of the procedure performed is incorrect
- The lack or misuse of an appropriate modifier
- The lack of supporting documentation

You will find that each payer has its own unique review process. It is best to contact the payer for the exact guidelines. In most cases, however, you will be asked to submit your appeal request in writing. When contacting the payer, be sure to inquire as to where the request should be sent and to whose attention it should be directed.

If you have additional reimbursement questions, please call the St. Jude Medical Reimbursement Hotline at 800-727-7846.