Nevro® HFX™ Reimbursement Guide

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Patient experiences with the HFX iQ™ or Senza Omnia™ spinal cord stimulation (SCS) system vary by individual, including the amount of pain relief. The occurrence of adverse effects associated with SCS implant surgery or use also varies by patient.

Indications for Use: The HFX iQ, Senza Omnia, and HFX Trial SCS systems aid in the management of chronic intractable pain of the trunk and/or limbs, and, when programmed to 10 kHz, are indicated as aids in the management of chronic intractable pain of the lower limbs associated with diabetic neuropathy and the management of non-surgical refractory back pain. **Contraindications:** These include patients who are poor SCS surgical candidates, are unable to operate the SCS system and fail to receive effective pain relief during trial stimulation. **Warnings:** Interference with other implanted stimulators, may result in sensing problems or inappropriate responses. Sources of electromagnetic interference may result in unexpected changes in stimulation, serious patient injury and system damage. Energy from diathermy can cause tissue damage, resulting in severe injury or death. Senza implantable stimulators are MR conditional and scanning under different conditions may result in severe patient injury or device malfunction. Use of certain medical devices or procedures (electrocautery, radiation therapy, ultrasonic scanning) may result in device damage. Induced electrical currents from radiofrequency (RF) or microwave ablation may cause heating, resulting in tissue damage. **Precautions:** Avoid activities that put stress on the implanted components. Safety has not been established for Transcranial Magnetic Stimulation (TMS) or Electroconvulsive Therapy (ECT) in patients who have an implanted SCS system. Persistent discomfort or excessive redness may indicate infection. **Adverse Events:** May include hematoma, epidural hemorrhage, paralysis, pain at implant site, infection and other surgical risks. Device related adverse events may include loss of pain relief or paresthesia, undesirable change in stimulation (uncomfortable, jolting or shocking sensation), tissue reaction or allergy to implanted materials. Refer to http://www.nevro.com/manuals for product manuals with complete indications, contraindications, warnings, precautions and potential adverse events.

HFX Spinal Cord Stimulation System Overview

Overview

- Delivers stimulation at standard low frequency **and the only device to delivery high-frequency stimulation (10 kHz) which is paresthesia-independent**
- Rechargeable implanted battery **designed for 10-year system life**
- Four IPGs in the Senza platform: Senza, Senza II, Senza Omnia, Senza HFX iQ

Patient Benefits of Approved Device

No driving restrictions

No impact on sleep

Average daily use is 24 hours vs 17 hours with traditional SCS due to elimination of paresthesia

Differences in Device Features	Paresthesia-Based SCS Systems	Nevro Senza SCS System
Therapeutic stimulation while sleeping	×	✓
No restrictions for driving	×	✓
Does not require perioperative paresthesia-mapping	×	✓
Procedure time predictability	×	✓

FDA Approvals Unique to Nevro Based on Level 1 Evidence

Indications for Use

Chronic Low Back and Leg Pain:

The Senza®, Senza II™, Senza Omnia™, and HFX iQ™ neuromodulation systems are indicated as aids in the management of chronic intractable pain of the trunk and/or limbs, including unilateral or bilateral pain associated with the following: failed back surgery syndrome, intractable low back pain, and leg pain.

Diabetic Neuropathy:

The Senza, Senza II, Senza Omnia, and HFX iQ neuromodulation systems, when *programmed to include a frequency of 10 kHz*, are indicated as aids in the management of chronic intractable pain of the lower limbs, including unilateral or bilateral pain, associated with diabetic neuropathy.

Non-Surgical Refractory Back Pain:

The Senza, Senza II, Senza Omnia, and HFX iQ neuromodulation systems, when *programmed to include a frequency of 10 kHz*, are indicated as aids in the management of non-surgical refractory back pain (intractable back pain without prior surgery and not a candidate for back surgery).

Medicare National Coverage Determination

Electrical Nerve Stimulators – 160.7*

The implantation of central nervous system stimulators may be **covered** as therapies for the relief of chronic intractable pain, subject to the following conditions:

No payment may be made for the implantation of dorsal column or depth brain stimulators or services and supplies related to such implantation, unless all of the conditions listed below have been met:

- The implantation of the stimulator is used only as a late resort (if not a last resort) for patients with chronic intractable pain;
- With respect to item a, other treatment modalities (pharmacological, surgical, physical, or psychological therapies) have been tried and did not prove satisfactory, or are judged to be unsuitable or contraindicated for the given patient;
- Patients have undergone careful screening, evaluation and diagnosis by a multidisciplinary team prior to implantation. (Such screening must include psychological, as well as physical evaluation);
- All the facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment training, and follow up of the patient (including that required to satisfy item c) must be available; and
- Demonstration of pain relief with a temporarily implanted electrode precedes permanent implantation.

Medicare Coverage Database

Medicare Benefit Policy Manual

* https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=240

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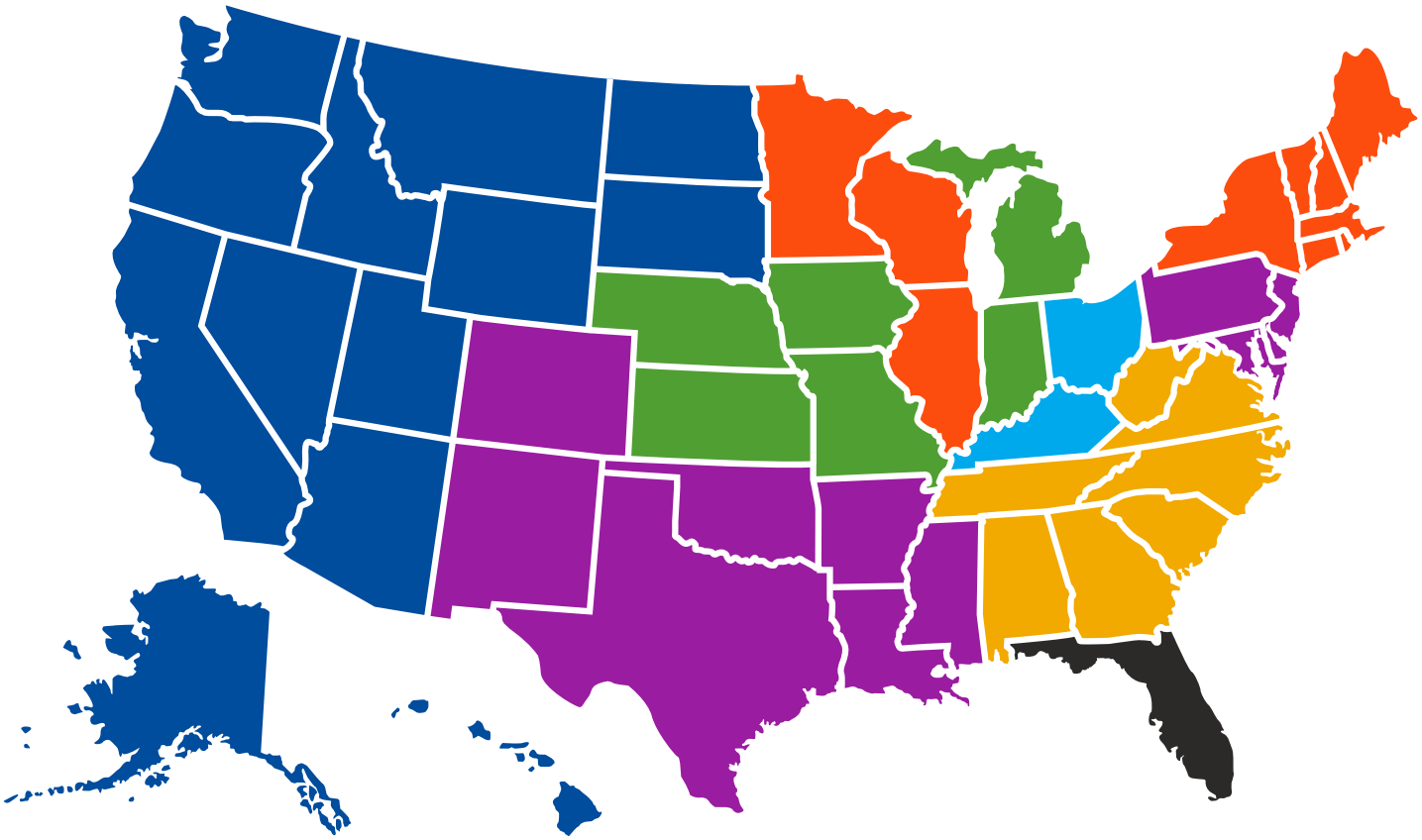
MAC Coverage Map - SCS



Noridian*

LCD: L35136/L36204
LCA: A57791/A57792

Novitas*

LCD: L35450
LCA: A57023

Palmetto*

LCD: L37632
LCA: A56876

FCSO*

LCD: L36035
LCA: A57709

CGS†

NCD: 160.7

WPS†

NCD: 160.7

NGS†

NCD: 160.7

* Follows local guidelines for SCS
† Follows NCD that covers SCS for "chronic intractable pain"

Medicare Prior Authorization

Prior authorization requirement is a process through which a request for provisional affirmation of coverage is submitted for review before the service is rendered to a beneficiary and before a claim is submitted for payment.

When is Prior Authorization Request Required?

- ✓ SCS Trials performed in the outpatient hospital setting
- ✓ SCS Permanent Implant cases performed in the outpatient hospital setting if the SCS trial was performed at a different site of care (e.g., office or ASC)
  - An additional Prior Authorization is not required for the SCS Permanent Implant if the SCS Trial was at the same hospital and performed by the same physician
  - The same authorization number, called a UTN (Unique Tracking Number) should be billed for the SCS trial and SCS Permanent Implant
  - All SCS Prior Authorizations are submitted with the same CPT

This information is from CMS' Operational Guide and FAQs as of December 19, 2023.

For more program details, please visit CMS' Website for the Operational Guide and FAQs:
Prior Authorization for Certain Hospital Outpatient Department (OPD) Services

Please also visit your local Medicare Administrative Contractor (MAC) website for more information about the specific requirements for submission.

CPT Code Requiring Prior Authorization 63650: Implantation of spinal neurostimulator electrodes, accessed through the skin

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Prior Authorization Checklist

Procedure Type:

✓ SCS Trial ✓ SCS Permanent Implant

Clinical Notes:

✓ Condition requiring procedure

✓ Physical examination

✓ Past treatments (typically 6 months or more) that are tried and failed including, but not limited to:

— Spine surgery — Injections — Physical therapy — Psychological therapy

— Chiropractic care — Medications — Other _____

✓ Documentation of appropriate psychological evaluation

✓ Imaging Reports

✓ Surgical consult or evaluation (may required by some payers)

For permanent placement, include all the above documentation, as well as documentation of pain relief with the temporary implanted electrode(s).

✓ A successful trial should be associated with at least 50% reduction of target pain or 50% reduction of analgesic medications.

This checklist is applicable for Medicare beneficiaries who have coverage through a Medicare Administrative Contractor (MAC). MACs include: CGS, First Coast, NGS, Noridian, Novitas, Palmetto, WPS

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Medicare Psychological Evaluation Information

CMS published Medicare Mental Health (MLN1986542) which has been cited as a resource to define appropriate psychological evaluations, including those required prior to SCS trials. Details include:

- What is covered by Medicare
- Who are eligible professionals and additional details on each (see snapshot of list below)
- Relevant CPT codes

Eligible Professionals

Medicare recognizes these Part B suppliers as eligible to furnish diagnostic and therapeutic mental health services, perform diagnostic tests, and furnish Behavioral Health Integration (BHI) and SBIRT services, as permitted under state law:

- Physicians (Medical Doctors [MDs] and Doctors of Osteopathy [DOs]), particularly Psychiatrists
- Clinical Psychologists (CPs)
- Clinical Social Workers (CSWs)
- Clinical Nurse Specialists (CNSs)
- Nurse Practitioners (NPs)
- Physician Assistants (PAs)
- Certified Nurse-Midwives (CNMs)
- Independently Practicing Psychologists (IPPs)
- Certified Registered Nurse Anesthetists (CRNAs) (supervision of diagnostic psychological and neuropsychological tests)

AdvantagePoint: A Streamlined Telehealth Psychological Evaluation Option

AdvantagePoint Behavioral offers accessible, streamlined convenient, high-quality behavioral screenings that are required by Medicare and commercial payers for people who are seeking approval for a medically necessary spinal cord stimulator.

AdvantagePoint offers appointments 7 days a week, including nights and weekends. In most cases, an appointment is available within a couple of days, during which time we verify each patient's benefits coverage by phone and communicate any out-of-pocket expense in advance of the appointment.

We accept most forms of major insurance and can pre-verify coverage to help understand out-of- pocket costs prior to the assessment. If insurance does not cover the assessment, affordable cash-pay option can be broken up into a payment plan upon request.

The AdvantagePoint and Nevro teams are ready to help. Call (877) 583-5633 to get started today or scan to register for the required Pre-surgical Evaluation.

Growing trend for payers requiring Surgical Consults

Some payers and third-party administrators, including the ones listed below, require that a patient must be seen by a surgeon for a surgical evaluation prior to their SCS trial. A copy of the surgical evaluation should be included with the patient's clinicals/medical records for prior authorization submission.

NOTE: Failure to submit the surgical consult may result in a delay for approval or a prior authorization denial.

Payer/Third-Party Administrator	Surgical Evaluation/consult Language from SCS policy (as of 1/1/2024)	Indication (s) Requiring Surgical Consult
Turning Point	"Treatment is determined by a multidisciplinary team, including a spine surgeon and an interventional pain management physician and it is determined that no further surgery is indicated"	All but PDN
eviCore	"Surgical intervention is not indicated or for patients who do not wish to proceed with spinal surgery"	FBSS
Carelon	"At least one surgical opinion has been obtained to ensure that the patient does not have a surgically correctable lesion (excludes CRPS)"	All but CRPS
Humana	"Surgical procedures: If appropriate for the medical condition, surgery has been tried and failed OR the individual is not a candidate for surgical interventions; AND- For those individuals with failed back surgery syndrome, they are not candidates for further surgical intervention; AND"	FBSS

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Example Surgical Consult Language (Carelon)

Stimulator Trial

Stimulator trial may be indicated when **ALL** of the following criteria are met:

- The patient has chronic intractable neuropathic pain of the trunk and/or limbs associated with at least **ONE** of the following conditions:
    - **Lumbosacral arachnoiditis** as documented by high levels of protein in the cerebrospinal fluid and/or imaging (MRI or myelography)
    - **Nerve root injuries** that are post-surgical or post-traumatic, including post laminectomy syndrome (failed back syndrome)
    - **Complex regional pain syndrome (CRPS)**, type I or type II (formerly known as reflex sympathetic dystrophy or causalgia)
- Severe pain and disability with documented pathology or an objective basis for the pain
- Dorsal column stimulation is being use as a late or last resort after documented failure of at least 6 consecutive months of physician-supervised conservative management
- There is no evidence of existing untreated drug addiction
- The patient has been evaluated by a pain amangement specialist prior to implantation
- All the facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment training, and follow-up of the patient must be available

At least one surgical opinion has been obtained to ennsure that the patient does not have a surgically correctable lesion (excludes CRPS)

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Surgical Consult Example

Best Practices for Surgical Consults

Stimulator trial may be indicated when **ALL** of the following criteria are met:

- Ordered by treating / implanting physician
- Administered by qualified surgeon (Spine or Neuro preferred)
- The evaluation clearly states there is no corrective surgery able to fix the neuropathic pain
- There are not other comorbidities / contraindications to surgery

Imaging review: MRI of the lumbar spine that was done on February 26, 2021 does not show any significant foraminal narrowing. No central canal stenosis noted. No significant disc degeneration. The conus does terminate at L2. No malaignment noted. No cord signal change.

Assessment/Plan: At this point I do not see anything from a structural standpoint that any kind of surgical intervention would be of a benefit to the patient. We did discuss this in great detail. I did recommend that she continue work with pain management and see about an implantable pain control device. She was told to call us if any further problems or concerns and we be happy to see her back if we need to do a reevaluation. Her questions and concerns were addressed.

Patient is a non smoker.

The patient's Body mass index is 37.8 kg/m^2.. BMI is above normal parameters. Recommendations include: Educational material and nutrition counseling.

Diagnoses and all orders for the visit:

1. **Chronic bilateral low back pain with bilateral sciatica (Primary)**
2. **Numbness and tingling of both legs**
3. **Class 2 obsesity due to excess calories with body mass index (BMI) of 37.0 to 37.9 in adult, unspecified whether serious or comorbidity present**
4. **Nonsmoker**

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CPT® Coding for Spinal Cord Stimulation

Current Procedural Terminology (CPT), Fourth Edition, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other qualified health care professionals. The purpose of the terminology is to provide a uniform language that accurately describes medical, surgical, and diagnostic services, and thereby provide an effective means for reliable nationwide communication among physicians and other qualified health care professionals, patients, and third parties.

The following CPT codes describe procedures associated with HFX Therapy. The codes are provided as a guide for physician and practitioner reporting. Actual code(s) billed should reflect the services provided to each individual patient in the office (non-facility) or outpatient hospital/ambulatory surgery center (facility) setting.

Final coding is up to the physician's discretion based on what procedures were performed and properly documented.

CPT Codes

CPT Code	CPT Description
Trial	
63650	Percutaneous implantation of neurostimulator electrode array, epidural
Implant with Percutaneous Leads	
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
Implant with Paddle Lead	
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or indirect coupling

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CPT® Codes

CPT Code	CPT Description
Revision/Replacement	
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver
Removal	
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminectomy, including fluoroscopy, when performed
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver
Analysis and Programming	
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, **without programming**
95971	**... with simple spinal cord or peripheral nerve (e.g., sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional**
95972	**...with complex spinal cord or peripheral nerve (e.g., sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional**

CPT Code	Procedure	Work RVU	Non-Facility PE RVU	Facility PE RVU	Malpractice RVU
63650	Percutaneous Lead Insertion	7.15	60.33	4.45	0.82
63655	Paddle Lead Insertion	10.92	NA	10.86	3.82
63661	Removal of Percutaneous Lead	5.08	14.52	3.85	1.02
63662	Removal of Paddle Lead	11.00	NA	11.06	3.93
63663	Revision / Replacement of Percutaneous Lead	7.75	18.26	4.67	1.14
63664	Revision / Replacement of Paddle Lead	11.52	NA	11.40	4.13
63685	Implantable Pulse Generator (IPG) Insertion / Replacement	5.19	NA	3.98	1.11
63688	Implantable Pulse Generator (IPG) Removal	4.35	NA	3.73	1.01

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Note: Analysis and programming of spinal cord stimulator systems may be provided by the treating physician, practitioner, or medical personnel (in accordance with the Medicare or relevant payer "incident-to" requirements) under the direct supervision of the physician (or other practitioner), with or without support from a manufacturer's representative. A physician should not bill if the service is performed by a manufacturer representative without payer consent. Nevro recommends that the insurance carrier be contacted for interpretation of applicable coding and billing policies.

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Modifiers

Facility Modifiers

The International Classification of Diseases, Tenth Revision, Clinical Modification – more commonly known as ICD-10-CM – is a classification system of diagnosis codes representing conditions and diseases, related to health problems, abnormal findings, signs and symptoms, injuries, and external causes of injuries and diseases. Used for medical claim reporting in all healthcare settings, ICD-10-CM codes are the primary means to establish medical necessity for payment of healthcare services and procedures.

Modifier	Description	Notes
-52	Reduced services	Report this modifier when a service or procedure is partially reduced or eliminated at the physician's discretion
-58	Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period	Report this modifier during the post-op period if a procedure or service was performed was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure or; c) for therapy following a diagnostic surgical procedure
-59	Distinct procedural service	Report this modifier when billing the same CPT for two or more distinct procedural services
-76	Repeat procedure or service by the same physician or other qualified health care professional	Report this modifier when a procedure or service was repeated subsequent to the original procedure or service
-78	Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period	Used when another procedure was performed during the post-op period of the initial procedure
-PO	Excepted service provided at an off-campus, outpatient, provider-based department of a hospital	Do not report this modifier for services performed in remote locations of a hospital, satellite facilities of a hospital, or in an off-campus dedicated emergency department
-PN	Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital	Do not report this modifier for services performed in remote locations of a hospital, satellite facilities of a hospital, or in an off-campus dedicated emergency department.

The following is a list of examples of ICD-10-CM diagnosis codes that may relate to indications associated with spinal cord stimulation and HFX procedures. This is not an all-inclusive list and the codes reported should have accurate documentation appropriate to the patient's condition(s). Coding is left to the discretion of the provider.

Surgical Modifiers

Global Surgical Modifiers

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HCPCS Level II Coding for Spinal Cord Stimulation

HCPCS Level II codes are developed and maintained by a joint editorial panel consisting of the Centers for Medicare and Medicaid Services (CMS), the Blue Cross Blue Shield Association, and the Health Insurance Association of America. HCPCS Level II codes may be used throughout the United States in all Medicare regions. They consist of one alpha character (A through V) followed by four digits.

Insurance companies and the government do not base payment solely on what was done for the patient. They need to know why the services were performed. In addition to using the HCPCS coding system for procedures and supplies, the ICD-10-CM system must be used to denote diagnosis.

HCPCS Codes

Device	HCPCS Code	Code Description
Medicare HCPCS Level II Codes*		
Pulse Generator	**C1822**	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system
Leads (8-contact, Paddle)	**C1778**	Lead, neurostimulator (implantable)
Trial Leads	**C1897**	Lead, neurostimulator, test kit (implantable)
Lead Extension	**C1883**	Adaptor/extension, pacing lead or neurostimulator lead (implantable)
Patient Programmer	**C1787**	Patient programmer, neurostimulator
Commercial Payer L-Codes		
Leads: 8-contact	**L8680**	Implantable neurostimulator electrode, each
Pulse Generator	**L8687**	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
External Recharger	**L8689**	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only
Remote Control (patient programmer)	**L8681**	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only

* All Medicare Level II HCPCS Codes have a Payment Indicator of N1 – Packaged service/item; no separate payment made

ICD-10-CM Coding for Spinal Cord Stimulation

The International Classification of Diseases, Tenth Revision, Clinical Modification – more commonly known as ICD-10-CM – is a classification system of diagnosis codes representing conditions and diseases, related to health problems, abnormal findings, signs and symptoms, injuries, and external causes of injuries and diseases. Used for medical claim reporting in all healthcare settings, ICD-10-CM codes are the primary means to establish medical necessity for payment of healthcare services and procedures.

The following is a list of examples of ICD-10-CM diagnosis codes that may relate to indications associated with spinal cord stimulation and HFX procedures. This is not an all-inclusive list and the codes reported should have accurate documentation appropriate to the patient's condition(s). Coding is left to the discretion of the provider.

ICD-10-CM Codes - Back Pain

Category	ICD-10-CM Code	Code Description
Disc Degeneration	**M51.35**	Other intervertebral disc degeneration, thoracolumbar region
Disc Degeneration	**M51.36**	Other intervertebral disc degeneration, lumbar region
Disc Disorder	**M51.06**	Intervertebral disc disorders with myelopathy, lumbar region
Disc Disorder	**M51.15**	Intervertebral disc disorders with radiculopathy, thoracolumbar region
Disc Disorder	**M51.16**	Intervertebral disc disorders with radiculopathy, lumbar region
Disc Disorder	**M51.17**	Intervertebral disc disorders with radiculopathy, lumbosacral region
Disc Displacement	**M51.25**	Other intervertebral disc displacement, thoracolumbar region
Disc Displacement	**M51.26**	Other intervertebral disc displacement, lumbar region
Dorsalgia	**M54.89**	Other Dorsalgia
Dorsalgia	**M54.9**	Dorsalgia, unspecified
Lumbago	**M54.40**	Lumbago with sciatica, unspecified side
Lumbago	**M54.41**	Lumbago with sciatica, right side
Lumbago	**M54.42**	Lumbago with sciatica, left side

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ICD-10-CM Codes - Back Pain (continued)

Category	ICD-10-CM Code	Code Description
Radiculopathy	**M54.15**	Radiculopathy thoracolumbar region
Radiculopathy	**M54.16**	Radiculopathy lumbar region
Radiculopathy	**M54.17**	Radiculopathy, lumbosacral region
Spinal Stenosis	**M48.06X**	Spinal stenosis, lumbar region
Spinal Stenosis	**M48.07**	Spinal stenosis, lumbosacral region
Spondylopathy	**M48.35**	Traumatic spondylopathy, thoracolumbar region
Spondylopathy	**M48.36**	Traumatic spondylopathy, lumbar region
Spondylopathy	**M48.37**	Traumatic spondylopathy, lumbosacral region
Spondylopathy	**M48.8X5**	Other specified spondylopathies, thoracolumbar region
Spondylopathy	**M48.8X6**	Other specified spondylopathies, lumbar region
Spondylopathy	**M48.8X7**	Other specified spondylopathies, lumbosacral region
Spondylopathy	**M49.85**	Spondylopathy in diseases classified elsewhere, thoracolumbar region
Spondylopathy	**M49.86**	Spondylopathy in diseases classified elsewhere, lumbar region
Spondylopathy	**M49.87**	Spondylopathy in diseases classified elsewhere, lumbosacral region
Spondylosis	**M47.10**	Other spondylosis with myelopathy, site unspecified
Spondylosis	**M47.16**	Other spondylosis with myelopathy, lumbar region
Spondylosis	**M47.25**	Other spondylosis with radiculopathy, thoracolumbar region
Spondylosis	**M47.26**	Other spondylosis with radiculopathy, lumbar region
Spondylosis	**M47.27**	Other spondylosis with radiculopathy, lumbosacral region
Spondylosis	**M47.815**	Spondylosis without myelopathy or radiculopathy, thoracolumbar region
Spondylosis	**M47.817**	Spondylosis without myelopathy or radiculopathy, lumbosacral region

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ICD-10-CM Codes - Diabetic Neuropathy

Category	ICD-10-CM Code	Code Description
Diabetic Neuropathy	**E08.40**	Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified
Diabetic Neuropathy	**E08.42**	Diabetes mellitus due to underlying condition with diabetic polyneuropathy
Diabetic Neuropathy	**E10.40**	Type 1 diabetes mellitus with diabetic neuropathy, unspecified
Diabetic Neuropathy	**E10.42**	Type 1 diabetes mellitus with diabetic polyneuropathy
Diabetic Neuropathy	**E11.40**	Type 2 diabetes mellitus with diabetic neuropathy, unspecified
Diabetic Neuropathy	**E11.42**	Type 2 diabetes mellitus with diabetic polyneuropathy
Diabetic Neuropathy	**E13.40**	Other specified diabetes mellitus with diabetic neuropathy, unspecified
Diabetic Neuropathy	**E13.42**	Other specified diabetes mellitus with diabetic polyneuropathy
Diabetic Neuropathy	**E08.4**	Diabetes mellitus due to underlying condition with neurological complications
Diabetic Neuropathy	**E08.41**	Diabetes mellitus due to underlying condition with diabetic mononeuropathy
Diabetic Neuropathy	**E08.43**	Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy
Diabetic Neuropathy	**E08.44**	Diabetes mellitus due to underlying condition with diabetic amyotrophy
Diabetic Neuropathy	**E08.49**	Diabetes mellitus due to underlying condition with other diabetic neurological complication
Diabetic Neuropathy	**E10.4**	Type 1 diabetes mellitus with neurological complications
Diabetic Neuropathy	**E10.41**	Type 1 diabetes mellitus with diabetic mononeuropathy
Diabetic Neuropathy	**E10.43**	Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy
Diabetic Neuropathy	**E10.44**	Type 1 diabetes mellitus with diabetic amyotrophy
Diabetic Neuropathy	**E10.49**	Type 1 diabetes mellitus with other diabetic neurological complication
Diabetic Neuropathy	**E114**	Type 2 diabetes mellitus with neurological complications
Diabetic Neuropathy	**E11.41**	Type 2 diabetes mellitus with diabetic mononeuropathy
Diabetic Neuropathy	**E11.43**	Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy
Diabetic Neuropathy	**E11.44**	Type 2 diabetes mellitus with diabetic amyotrophy
Diabetic Neuropathy	**E11.49**	Type 2 diabetes mellitus with other diabetic neurological complication
Diabetic Neuropathy	**E13.4**	Other specified diabetes mellitus with neurological complications
Diabetic Neuropathy	**E13.41**	Other specified diabetes mellitus with diabetic mononeuropathy
Diabetic Neuropathy	**E13.43**	Other specified diabetes mellitus with diabetic autonomic (poly]neuropathy
Diabetic Neuropathy	**E13.44**	Other specified diabetes mellitus with diabetic amyotrophy
Diabetic Neuropathy	**E13.49**	Other specified diabetes mellitus with other diabetic neurological complication

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Spinal Cord Stimulation (SCS): 2024 Physician Coding and Reimbursement Reference

CPT® Procedure Codes for Spinal Cord Stimulation

The following CPT codes are provided as a guide for physician and practitioner reporting. Actual code(s) billed should reflect the services provided to each individual patient in the office (non-facility) or hospital/ASC (facility) setting. The Medicare fee schedules listed reflect the 2024 national average and have not been geographically wage-adjusted. Some CPT codes are subject to the multiple procedure discount rule. Providers may use Medicare's Physician Fee Schedule Search Look-up Tool, available at CMS.gov, for payment information by locality.

Procedure	CPT Code	Description	2024 Medicare Non-Facility National Average	2024 Medicare Facility National Average	Global Period
Trial	**63650**	*Percutaneous implantation of neurostimulator electrode array, epidural*	$2,236	$407	10
SCS Implant with Perc Leads	**63650**	*Percutaneous implantation of neurostimulator electrode array, epidural*	N/A	$407	10
	63685	*Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling*	N/A	$337	10
SCS Implant with Paddle Lead	**63655**	*Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural*	N/A	$838	90
	63685	*Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling*	N/A	$336	10

CY 2024 Medicare Physician Fee Schedule Final Rule, Federal Register (Regulation #CMS-1784-F), Addendum B - Relative Value Units and Related Information Used in CY 2024 Final Rule, Addendum E - Final CY 2024 Geographic Practice Cost Indices (GPCIs) by State and Medicare Locality.

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Spinal Cord Stimulation (SCS): 2024 Physician Coding and Reimbursement Reference

Procedure	CPT Code	Description	2024 Medicare Non-Facility National Average	2024 Medicare Facility National Average	Global Period
Revision	**63663**	*Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed*	$889	$444	10
	63664	*Revision including replacement, when performed, of spinal neurostimulator electrode plate/ paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed*	N/A	$886	90
	63688	*Revision or removal of implanted spinal neurostimulator pulse generator or receiver*	N/A	$380	10
Removal	**63661**	*Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed*	$675	$326	10
	63662	*Removal of spinal neurostimulator electrode plate/ paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed*	N/A	$851	90
	63688	*Revision or removal of implanted spinal neurostimulator pulse generator or receiver*	N/A	$298	10

CY 2024 Medicare Physician Fee Schedule Final Rule, Federal Register (Regulation #CMS-1784-F), Addendum B - Relative Value Units and Related Information Used in CY 2024 Final Rule, Addendum E - Final CY 2024 Geographic Practice Cost Indices (GPCIs) by State and Medicare Locality.

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Spinal Cord Stimulation (SCS): 2024 Physician Coding and Reimbursement Reference

Procedure	CPT Code	Description	2024 Medicare Non-Facility National Average	2024 Medicare Facility National Average
Programming	**95970**	*Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming*	$18	$18
	95971	*Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (e.g., sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional*	$47	$38
	95972	*…. with complex spinal cord or peripheral nerve (e.g., sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional*	$56	$39

Note: Analysis and programming of spinal cord stimulator systems may be provided by the treating physician, practitioner, or medical personnel (in accordance with the Medicare or relevant payer "incident-to" requirements) under the direct supervision of the physician (or other practitioner), with or without support from a manufacturer's representative. A physician should not bill if the service is performed by a manufacturer representative.

CY 2024 Medicare Physician Fee Schedule Final Rule, Federal Register (Regulation #CMS-1784-F), Addendum B - Relative Value Units and Related Information Used in CY 2024 Final Rule, Addendum E - Final CY 2024 Geographic Practice Cost Indices (GPCIs) by State and Medicare Locality.

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Spinal Cord Stimulation (SCS): Medicare Physician Case Examples

Medicare Reimbursement Examples

The below calculations represent the formula Medicare uses to calculate the physician reimbursement after applying the multiple procedure discount rules. These examples reflect rounded national averages, are not geographically adjusted.

SCS Trial – Site of Service: Non-Facility (Office)				
CPT 63650	**+**	**CPT 63650**	**=**	**2024 Medicare Allowable**
$2,236	**+**	**$1,118** *50% reduction applied*	**=**	**$3,354**

SCS Trial – Site of Service: Facility (ASC/Hospital)				
CPT 63650	**+**	**CPT 63650**	**=**	**2024 Medicare Allowable**
$407	**+**	**$204** *50% reduction applied*	**=**	**$611**

SCS Implant with Two Percutaneous Leads – Site of Service: Facility (ASC/Hospital)						
CPT 63650	**+**	**CPT 63650**	**+**	**CPT 63685**	**=**	**2024 Medicare Allowable**
$407	**+**	**$204** *50% reduction applied*	**+**	**$168** *50% reduction applied*	**=**	**$779**

CY 2024 Medicare Physician Fee Schedule Final Rule, Federal Register (Regulation #CMS-1784-F), Addendum B - Relative Value Units and Related Information Used in CY 2024 Final Rule, Addendum E - Final CY 2024 Geographic Practice Cost Indices (GPCIs) by State and Medicare Locality.

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Spinal Cord Stimulation (SCS): 2024 ASC Coding and Reimbursement Reference

CPT® Procedure Codes for Spinal Cord Stimulation

The following CPT codes are provided as a guide for Ambulatory Surgery Center (ASC) reporting. Actual code(s) billed should reflect the services provided to each individual patient. The Medicare Payment Rates below reflect the 2024 national average and have not been geographically or wage adjusted.

Procedure	CPT Code	Description	Subject to Multiple Procedure Discounting	*Payment Indicator	2024 Medicare National Average
Trial	**63650**	*Percutaneous implantation of neurostimulator electrode array, epidural*	N	J8	$4,952
SCS Implant with Perc Leads	**63650**	*Percutaneous implantation of neurostimulator electrode array, epidural*	N	J8	$4,952
	63685	*Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling*	N	J8	$25,298
SCS Implant with Paddle Lead	**63655**	*Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural*	N	J8	$17,994
	63685	*Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling*	N	J8	$25,298

*ASC Payment Indicator

Indicator	Descriptor
J8	Device-intensive procedure; paid at adjusted rate

2024 Payment Rate published in Addendum AA--Final ASC Covered Surgical Procedures for CY 2024, Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Final Rule (CMS-1785-CN)

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Spinal Cord Stimulation (SCS): 2024 ASC Coding and Reimbursement Reference

Procedure	CPT Code	Description	Subject to Multiple Procedure Discounting	*Payment Indicator	2024 Medicare National Average
Revision	63663	*Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed*	N	J8	$4,864
	63664	*Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed*	N	J8	$10,317
	63688	*Revision or removal of implanted spinal neurostimulator pulse generator or receiver*	N	J8	$1,898
Removal	63661	*Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed*	N	G2	$898
	63662	*Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed*	Y	G2	$1,898
	63688	*Revision or removal of implanted spinal neurostimulator pulse generator or receiver*	Y	J8	$1,898

*ASC Payment Indicator

Indicator	Descriptor
G2	Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight
J8	Device-intensive procedure; paid at adjusted rate

2024 Payment Rate published in Addendum AA--Final ASC Covered Surgical Procedures for CY 2024, Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Final Rule (CMS-1785-CN)

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Spinal Cord Stimulation (SCS): 2024 ASC Coding and Reimbursement Reference

Medicare Reimbursement Examples

The below calculations represent the formula Medicare used to calculate the allowable when multiple procedures are billed. These examples reflect rounded national averages, are not geographically adjusted.

SCS Trial				
CPT 63650	+	CPT 63650	=	2024 Medicare Allowable
$4,952	+	$4,952	=	$9,904

SCS Implant with Two Percutaneous Leads						
CPT 63685	+	CPT 63650	+	CPT 63650	=	2024 Medicare Allowable
$25,298	+	$4,952	+	$4,952	=	$35,202

SCS Implant with Paddle Lead				
CPT 63685	+	CPT 63655	=	2024 Medicare Allowable
$25,298	+	$17,994	=	$43,292

2024 Payment Rate published in Addendum AA--Final ASC Covered Surgical Procedures for CY 2024, Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Final Rule (CMS-1785-CN)

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Spinal Cord Stimulation (SCS): 2024 Outpatient Hospital Coding and Reimbursement Reference

CPT® Procedure Codes for Spinal Cord Stimulation

The following CPT codes are provided as a guide for hospital outpatient department (HOPD) reporting. Actual code(s) billed should reflect the documented services provided to each individual patient. The Medicare Outpatient Prospective Payment System (OPPS) payment rates listed are a national average and have not been geographically adjusted.

Comprehensive APCs

Effective January 1, 2015, the Centers for Medicare and Medicaid Services (CMS) formed Comprehensive APCs (C-APCs) for hospital outpatient payment of device-intensive procedures, including spinal cord stimulation therapy implant, revision and replacement procedures. CMS established status indicator "J1" to designate CPT codes assigned to C-APCs. Note that, generally, all other items and services reported on the same claim are considered adjunctive services and included in the single C-APC payment rate. If there are cases with multiple J1 status indicator CPT codes on a single claim, the C-APC payment is made for the primary CPT code, which typically is the code with the highest cost per the OPPS Addendum J ranking. The result is a single C-APC payment for the comprehensive service based on all included charges on the claim.

Procedure	CPT Code	Description	MUE	SI	APC	2024 Medicare National Average
Trial	**63650**	*Percutaneous implantation of neurostimulator electrode array, epidural*	2	J1	5462	$6,523
SCS Implant with Perc Leads	**63650**	*Percutaneous implantation of neurostimulator electrode array, epidural*	2	J1	5462	$6,523 *Included in C-APC*
	63685	*Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling*	1	J1	5465	$29,617

2024 Payment Rate published in Addendum B Update - OPPS Payment by HCPCS Code for CY 2024, Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Final Rule (CMS-1785-CN)

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Spinal Cord Stimulation (SCS): 2024 Outpatient Hospital Coding and Reimbursement Reference

Procedure	CPT Code	Description	MUE	SI	APC	2024 Medicare National Average
SCS Implant with Paddle Lead	**63655**	*Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural*	1	J1	5464	$20,865 *Included in C-APC*
	63685	*Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling*	1	J1	5465	$29,617
Revision	**63663**	*Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed*	1	J1	5462	$6,523
	63664	*Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed*	1	J1	5463	$12,993
	63688	*Revision or removal of implanted spinal neurostimulator pulse generator or receiver*	1	J1	5461	$3,245
Removal	**63661**	*Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed*	1	Q2	5431	$1,841.54
	63662	*Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed*	1	J1	5461	$3,245
	63688	*Revision or removal of implanted spinal neurostimulator pulse generator or receiver*	1	J1	5461	$3,245

2024 Payment Rate published in Addendum B Update - OPPS Payment by HCPCS Code for CY 2024, Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Final Rule (CMS-1785-CN)

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Spinal Cord Stimulation (SCS): 2024 Outpatient Hospital Coding and Reimbursement Reference

OPPS Status Indicators[6]

Status Indicator	OPPS Payment Status
J1	Hospital Part B services paid through a comprehensive APC.
Q1	STV-packaged codes, paid under OPPS, packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "S", "T", or "V".
Q2	T-packaged codes, paid under OPPS, packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "T".
S	Procedure or service, not discounted when multiple

Medicare Reimbursement Examples

The below calculations represent the formula Medicare uses to calculate the allowable payment amount when multiple procedures are billed. These examples reflect rounded national averages, are not geographically adjusted, and are for illustrative purposes only.

SCS Trial				
CPT 63650	**+**	**CPT 63650**	**=**	**2024 Medicare Allowable**
$6,523 *Paid per C-APC 5462*	**+**	**$0** *Inclusive of C-APC 5462*	**=**	**$6,523**

SCS Implant with Two Percutaneous Leads						
CPT 63685	**+**	**CPT 63650**	**+**	**CPT 63650**	**=**	**2024 Medicare Allowable**
$29,617 *Paid per C-APC 5465*	**+**	**$0** *Inclusive of C-APC 5462*	**+**	**$0** *Inclusive of C-APC 5462*	**=**	**$29,617**

SCS Implant with Paddle Lead				
CPT 63685	**+**	**CPT 63655**	**=**	**2024 Medicare Allowable**
$29,617 *Paid per C-APC 5465*	**+**	**$0** *Inclusive of C-APC 5462*	**=**	**$29,617**

2024 Payment Rate published in Addendum B Update - OPPS Payment by HCPCS Code for CY 2024, Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Final Rule (CMS-1785-CN)

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Introduction to HFX Access™

Nevro's patient access program, HFX Access, is available to assist patients in navigating the prior authorization process for HFX SCS Therapy.

Access can support your patients' pathway to approval including:

- ✓ Prior Authorization / Pre-Determination
- ✓ Denial Support through internal and external appeal process including indication-specific toolkits
- ✓ Billing / Coding / Coverage questions

HFX Access: By the Numbers

With over **30,000** SCS Prior Authorizations processed by our team, HFX Access is a proven solution for patient access with quick processing time, high approval rates, and strong appeal win rates.

90%	75%	>50%
Cases submitted in the first 48 hours*	Approval Rate at Initial Prior Authorization*	Appeal Rate Success*

Please contact your local Nevro Representative or email HFXAccess@nevro.com for more information or to enroll.

* Source: Data on File. Submissions dependent on complete information received and individual approval rates may vary depending on payer and geographic location.

Enrolling with HFX Access™

Nevro HFX Access team helps manage the process to get Patients access to HFX SCS Therapy.

Enrollment Process

Preferred Method: Patient Authorization Form

We require a signed Patient Authorization Form for each case to provide consent for HFX Access to work on behalf of the patient. It allows our team to work with the patient's care team, including their PCP, to support Prior Authorization and Appeal submissions.

Patient Authorization Form

Documentation to Submit to HFX Access:

- ✓ Completed Patient Authorization Form (signed by the patient)
- ✓ Completed Intake Form
- ✓ Demographics Sheet
- ✓ Psychological Evaluation
- ✓ Clinical Records that support medical necessity (6 months or more is highly preferred)
- ✓ Imaging reports if applicable
- ✓ Surgical Consult or Evaluation if required (Example here)
- ✓ Any insurance correspondence or letters about the patient's case

SCS Intake Form

Alternate Method: Signed Business Associate Agreement (BAA)

If you prefer a BAA instead of the Patient Authorization Form, please contact your Nevro representative to begin the alternative enrollment process.

Note: If the Prior Authorization is denied, we will need a signed and completed Patient Authorization Form to initiate the patient appeal process.

Helpful Resources

Payer Policy Tool	Customized reports with summarized coverage language for your Top 5 Payers and Medicare.	Contact Nevro Market Access
Additional Payer Resources	Payer resources such as Appeal Letter Templates, Letters of Medical Necessity, and Coverage Checklists	Contact Nevro Market Access

Patient Authorization Form

What is it?

The Patient Authorization Form is signed by a patient to provide consent for HFX Access to release their medical information to the payer.

Why is it important?

When a patient signs this form, HFX Access can submit paperwork on their behalf to seek prior authorization with the payer and act as their designated representative to appeal the health plan's decision if they don't approve the prior authorization request.

When is it required?

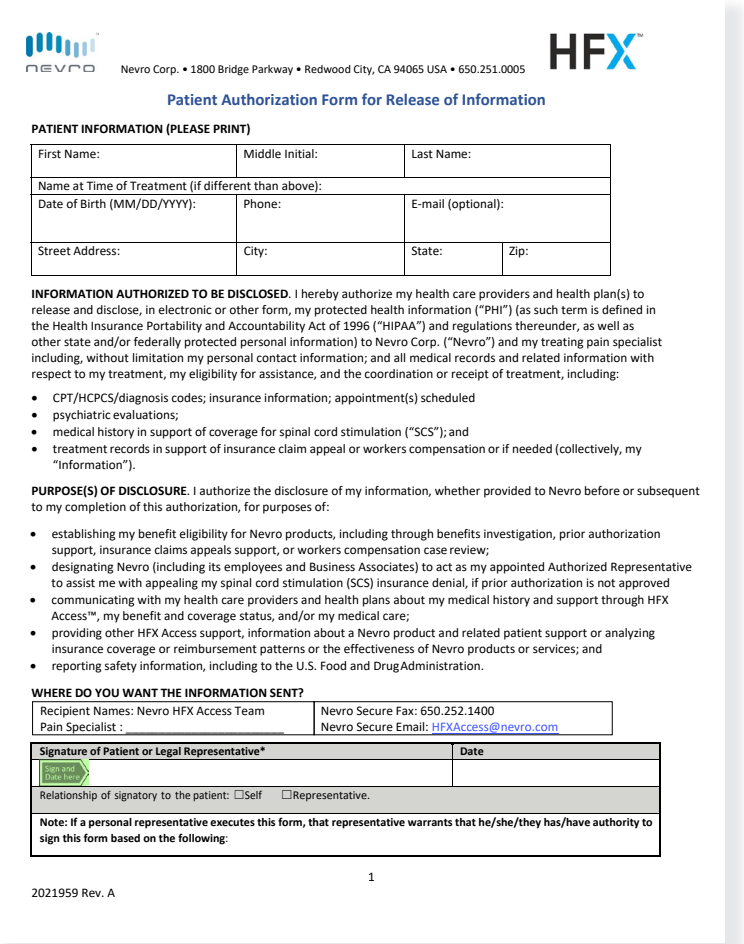
Receiving the patient authorization form all patients is preferred as it speeds up the turnaround time, but is required if the prior auth is not initiated by the treating physician (e.g. initiated by a PCP).

If we have a fully executed BAA in place → The Patient Authorization Form is not required for initial patient submission.

However, we will need it to be signed to support any patient appeals so we can act as the patient's designated representative to appeal the health plan's decision if they don't approve the prior authorization request.

If we don't have a BAA in place →
Please send this form in with all cases.

The Patient Authorization Form can be found here.



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HFX

Patient Authorization Form for Release of Information

PATIENT INFORMATION (PLEASE PRINT)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:

INFORMATION AUTHORIZED TO BE DISCLOSED. I hereby authorize my health care providers and health plan(s) to release and disclose, in electronic or other form, my protected health information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations thereunder, as well as other state and/or federally protected personal information) to Nevro Corp. ("Nevro") and my treating pain specialist including, without limitation my personal contact information; and all medical records and related information with respect to my treatment, my eligibility for assistance, and the coordination or receipt of treatment, including:

- CPT/HCPCS/diagnosis codes; insurance information; appointment(s) scheduled
- psychiatric evaluations;
- medical history in support of coverage for spinal cord stimulation ("SCS"); and
- treatment records in support of insurance claim appeal or workers compensation or if needed (collectively, my "Information").

PURPOSE(S) OF DISCLOSURE. I authorize the disclosure of my information, whether provided to Nevro before or subsequent to my completion of this authorization, for purposes of:

- establishing my benefit eligibility for Nevro products, including through benefits investigation, prior authorization support, insurance claims appeals support, or workers compensation case review;
- designating Nevro (including its employees and Business Associates) to act as my appointed Authorized Representative to assist me with appealing my spinal cord stimulation (SCS) insurance denial, if prior authorization is not approved
- communicating with my health care providers and health plans about my medical history and support through HFX Access™, my benefit and coverage status, and/or my medical care;
- providing other HFX Access support, information about a Nevro product and related patient support or analyzing insurance coverage or reimbursement patterns or the effectiveness of Nevro products or services; and
- reporting safety information, including to the U.S. Food and DrugAdministration.

WHERE DO YOU WANT THE INFORMATION SENT?

Recipient Names: Nevro HFX Access Team Pain Specialist : _____	Nevro Secure Fax: 650.252.1400 Nevro Secure Email: HFXAccess@nevro.com

Signature of Patient or Legal Representative*	Date
Sign and Date here	
Relationship of signatory to the patient: ☐Self ☐Representative.	
Note: If a personal representative executes this form, that representative warrants that he/she/they has/have authority to sign this form based on the following:	

1

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Nevro's HFX Access™ Intake Form

Page 1: Patient Demographics and Physician Information

The purple fields are editable, so you can save a copy with the physician and facility information pre-populated!

Page 2: Checklist for applicable CPTs and HCPCS for Prior Authorization

The form is categorized by procedure type (SCS Trial, SCS Perm, SCS Revision/Replacement/Removal) to streamline your PA request.

Page 3: Checklist for ICD-10 Diagnosis Codes

We included a list of commonly used ICD-10s Diagnosis Codes for SCS, including Painful Diabetic Neuropathy (PDN) to make it easier for you. If you don't see the applicable codes listed, please complete "other" please specify.

Page 4: Patient Treatment History

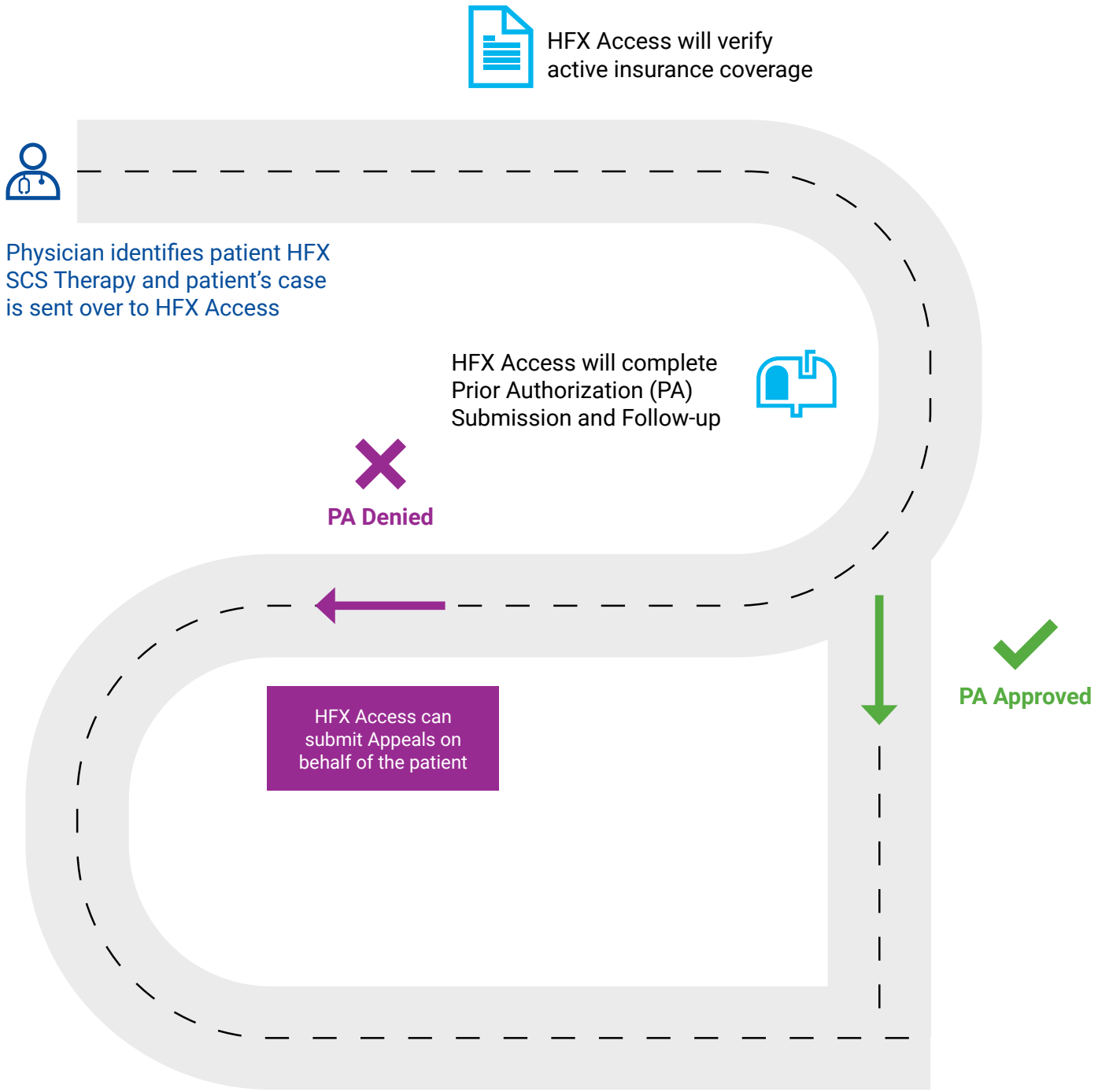
This is a new page and it's intended to serve as a coversheet to help highlight that your patient has met the medical necessity guidelines for SCS Therapy. We organized this page to match the type of information that payers are looking for during their review of the clinical documents.

This page is ***optional***; however, we highly encourage you to complete to the best of your ability as it will help streamline the PA request and reduce payer denials due to missing information.

Page 5: Physician Attestation (signature page)

This page is ***optional*** as well; however, by signing this packet, we can submit the full intake form as part of the clinical records to the payer!

Prior Authorization (PA) Journey with HFX Access™



What happens if prior authorization is denied?

Patients have the right to appeal a payer's denial through the following pathway:

First Level Internal Appeal and/or Peer to Peer

HFX Access™ can submit an appeal letter with clinical documentation to demonstrate medical necessity.

Second Level Internal Appeal

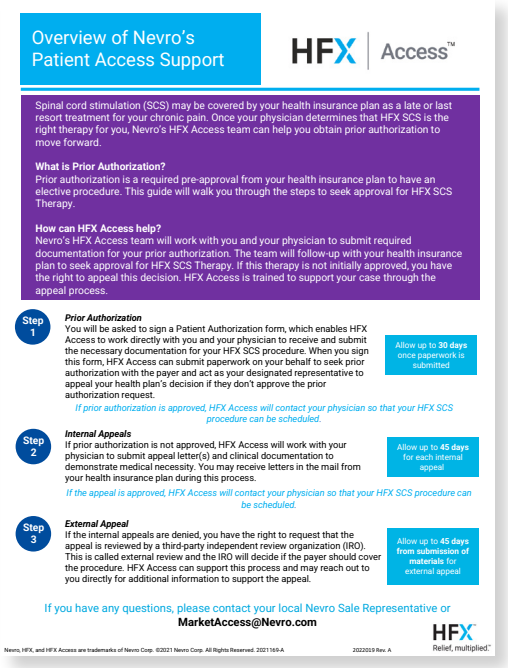
Payers typically allow two levels of internal appeals to establish medical necessity

External Review

If the internal appeals are denied, patients have the right to request that the appeal is reviewed by a third-party independent review organization (IRO). The decision made by the IRO is binding for all parties.

Allow up to 45 days each internal appeal

Allow up to 45 days from submission of materials for external appeal



Overview of Nevro's Patient Access Support

HFX Access™

Spinal cord stimulation (SCS) may be covered by your health insurance plan as a late or last resort treatment for your chronic pain. Once your physician determines that HFX SCS is the right therapy for you, Nevro's HFX Access team can help you obtain prior authorization to move forward.

What is Prior Authorization?
Prior authorization is a required pre-approval from your health insurance plan to have an elective procedure. This guide will walk you through the steps to seek approval for HFX SCS Therapy.

How can HFX Access help?
Nevro's HFX Access team will work with you and your physician to submit required documentation for your prior authorization. The team will follow-up with your health insurance plan to seek approval for HFX SCS Therapy. If this therapy is not initially approved, you have the right to appeal this decision. HFX Access is trained to support your case through the appeal process.

Step 1 — *Prior Authorization*
You will be asked to sign a Patient Authorization form, which enables HFX Access to work directly with you and your physician to receive and submit the necessary documentation for your HFX SCS procedure. When you sign this form, HFX Access can submit paperwork on your behalf to seek prior authorization with the payer and act as your designated representative to appeal your health plan's decision if they don't approve the prior authorization request.
Allow up to **30 days** once paperwork is submitted
If prior authorization is approved, HFX Access will contact your physician so that your HFX SCS procedure can be scheduled.

Step 2 — *Internal Appeals*
If prior authorization is not approved, HFX Access will work with your physician to submit appeal letter(s) and clinical documentation to demonstrate medical necessity. You may receive letters in the mail from your health insurance plan during this process.
Allow up to **45 days** for each internal appeal
If the appeal is approved, HFX Access will contact your physician so that your HFX SCS procedure can be scheduled.

Step 3 — *External Appeal*
If the internal appeals are denied, you have the right to request that the appeal is reviewed by a third-party independent review organization (IRO). This is called external review and the IRO will decide if the payer should cover the procedure. HFX Access can support this process and may reach out to you directly for additional information to support the appeal.
Allow up to **45 days from submission of materials** for external appeal

If you have any questions, please contact your local Nevro Sale Representative or **MarketAccess@Nevro.com**

HFX Relief, multiplied.™

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Nevro has an overview one-pager to help your patients navigate the PA process

Frequently Asked Questions

When obtaining prior authorization for an IPG replacement, should both CPT 63688 (IPG removal) and 63685 (PG insertion) be used?

For an IPG replacement, the applicable CPT would be 63685 *(Insertion or* ***replacement*** *of spinal neurostimulator pulse generator or receiver, direct or inductive coupling)*.

CPT 63688 should only be used if there is an IPG Revision and/or removal (with no replacement).

Centers for Medicare and Medicaid Services (CMS) maintains procedure to procedure (PTP) edits, which is a list of procedures that cannot be "performed at the same patient encounter because the two procedures were mutually exclusive based on anatomic, temporal, or gender considerations."

There is a PTP edit for billing both CPT 63685 and 63688 together and this information can be found in the latest NCCI section of the CMS website. There is a National Correct Coding Initiative (NCCI) edit if these two CPTs are billed together.

Click here for CMS' PTP Edits

Is it standard to code two units of CPT 63685 (PG insertion)?

Centers for Medicare and Medicaid Services (CMS) has an edit, called an MUE, which stands for Medically Unlikely Edits. **MUEs are the maximums on the number of units of service per CPT code that can be reported by a provider for a patient on the same date of service**. It's common for commercial payers to also follow these guidelines. Below are the MUEs for the most common SCS CPTs. We also list the MUEs for all SCS CPTs in our Outpatient Hospital Reimbursement and Coding Guide. These are applicable for all sites of service, including physician billing.

Click here for more CMS information

CPT	Short Descriptor	MUE
63650	Percutaneous implantation of neurostimulator electrode array, epidural	2
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	1
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epi-dural	1

Can I obtain a prior authorization for a lead replacement with both CPT 63661 (perc lead removal) and 63650 (perc lead insertion)?

For a perc lead replacement, the applicable CPT would be 63663 (*revision including* ***replacement****, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed*).

Centers for Medicare and Medicaid Services (CMS) maintains Procedure to Procedure (PTP) edits, which is a list of procedures that cannot be "performed at the same patient encounter because the two procedures were mutually exclusive based on anatomic, temporal, or gender considerations."

There is a PTP edit for billing both CPT 63661 and 63650 together and this information can be found in the latest NCCI section of the CMS website. There is a National Correct Coding Initiative (NCCI) edit if these two CPTs are billed together.

Click here for CMS' PTP Edits

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Frequently Asked Questions

Is L8680 (implantable neurostimulator electrode) separately payable?

It depends on the payer and your commercial contracts.

For Traditional Medicare: L8680 (Implantable neurostimulator electrode, each) is no longer covered by CMS (Medicare) as of 4/1/2014 and the cost of leads is considered bundled into procedure CPT 63650.

Commercial or Other Payers: Depending on the facility or office's contract, L8680 may be separately payable. Nevro does not have any visibility to commercial contracts.

What diagnosis code(s) should I use to have a case be approved?

Nevro cannot provide guidance on what diagnostic codes to use for a patient. However, please refer to the list of commonly used diagnostic codes for SCS procedures on pages 15-17. This list is not exhaustive and diagnostic coding selection must be based on the medical judgment of the provider.

What are the commercial payer requirements for a psychological evaluation? Are online assessments acceptable?

Typically, the payer will include information in their SCS Medical Policy about what they are looking for in the evaluation. For Medicare, refer to the Medicare Learning Network article MLN1986542 for guidance on Medicare Mental Health including eligible professions.

For commercial payers, individual policy language may vary, for example, Cigna's policy has the following language:

"*An attestation by a behavioral health provider (i.e., a face-to-face or virtual assessment with or without psychological questionnaires and/or psychological testing) reveals no evidence of an inadequately controlled mental and/or behavioral health conditions/issues (i.e., substance use disorders, depression, or psychosis) that would impact perception of pain and/or negatively impact the success of a SCS or contraindicate placement of the device*"

It is recommended to pull the applicable policy to reference what is required for submission.

Are any requirements on how old the psych evaluation can be?

None of the payers have specific guidelines on how old a psych evaluation can be for submission. If there are questions or concerns, contact the payer directly. HFX Access can try and submit with what is provided but there can be no guarantees of validity.

What information is required to demonstrate that the patient had a successful trial?

Most payers consider a trial to be successful if the patient experiences at least 50% pain relief. The payer's SCS medical policy may also provide guidance about how long the SCS trial should last (i.e. 3 to 7 days). Lastly payers, such as Anthem BCBS (Carelon), also expect documentation of functional improvement. We recommend reviewing the payer's SCS policy for specific information pertaining to their expectations.

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Frequently Asked Questions

What is Medicare's general turnaround time for prior authorization (PA)?

For Medicare's Prior Authorization Requirement (PAR) effective July 1, 2021, the Medicare Administrative Contractors (MACs) are expected to send their initial decision within **10 business days** following the receipt of the initial request. If additional information is requested and there needs to be a resubmission, the timeline is also **10 business days**. This information can be found at CMS' Prior Authorization (PA) Program for Certain Hospital Outpatient Department (OPD) Services - Operational Guide.

For Commercial payers, turnaround time can vary depending on case volume and payer-specific workflows, however it is common for prior authorizations to be processed anywhere between 7 – 21 days.

If the trial is done at the same hospital with the same physician, does Medicare require a prior authorization for the permanent implant as well?

No, they don't need a second prior authorization pursuant to the following language from CMS:

- "*Providers who plan to perform both the trial and permanent implantation procedures using CPT code 63650 in the OPD will only require prior authorization for the trial procedure.*"
- *"When the trial is rendered in a setting other than the OPD, providers will need to request prior authorization for CPT code 63650 as part of the permanent implantation procedure in the hospital OPD.*"

Click here for CMS Prior Authorization Pogram

Which sites of service require Medicare prior authorization?

The information from Medicare's Prior Authorization FAQs, can be found online here. If your facility is billing as an outpatient hospital or on a type of bill 13X, then prior authorization is required.

What provider types require prior authorization for these services?

Only hospital OPD services require prior authorization as part of this program. Other facility/provider types such as physician's offices, critical access hospitals, or ambulatory surgery centers that submit claims other than type of bill 13X are not required to submit prior authorization requests.

The full Operational Guide can be found online here.

If the ASC is participating in Medicare's ***Hospital without Walls*** program which was activated for the COVID-19 public health emergency, then prior authorization is required for Medicare beneficiaries.

Click here for more information

Does Nevro offer a product donation / patient assistance program?

Yes, we do! The program overview and application are available online under the Providers section of the Nevro website. The applicable documentation must be completed by the patient, physician, and facility rendering the services.

Application Link

What is Nevro's warranty on our IPG?

Nevro's IPGs are covered by a five year warranty from the date of implantation. Tech Services can assist with any questions specific to our warranties.

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