2021 Quick Reference Guide

BARRICAID®

Hospital Outpatient 2021

Coding and Payment Guide for Medicare Reimbursement: The following are the 2021 Medicare coding and national payment rates for the Barricaid procedures performed in the outpatient hospital setting. Comprehensive Ambulatory Payment Classification (C-APCs) are effective for services performed in an Outpatient Hospital. A C-APC is a single all-inclusive payment for a primary device dependent service and all adjunct services provided to support the delivery of the primary service.

HCPCS Level II Descriptors[1,2,3]

HCPCS	Description	APC[4]	Status Indicator[5]	National Average Payment[6]
Barricaid Procedure				
C9757	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar.	5115	J1	$12,314.76
C9757 is the procedure code used to describe the combined procedure(s) of a lumbar discectomy AND the insertion of the Barricaid Annular Closure Device. New code implemented by CMS on JAN-1-2020 to enable facility payment for Barricaid use.				

Revenue Codes[7]		
HCPCS	Description	Revenue Code
C9757	OR Services	0360
C1713	Anchor/screw bn/bn, tis/bn	0278

Please see Instructions for Use, indications for use, contraindications, warnings, and precautions. US FDA PMA P160050 www.barricaid.com/instructions/

Disclaimer: This reimbursement information is provided by Intrinsic for informational purposes only. This is not an affirmative instruction as to which codes and modifiers to use for a particular service or item. Any coding, coverage, and payment information contained herein is gathered from various resources and is subject to change without notice. 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. Intrinsic recommends that you consult with your payors, reimbursement specialists and/or legal counsel regarding coding, coverage, and reimbursement matters. 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. Medicare device edits link: http://www.cms.gov/HospitalOutpatientPPS/02_device_procedure.asp. Please verify with local payers for specific device coding requirements
3. C-codes are required for billing Medicare outpatient procedures with the applicable CPT codes, but are not separately payable by Medicare.
4. 2-42 CFR Parts 411, 412, 416, 419, 422, 423, and 424 [CMS-1736-FC]
5. S: Procedure or Service, Not Discounted When Multiple; J1: Hospital Part B services paid through a comprehensive APC.
6. 2021 Medicare National Average payment rates, unadjusted for wage. "National Average Payment" is the amount Medicare determines to be the maximum allowance for any Medicare covered procedure. Actual payment will vary based on the maximum allowance less any applicable deductibles, co-insurance etc.
7. National Uniform Billing Committee (NUBC) /American Hospital Association (AHA). https://www.nubc.org/

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