Revi

2025 Coding & Reimbursement Guide

Blue Wind MEDICAL

MKL-0165 Rev. 06 August 2025

Medicare 2025 National Payment

DIAGNOSIS CODING	
N39.41	Urge Incontinence.
R39.15	Urgency of urination.
Z45.42	Encounter for adjustment and management of neurostimulator.

CPT[1]	CPT Description	Physician[2]	Hospital Outpatient[3]		Ambulatory Surgical Center[3]	
			Status Indicator	Payment	Status Indicator	Payment
0817T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (e.g., array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; **subfascial.**	MAC Priced	J1	$21,444	J8	$19,839
0819T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; **subfascial.**	MAC Priced	J1	$3,439	G2	$1,944
Hospital Part B services Status Indicator J1 and ASC Status Indicators J8/G2: All covered services are packaged and paid through a comprehensive payment amount.						
0589T	Electronic analysis with simple programming of implanted integrated neurostimulation system for bladder dysfunction [eg, electrode array and receiver], including contact group[s], amplitude, pulse width, frequency [Hz], on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, **1-3 parameters**.	MAC Priced	N/A	N/A	N/A	N/A
0590T	Electronic analysis with complex programming of implanted integrated neurostimulation system for bladder dysfunction [eg, electrode array and receiver], including contact group[s], amplitude, pulse width, frequency [Hz], on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, **4 or more parameters**.	MAC Priced	N/A	N/A	N/A	N/A

HCPCS Codes

Healthcare Common Procedure Coding System (HCPCS)[4] Level II codes should be reported for all device-intensive procedures performed in the outpatient setting. HCPCS codes are utilized by facilities to report costs associated with supplies. While HCPCS codes do not generally result in additional payment, it is important for facilities to report HCPCS codes for the supply of the device codes for future rate-setting purposes. Private payers should be referenced for specific HCPCS reimbursement and reporting requirements.

In addition to the CPT code for the procedure, facilities should report the following HCPCS indicating the supply of the Revi® Implantable Tibial Neuromodulation Device:

Device Code Hospital or ASC Outpatient Only

HCPCS	HCPCS Description
C1767 (Medicare-Hospital Only)	Generator, neurostimulator (implantable), non-rechargeable.
L8679 (Non-Medicare)	Implantable neurostimulator pulse generator, any type.

Category III CPT Codes for Physician and Outpatient Facilities

Physicians and outpatient facilities use Current Procedural Terminology (CPT®) codes to report procedures and services. The American Medical Association has established Category III CPT codes for reporting the subfascial insertion, replacement, revision, and removal of the Revi® Implantable Tibial Neuromodulation Device. Category III CPT codes are used for emerging technology, services, and procedures, and enable physicians and outpatient facilities to report accurately and provide data on clinical efficacy, utilization, and outcomes.

For physicians, Category III CPT codes are considered Medicare Administrative Contractor (MAC) priced therefore each MAC will assign their own payment rates. Each MAC may establish physician reimbursement on their contractor physician fee schedule or on a per case basis.

Medicare reimburses Hospital Outpatient Departments (HOPDs) for services under the Ambulatory Payment Classification (APC) system. Each CPT code is assigned to an APC based on clinical and resource homogeneity, and each APC is assigned a payment rate in the Outpatient Prospective Payment System (OPPS) as well as a payment Status Indicator. Ambulatory Surgical Centers (ASCs) are reimbursed by Medicare according to a fee schedule assigned to each individual CPT code.

For private payer claims, providers should reference payer guidelines for any specific Category III CPT code billing requirements. Private payers reimburse physicians and outpatient facilities at negotiated/contracted rates.

Physician Reporting of Category III CPT Codes

When reporting Category III CPT codes, physicians can include a crosswalk to a Category I CPT code with an established national payment and Relative Value Units (RVUs) to facilitate reimbursement. This crosswalk procedure should have similar time, physician work and complexity to the procedure performed utilizing the Revi® Implantable Tibial Neuromodulation Device.

When providing a CPT crosswalk, information submitted with the claim should include:

- A brief statement identifying a comparable procedure CPT code, its Medicare RVUs and payment, along with information outlining the similarities and differences between the procedures and anticipated payment
- Office notes to support medical necessity.
- Operative report detailing the procedure including the time, work, and resources involved.
- A copy of the FDA approval letter and any relevant published clinical literature.
- Additionally, physicians may consider providing a clinical and resource comparison to alternative treatments.

Sample Revi CMS-1500 Claim Form

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME O

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

19
Category III CPT Code Example Comments

READ ... E COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED ... RE. I authorize the release of any medical or other information necessary to process this claim. I also requ... ment benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

CPT 0817T is similar in work and time to CPT XXXXX

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. N39.41 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
				0817T					NPI	
									NPI	
									NPI	
									NPI	
									NPI	
									NPI	

21A
Example Diagnosis Code

24D
Example Procedure Code for Revi

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

Facility Billing

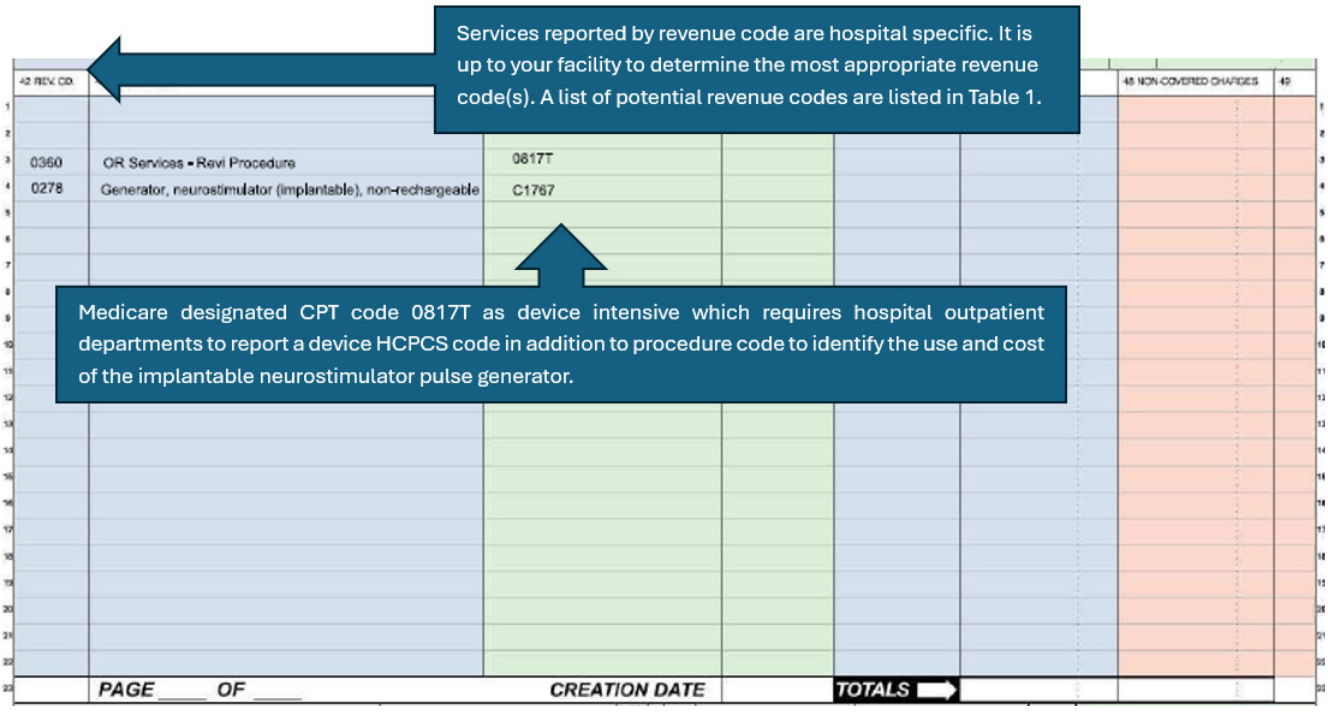
Revenue Codes

Facility billing staff should confirm the appropriate revenue codes to use at their facility. The following revenue codes may be appropriate for reporting components of the Revi procedure:

Code	Description
0278	Medical/surgical supplies and devices - other implants
0360	Operating room services - general
0361	Operating room services – minor surgery
0490	Ambulatory surgical care – general
0510	Clinic – general classification
0519	Clinic – other clinic

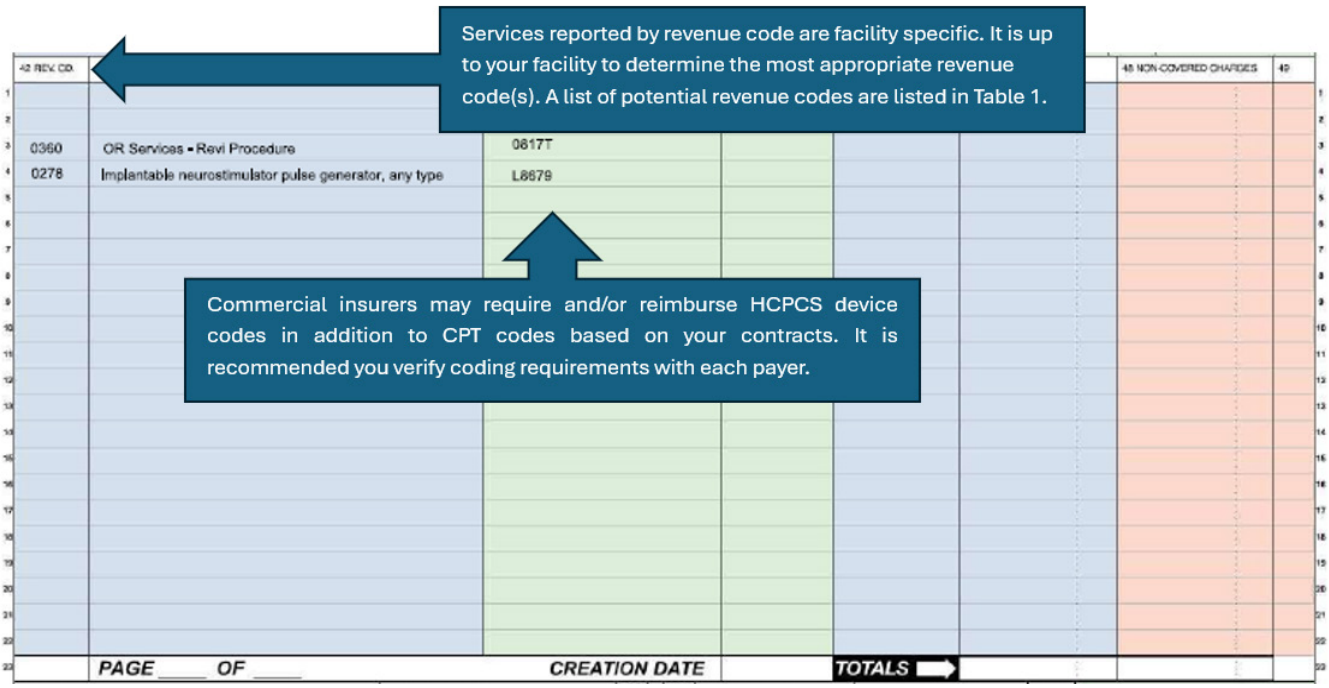
Sample Hospital Outpatient Claim Forms

Hospital Outpatient Medicare Billing



Sample Ambulatory Surgery Center Claim Forms

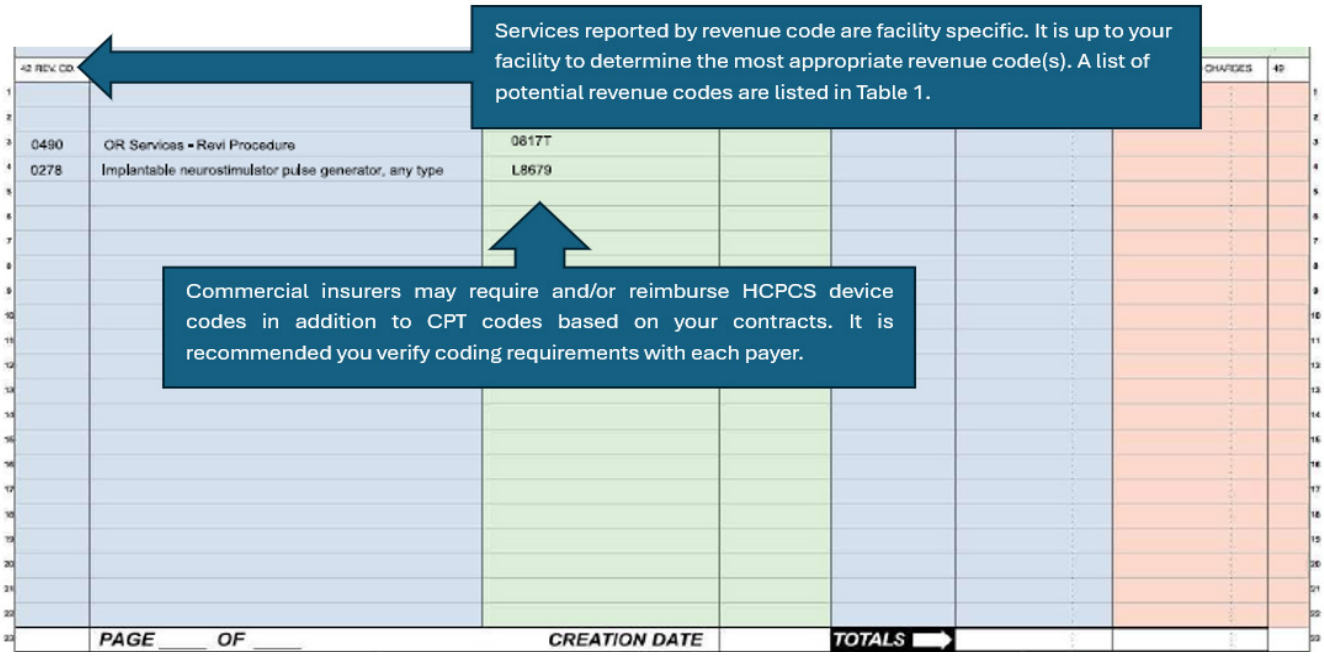
Hospital Non-Medicare Outpatient Billing



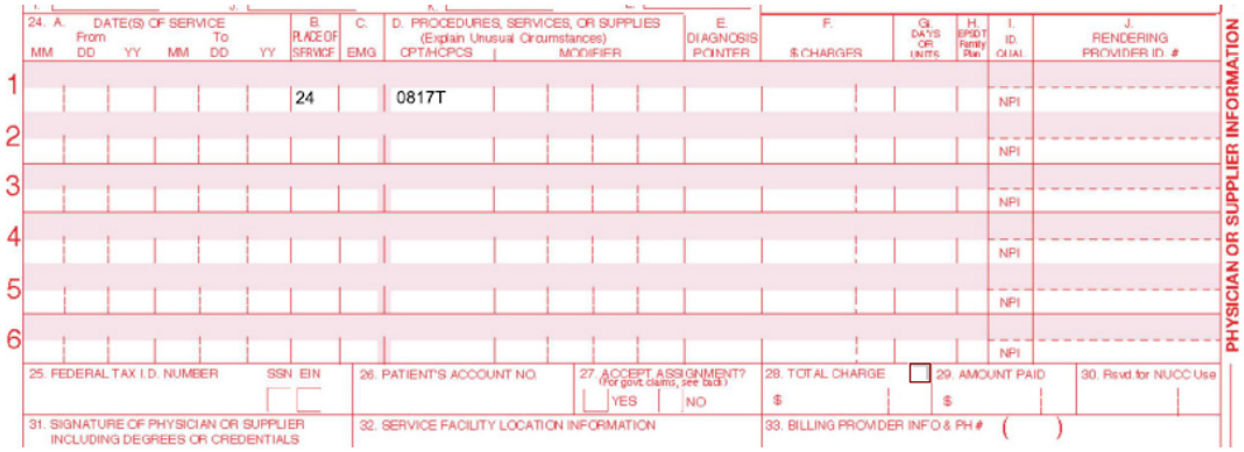
Hospital-Based Ambulatory SurgerCenter Medicare Outpatient Billing

Sample Ambulatory Surgery Center Claim Forms

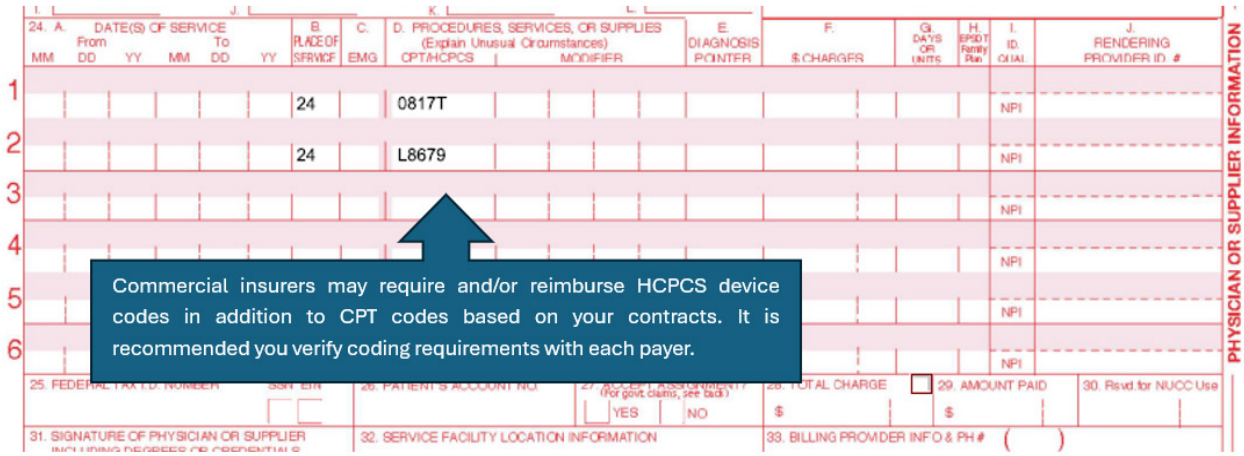
Hospital-Based Ambulatory Surgery Center Non-Medicare Outpatient Billing



Freestanding Ambulatory Surgery Center Medicare Outpatient Billing



Freestanding Ambulatory Surgery Center Non-Medicare Outpatient Billing



Revi Access

Revi Access, powered by JDL Access, is BlueWind Medical's patient access program designed to support physicians and patients through the insurance coverage process for Revi. Experienced patient advocates work closely with physician offices to facilitate prior authorizations, pre-service appeals, and post-service claims appeals, while providing updates through a HIPAA-compliant platform.

For questions about Revi Access, please contact us at:

Phone: (844)-610-4784
Email: reviaccess@jdlaccess.com

For general reimbursement questions, please email us at:

reimbursement@bluewindmedical.com

Indications for Use:

The Revi System is indicated for the treatment of patients with symptoms of urgency incontinence alone or in combination with urinary urgency.

Contraindications:

- Are unable, or do not have the necessary assistance, to operate the Revi System.
- Are men who have obstructive Benign Prostatic Hyperplasia (BPH) or other lower urinary tract obstructions.
- Are implanted with any metallic implant in the immediate area (8 in/20 cm distance) intended for implantation.
- Have nerve damage that could impact treatment.
- Are at high surgical risk or patients with multiple illnesses or active general infections that expose them to excessive bleeding or delayed or non-healing wounds.
- Have known allergies to one of the implant materials (see implant specification in the Surgical Technique Guide).
- Are pregnant.
- Have open wounds or sores on the lower leg or foot.
- Had prior surgery in the implant area.
- Had previous, unhealed trauma in the implant area.
- Have pitting edema (≥2+) in the lower leg.
- Have Venous disease/insufficiency in the lower leg.
- Have Arterial disease/insufficiency in the lower leg.
- Have Vasculitis or dermatologic conditions in the lower leg.
- Have infections near the implantation site in the lower leg.

References:

1. 2025 CPT® Professional Edition. Current Procedural Terminology (CPT®) is copyright 2025 by the American Medical Association, Chicago, IL. CPT is a registered trademark of the American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
2. CMS 1807-F, 2025 Medicare Physician Fee Schedule Final Rule.
3. CMS-1809-FC, 2024 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Final Rule with Correction Notice.
4. 2025 HCPCS Level II Expert. Copyright 2025 AAPC.

The information contained in this guide is presented for illustrative purposes only and is subject to change without notice. BlueWind Medical makes no statement, promise, or guarantee regarding reimbursement nor does this constitute legal advice. It is always the responsibility of the provider to determine if the services provided are accurately described by any specific code(s) and to report services consistent with specific payer requirements. In all cases, services billed must be medically necessary, actually performed as reported and appropriately documented in the medical record. Payer policies vary and should be verified prior to treatment. Payment rates provided are Medicare national unadjusted payments.

Disclaimer: Information contained in this document is publicly available obtained from third-party sources. Although we have made every effort to provide information that is current at the time of its issue, it is subject to change at any time. It is recommended that you consult your legal counsel, reimbursement/compliance advisor and/or payer organization(s) for interpretation of payer-specific coding, coverage, and payment expectations. Content does not constitute medical, legal or reimbursement advice or direction to the provider. Nothing herein constitutes any promise or guarantee of payment.The provider uses independent judgement and is solely responsible for determining appropriate treatment for the patient based on the unique medical needs of each patient. It is the responsibility of the provider to determine appropriate coding, medical necessity, site of service, documentation requirements and payment levels, and to submit the relevant codes, modifiers and charges for services rendered. Any claims for services submitted by the provider should be appropriately and accurately consistent with FDA approved labeling. BlueWind Medical does not promote the use of its products outside of their FDA approved labeling.