

*Revi*



## 2026 Coding & Reimbursement Guide

## Medicare 2026 National Payment

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

CPT <sup>1</sup>	CPT Description	Physician <sup>2</sup>	Hospital Outpatient <sup>3</sup>		Ambulatory Surgical Center <sup>3</sup>	
			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; <b>subfascial</b> .	MAC Priced	J1	\$19,820	J8	\$16,728
0819T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; <b>subfascial</b> .	MAC Priced	J1	\$3,572	G2	\$2,003

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, <b>1-3 parameters</b> .	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, <b>4 or more parameters</b> .	MAC Priced	N/A	N/A	N/A	N/A

## HCPCS Codes

Healthcare Common Procedure Coding System (HCPCS)<sup>4</sup> 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<sup>®</sup> 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<sup>®</sup>) 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<sup>®</sup> 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<sup>®</sup> 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.









## 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](mailto:reviaccess@jdlaccess.com)

### For general reimbursement questions, please email us at:

[reimbursement@bluewindmedical.com](mailto:reimbursement@bluewindmedical.com)

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## 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 ( $\geq 2+$ ) 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.

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## References:

1. 2026 CPT® Professional Edition. Current Procedural Terminology (CPT®) is copyright 2026 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 1832-F, 2026 Medicare Physician Fee Schedule Final Rule.
3. CMS-1834-FC, 2026 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Final Rule with Correction Notice.
4. 2026 HCPCS Level II Expert. Copyright 2026 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.

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