Revi

2026 Coding & Reimbursement Guide

Blue Wind MEDICAL

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Physician & Facility Coding and Payment - Medicare

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	$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; **subfascial.**	MAC Priced	J1	$3,572	G2	$2,003
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

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.

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

HCPCS Codes

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:

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

Medicare designated CPT code 0817T as device intensive which requires hospital outpatient departments to report a device HCPCS code in addition to procedure code 0817T to identify the use and cost of the implantable neurostimulator pulse generator. Additional Medicare payment is not allowed but including a separate device code will ensure claims are not rejected for being incomplete. Assigning appropriate charges to the device code, based on your unique CCR, will help to protect future APC assignment and rate setting.

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.

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

Additional Information

- Per CPT Assistant, analysis and programming are integral to insertion, replacement, and revision[4].
- Codes 0589T, 0590T are assigned only when performed by physicians or QHP on a different date of service from the implant.
- Commercial payers may process L8679 separately for payment.
- Status Indicator (SI) shows how a code is handled for payment purposes. J1 = paid under comprehensive APC, single payment based on primary service without separate payment for other adjunctive services. The Payment Indicator shows how a code is handled for payment purposes. J8 = device-intensive procedure, payment amount adjusted to incorporate device cost.

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. CPT Assistant, July 2024, p. 4.