BARRICAID®

Objection Handling

Economic

Objection: New tech is never reimbursed. You're adding implant costs to a procedure that doesn't have any.	
Clarify:	Are you referring to surgeon or facility reimbursement for new spine technology?
Clarify:	How would you view Barricaid if you found out that it did reimburse the facility and the surgeon?
Point:	**4,000 claim reviews - validate facility and surgeon reimbursement.**
Point:	**Our team specializes in reviewing contracts to ensure feasible payments. Additionally, we have a risk mitgation program that protects facilities from non-payment (Patient First).**
Point:	**Prior to 2026, surgeons billed unlisted code which was challenging for some sites. The new Barricaid CPT Add-on code (+63032) reimburses with an additional 4.08 total RVUs for the time spent implanting the device[3].**

Objection: I make money when I do fusions. Will Barricaid reduce my fusions?	
Clarify:	Is it a bad thing if the patient doesn't reherniate?
Clarify:	As Barricaid becomes accepted as standard of care, what do you see happening for surgeons who don't have Barricaid in their surgical armamentarium?
Clarify:	Second opinions for discectomies are common. If you are not offering Barricaid, is there a chance you might lose that patient to a competitor?
Clarify:	Barricaid is only for specific patients who meet indications. What about radicular patients who reherniate but are otherwise stable and not fusion candidates?
Point:	**Yes, Barricaid is intended to reduce the incidence of reoperation.**
Point:	**There are many determining factors regarding the decision to fuse. When you decide to fuse, Barricaid does not interfere with that technique regardless of approach.**
Point:	**Barricaid is not appropriate for patients with instability or disc collapse.**

Objection: 63032 is an add-on code? Does that mean it only pays 50%?	
Point:	**You may be confusing this with multiple procedure reporting, which are subject to fee reductions.**
Point:	**Add-on codes are never subject to multiple procedure fee reductions.[8]**
Point:	**+63032 must be reported with 63030 and is not subject to multiple procedure fee reductions.[8]**

1 Wilke 1999
2 Internal Data on File
3. Addendum B – Relative Value Units and Related Information Used in CY 2026 Final Rule CMS.gov
*Non-Qualifying APM Participants (Non-QPs) conversion factor of $33.40 used for calculation
4 J.clineuro 2018 - Kerezoudis
5 J Bone Joint Surg Am. 2003 - Carragee et al
6 FREEDOM Registry Data on File
7 Some studies outside US indications. Values at min 1 yr post-op. Minimum study size of 20 Barricaid subjects.
8 CMS Procedural Coding https://www.cms.gov/national-correct-coding-initiative-ncci

Clinical

Objection: I have tried annular closure before / I heard annular closure does not work.	
Clarify:	Was it a bone-anchored implant or was it a suture based product that you are referring to?
Clarify:	What were you looking to accomplish when you tried this device?
Clarify:	Did the device not live up to your expectation from a clinical or economic standpoint?
Point:	**Barricaid is the only device ever FDA approved for annular closure. Only a device anchored to bone can withstand the intradiscal pressure (330 PSI)[1] without migrating.**
Point:	**Reimbursement: 6 years of increasing facility reimbursement[2] and a new 2026 add-on CPT code for surgeons.**
Point:	**Clinical: Published 2, 5 year RCT and Two Level 1A Meta-Analyses.**

Objection: I just am not sure that I see many reherniations / I don't see clinical value.	
Clarify:	What do you tell your discectomy patients about their risk of reherniation, according to literature?
Clarify:	Do you think that large annular tears are more likely to reherniate?
Clarify:	Are you currently meausring the size of the defect and using the new corresponding ICD-10 codes?
Clarify:	How do you treat a reherniated patient that comes to you for a second opinion? Discectomy or fusion?
Clarify:	What are you currently doing to prevent reherniation?
Point:	**Literature shows that about 50% of revision microdiscectomies receive a fusion.[4]**
Point:	**Do you see the value in preserving the motion segment (maintain disc height) and repressurizing the disc?**

Objection: This is just a product looking for a procedure / Barricaid lacks clinical evidence.	
Clarify:	How many devices do you think are FDA approved for annular closure?
Clarify:	Why leave a hole open in the annulus? Why do surgeons close skin, muscle, fascia, dura but not the annulus?
Clarify:	Did you know Barricaid has published 2, 5 year RCT studies and Two Level 1A Meta-Analyses?
Point:	**Stanford study identified clinical need to close large annular defects 15 years before Barricaid was FDA approved.**
Point:	**>40% of discectomy patients have large (≥6mm) defects and are at high-risk for reherniation[6]. These patients need more protection than a standard discectomy can offer.**
Point:	**Barricaid has been proven to reduce reoperation for reherniation by 81% in 8 distinct patient populations.[7]**
Point:	**Did you know that the intra-discal pressure is over 330 PSI and Barricaid is designed to withstand that force by effectively plugging the annulus from the inside to reduce reoperation for reherniation by over 80%?**

Objection: I am moving my practice towards endoscopic discectomy. Is Barricaid compatible?	
Clarify:	Are you referring to uni-portal or dual-portal approach?
Clarify:	Do you think that endoscopic discectomy would limit you from implanting Barricaid?
Clarify:	Are you currently doing anything to close large defects when you encounter them?
Point:	**Barricaid has been implanted by multiple surgeons across the country through a dual or accessory port.**
Point:	**Barricaid supports labs throughout the country that are teaching this technique if you are interested.**