SPINAL CORD STIMULATION
COMMONLY BILLED CODES

EFFECTIVE JANUARY 1, 2020

Medtronic

Medtronic provides this information for your convenience only. It does not constitute legal advice or a recommendation regarding clinical practice. Information provided is gathered from third-party sources and is subject to change without notice due to frequently changing laws, rules and regulations. The provider has the responsibility to determine medical necessity and to submit appropriate codes and charges for care provided. Medtronic makes no guarantee that the use of this information will prevent differences of opinion or disputes with Medicare or other payers as to the correct form of billing or the amount that will be paid to providers of service. Please contact your Medicare contractor, other payers, reimbursement specialists and/or legal counsel for interpretation of coding, coverage and payment policies. This document provides assistance for FDA approved or cleared indications. Where reimbursement is sought for use of a product that may be inconsistent with, or not expressly specified in, the FDA cleared or approved labeling (eg, instructions for use, operator's manual or package insert), consult with your billing advisors or payers on handling such billing issues. Some payers may have policies that make it inappropriate to submit claims for such items or related service.

The following information is calculated per the footnotes included and does not take into effect Medicare payment reductions resulting from sequestration associated with the Budget Control Act of 2011. Sequestration reductions went into effect on April 1, 2013.

FOR QUESTIONS PLEASE CONTACT US AT NEURO.US.REIMBURSEMENT@MEDTRONIC.COM

ICD-10-CM[1] Diagnosis Codes

Diagnosis codes are used by both physicians and hospitals to document the indication for the procedure.

Spinal cord stimulation therapy is directed at managing chronic, intractable pain rather than treating the underlying disorder. Pain codes from the G89 series are used as the principal diagnosis when the encounter is for pain control or pain management, rather than for management of the underlying condition. Specifically, when a patient is admitted for insertion of a neurostimulator for pain control, the G89 pain code is sequenced as the principal diagnosis.[2] Additional codes may then be assigned to identify the underlying cause as well to give more detail about the nature and location of the pain. When the encounter is for a procedure aimed at treating the underlying condition and a neurostimulator is also inserted for pain control, the underlying disorder is assigned as the principal diagnosis. However, an encounter specifically to insert a neurostimulator is most common.

Chronic Pain Disorders	**G89.0**	Central pain syndrome
	G89.29	Other chronic pain
	G89.4	Chronic pain syndrome
	Note: Pain must be specifically documented as "chronic" to assign code G89.29. To assign code G89.4, the documentation must specifically state either "chronic pain syndrome" or chronic pain associated with significant psychosocial dysfunction. Similarly, "central pain syndrome" is a diagnosis and must be specifically documented to assign code G89.0.	
Reflex Sympathetic Dystrophy (RSD) (Complex Regional Pain Syndrome I, CRPS I)	**G90.511**	Complex regional pain syndrome I of right upper limb
	G90.512	Complex regional pain syndrome I of left upper limb
	G90.513	Complex regional pain syndrome I of upper limb, bilateral
	G90.519	Complex regional pain syndrome I of unspecified upper limb
	G90.521	Complex regional pain syndrome I of right lower limb
	G90.522	Complex regional pain syndrome I of left lower limb
	G90.523	Complex regional pain syndrome I of lower limb, bilateral
	G90.529	Complex regional pain syndrome I of unspecified lower limb
	Note: ICD-10-CM does not have a default code for "Complex Regional Pain Syndrome"; type I or II must be specified. Pain codes from the G89 series should not be assigned separately with the codes for reflex sympathetic dystrophy because pain is a known component of this disorder.	

CONTINUED ON NEXT PAGE

ICD-10-CM[1] Diagnosis Codes continued

Causalgia (Complex Regional Pain Syndrome II, CRPS II)	**G56.40**	Causalgia of unspecified upper limb
	G56.41	Causalgia of right upper limb
	G56.42	Causalgia of left upper limb
	G56.43	Causalgia of bilateral upper limbs
	G57.70	Causalgia of unspecified lower limb
	G57.71	Causalgia of right lower limb
	G57.72	Causalgia of left lower limb
	G57.73	Causalgia of bilateral lower limbs
	Note: ICD-10-CM does not have a default code for "Complex Regional Pain Syndrome"; type I or II must be specified. Pain codes from the G89 series should not be assigned separately with the codes for causalgia because pain is a known component of this disorder.	
Arachnoiditis	**G03.1**	Chronic meningitis
	G03.9	Meningitis, unspecified
Peripheral Neuropathy of the Extremities	**G56.90**	Unspecified mononeuropathy of unspecified upper limb
	G56.91	Unspecified mononeuropathy of right upper limb
	G56.92	Unspecified mononeuropathy of left upper limb
	G56.93	Unspecified mononeuropathy of bilateral upper limbs
	G57.90	Unspecified mononeuropathy of unspecified lower limb
	G57.91	Unspecified mononeuropathy of right lower limb
	G57.92	Unspecified mononeuropathy of left lower limb
	G57.93	Unspecified mononeuropathy of bilateral lower limbs
Epidural Fibrosis	**G96.12**	Meningeal adhesions (spinal) (cerebral)
Radiculopathy	**M50.10**	Cervical disc disorder with radiculopathy, unspecified cervical region
	M50.11	Cervical disc disorder with radiculopathy, high cervical region
	M50.121	Cervical disc disorder at C4-C5 level with radiculopathy
	M50.122	Cervical disc disorder at C5-C6 level with radiculopathy
	M50.123	Cervical disc disorder at C6-C7 level with radiculopathy
	M50.13	Cervical disc disorder with radiculopathy, cervicothoracic region
	M51.14	Intervertebral disc disorders with radiculopathy, thoracic region
	M51.15	Intervertebral disc disorders with radiculopathy, thoracolumbar region
	M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
	M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
	M54.12	Radiculopathy, cervical region
	M54.13	Radiculopathy, cervicothoracic region
	M54.14	Radiculopathy, thoracic region
	M54.15	Radiculopathy, thoracolumbar region
	M54.16	Radiculopathy, lumbar region
	M54.17	Radiculopathy, lumbosacral region

CONTINUED ON NEXT PAGE

ICD-10-CM[1] Diagnosis Codes continued

Post Laminectomy Syndrome	**M96.1**	Post laminectomy syndrome, not elsewhere classified
Device Complications[3,4]	**T85.112A**	Breakdown (mechanical) of implanted electronic neurostimulator of spinal cord electrode (lead)
	T85.113A	Breakdown (mechanical) of implanted electronic neurostimulator, generator
	T85.122A	Displacement of implanted electronic neurostimulator of spinal cord electrode (lead)
	T85.123A	Displacement of implanted electronic neurostimulator, generator
	T85.192A	Other mechanical complication of implanted electronic neurostimulator of spinal cord electrode (lead)
	T85.193A	Other mechanical complication of implanted electronic neurostimulator, generator
	T85.733A	Infection and inflammatory reaction due to implanted electronic neurostimulator of spinal cord, electrode (lead)
	T85.734A	Infection and inflammatory reaction due to implanted electronic neurostimulator generator
	T85.820A	Fibrosis due to nervous system prosthetic devices, implants and grafts
	T85.830A	Hemorrhage due to nervous system prosthetic devices, implants and grafts
	T85.840A	Pain due to nervous system prosthetic devices, implants and grafts
	T85.890A	Other specified complication of nervous system prosthetic devices, implants and grafts[5]
Attention to Device[6]	**Z45.42**	Encounter for adjustment and management of neurostimulator
Neurostimulator Status[7]	**Z96.82**	Presence of neurostimulator

1. Centers for Disease Control and Prevention, National Center for Health Statistics. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). http://www.cdc.gov/nchs/icd/icd10cm.htm. Updated October 1, 2019.
2. ICD-10-CM Official Guidelines for Coding and Reporting FY 2020, I.C.6.b.1(a).
3. When a device complication is the reason for the encounter, the device complication code is sequenced as the primary diagnosis followed by a code for the underlying condition. If the purpose of the encounter is directed toward the underlying condition or the device complication arises after admission, the underlying condition is sequenced as the primary diagnosis followed by the device complication code.
4. Device complication codes ending in "A" are technically defined as "initial encounter" but continue to be assigned for each encounter in which the patient is receiving active treatment for the complication (ICD-10-CM Official Guidelines for Coding and Reporting FY 2020, I.C.19.A).
5. According to ICD-10-CM manual notes, "other specified complication" includes erosion or breakdown of a subcutaneous device pocket.
6. Code Z45.42 is used as the primary diagnosis when patients are seen for routine device maintenance, such as periodic device checks and programming, as well as routine device replacement. A secondary diagnosis code is then used for the underlying condition. (ICD-10-CM Official Guidelines for Coding and Reporting FY 2020, I.C.21.c.7).
7. Code Z96.82 is a status code, assigned to indicate that the patient currently has an implanted neurostimulator that was placed during a prior encounter. This code is not assigned during the same encounter in which the neurostimulator is implanted, replaced, removed, revised, interrogated or programmed.

ICD-10-PCS[1] Procedure Codes

Hospitals use ICD-10-PCS procedure codes for inpatient services.

Lead Implantation[2]	**00HU0MZ**	Insertion of neurostimulator lead into spinal canal, open approach
	00HU3MZ	Insertion of neurostimulator lead into spinal canal, percutaneous approach
Lead Removal[3]	**00PU0MZ**	Removal of neurostimulator lead from spinal canal, open approach
	00PU3MZ	Removal of neurostimulator lead from spinal canal, percutaneous approach
Lead Replacement	Two codes are required to identify a device replacement: one code for implantation of the new device and one code for removal of the old device.[4]	
Lead Revision[5]	**00WU0MZ**	Revision of neurostimulator lead in spinal canal, open approach
	00WU3MZ	Revision of neurostimulator lead in spinal canal, percutaneous approach
Generator Implantation[6,7]	**0JH70DZ**	Insertion of multiple array stimulator generator into back subcutaneous tissue and fascia, open approach
	0JH80DZ	Insertion of multiple array stimulator generator into abdomen subcutaneous tissue and fascia, open approach
	0JH70EZ	Insertion of multiple array rechargeable stimulator generator into back subcutaneous tissue and fascia, open approach
	0JH80EZ	Insertion of multiple array rechargeable stimulator generator into abdomen subcutaneous tissue and fascia, open approach
Generator Removal[7]	**0JPT0MZ**	Removal of stimulator generator in trunk subcutaneous tissue and fascia, open approach
	0JPT3MZ	Removal of stimulator generator in trunk subcutaneous tissue and fascia, percutaneous approach
Generator Replacement	Two codes are required to identify a device replacement: one code for implantation of the new device and one code for removal of the old device.[4]	
Generator Revision[8,9]	**0JWT0MZ**	Revision of stimulator generator in trunk subcutaneous tissue and fascia, open approach
	0JWT3MZ	Revision of stimulator generator in trunk subcutaneous tissue and fascia, percutaneous approach

1. U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS). https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-PCS.html . Updated October 1, 2019.
2. Approach value 0-Open is used when leads are placed via laminectomy. Approach value 3-Percutaneous is used when leads are placed by spinal needle via puncture or minor incision.
3. Approach value 0-Open is used when leads are removed via laminectomy or other direct surgical exposure of the spinal canal. Approach value 3-Percutaneous is used when leads are removed by puncture or minor incision. Only the ICD-10-PCS codes for surgical removal are displayed. Approach value X-External is also available for removal of leads by simple pull.
4. CMS ICD-10-PCS Reference Manual 2016, p.67. See also *Coding Clinic,* 3rd Q 2014, p.19.
5. For Lead Revision, the ICD-10-PCS codes refer to surgical revision of leads within the spinal canal, eg. repositioning. For revision of the subcutaneous portion of the lead or revision of a subcutaneous extension, see Generator Revision.
6. Codes defined as "multiple array" include dual array neurostimulator pulse generators, a type of multiple array generator in which two leads are connected to one generator. PrimeAdvanced is a dual-array non-rechargeable generator (device value D). Intellis, RestoreAdvanced, RestoreSensor, and RestoreUltra are dual-array rechargeable generators (device value E). See also the ICD-10-PCS Device Key. Do *not* assign default device value M-Stimulator Generator.
7. Placement of a neurostimulator generator is shown with the approach value 0-Open because creating the pocket requires surgical dissection and exposure. Removal also usually requires surgical dissection to free the device.
8. The ICD-10-PCS codes shown can be assigned for opening the pocket for generator revision, as well as reshaping or relocating the pocket while reinserting the *same* generator. However, there are no ICD-10-PCS codes specifically defined for revising the subcutaneous portion of a lead or an extension. Because these services usually involve removing and reinserting the same generator as well, they can also be represented by the ICD-10-PCS generator revision codes.
9. Approach value X-External is also available for external generator manipulation without opening the pocket, eg. to correct a flipped generator.

HCPCS II Device Codes[1] (Non-Medicare)

These codes are utilized by the entity that purchased and supplied the medical device, DME, drug, or supply to the patient. For implantable devices, that is generally the facility. It may also be the physician, most commonly for trial leads placed in the office. HCPCS II device codes are only reported on outpatient bills.[2] For specific Medicare hospital outpatient instructions for medical devices, see the Device C-Codes (Medicare) below.

Lead[3]	**L8680**	Implantable neurostimulator electrode, each
Pulse Generator[4]	**L8679**	Implantable neurostimulator pulse generator, any type
	L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
	L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
External Recharger	**L8689**	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only
Patient Programmer	**L8681**	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only

1. Healthcare Common Procedure Coding System (HCPCS) Level II codes are maintained by the Centers for Medicare and Medicaid Services. http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html. Accessed November 7, 2019.
2. Although HCPCS II codes cannot be reported on an inpatient bill, some hospitals may choose to assign them with inpatient encounters strictly for internal tracking purposes.
3. Physicians should not submit code L8680 to Medicare for leads placed in the office, because the cost of the lead is already valued in the CPT procedure code. Code L8680 is also not recognized as valid by Medicare. Code L8680 remains available for use with non-Medicare payers, though physicians should check with the payer for specific coding and billing instructions. Likewise, hospitals and ASCs may be able to submit L8680 for non-Medicare payers but should check with the payer for instructions.
4. Generator codes L8687-L8688 are not recognized by Medicare. Specifically for billing Medicare, code L8679 is available for physician use, while hospitals typically use C-codes and ASCs generally do not submit HCPCS II codes for devices. For non-Medicare payers, codes L8687-L8688 remain available. However, all providers should check with the payer for specific coding and billing instructions.

Device C-Codes[1] (Medicare)

Medicare provides C-codes, a type of HCPCS II code, for hospital use in billing Medicare for medical devices in the outpatient setting. Although other payers may also accept C-codes, regular HCPCS II device codes are generally used for billing non-Medicare payers. Unlike regular HCPCS II device codes, the extension is separately codable using C-codes.

ASCs, however, usually should not assign or report HCPCS II device codes for devices on claims sent to Medicare. Medicare generally does not make a separate payment for devices in the ASC. Instead, payment is "packaged" into the payment for the ASC procedure. ASCs are specifically instructed not to bill HCPCS II device codes to Medicare for devices that are packaged.[2]

Pulse Generator (non-rechargeable)	**C1767**	Generator, neurostimulator (implantable) non-rechargeable
Pulse Generator (rechargeable)	**C1820**	Generator, neurostimulator (implantable), with rechargeable battery and charging system
Extension	**C1883**	Adaptor/extension, pacing lead or neurostimulator lead (implantable)
Leads	**C1778**	Lead, neurostimulator (implantable)
	C1897	Lead, neurostimulator, test kit (implantable)
Patient Programmer	**C1787**	Patient programmer, neurostimulator

1. Healthcare Common Procedure Coding System (HCPCS) Level II codes, including device C-codes, re maintained by the Centers for Medicare and Medicaid Services. http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html. Accessed November 7, 2019.
2. ASCs should report all charges incurred. However, only charges for non-packaged items should be billed as separate line items. For example, the ASC should report its charge for the generator. However, because the generator is a packaged item, the charge should not be reported on its own line. Instead, the ASC should bill a single line for the implantation procedure with a single total charge, including not only the charge associated with the operating room but also the charges for the generator device and all other packaged items. Because of a Medicare requirement to pay the lesser of the ASC rate or the line-item charge, breaking these packaged charges out onto their own lines can result in incorrect payment to the ASC. Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual, Chapter 14—Ambulatory Surgical Centers, Section 40. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf. Accessed November 7, 2019. See also MLN Matters SE0742 p.9-10: Centers for Medicare and Medicaid Services. MLN Matters Number SE0742 Revised. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0742.pdf. Accessed November 7, 2019.

Device Edits (Medicare)[1]

Medicare's procedure-to-device edits require that when certain CPT® procedure codes for device implantation are submitted on a hospital outpatient bill, HCPCS II codes for devices must also be billed. Effective January 2015, the edits are broadly defined and may include any HCPCS II device code with any CPT procedure code used in earlier versions of the edits.[2] Within this context, the HCPCS II device codes shown below are appropriate for the CPT procedure codes and will pass the edits.

CPT Procedure Code[3]	CPT Code Description[3]	HCPCS II Device Codes	HCPCS II Code Description
63650[4]	Percutaneous implantation of neurostimulator electrode array, epidural	**C1778**	Lead, neurostimulator (implantable)
		C1897	Lead, neurostimulator, test kit (implantable)
63655[4,5]	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	**C1778**	Lead, neurostimulator (implantable)
63685[6]	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	**C1767**	Generator, neurostimulator (implantable), non-rechargeable
		C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system

1. Centers for Medicare & Medicaid Services. Medicare Program: Changes to Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems...Final Rule. 84 Fed. Reg. 61299. https://www.govinfo.gov/content/pkg/FR-2019-11-12/pdf/2019-24138.pdf . Published November 12, 2019.
2. Centers for Medicare & Medicaid Services. Procedure to Device Edits. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Archives.html. Last updated April 10, 2013.
3. CPT copyright 2019 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.
4. HCPCS II code L8680 will also pass the edits with CPT procedure codes 63650 and 63655, but this code is not shown because it is not otherwise recognized by Medicare.
5. HCPCS II device code C1897 will pass the edits with CPT procedure codes 63655. In practice, however, HCPCS device code C1897 is not appropriate with CPT procedure code 63655 because this type of kit is not currently used when testing is performed via laminectomy
6. HCPCS II device codes L8687-L8688 for the various generator types will also pass the edits with CPT procedure code 63685, but these codes are not shown because they are not otherwise recognized by Medicare. HCPCS II device code L8679 does not satisfy the edits.

Physician Coding and Payment — January 1, 2020 – December 31, 2020

CPT® Procedure Codes

Physicians use CPT codes for all services. Under Medicare's Resource-Based Relative Value Scale (RBRVS) methodology for physician payment, each CPT code is assigned a point value, known as the relative value unit (RVU), which is then converted to a flat payment amount.

Procedure	CPT Code and Description[1]	Medicare RVUs[2]		Medicare National Average[3]	
		For physician services provided in:[4]			
		Physician Office[5]	Facility	Physician Office[5]	Facility
Screening Test[6,7,8]	**63650** Percutaneous implantation of neurostimulator electrode array, epidural[9,10]	54.18	11.93	$1,955	$431
Lead Implantation[6,7,8]	**63650** Percutaneous implantation of neurostimulator electrode array, epidural[9,10]	54.18	11.93	$1,955	$431
	63655 Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	N/A	24.01	N/A	$867
Generator Implantation or Replacement[7,11]	**63685** Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	N/A	10.37	N/A	$374
Removal of Leads[7,12,13,14]	**63661** Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	18.32	9.33	$661	$337
	63662 Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	N/A	24.30	N/A	$877
Revision or Replacement of Leads[7,13,14]	**63663** Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed	24.38	13.00	$880	$469
	63664 Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy when performed	N/A	25.29	N/A	$913
Revision or Removal of Generator[7,11]	**63688** Revision or removal of implanted spinal neurostimulator pulse generator or receiver	N/A	10.70	N/A	$386

CONTINUED ON NEXT PAGE

Physician Coding and Payment continued

Procedure	CPT Code and Description[1]	Medicare RVUs[2]		Medicare National Average[3]	
		For physician services provided in:[4]			
		Physician Office[5]	Facility	Physician Office[5]	Facility
Analysis/ Programming **Note:** In the office, analysis and programming may be furnished by a physician, practitioner with an "incident to" benefit, or auxiliary personnel under the direct supervision of the physician (or other practitioner), with or without support from a manufacturer's representative. The patient or payer should not be billed for services rendered by the manufacturer's representative. Contact your local contractor or payer for interpretation of applicable policies.	**95970** Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming [15]	0.55	0.54	$20	$19
	95971 Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/ transmitter programming by physician or other qualified health care professional [16,17,18]	1.44	1.17	$52	$42
	95972 Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/ transmitter programming by physician or other qualified health care professional [16,17,18]	1.62	1.19	$58	$43

CONTINUED ON NEXT PAGE

Physician Coding and Payment continued

1. CPT copyright 2019 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.
2. Centers for Medicare & Medicaid Services. Medicare Program; CY2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B Policies Final Rule; 84 Fed. Reg. 62568-63563. https://www.govinfo.gov/content/pkg/FR-2019-11-15/pdf/2019-24086.pdf . Published November 15, 2019. The total RVU as shown here is the sum of three components: physician work RVU, practice expense RVU, and malpractice RVU.
3. Medicare national average payment is determined by multiplying the sum of the three RVUs by the conversion factor. The conversion factor for CY 2020 is $36.0896 per 84 Fed. Reg. 63152. https://www.govinfo.gov/content/pkg/FR-2019-11-15/pdf/2019-24086.pdf . Published November 15, 2019. See also the January 2020 release of the PFS Relative Value File RVU20A at http:/www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html. Released November 7, 2019. Final payment to the physician is adjusted by the Geographic Practice Cost Indices (GPCI). Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the payment amount shown.
4. The RVUs shown are for the physician's services and payment is made to the physician. However, there are different RVUs and payments depending on the setting in which the physician rendered the service. "Facility" includes physician services rendered in hospitals, ASCs, and SNFs. Physician RVUs and payments are generally lower in the "Facility" setting because the facility is incurring the cost of some of the supplies and other materials. Physician RVUs and payments are generally higher in the "Physician Office" setting because the physician incurs all costs there.
5. "N/A" shown in Physician Office setting indicates that Medicare has not developed RVUs in the office setting because the service is typically performed in a facility (eg, in a hospital). However, if the local contractor determines that it will cover the service in the office, then it is paid using the facility RVUs at the facility rate. Centers for Medicare & Medicaid Services. CY 2020 PFS Final Rule Addenda. Addendum A CMS-1715-F-CY2020. Explanation of Addendum B and C. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F. Released November 1, 2019.
6. As defined and as published by the AMA (*CPT Assistant,* June 1998, p.4), these codes represent a single lead. When more than one lead is placed, each is coded separately. However, Medicare does not permit the use of bilateral modifier –50 or –LT/ –RT on these codes. Some payers recognize that each code represents a distinct lead when modifier –51 or modifier –59 is appended to the additional codes. Note that Medicare's Medically Unlikely Edits allow 2 units for code 63650 on the same date of service, but only 1 unit for code 63655. Denials for units in excess of the MUE values may be appealed.
7. Surgical procedures are subject to a "global period." The global period defines other physician services that are generally considered part of the surgery package. The services are not separately coded, billed or paid when rendered by the physician who performed the surgery. These services include: preoperative visits the day before or the day of the surgery, postoperative visits related to recovery from the surgery for 10 or 90 days depending on the specific procedure, treatment of complications unless they require a return visit to the operating room, and minor postoperative services such as dressing changes and suture removal. Medicare Claims Processing Manual, Chapter 12—Physicians/Nonphysician Practitioners, Section 40.1. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf . Accessed November 7, 2019.
8. The published vignettes for codes 63650 and 63655 include fluoroscopy and, according to guidelines published by the American Association of Neurological Surgeons (*2019 AANS Guide to Coding,* p.68), its use is inherent to lead implantation and should not be coded separately. In addition, National Correct Coding Initiative (NCCI) edits prohibit coding fluoroscopy separately with 63650 and 63655. See also *CPT Assistant,* January 2016, p.12.
9. The Physician Office RVUs for code 63650 are valued to include payment for the lead and other practice expenses associated with office-based lead insertion, eg, screening tests (trials). HCPCS code L8680 should not be reported separately for the lead in conjunction with office-based lead insertion.
10. The AMA has published (*CPT Assistant,* October 2013, p.19) that use of an incision to admit the needle or to anchor the lead is inherent to percutaneous placement and does not alter use of code 63650. See also *2019 AANS Guide to Coding,* p.68.
11. When an existing generator is removed and replaced by a new generator, only the generator replacement code 63685 may be assigned. NCCI edits do not allow removal of the existing generator to be coded separately. Also note that, according to NCCI policy, use of the CPT code for generator "insertion or replacement" requires placement of a new generator. When the *same* generator is removed and then re-inserted, the "revision" code is used (NCCI Policy Manual 1/1/2020, Chapter VIII, C.16.).
12. The AMA has published that the work of removing a temporary trial lead is inherent to the original percutaneous placement code 63650 and is not coded separately. Code 63661 cannot be assigned for removal of a temporary trial lead that was placed percutaneously. Further, codes 63661 and 63662 apply to surgical removal of permanent leads. Removal of a permanent lead by simple pull is not coded (*CPT Assistant,* August 2010, p.8,15; April 2011, p.10-11,15).
13. The AMA has published that replacement codes 63663 and 63664 are assigned when a permanent lead is replaced by another permanent lead of the same type via the same approach at the same spinal level. The work of removing the existing permanent lead is included and is not coded separately (*CPT Assistant,* August 2010, p.8,15; April 2011, p.10-11,15). In addition, NCCI edits do not permit removal codes 63661 and 63662 to be assigned separately with replacement codes 63663 and 63664.
14. The AMA has published that when a permanent percutaneous lead is removed and a new lead is placed via a fresh laminectomy at the same or a different spinal level, insertion code 63655 is assigned with removal code 63661 (*CPT Assistant,* April 2011, p.11,15). NCCI edits allow this combination without use of a modifier.
15. Code 95970 is used for electronic analysis (interrogation) of the implanted neurostimulator without programming. Per CPT manual instructions, code 95970 is integral to lead and/or generator implantation and cannot be assigned separately. See also *CPT Assistant,* February 2019, p.6. NCCI edits also prohibit coding 95970 separately with lead or generator implantation. In addition, per CPT manual instructions, test stimulation during an implantation procedure is considered integral and code 95970 cannot be assigned to represent this.
16. Programming codes 95971 and 95972 also may not be assigned to represent test stimulation during the implantation procedure, and NCCI edits do not permit programming codes 95971 and 95972 to be coded separately with lead or generator implantation. However, an override is permitted in the context of actual programming performed at the time of lead or generator implantation.
17. According to CPT manual instructions, "simple" programming involves changes to three or fewer parameters and "complex" programming involves changes to four or more parameters.
18. According to CPT manual instructions, programming codes may be assigned as long as iterative adjustments to the parameters are made and assessed, regardless of whether the final settings are ultimately changed. See also *CPT Assistant,* February 2019, p.6.

Hospital Outpatient Coding and Payment — Effective January 1, 2020 – December 31, 2020

CPT® Procedure Codes

Hospitals use CPT codes for outpatient services. Under Medicare's APC methodology for hospital outpatient payment, each CPT code is assigned to one of approximately 770 ambulatory payment classes. Each APC has a relative weight that is then converted to a flat payment amount. Multiple APCs can sometimes be assigned for each encounter, depending on the number of procedures coded and whether any of the procedure codes map to a Comprehensive APC.

For 2020, there are 67 APCs which are designated as Comprehensive APCs (C-APCs). Each CPT procedure code assigned to one of these C-APCs is considered a primary service, and all other procedures and services coded on the bill are considered adjunctive to delivery of the primary service. This results in a single APC payment and a single beneficiary copayment for the entire outpatient encounter, based solely on the primary service. Separate payment is not made for any of the other adjunctive services. Instead, the payment level for the C-APC is calculated to include the costs of the other adjunctive services, which are packaged into the payment for the primary service.

When more than one primary service is coded for the same outpatient encounter, the codes are ranked according to a fixed hierarchy. The C-APC is then assigned according to the highest ranked code. In some special circumstances, the combination of two primary services leads to a "complexity adjustment" in which the entire encounter is re-mapped to another higher-level APC. There is one complexity adjustment for spinal cord stimulation therapy for 2020.

As shown on the tables below, spinal cord stimulation is subject to C-APCs specifically for implantation and revision/replacement of the leads, and implantation/replacement of the generator. C-APCs are identified by status indicator J1.

Procedure	CPT Code and Description[1]	APC[2]	APC Title[2]	SI[2,3]	Relative Weight[2]	Medicare National Average[2,4]
Screening Test[5,6]	**63650** Percutaneous implantation of neurostimulator electrode array, epidural[7]	5462	Level 2 Neurostimulator and Related Procedures	J1	76.5800	$6,187
Lead Implantation[5,6,8]	**63650** Percutaneous implantation of neurostimulator electrode array, epidural[7]	5462	Level 2 Neurostimulator and Related Procedures	J1	76.5800	$6,187
	63655 Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	5463	Level 3 Neurostimulator and Related Procedures	J1	238.6273	$19,279
Generator Implantation or Replacement[9,10]	**63685** Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	5464	Level 4 Neurostimulator and Related Procedures	J1	360.4117	$29,119
Removal of Leads [11,12,13]	**63661** Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed[14]	5431	Level 1 Nerve Procedures	Q2	21.2809	$1,719
	63662 Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy when performed	5461	Level 1 Neurostimulator and Related Procedures	J1	38.9699	$3,149

CONTINUED ON NEXT PAGE

Hospital Outpatient Coding and Payment continued

Procedure	CPT Code and Description[1]	APC[2]	APC Title[2]	SI[2,3]	Relative Weight[2]	Medicare National Average[2,4]
Revision or Replacement of Leads[12,13]	**63663** Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed	5462	Level 2 Neurostimulator and Related Procedures	J1	76.5800	$6,187
	63664 Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle (s) placed via laminotomy or laminectomy, including fluoroscopy when performed	5463	Level 3 Neurostimulator and Related Procedures	J1	238.6273	$19,279
Revision or Removal of Generator[9]	**63688** Revision or removal of implanted spinal neurostimulator pulse generator or receiver	5461	Level 1 Neurostimulator and Related Procedures	J1	38.9699	$3,149
Revision of Leads ***plus*** **Revision of Generator**[15]	**63663** Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed *plus* **63688** Revision or removal of implanted spinal neurostimulator pulse generator or receiver	5463	Level 3 Neurostimulator and Related Procedures	J1	238.6273	$19,279

CONTINUED ON NEXT PAGE

Hospital Outpatient Coding and Payment continued

Procedure	CPT Code and Description[1]	APC[2]	APC Title[2]	SI[2,3]	Relative Weight[2]	Medicare National Average[2,4]
Analysis and Programming **Note**: In the hospital, analysis and programming may be furnished by a physician or other practitioner, with or without support from a manufacturer's representative. Neither the payer or patient should be billed for services rendered by the manufacturer's representative. Contact your local contractor or payer for interpretation of applicable policies.	**95970** Electronic analysis of implanted neurostimulator pulse generator/ transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/ transmitter, without programming[14,16]	5734	Level 4 Minor Procedures	Q1	1.3495	$109
	95971 Electronic analysis of implanted neurostimulator pulse generator/ transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional [17,18,19]	5742	Level 2 Electronic Analysis of Devices	S	1.4039	$113
	95972 Electronic analysis of implanted neurostimulator pulse generator transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/ transmitter programming by physician or other qualified health care professional [17,18,19]	5742	Level 2 Electronic Analysis of Devices	S	1.4039	$113

CONTINUED ON NEXT PAGE

Hospital Outpatient Coding and Payment

1. CPT copyright 2019 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.
2. Centers for Medicare & Medicaid Services. Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems..Final Rule. 84 Fed Reg 61142-61492. https://www.govinfo.gov/content/pkg/FR-2019-11-12/pdf/2019-24138.pdf . Published November 12, 2019. Correction Notice 85 Fed Reg 224-230. https://www.govinfo.gov/content/pkg/FR-2020-01-03/pdf/2019-28364.pdf . Published January 3, 2020.
3. 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; S = always paid at 100% of rate; T = paid at 50% of rate when billed with another higher-weighted T procedure; Q1 = STV packaged codes, not paid separately when billed with an S, T, or V procedure; Q2 = T packaged codes, not paid separately when billed with a T procedure. See note 14 for more detailed information on the Status Indicators for codes 63661 and 95970.
4. Medicare national average payment is determined by multiplying the APC weight by the conversion factor. The conversion factor for 2020 is $80.793. The conversion factor of $80.793 assumes that hospitals meet reporting requirements of the Hospital Outpatient Quality Reporting Program. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems.. Final Rule. 84 Fed Reg 61184. https://www.govinfo.gov/content/pkg/FR-2019-11-12/pdf/2019-24138.pdf . Published November 12, 2019. Correction Notice 85 Fed Reg 224,226. https://www.govinfo.gov/content/pkg/FR-2020-01-03/pdf/2019-28364.pdf . Published January 3, 2020. Payment is adjusted by the wage index for each hospital's specific geographic locality, so payment will vary from the national average Medicare payment levels displayed. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the national average payment amount shown.
5. As defined and as published by the AMA (*CPT Assistant,* June 1998, p.4), these codes represent a single lead, and when more than one lead is placed, each is coded separately. However, Medicare does not permit the use of bilateral modifier –50 or –LT/–RT on these codes. Some payers recognize that each code represents a distinct lead when modifier –59 is appended to the additional codes. Note that Medicare's Medically Unlikely Edits allow 2 units for code 63650 on the same date of service, but only 1 unit for code 63655. Denials for units in excess of the MUE values may be appealed.
6. The published vignettes for codes 63650 and 63655 include fluoroscopy and, according to guidelines published by the American Association of Neurological Surgeons (*2019 AANS Guide to Coding,* p.68), its use is inherent to lead implantation and should not be coded separately. In addition, National Correct Coding Initiative (NCCI) edits prohibit coding fluoroscopy separately with 63650 and 63655. See also *CPT Assistant,* January 2016, p.12.
7. The AMA has published (*CPT Assistant,* October 2013, p.19) that use of an incision to admit the needle or to anchor the lead is inherent to percutaneous placement and does not alter use of code 63650. See also *2019 AANS Guide to Coding,* p.68.
8. When implantation of two leads is coded and billed, ie. 63650 plus 63650-59 or 63655 plus 63655-59, the entire encounter continues to map to the APCs shown. Because these are C-APCs and no complexity adjustment applies, there is no additional payment for the second lead.
9. When an existing generator is removed and replaced by a new generator, only the generator replacement code 63685 may be assigned. NCCI edits do not allow removal of the existing generator to be coded separately. Also note that, according to NCCI policy, use of the CPT code for generator "insertion or replacement" requires placement of a new generator. When the *same* generator is removed and then re-inserted, the "revision" code is used. (NCCI Policy Manual 1/1/2020, Chapter VIII, C.16.).
10. When generator implantation is coded and billed together with lead implantation, for example 63685 plus 63650, the entire encounter continues to map to the APC for generator implantation. Because this is a C-APC and no complexity adjustment applies, there is no additional payment for the lead.
11. The AMA has published that the work of removing a temporary trial lead is inherent to the original percutaneous placement code 63650 and is not coded separately. Code 63661 cannot be assigned for removal of a temporary trial lead that was placed percutaneously. Further, codes 63661 and 63662 apply to surgical removal of permanent leads. Removal of a permanent lead by simple pull is not coded (*CPT Assistant,* August 2010, p.8,15; April 2011, p.10-11,15).
12. The AMA has published that replacement codes 63663 and 63664 are assigned when a permanent lead is replaced by another permanent lead of the same type via the same approach at the same spinal level. The work of removing the existing permanent lead is included and is not coded separately (*CPT Assistant,* August 2010, p.8,15; April 2011, p.10-11,15). In addition, NCCI edits do not permit removal codes 63661 and 63662 to be assigned separately with replacement codes 63663 and 63664.
13. The AMA has published that when a permanent percutaneous lead is removed and a new lead is placed via a fresh laminectomy at the same or a different spinal level, insertion code 63655 is assigned with removal code 63661 (*CPT Assistant,* April 2011, p.11,15). NCCI edits allow this combination without use of a modifier.
14. For Status Indicators, code 63661 is Q2 and code 95970 is Q1, indicating that these codes are generally not paid separately when billed with other procedure codes. When billed alone, code 63661 is J1 and code 95970 is S.
15. The combination of code 63663 and 63688 qualifies for a complexity adjustment. Individually, code 63663 maps to APC 5462 and code 63688 maps to APC 5461. When submitted together, the entire encounter is re-mapped to APC 5463.
16. Code 95970 is used for electronic analysis (interrogation) of the implanted neurostimulator without programming. Per CPT manual instructions, code 95970 is integral to lead and/or generator implantation and cannot be assigned separately. See also *CPT Assistant,* February 2019, p.6. NCCI edits also prohibit coding 95970 separately with lead or generator implantation. In addition, per CPT manual instructions, test stimulation during an implantation procedure is considered integral and code 95970 cannot be assigned to represent this.
17. Programming codes 95971 and 95972 also may not be assigned to represent test stimulation during the implantation procedure, and NCCI edits do not permit programming codes 95971 and 95972 to be coded separately with lead or generator implantation. However, an override is permitted in the context of actual programming performed at the time of lead or generator implantation.
18. According to CPT manual instructions, "simple" programming involves changes to three or fewer parameters and "complex" programming involves changes to four or more parameters.
19. According to CPT manual instructions, programming codes may be assigned as long as iterative adjustments to the parameters are made and assessed, regardless of whether the final settings are ultimately changed. See also *CPT Assistant,* February 2019, p.6.

Hospital Inpatient Coding and Payment — Effective October 1, 2019 – September 30, 2020

MS-DRG Assignments

Under Medicare's MS-DRG methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 760 diagnosis-related groups, based on the ICD-10-CM codes assigned to the diagnoses and ICD-10-PCS codes assigned to the procedures. Each MS-DRG has a relative weight that is then converted to a flat payment amount. Only one MS-DRG is assigned for each inpatient stay, regardless of the number of procedures performed. The MS-DRGs shown are those typically assigned to the following scenarios. For spinal cord stimulation therapy for chronic pain, DRG assignment varies depending on the diagnosis and the specific procedures performed.

Procedure	Scenario		MS-DRG[1]	MS-DRG Title[1,2]	Relative Weight[1]	Medicare National Average[3]
Screening Test	DRGs are not shown for the screening test because this is rarely performed on an inpatient basis. However, if performed, see the DRGs for Implantation or Replacement: Leads Only					
Note:	**1) *Nervous system disorders*** include: chronic pain disorders, reflex sympathetic dystrophy (CRPS I), causalgia (CRPS II), arachnoiditis, peripheral neuropathy and epidural fibrosis, as well as device complications and attention to device. **2) *Musculoskeletal system disorders*** include: radiculopathy[4] and post laminectomy syndrome.					
Implantation or Replacement: Whole System	Whole system (generator plus leads)	Nervous system disorders[5]	028	Spinal Procedures W MCC	5.5904	$34,990
			029	Spinal Procedures W CC or Spinal Neurostimulators	3.2070	$20,072
		Musculoskeletal system disorders[6]	518	Back and Neck Procedures Except Spinal Fusion W MCC or Disc Device/Neurostimulator	3.4086	$21,334
Implantation or Replacement: Generator Only	Generator only (any type)	Nervous system disorders[7]	040	Peripheral/Cranial Nerve and Other Nervous System Procedures W MCC	3.9404	$24,663
			041	Peripheral/Cranial Nerve and Other Nervous System Procedures W CC or Peripheral Neurostimulator	2.3715	$14,843
			042	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	1.8483	$11,568
		Musculoskeletal system disorders[8]	981	Extensive OR Procedure Unrelated to Principal Diagnosis W MCC	4.4907	$28,107
			982	Extensive OR Procedure Unrelated to Principal Diagnosis W CC	2.4381	$15,260
			983	Extensive OR Procedure Unrelated to Principal Diagnosis W/O CC/MCC	1.6371	$10,247

CONTINUED ON NEXT PAGE

Hospital Inpatient Coding and Payment continued

Procedure	Scenario		MS-DRG[1]	MS-DRG Title[1,2]	Relative Weight[1]	FY 2017 Medicare National Average[3]
Implantation or Replacement: Leads Only	Leads only (one or more)	Nervous system disorders[5]	028	Spinal Procedures W MCC	5.5904	$34,990
			029	Spinal Procedures W CC or Spinal Neurostimulators	3.2070	$20,072
			030	Spinal Procedures W/O CC/MCC	2.2721	$14,221
		Musculoskeletal system disorders[6]	518	Back and Neck Procedures Except Spinal Fusion W MCC or Disc Device/Neurostimulator	3.4086	$21,334
			519	Back and Neck Procedures Except Spinal Fusion W CC	1.9087	$11,946
			520	Back and Neck Procedures Except Spinal Fusion W/O CC/ MCC	1.3380	$8,374
Removal (without replacement)[5,9,10]	Whole system[11] (generator [any type] plus leads [one or more])		028	Spinal Procedures W MCC	5.5904	$34,990
			029	Spinal Procedures W CC or Spinal Neurostimulators	3.2070	$20,072
			030	Spinal Procedures W/O CC/MCC	2.2721	$14,221
	Generator only (any type)		These codes are not considered "significant procedures" for the purpose of DRG assignment. A non-surgical (ie, medical) DRG is assigned to the stay according to the principal diagnosis.			
	Leads only (one or more)		028	Spinal Procedures W MCC	5.5904	$34,990
			029	Spinal Procedures W CC or Spinal Neurostimulators	3.2070	$20,072
			030	Spinal Procedures W/O CC/MCC	2.2721	$14,221
Revision[5,9,10]	Leads only[12] (one or more)		028	Spinal Procedures W MCC	5.5904	$34,990
			029	Spinal Procedures W CC or Spinal Neurostimulators	3.2070	$20,072
			030	Spinal Procedures W/O CC/MCC	2.2721	$14,221
	Generator only (any type)		These codes are not considered "significant procedures" for the purpose of DRG assignment. A non-surgical (ie, medical) DRG is assigned to the stay according to the principal diagnosis.			

CONTINUED ON NEXT PAGE

Hospital Inpatient Coding and Payment

1. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Policy Changes and FY2020 Rates Final Rule 84 Fed. Reg. 42044-42701. https://www.govinfo.gov/content/pkg/FR-2019-08-16/pdf/2019-16762.pdf. Published August 16, 2019. Correction Notice 84 Fed. Reg. 53603-53630 https://www.govinfo.gov/content/pkg/FR-2019-10-08/pdf/2019-21865.pdf. Published October 8, 2019.
2. W MCC in MS-DRG titles refers to secondary diagnosis codes that are designated as major complications or comorbidities. MS-DRGs W MCC have at least one major secondary complication or comorbidity. Similarly, W CC in MS-DRG titles refers to secondary diagnosis codes designated as other (non-major) complications or comorbidities, and MS-DRGs W CC have at least one other (non-major) secondary complication or comorbidity. MS-DRGs W/O CC/MCC have no secondary diagnoses that are designated as complications or comorbidities, major or otherwise. Note that some secondary diagnoses are only designated as CCs or MCCs when the conditions were present on admission, and do not count as CCs or MCCs when the conditions were acquired in the hospital during the stay.
3. Payment is based on the average standardized operating amount ($5,796.63) plus the capital standard amount ($462.33). Centers for Medicare & Medicaid Services. Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Policy Changes and FY2020 Rates Final Rule 84 Fed Reg 42651-42652 https://www.govinfo.gov/content/pkg/FR-2019-08-16/pdf/2019-16762.pdf. Published August 16, 2019. Correction Notice 84 Fed. Reg. 53613-53614. https://www.govinfo.gov/content/pkg/FR-2019-10-08/pdf/2019-21865.pdf. Published October 8, 2019. Tables 1A-1D. The payment rate shown is the standardized amount for facilities with a wage index greater than one. The average standard amounts shown also assume facilities receive the full quality update. The payment will also be adjusted by the Wage Index for specific geographic locality. Therefore, payment for a specific hospital will vary from the stated Medicare national average payment levels shown. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the national average payment amount shown.
4. Radiculopathy is considered a musculoskeletal disorder for DRG purposes, with two exceptions: cervical and cervicothoracic codes M54.12 and M54.13 are considered nervous system disorders.
5. There are three MS-DRGs for spinal procedures with a nervous system principal diagnosis (DRGs 028, 029, and 030); the difference is whether secondary diagnoses are designated as MCCs or CCs. However, for a whole system neurostimulator implantation in which both generator plus leads are coded, MS-DRG 030 cannot be assigned. Instead, MS-DRG 029 is automatically assigned for a whole system implantation regardless of whether a CC is present or not. If an MCC is also present with a whole system implantation, MS-DRG 028 is assigned. For other spinal procedures, such as lead only implantation or lead removal, the full range of MS-DRGs 028, 029, and 030 is available.
6. There are three MS-DRGs for back and neck procedures with a musculoskeletal system principal diagnosis (DRGs 518, 519 and 520); the difference is whether secondary diagnoses are designated as MCCs or CCs. However, for a whole system neurostimulator implantation in which both generator plus leads are coded, MS-DRG 518 is automatically assigned regardless of whether an MCC is present. For other spinal procedures, such as lead only implantation, the full range of MS-DRGs 518, 519 and 520 is available.
7. The ICD-10-PCS codes for generator implantation are not specific to spinal neurostimulation so the MS-DRGs for Other Nervous System Procedures are assigned rather than the MS-DRGs for Spinal Procedures.
8. The generator implantation codes are designated as nervous system procedures only. When a musculoskeletal disorder is used as the principle diagnosis, the "mismatch" DRGs of 981, 982, and 983 are assigned. The DRGs are valid and payable.
9. Procedures involving device removal without replacement and device revision are typically performed as an outpatient. They are shown here for the occasional scenario where removal or revision take place as an inpatient.
10. Neurostimulators may be revised or removed for diagnoses involving device complications, which are classified as nervous system disorders. Because neurostimulators are classified as nervous system devices, removal and revision procedures are assigned to Nervous System MS-DRGs in these scenarios.
11. When the generator and leads are removed together, the lead removal code is the "driver" and groups to the DRGs shown.
12. For lead revision, the DRGs reflect surgical revision of the intraspinal portion of the lead, eg, repositioning a displaced lead within the spinal canal.

ASC Coding and Payment — Effective January 1, 2020 – December 31, 2020

CPT® Procedure Codes

ASCs use CPT codes for their services. Medicare payment for procedures performed in an ambulatory surgery center is generally based on Medicare's ambulatory patient classification (APC) methodology for hospital outpatient payment. However, Comprehensive APCs (C-APCs) are used only for hospital outpatient services and are not applied to procedures performed in ASCs. Alternately, payment for some CPT codes is based on the physician fee schedule payment, particularly for procedures commonly performed in the physician office.

Each CPT code designated as a covered procedure in an ASC is assigned a comparable weight as under the hospital outpatient APC system. This is then converted to a flat payment amount using a conversion factor unique to ASCs. Multiple procedures can be paid for each claim. Certain ancillary services, such as imaging, are also covered when they are integral to covered surgical procedures, although they may not be separately payable. In general, there is no separate payment for devices; their payment is packaged into the payment for the procedure.

Procedure	CPT Code and Description[1]	Payment Indicator[2,3,4]	Multiple Procedure Discounting[5]	Relative Weight[2,4]	Medicare National Average[2,4,6]
Screening Test[7]	**63650** Percutaneous implantation of neurostimulator electrode array, epidural[8]	J8	N	94.5580	$4,515
Lead Implantation[7]	**63650** Percutaneous implantation of neurostimulator electrode array, epidural[8]	J8	N	94.5580	$4,515
	63655 Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	J8	N	333.9190	$15,944
Generator Implantation or Replacement[9]	**63685** Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	J8	N	491.5123	$23,468
Removal of Leads[10, 11,12]	**63661** Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed	G2	N	16.6878	$797
	63662 Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy when performed	G2	N	38.6610	$1,846
Revision or Replacement of Leads[11,12]	**63663** Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed	J8	N	92.4349	$4,413
	63664 Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy when performed	J8	N	304.1766	$14,524
Revision or Removal Of Generator[9]	**63688** Revision or removal of implanted spinal neurostimulator pulse generator or receiver	A2	N	38.6610	$1,846

CONTINUED ON NEXT PAGE

ASC Coding and Payment

1. CPT copyright 2019 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.
2. Centers for Medicare & Medicaid Services. Medicare Program: Changes to Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems. Final Rule. 84 Fed. Reg. 61370-61410. https://www.govinfo.gov/content/pkg/FR-2019-11-12/pdf/2019-24138.pdf. Published November 12, 2019. Correction Notice 85 Fed Reg 224-230. https://www.govinfo.gov/content/pkg/FR-2020-01-03/pdf/2019-28364.pdf. Published January 3, 2020.
3. The Payment Indicator shows how a code is handled for payment purposes. J8 = device-intensive procedure, payment amount adjusted to incorporate device cost; A2 = surgical procedure, payment based on hospital outpatient rate adjusted for ASC; G2 = surgical procedure, non-office-based, payment based on hospital outpatient rate adjusted for ASC.
4. Medicare national average payment is determined by multiplying the relative weight by the ASC conversion factor. The 2020 ASC conversion factor is $47.747. The conversion factor of $47.747 assumes the ASC meets quality reporting requirements. Centers for Medicare & Medicaid Services. Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems. Final Rule. 84 Fed. Reg. 61410. https://www.govinfo.gov/ content/pkg/FR-2019-11-12/pdf/2019-24138.pdf. Published November 12, 2019. Correction Notice 85 Fed Reg 226, 228. https://www.govinfo.gov/content/pkg/FR-2020-01-03/pdf/2019-28364.pdf. Published January 3, 2020. Payment is adjusted by the wage index for each ASC's specific geographic locality, so payment will vary from the stated national average Medicare payment levels displayed. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the national average payment amount shown.
5. When multiple procedures are coded and billed, payment is usually made at 100% of the rate for the first procedure and 50% of the rate for the second and all subsequent procedures. These procedures are marked "Y." However, procedures marked "N" are not subject to this discounting and are paid at 100% of the rate regardless of whether they are submitted with other procedures.
6. For Medicare billing, ASCs use a CMS-1500 form.
7. As defined and as published by the AMA (*CPT Assistant,* June 1998, p.4), these codes represent a single lead. When more than one lead is placed, each is coded separately. Medicare instructs that bilateral procedures should either be reported with the CPT procedure code repeated on two separate lines, or reported on a single line with units of "2". Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual, Chapter 14—Ambulatory Surgery Centers, section 40.5: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf. Updated May 23, 2008. Accessed November 7, 2019. Medicare's Medically Unlikely Edits allow 2 units for code 63650 on the same date of service, but only 1 unit for code 63655. Denials for units in excess of the MUE values may be appealed. For billing multiple leads to non-Medicare payers, contact the payer for instructions.
8. The AMA has published (*CPT Assistant*, October 2013, p.19) that use of an incision to admit the needle or to anchor the lead is inherent to percutaneous placement and does not alter use of code 63650. See also *2019 AANS Guide to Coding,* p.68.
9. When an existing generator is removed and replaced by a new generator, only the generator replacement code 63685 may be assigned. NCCI edits do not allow removal of the existing generator to be coded separately. Also note that, according to NCCI policy, use of the CPT code for generator "insertion or replacement" requires placement of a new generator. When the *same* generator is removed and then re-inserted, the "revision" code is used. (NCCI Policy Manual 1/1/2020, Chapter VIII, C.16).
10. The AMA has published that the work of removing a temporary trial lead is inherent to the original percutaneous placement code 63650 and is not coded separately. Code 63661 cannot be assigned for removal of a temporary trial lead that was placed percutaneously. Further, codes 63661 and 63662 apply to surgical removal of permanent leads. Removal of a permanent lead by simple pull is not coded (*CPT Assistant,* August 2010, p.8,15; April 2011, p.10-11,15).
11. The AMA has published that replacement codes 63663 and 63664 are assigned when a permanent lead is replaced by another permanent lead of the same type via the same approach at the same spinal level. The work of removing the existing permanent lead is included and is not coded separately. (*CPT Assistant,* August 2010, p.8,15; April 2011, p.10-11,15). In addition, NCCI edits do not permit removal codes 63661 and 63662 to be assigned separately with replacement codes 63663 and 63664.
12. The AMA has published that when a permanent percutaneous lead is removed and a new lead is placed via a fresh laminectomy at the same or a different spinal level, insertion code 63655 is assigned with removal code 63661 (*CPT Assistant,* April 2011, p.11,15). NCCI edits allow this combination without use of a modifier.

Medtronic

Medtronic Inc.
710 Medtronic Pkwy
Minneapolis, MN 55432
USA
Tel. 1-763-505-5000

medtronic.com