Medtronic

Deep brain stimulation

2026 coding and payment guide

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Physician coding and payment

Effective January 1, 2026 – December 31, 2026

Procedure	CPT procedure code and description[1]	Medicare work RVUs[2]	Medicare national average[†,3] For physician services provided in:	
			Physician office	Facility
Bone marker fiducial placement[a]	**N/A**	N/A	N/A	N/A
Lead implantation or replacement[b]	**61863** Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array	20.19	N/A	$1,496
	61864 each additional array	4.38	N/A	$259
	61867 Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array	32.20	N/A	$2,206
	61868 each additional array	7.71	N/A	$456
Generator implantation or replacement[c]	**61885** Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling, with connection to a single electrode array	5.90	N/A	$558
	61886 Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling, with connection to 2 or more electrode arrays	9.68	N/A	$932
	For bilateral stimulation via implantation or replacement of two single array pulse generators, one on each side connected to a single lead, use 61885-50 for the generators plus 61863 and 61864 or 61867 and 61868 for the leads.[d] For bilateral stimulation via implantation or replacement of one dual array pulse generator with connection to two leads, use 61886 for the generator plus 61863 and 61864 or 61867 and 61868 for the leads.			
Intraoperative stimulation with microelectrode recording[e,f]	**95961-26** Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of attendance by physician or other qualified healthcare professional	2.97	N/A	$170
	95962-26 each additional hour of attendance by physician or other qualified healthcare professional	3.21	N/A	$182

† Rates shown reflect the CY 2026 Medicare Physician Fee Schedule for clinicians who did not qualify as participants in Advanced Alternative Payment Model (APM). Physicians and other eligible clinicians who qualify as participants in an Advanced APM under the Quality Payment Program may receive higher payment rates.

Physician coding and payment – continued

Procedure	CPT procedure code and description[1]	Medicare work RVUs[2]	Medicare national average[3]	
			For physician services provided in:	
			Physician office	Facility
Revision or removal of leads or generator[b,c]	**61880** Revision or removal of intracranial neurostimulator electrodes	6.78	N/A	$620
	61888 Revision or removal of cranial neurostimulator pulse generator or receiver	5.10	N/A	$403
Analysis and 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 the local contractor or payer for interpretation of applicable policies.*	**95970** Electronic analysis of implanted neurostimulator pulse generator/transmitter 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	0.35	$20	$16
	95983 Electronic analysis of implanted neurostimulator pulse generator/transmitter by physician or other qualified health care professional, with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional[g,h,i]	0.91	$52	$42
	95984 with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional[g,h,i]	0.80	$45	$37

HCPCS II device codes[4]

Device C-codes†

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

The device C-codes above are applicable to this therapy. To determine if there is a C-code for a particular Medtronic device, click here for a C-code finder to search by model number, product name, C-code, C-code description, or product category.

Device L-codes†

Pulse generator[i]	**L8679**	Implantable neurostimulator pulse generator, any type
	L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension
	L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
	L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
Patient programmer	**L8681**	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
External recharger	**L8689**	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only

† The entity (provider or facility) that purchases the device should consult with the payer to determine the appropriate device code(s) to use.

Hospital outpatient coding and payment

Effective January 1, 2026 – December 31, 2026

Procedure	CPT procedure code and description[1]	APC[5]	APC Level	Status indicator[5,k]	Relative weight[5]	Medicare national average[5]
Bone marker fiducial placement[a]	**N/A**	N/A	N/A	N/A	N/A	N/A
Diagnostic imaging[l] **and planning**	**70450** CT, head or brain without contrast material[l]	5522	Level 2	Q3	1.1684	$107
	70551 MRI, brain (including brain stem), without contrast material[m]	5523	Level 3	Q3	2.6666	$244
	76376 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image post- processing under concurrent supervision, not requiring image post-processing on an independent workstation[n]	N/A	N/A	N/A	N/A	N/A
	76377 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image post- processing under concurrent supervision, requiring image post-processing on an independent workstation[n]	N/A	N/A	N/A	N/A	N/A
Generator implantation or replacement[c]	**61885** Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling, with connection to a single electrode array	5465	Level 5	J1	344.8675	$31,526
	61886 Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling, with connection to 2 or more electrode arrays	5465	Level 5	J1	344.8675	$31,526
	Note: For bilateral stimulation via implantation or replacement of two single array pulse generators, one on each side connected to a single lead, use 61885-50.[o] For bilateral stimulation via implantation or replacement of one dual array pulse generator with connection to two leads, use 61886.[p] Under Comprehensive APCs for 2025, use of 61885-50 (ie, the equivalent of two occurrences of 61885 and 61885 during the same encounter) does not qualify for a complexity adjustment. When 61885-50 is submitted to show that two generators were placed bilaterally, the entire encounter remains under APC 5464.					
Revision or removal of leads or generator[c]	**61880** Revision or removal of intracranial neurostimulator electrodes	5461	Level 1	J1	39.0727	$3,572
	61888 Revision or removal of cranial neurostimulator pulse generator or receiver	5463	Level 3	J1	124.5314	$11,384

Hospital outpatient coding and payment (continued)

Procedure	CPT procedure code and description[1]	APC[5]	APC level	Status indicator[5,k]	Relative weight[5]	Medicare national average[5]
Analysis/ 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 nor patient should be billed for services rendered by the manufacturer's representative. Contact the local contractor or payer for interpretation of applicable policies.*	**95970** Electronic analysis of implanted neurostimulator pulse generator/transmitter 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	5734	Level 4	Q1	1.4870	$136
	95983 Electronic analysis of implanted neurostimulator pulse generator/transmitter by physician or other qualified health care professional, with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional[g,h,i]	5742	Level 2	S	1.0625	$97
	95984 with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face- to-face time with physician or other qualified health care professional[g,h,i]	N/A	N/A	N	N/A	N/A

Hospital inpatient coding and payment

Effective October 1, 2025 – September 30, 2026

ICD-10-PCS procedure codes[6]

Lead Implantation	**00H00MZ**	Insertion of neurostimulator lead into brain, open approach
	00H03MZ	Insertion of neurostimulator lead into brain, percutaneous approach
Extension implantation	**0JHS3YZ**	Insertion of other device into head and neck subcutaneous tissue and fascia, percutaneous approach (extension)
Generator implantation[q]	**0JH60BZ**	Insertion of single array stimulator generator into chest subcutaneous tissue and fascia, open approach
	0JH60DZ	Insertion of multiple array stimulator generator into chest subcutaneous tissue and fascia, open approach
	0JH60EZ	Insertion of multiple array rechargeable stimulator generator into chest subcutaneous tissue and fascia, open approach
Lead removal	**00P00MZ**	Removal of neurostimulator lead from brain, open approach
	00P03MZ	Removal of neurostimulator lead from brain, percutaneous approach
Extension removal	**0JPS3YZ**	Removal of other device from head and neck subcutaneous tissue and fascia, percutaneous approach (extension)
Generator removal	**0JPT0MZ**	Removal of stimulator generator from trunk subcutaneous tissue and fascia, open approach
	0JPT3MZ	Removal of stimulator generator from trunk subcutaneous tissue and fascia, percutaneous approach
Lead replacement or 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.[r]	
Lead revision[s]	**00W00MZ**	Revision of neurostimulator lead in brain, open approach
	00W03MZ	Revision of neurostimulator lead in brain, percutaneous approach
Extension revision	**0JWS3YZ**	Revision of other device in head and neck subcutaneous tissue and fascia, percutaneous approach (extension)
Generator revision[t]	**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

MS-DRG assignments for essential tremor, Parkinson's disease, epilepsy, and dystonia

Procedure	Scenario	MS-DRG[7]	MS-DRG title[7]	Relative weight[7]	Medicare national average[8]
Implantation or replacement: whole system	Single array or multiple array generator (non-rechargeable or rechargeable) plus leads (one or more)	023	Craniotomy with major device implant or acute complex CNS principal diagnosis W MCC or antineoplastic implant or epilepsy W/ neurostimulator	5.7303	$41,698
		024	Craniotomy with major device implant or acute complex CNS principal diagnosis W/O MCC or antineoplastic implant or epilepsy W/ neurostimulator	3.9119	$28,466

Hospital inpatient coding and payment - MS-DRG assignments for essential tremor, Parkinson's disease, epilepsy, and dystonia (continued)

Procedure	Scenario	MS-DRG[7]	MS-DRG title[7]	Relative weight[7]	Medicare national average[8]
Implantation or replacement: generator only or lead only	Generator only (any type)	040	Peripheral/cranial nerve and other nervous system procedures W MCC	3.8612	$28,097
		041	Peripheral/cranial nerve and other nervous system procedures W CC or peripheral neurostimulator	2.1987	$15,999
		042	Peripheral/cranial nerve and other nervous system procedures W/O CC/MCC	1.7277	$12,572
	Leads only (one or more)	025	Craniotomy and endovascular intracranial procedures W MCC	4.5467	$33,085
		026	Craniotomy and endovascular intracranial procedures W CC	3.1092	$22,625
		027	Craniotomy and endovascular intracranial procedures WO CC/MCC	2.5229	$18,359
Removal (without replacement)[u]	Whole system (generator [any type] plus leads [one or more])[v]	025	Craniotomy and endovascular intracranial procedures W MCC	4.5467	$33,085
		026	Craniotomy and endovascular intracranial procedures W CC	3.1092	$22,625
		027	Craniotomy and endovascular intracranial procedures WO CC/MCC	2.5229	$18,359
	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)	025	Craniotomy and endovascular intracranial procedures W MCC	4.5467	$33,085
		026	Craniotomy and endovascular intracranial procedures W CC	3.1092	$22,625
		027	Craniotomy and endovascular intracranial procedures WO CC/MCC	2.5229	$18,359
Revision	Leads[w] (one or more)	025	Craniotomy and endovascular intracranial procedures W MCC	4.5467	$33,085
		026	Craniotomy and endovascular intracranial procedures W CC	3.1092	$22,625
		027	Craniotomy and endovascular intracranial procedures WO CC/MCC	2.5229	$18,359
	Generator (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.			

MS-DRG assignments for obsessive-compulsive disorder ‡

Procedure	Scenario	MS-DRG[7]	MS-DRG title[7]	Relative weight[7]	Medicare national average[8]
Implantation or replacement: whole system[x]	Generator (any type) plus leads (one or more)	876	OR procedures W principal diagnoses of mental illness	3.8649	$28,124
Implantation or replacement: generator only or lead only[x]	Generator only (any type)	876	OR procedures W principal diagnoses of mental illness	3.8649	$28,124
	Leads only (one or more)	876	OR procedures W principal diagnoses of mental illness	3.8649	$28,124
Removal (without replacement)[u,y]	Whole system (generator [any type] plus leads [one or more])[s]	025	Craniotomy and endovascular intracranial procedures W MCC	4.5467	$33,085
		026	Craniotomy and endovascular intracranial procedures W CC	3.1092	$22,625
		027	Craniotomy and endovascular intracranial procedures WO CC/MCC	2.5229	$18,359
	Generator only (any type)	These codes are not considered "significant procedures" for the purpose of DRG assignment. A non-surgical (i.e., medical) DRG is assigned to the stay according to the principal diagnosis.			
	Leads only (one or more)	025	Craniotomy and endovascular intracranial procedures W MCC	4.5467	$33,085
		026	Craniotomy and endovascular intracranial procedures W CC	3.1092	$22,625
		027	Craniotomy and endovascular intracranial procedures WO CC/MCC	2.5229	$18,359
Revision[y]	Leads[w] (one or more)	025	Craniotomy and endovascular intracranial procedures W MCC	4.5467	$33,085
		026	Craniotomy and endovascular intracranial procedures W CC	3.1092	$22,625
		027	Craniotomy and endovascular intracranial procedures WO CC/MCC	2.5229	$18,359
	Generator (any type)	These codes are not considered "significant procedures" for the purpose of DRG assignment. A non-surgical (i.e., medical) DRG is assigned to the stay according to the principal diagnosis			

‡**Humanitarian device**: The effectiveness of devices for the treatment of obsessive-compulsive disorder has not been demonstrated. DBS therapy for obsessive-compulsive disorder is approved under a Humanitarian Device Exemption, which only allows devices to be implanted in facilities with an Institutional Review Board.

ASC coding and payment

Effective January 1, 2026 – December 31, 2026

For Essential Tremor, Parkinson's Disease, epilepsy, and dystonia

Procedure	CPT procedure code and description[1]	Payment indicator[z]	Multiple procedure discounting[aa]	Relative weight[9]	Medicare national average[9]
Generator implantation or replacement[c]	**61885** Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling, with connection to a single electrode array	J8	N	496.8724	$27,985
	61886 Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling, with connection to 2 or more electrode arrays	J8	N	486.5230	$27,402
	For bilateral stimulation via implantation or replacement of two single array pulse generators, one on each side connected to a single lead, report 61885 twice. This can be with 61885 repeated on two separate lines, or on a single line with units of 2.[bb] For bilateral stimulation via implantation or replacement of one dual array pulse generator with connection to two leads, use 61886.[p]				
Revision or removal of leads or generator[c]	**61880** Revision or removal of intracranial neurostimulator electrodes	G2	Y	35.5707	$2,003
	61888 Revision or removal of cranial neurostimulator pulse generator or receiver	J8	Y	154.2555	$8,688

Annual references

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2. PFS 2026 Final Rule CMS-1832-F Addenda. Cms.gov. Published October 31, 2025. https://www.cms.gov/files/zip/cy-2026-pfs-final-rule-addenda.zip. Although the total RVU consists of three components, only the physician work RVU is shown here.
3. PFS 2026 Final Rule CMS-1832-F | CMS. Cms.gov. Published October 31, 2025. https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-f. Local physician rates will vary based on location specific factors not reflected in this document.
4. HHCPCS 2025 Level II Professional Edition. American Medical Association; 2024.
5. OPPS 2026 Final Rule CMS-1834-FC | CMS. Cms.gov. Published November 21, 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1834-fc. Rates shown reflect the unadjusted OPPS payment rates. Actual reimbursement may vary based on hospital-specific factors, such as wage index, geographic adjustments, and other CMS payment modifiers.
6. AAPC. *ICD-10-PCS Code Book 2026*. AAPC; 2025.
7. CMS. ICD-10-CM/PCS MS-DRG v43.0 Definitions Manual. Cms.gov. Published 2025. https://www.cms.gov/icd10m/FY2026-fr-v43-fullcode-cms/fullcode_cms/P0001.html
8. FY 2026 IPPS Final Rule Home Page | CMS. Cms.gov. Published July 31, 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps-final-rule-home-page. Rates shown reflect the unadjusted IPPS payment rates. Actual reimbursement may vary based on hospital-specific factors, such as wage index, geographic adjustments, and other CMS payment modifiers.
9. ASC 2026 Final Rule CMS-1834-FC | CMS. Cms.gov. Published November 21, 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and-notices/cms-1834-fc. Rates shown reflect the unadjusted ASC payment rates. Actual reimbursement may vary based on hospital-specific factors, such as wage index, geographic adjustments, and other CMS payment modifiers.

Important information

a. The AMA has published that placement of fiducials is integral to DBS lead implantation and is not coded separately. This is true even if the fiducials are placed during a separate encounter, in the physician's office, and/or on a different date prior to the lead implantation. *CPT Assistant, October 2010, p.9*.

b. When an existing lead is removed and replaced by a new lead, only the lead implantation code 61863-61867 may be assigned. For lead replacement, NCCI edits do not permit removal of the existing lead to be coded separately with placement of the new lead.

c. When an existing generator is removed and replaced by a new generator, only the generator replacement code 61885 or 61886 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 CPT code 61885 or 61886 for generator "insertion or replacement" requires placement of a new generator. When the same generator is removed and then re-inserted, "revision" code 61888 is used. *NCCI Policy Manual 1/1/2024, Chapter VIII, C.16*.

d. Medicare permits the use of bilateral modifier -50 with code 61885. To show bilateral placement of two single-array generators, submit 61885-50 with 1 unit. *Centers for Medicare and Medicaid Services. Transmittal 1421, CR 8853*. See also *Medicare Claims Processing Manual, Chapter 12–Physicians/Nonphysician Practitioners, section 40.7.B*. Note that Medicare's Medically Unlikely Edits allow 1 unit for code 61885.

e. As defined, microelectrode recording (MER)is included in lead implantation codes 61867-61868. CPT manual instructions and NCCI edits do not allow 95961-95962 to be coded separately with lead implantation when MER is performed by the operating surgeon. However, according to CPT manual instructions, when another physician (eg, neurologist or neurophysiologist) performs the cortical or subcortical mapping during the placement of the electrode array, that physician may report codes 95961-95962 separately.

f. When 95961-95962 are reported separately (ie, performed by a different physician), the time counted includes setting up/assessing the stimulating/recording equipment, making connections to the implanted electrodes, doing the mapping/stimulating (including conferring with the surgeon) until all stimulation is complete, and reporting. *CPT Assistant, October 2023*.

g. Per CPT manual instructions, programming performed at the time of lead or generator implantation is not integral and may be coded separately. NCCI edits prohibit use of programming codes 95983 and 95984 with lead or generator implantation codes, but they allow an override in this scenario.

h. 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.

i. Codes 95983 and 95984 are defined for 15 minutes. According to CPT manual instructions, a unit of service is attained when the midpoint of time is passed, ie, 8 minutes. Initial or additional programming of less than 8 minutes is not coded.

j. Generator codes L8686-L8688 are not recognized as valid by Medicare. When billing Medicare, hospitals typically use C-codes and ASCs generally do not submit HCPCS II codes for devices. For non-Medicare payers, codes L8686-L8688 remain available. However, all providers should check with the payer for specific coding and billing instructions. *Medicare Claims Processing Manual, Chapter 32 – Billing Requirements for Special Services, Section 68 IDE Studies and Section 69 Qualifying Clinical Trials*.

k. Status Indicator (SI) shows how a code is handled for payment purposes: J1 = paid under a comprehensive APC, single payment based on primary service without separate payment for other adjunctive services; N = packaged service, no separate payment; S = always paid at 100% of rate; Q1 = STV packaged codes, not paid separately when billed with an S, T, or V procedure.

l. Pre-operative CT and MRI imaging may be coded separately when they represent full-scale diagnostic imaging, and the interpretation is documented via a formal imaging report. However, some payers may require imaging guidance codes such as 77011 and 77021 instead. Intra-operative imaging is part of surgical navigation and should not be coded separately.

m. More broadly, these codes have status indicator Q3. For CT and MRI, status indicator Q3 shows that the service may be part of a composite APC if billed with other similar imaging services. However, within the context of services related to Medtronic DBS Therapy, the codes will generally be paid separately under the APCs, status indicator, and rates shown.

n. The 3D rendering codes are reported in addition to the code for the base CT or MRI procedure. However, they are packaged into APC payment for the base imaging and are not separately payable.

o. Medicare permits the use of bilateral modifier -50 with code 61885. To show bilateral placement of two single-array generators, submit 61885-50 with 1 unit. *Centers for Medicare and Medicaid Services. Transmittal 1421, CR 8853*.

p. See *AHA's Coding Clinic for HCPCS, 3rd Q 2011, p.10* for bilateral stimulation via a dual array neurostimulator generator.

q. Codes defined as "multiple array" include dual array neurostimulator generators, a type of multiple array generator in which two leads are connected to one generator. See the ICD-10-PCS Device Key for specific model names and related device values. Do not assign default device value M- Stimulator Generator.

r. *CMS ICD-10-PCS Reference Manual 2016, p.67*; see also *Coding Clinic, 3rd Q 2014, p.19-20*.

s. For lead revision, the ICD-10-PCS codes refer to surgical revision of the intracranial portion of the lead, eg, repositioning. For revision of the subcutaneous portion of the lead or revision of a subcutaneous extension, see Generator Revision.

t. 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 generator as well, they can also be represented by the generator revision codes.

u. Procedures involving device removal without replacement, particularly for generators, are frequently performed as outpatient. They are shown here for the occasional scenario where removal takes place as an inpatient.

v. When the generator and leads are removed together, the lead removal code is the "driver" and groups to the DRGs shown.

w. For lead revision, the DRGs reflect surgical revision of the intracranial portion of the lead, eg, repositioning a displaced lead within brain tissue.

x. Although neurostimulators are nervous system devices, implantation procedures are assigned to the Mental Disorder MS-DRG when neurostimulators are implanted for the diagnosis of obsessive-compulsive disorder.

y. Because neurostimulators are nervous system devices, removal and revision procedures are assigned to Nervous System MS-DRGs in scenarios where neurostimulators are revised or removed for diagnoses involving device complications and routine device replacement.

z. The Payment Indicator shows how a code is handled for payment purposes. J8 = device-intensive procedure, payment amount adjusted to incorporate device cost; G2 = surgical procedure, non-office-based, payment based on hospital outpatient rate adjusted for ASC.

aa. 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.

bb. Medicare does not recognize the use of bilateral modifier -50 for payment in the ASC and 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 2 units. *Medicare Claims Processing Manual, Chapter 14–Ambulatory Surgery Centers, section 40.5*. Medicare's Medically Unlikely Edits (MUE) allow 1 unit for code 61885, but this value is doubled for ASCs. *Centers for Medicare and Medicaid Services, Transmittal 1421, CR 8853, 4-General Processing Instructions*. For billing bilateral neurostimulators to non-Medicare payers, contact the payer for instructions.

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