Medtronic

Gastric Electrical Stimulation

Commonly Billed Codes

2022

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COMMONLY BILLED CODES

Humanitarian Device: The Enterra™ Therapy system for gastric electrical stimulation is authorized by Federal law for use in treatment of chronic intractable (drug refractory) nausea and vomiting secondary to gastroparesis of diabetic or idiopathic etiology. The effectiveness of this device for this use has not been demonstrated.

The Enterra™ system must be implanted in an IRB-approved facility.

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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. Medtronic Gastrointestinal Electronic Stimulation (GES) is intended to treat the symptoms of chronic intractable nausea and vomiting secondary to gastroparesis of diabetic or idiopathic etiology. Because symptom codes are generally not acceptable as the principal diagnosis, the principal diagnosis is coded to the underlying conditions as shown.

Diabetic Gastroparesis[2]	**Diabetic Gastroparesis**	
	E10.43	Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy
	E11.43	Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy
	E13.43	Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy[3]
	plus	
	K31.84	Gastroparesis
	Gastroparesis due to Secondary Diabetes[4]	
	E08.43	Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy
	E09.43	Drug or chemical induced diabetes mellitus with neurological complications with diabetic autonomic (poly)neuropathy
	plus	
	K31.84	Gastroparesis
Idiopathic Gastroparesis	**K31.84**	Gastroparesis

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ICD-10-CM[1] Diagnosis Codes continued

Device Complications[5,6]	**T85.111A**	Breakdown (mechanical) of implanted electronic neurostimulator of peripheral nerve electrode (lead)[7]
	T85.113A	Breakdown (mechanical) of implanted electronic neurostimulator, generator
	T85.121A	Displacement of implanted electronic neurostimulator of peripheral nerve electrode (lead)[7]
	T85.123A	Displacement of implanted electronic neurostimulator, generator
	T85.191A	Other mechanical complication of implanted electronic neurostimulator of peripheral nerve electrode (lead)[7]
	T85.193A	Other mechanical complication of implanted electronic neurostimulator, generator
	T85.732A	Infection and inflammatory reaction due to implanted electronic neurostimulator of peripheral nerve, electrode (lead)[7]
	T85.734A	Infection and inflammatory reaction due to implanted electronic neurostimulator generator
	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[8]
Attention to Device[9]	**Z45.42**	Encounter for adjustment and management of neurostimulator
Neurostimulator Status[10]	**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). https://www.cdc.gov/nchs/icd/icd10cm.htm. Updated October 1, 2021.
2. Diabetic gastroparesis involves two codes, one for diabetes and one for gastroparesis. Coding Clinic, 4th Q 2013, p.114. The diabetes code is always sequenced before the code for gastroparesis.
3. "Other specified" types of diabetes include diabetes mellitus due to genetic defects in insulin action and post-pancreatectomy diabetes mellitus, as well as diabetes mellitus "type 1.5". Coding Clinic, 3rd Q 2018, p.4-5.
4. Secondary diabetes is caused by some other condition or event. ICD-10-CM manual notes provide code sequencing instructions. In diabetes due to an underlying condition, eg, cystic fibrosis or pancreatic cancer, the other condition is coded separately and sequenced before the code for diabetes. In drug or chemical induced diabetes, eg, diabetes due to long-term steroid use, sequencing depends on whether diabetes resulted from poisoning or overdose or was the result of an adverse effect of the drug.
5. 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. ICD-10-CM Official Guidelines for Coding and Reporting FY 2022, II..G.
6. 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 2022, I.C.19.A.
7. According to ICD-10-CM manual notes, complications of gastric neurostimulator leads are assigned to codes for "peripheral nerve electrode (lead)". Although the leads are placed in stomach tissue, neurostimulators are classified as nervous system devices.
8. According to ICD-10-CM manual notes, "other specified complication" includes erosion or breakdown of a subcutaneous device pocket.
9. 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 2022, I.C.21.c.7.
10. 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.

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ICD-10-PCS[1] Procedure Codes

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

Lead Implantation[2]	**0DH60MZ**	Insertion of stimulator lead into stomach, open approach
	0DH64MZ	Insertion of stimulator lead into stomach, percutaneous endoscopic approach
Lead Removal[2]	**0DP60MZ**	Removal of stimulator lead from stomach, open approach
	0DP64MZ	Removal of stimulator lead from stomach, percutaneous endoscopic 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.[3]	
Lead Revision[2, 4]	**0DW60MZ**	Revision of stimulator lead in stomach, open approach
	0DW64MZ	Revision of stimulator lead in stomach, percutaneous endoscopic approach
Neurostimulator Generator Implantation[5, 6, 7]	**0JH80DZ**	Insertion of multiple array stimulator generator into abdomen subcutaneous tissue and fascia, open approach
Neurostimulator Generator Removal[7]	**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
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.[3]	
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/icd-10/2022-icd-10-pcs . Updated October 1, 2021.
2. Approach value 0-Open is used when lead procedures are performed via laparotomy and approach value 4-Percutaneous Endoscopic is used when lead procedures are performed via laparoscopy.
3. CMS ICD-10-PCS Reference Manual 2016, p.67. See also Coding Clinic, 3rd Q 2014, p.19-20.
4. For Lead Revision, the ICD-10-PCS codes refer to surgical revision of leads within the intra-abdominal space or gastric tissue, eg. repositioning. For revision of the subcutaneous portion of the lead, see Generator Revision.
5. Body part value 8-Abdomen is shown because the Enterra™ generator is typically placed into the subcutaneous tissue of the abdomen. Other body part values are also available for sites such as subcutaneous tissue of chest and subcutaneous tissue of back.
6. Device value D-Multiple Array Stimulator Generator is shown because Enterra™ is a dual array non-rechargeable generator. See also the ICD-10-PCS Device Key. "Multiple array" includes dual array neurostimulator generators for which two leads are connected to one generator. Do *not* assign default 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 re-inserting the *same* generator. However, there are no ICD-10-PCS codes specifically defined for revising the subcutaneous portion of a lead. Because these services usually involve removing and re-inserting the 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.

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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. HCPCS II device codes are only reported on physician office and facility 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
	L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension

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 December 30, 2021.
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. The Enterra™ system requires two leads, each containing one electrode. Lead code L8680 is not recognized as valid by Medicare. Hospitals typically use C-codes and ASCs generally do not submit HCPCS II codes for devices. For non-Medicare payers, code L8680 remains available but hospitals should check with the payer for instructions.
4. Generator code L8688 is 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, code L8688 remains available. However, all providers should check with the payer for specific coding and billing instructions.

Device C-Codes (Medicare)[1]

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.

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
Lead[3]	**C1778**	Lead, neurostimulator (implantable)

1. Healthcare Common Procedure Coding System (HCPCS) Level II codes, including device C-codes, are maintained by the Centers for Medicare and Medicaid Services. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update. Accessed November 30, 2021.
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 but 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 30, 2021.
3. The Enterra™ system requires two leads with one electrode each.

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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	CPT Code Description[3]	HCPCS II Device Codes	HCPCS II Code Description
43647[4]	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	**C1778**	Lead, neurostimulator (implantable)
64590[5]	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling	**C1767**	Generator, neurostimulator (implantable), non-rechargeable

Effective March 1, 2020, Medicare also maintains a separate edit for neurostimulator generator HCPCS II code L8679 requiring that certain CPT codes must be present on the bill whenever L8679 is submitted.[6]

HCPCS II Device Codes	HCPCS II Code Description	CPT Procedure Code	CPT Code Description
L8679	Implantable neurostimulator pulse generator, any type	**64590**	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling
		64595	Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver

1. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems. Final Rule. 86 Fed Reg 63618-63619. https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf Published November 16, 2021.
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.
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4. HCPCS II device code L8680 will also pass the edits with CPT procedure code 43647, but this code is not shown because it is not otherwise recognized by Medicare.
5. HCPCS II device code L8688 for the generator type will also pass the edits with CPT procedure code 64590 but this code is not shown because it is not otherwise recognized by Medicare.
6. See MLN Matters SE20001. https://www.cms.gov/files/document/se20001.pdf. Published January 29, 2020. Accessed November 30, 2021.

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Physician Coding and Payment — January 1, 2022 – December 31, 2022

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
Lead Implantation or Replacement, Laparoscopic[6,7,8]	**43647** Laparoscopy, surgical, implantation or replacement of gastric neurostimulator electrodes, antrum[9,10]	—	Contractor Priced	—	Contractor Priced
Lead Implantation or Replacement, Open[6,7,8]	**43881** Implantation or replacement of gastric neurostimulator electrodes, antrum, open[9,10]	—	Contractor Priced	—	Contractor Priced
Generator Implantation or Replacement[6,11]	**64590** Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling	See note 12	4.73	See note 12	$164
Lead Revision or Removal, Laparoscopic[6,7]	**43648** Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum[9,10]	—	Contractor Priced	—	Contractor Priced
Lead Revision or Removal, Open[6,7]	**43882** Revision or removal of gastric neurostimulator electrodes, antrum, open[9,10]	—	Contractor Priced	—	Contractor Priced
Generator Revision or Removal[6,11]	**64595** Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver	See note 12	3.73	See note 12	$129
Endoscopy (EGD)	**43235** Esophagogastroduodenoscopy, flexible, transoral, diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)[13]	9.09	3.59	$315	$124

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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.	**95980** Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter, intraoperative, with programming[14]	N/A	1.34	N/A	$46
	95981 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter, subsequent, without reprogramming	1.13	0.52	$39	$18
	95982 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter, subsequent, with reprogramming[15]	1.73	1.07	$60	$37

Physician Coding and Payment *continued*

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2. Centers for Medicare & Medicaid Services. Medicare Program; CY2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies Final Rule; 86 Fed. Reg. 64996-66031 https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf . Published November 19, 2021. 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 2022 is $34.6062 per 86 Fed. Reg. 65619 as amended by the Protecting Medicare and American Farmers from Sequester Cuts Act, signed December 10, 2021. See also the current 2022 release of the PFS Relative Value File at http:/www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files . 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 2022 PFS Final Rule Addenda. Addendum A CMS-1751-F-CY2022. Explanation of Addendum B and C. https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1751-f. Released November 22, 2021.
6. Surgical procedures are subject to a "global period." The global period defines other physician services that are generally considered part of the surgery and are not separately coded, billed, or paid when rendered by the physician who performed the surgery. The services include: preoperative visits the day before or the day of the surgery, postoperative visits related to recovery from the surgery for 10 days or more depending on the specific procedure and the contractor, 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 30, 2021.
7. When an existing lead is removed and replaced by a new lead, only the lead implantation code 43647 or 43881 may be assigned. For lead replacement, National Correct Coding Initiative (NCCI) edits do not allow removal of the existing lead to be coded separately with implantation of the new lead.
8. Although two leads are implanted, these codes are assigned just once. The published vignettes for lead implantation codes 43647 and 43881 include two leads, and Medicare's Medically Unlikely Edits (MUE) allow only 1 unit for code 43647 and 1 unit for code 43881.
9. For Medicare, this is a contractor-priced code. Contractors establish the RVUs and the payment amount, as well as the global period, usually on an individual basis after review of the procedure report.
10. Although payment to the physician is determined by the contractor, physicians should note that Medicare restricts corresponding payment to the facility by site of service. On a practical basis, these restrictions for the facility may impact the available sites of service for the physician as well. Medicare allows laparoscopic lead implantation 43647 and laparoscopic lead revision 43648 to be performed in the hospital outpatient setting. However, open lead implantation 43881 and open lead revision 43882 are currently permitted only as inpatient and if performed on an outpatient basis, the hospital will not be paid. Medicare Claims Processing Manual, Chapter 4-Part B Hospital, section 180.7 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf . Accessed November 30, 2021. Medicare does not allow any lead procedures, laparoscopic or open, in the ASC and if performed there, Medicare makes no payment to the ASC. Medicare Claims Processing Manual, Chapter 14-Ambulatory Surgical Centers, section 10.2, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf . Accessed November 30, 2021.
11. When an existing generator is removed and replaced by a new generator, only the generator replacement code 64590 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 1/1/2022, Chapter VIII, C.16.
12. RVUs exist for this code in the office setting. However, the RVUs are not displayed because generator implantation and replacement customarily take place in the facility setting.
13. An EGD performed by a different physician, performed for distinct diagnostic purposes, or performed at a separate encounter from lead implantation may be coded separately. However, according to NCCI policy, an EGD should not be coded separately when performed during the same operative episode as lead implantation to assess the surgical field and anatomic landmarks, to ensure no intraoperative injury occurred, or to verify successful lead placement. NCCI Policy Manual 1/1/2022, Chapter I, B-Surgical-3 and Chapter VI, C.6.
14. According to CPT manual instructions, test stimulation during an implantation procedure is considered integral and cannot be coded separately as programming.
15. 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.

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Hospital Outpatient Coding and Payment — Effective January 1, 2022 – December 31, 2022

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 820 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 2022, there are 69 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 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. However, there are no complexity adjustments for Enterra™ therapy for 2022.

As shown on the tables below, Enterra™ therapy is subject to C-APCs specifically for implantation/replacement of the leads, and for 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]
Lead Implantation or Replacement, Laparoscopic[5,6,7]	**43647** Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	5463	Level 3 Neurostimulator and Related Procedures	J1	136.4195	$11,483
Generator Implantation or Replacement[8,9]	**64590** Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling	5464	Level 4 Neurostimulator and Related Procedures	J1	248.4354	$20,913
Lead Revision or Removal, Laparoscopic[5,6]	**43648** Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	5361	Level 1 Laparoscopy and Related Services	J1	61.3908	$5,168
Generator Revision or Removal[8]	**64595** Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver	5461	Level 1 Neurostimulator and Related Procedures	J1	39.7464	$3,346
Endoscopy[10] **(EGD)**	**43235** Esophagogastroduodenoscopy, flexible, transoral, diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)	5301	Level I Upper GI Procedures	T	9.8173	$826

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/ Programming **Note:** In the hospital, analysis and programming may be furnished by a physician or nurse, 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 the contractor or payer for interpretation of applicable policies.	**95980** Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/ transmitter, intraoperative, with programming[11]	N/A	N/A	N	N/A	N/A
	95981 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter, subsequent, without reprogramming [12]	5734	Level 4 Minor Procedures	Q1	1.3681	$115
	95982 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/ transmitter, subsequent, with reprogramming[12, 13]	5741	Level 1 Electronic Analysis of Devices	Q1	0.4518	$38

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2. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems. Final Rule. 86 Fed Reg 63458-63998. https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf . Published November 16, 2021.
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; N = packaged service, no separate payment; 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. See note 12 for more detailed information on the Status Indicator for codes 95981 and 95982.
4. Medicare national average payment is determined by multiplying the APC weight by the conversion factor. The conversion factor for 2022 is $84.117. The conversion factor of $84.117 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. 86 Fed Reg 63500. https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf . Published November 16, 2021. 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. Medicare allows laparoscopic lead procedures 43647 and 43648 to be performed in the hospital outpatient setting. However, open lead procedures 43881 and 43882 are currently permitted only as inpatient and are not payable to the hospital in the outpatient setting. If performed on an outpatient basis, the hospital will not be paid for these services. See Medicare Claims Processing Manual, Chapter 4-Part B Hospital, section 180.7 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf . Accessed November 30, 2021.
6. When an existing generator is removed and replaced by a new generator, only the generator replacement code 64590 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 1/1/2022, Chapter VIII, C.16.
7. Although two leads are implanted, code 43647 is assigned once. The code's published vignette includes two leads, and Medicare's Medically Unlikely Edits (MUE) allow only 1 unit for code 43647.
8. When an existing generator is removed and replaced by a new generator, only the generator replacement code 64590 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 1/1/2021, Chapter VIII, C.16.
9. When generator implantation 64590 is coded and billed together with lead implantation 43647, 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.
10. An EGD performed for distinct diagnostic purposes or performed at a separate encounter from lead implantation may be coded separately. However, according to NCCI policy, an EGD should not be coded separately when performed during the same operative episode as lead implantation to assess the surgical field and anatomic landmarks, to ensure no intraoperative injury occurred, or to verify successful lead placement. NCCI Policy Manual 1/1/2022, Chapter I, B-Surgical-3 and Chapter VI, C.6.
11. According to CPT manual instructions, test stimulation during an implantation procedure is considered integral and cannot be coded separately as programming.
12. The Status Indicator for codes 95981 and 95982 is Q1, indicating that these codes are generally not paid separately when billed with other procedure codes. When billed alone, these codes are Status S.
13. 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.

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Hospital Inpatient Coding and Payment — Effective October 1, 2021 – September 30, 2022

Medicare MS-DRG Assignments

Under Medicare's MS-DRG methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 765 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 Enterra™ therapy, 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]
Implantation or Replacement: Whole System	Generator plus leads	Diabetic gastroparesis[4,5]	040	Peripheral/Cranial Nerve and Other Nervous System Procedures W MCC	3.8648	$25,485
			041	Peripheral/Cranial Nerve and Other Nervous System Procedures W CC or Peripheral Neurostimulator	2.3497	$15,494
		Idiopathic gastroparesis[6]	981	Extensive OR Procedure Unrelated to Principal Diagnosis W MCC	4.6145	$30,429
			982	Extensive OR Procedure Unrelated to Principal Diagnosis W CC	2.5366	$16,727
			983	Extensive OR Procedure Unrelated to Principal Diagnosis W/O CC/ MCC	1.6523	$10,896
Implantation or Replacement: Leads Only *or* Generator Only	Leads only (one or more) (either approach) *or* Generator only	Diabetic gastroparesis[4,5]	040	Peripheral/Cranial Nerve and Other Nervous System Procedures W MCC	3.8648	$25,485
			041	Peripheral/Cranial Nerve and Other Nervous System Procedures W CC or Peripheral Neurostimulator	2.3497	$15,494
			042	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	1.9012	$12,537
		Idiopathic gastroparesis[6]	981	Extensive OR Procedure Unrelated to Principal Diagnosis W MCC	4.6145	$30,429
			982	Extensive OR Procedure Unrelated to Principal Diagnosis W CC	2.5366	$16,727
			983	Extensive OR Procedure Unrelated to Principal Diagnosis W/O CC/ MCC	1.6523	$10,896

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Hospital Inpatient Coding and Payment *continued*

Procedure	Scenario	MS-DRG[1]	MS-DRG Title[1,2]	Relative Weight[1]	Medicare National Average[3]
Removal (without replacement) [4,7,8]	Whole system (generator plus leads)[9] *or* Leads only (one or more)	040	Peripheral/Cranial Nerve and Other Nervous System Procedures W MCC	3.8648	$25,485
		041	Peripheral/Cranial Nerve and Other Nervous System Procedures W CC or Peripheral Neurostimulator	2.3497	$15,494
		042	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	1.9012	$12,537
	Generator only	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.			
Revision[7,10]	Leads only[11] (one or more)	981	Extensive OR Procedure Unrelated to Principal Diagnosis W MCC	4.6145	$30,429
		982	Extensive OR Procedure Unrelated to Principal Diagnosis W CC	2.5366	$16,727
		983	Extensive OR Procedure Unrelated to Principal Diagnosis W/O CC/MCC	1.6523	$10,896
	Generator only	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.			

1. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Policy Changes and FY2022 Rates Final Rule 86 Fed. Reg. 44774-45615. https://www.govinfo.gov/content/pkg/FR-2021-08-13/pdf/2021-16519.pdf. Published August 13, 2021. Correction Notice 86 Fed. Reg. 58019-58039. https://www.govinfo.gov/content/pkg/FR-2021-10-20/pdf/2021-22724.pdf. Published October 20, 2021.
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 ($6,121.65) plus the capital standard amount ($472.59). Centers for Medicare & Medicaid Services. Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Policy Changes and FY2022 Rates. Final Rule 86 Fed Reg 45544-45545 https://www.govinfo.gov/content/pkg/FR-2021-08-13/pdf/2021-16519.pdf. Published August 13, 2021. Correction Notice 86 Fed. Reg. 58026-58027. https://www.govinfo.gov/content/pkg/FR-2021-10-20/pdf/2021-22724.pdf. Published October 20, 2021. 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. There are three MS-DRGs for Enterra™ procedures with diabetic gastroparesis as principal diagnosis: DRGs 040, 041, and 042. The difference is whether any secondary diagnoses are designated as MCCs or CCs. However, for whole system implantation in which both the leads and the generator are coded, MS-DRG 042 cannot be assigned. Instead, MS-DRG 041 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 040 is assigned. For other Enterra™ procedures, such as lead only implantation or lead removal, the full range of MS-DRGs 040, 041, and 042 can be assigned.
5. For gastroparesis due to secondary diabetes, in which the diabetes is caused by some other condition or event (eg, diabetes due to cystic fibrosis, pancreatic cancer, long-term steroid use), the other condition is coded separately and may be sequenced before the codes for diabetes and gastroparesis. This may cause DRG assignment to vary, depending on the nature of the other condition.
6. When used as the principal diagnosis, code K31.84 is designated as a digestive system diagnosis. However, because the Enterra™ procedure codes are designated as nervous system procedures, the "mismatch" DRGs of 981, 982, and 983 are assigned. These DRGs are valid and payable.
7. 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.
8. Neurostimulators may be removed for diagnoses involving device complications. Because neurostimulator device complications are designated as nervous system diagnoses and neurostimulators are classified as nervous system devices, removal procedures are assigned to Nervous System MS-DRGs in these scenarios
9. When the generator and leads are removed together, the lead removal code is the "driver" and groups to the DRGs shown.
10. Neurostimulators may be revised for diagnoses involving device complications. Because neurostimulator device complications are designated as nervous system diagnoses but lead revision is designated as a digestive system procedure, the "mismatch" DRGs of 981, 982, and 983 are assigned. These DRGs are valid and payable.
11. For lead revision, the DRGs reflect surgical revision of the intra-abdominal or gastric portion of the lead, eg, repositioning a displaced lead within the stomach wall.

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ASC Coding and Payment (Medicare) — Effective January 1, 2022 – December 31, 2022

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 although Comprehensive APCs (C-APCs) are used only for hospital outpatient services and are not applied to procedures performed in ASCs. Alternately, ASC 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 relative 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]
Generator Implantation or Replacement[7,8]	**64590** Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling	J8	N	369.2820	$18,433
Generator Revision or Removal[7,8]	**64595** Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver	J8	Y	60.0563	$2,998
Endoscopy[9] (EGD)	**43235** Esophagogastroduodenoscopy, flexible, transoral, diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)	A2	Y	8.3958	$419

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2. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems... Final Rule. 86 Fed Reg 63761-63815. https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf. Published November 16, 2021.
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.
4. Medicare national average payment is determined by multiplying the ASC weight by the ASC conversion factor. The 2022 ASC conversion factor is $49.916. The conversion factor of $49.916 assumes the ASC meets quality reporting requirements. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems... Final Rule. 86 Fed Reg 63815. https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf. Published November 16, 2021. Payment is adjusted by the wage index for each ASC'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. When multiple procedures are coded and billed, payment is usually made at 100% of the rate for the first procedures and 50% of the rate for the second and all subsequent procedures. Procedures subject to discounting are marked "Y." However, procedures marked "N" are not subject to 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. For CY 2022, only Enterra™ generator procedures are designated as "ASC-Covered Surgical Procedures" for Medicare. Lead procedures, open and laparoscopic, are not on Medicare's list of covered ASC procedures. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems. Final Rule. 86 Fed Reg 63777-63780. https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf. Published November 16, 2021. If lead procedures are performed in an ASC, Medicare makes no payment to the facility and the beneficiary is personally liable for the facility charges. Medicare Claims Processing Manual, Chapter 14—Ambulatory Surgical Centers, section 10.2. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf. Accessed November 30, 2021.
8. When an existing generator is removed and replaced by a new generator, only the generator replacement code 64590 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 1/1/2022, Chapter VIII, C.16.
9. An EGD performed for distinct diagnostic purposes or performed at a separate encounter from lead implantation may be coded separately. However, according to NCCI policy, an EGD should not be coded separately when performed during the same operative episode as lead implantation to assess the surgical field and anatomic landmarks, to ensure no intraoperative injury occurred, or to verify successful lead placement. NCCI Policy Manual 1/1/2022, Chapter I, B-Surgical-3 and Chapter VI, C.6.

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