Medtronic

Implantable tibial neuromodulation

2026 coding and payment guide

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Physician coding and payment

Effective January 1, 2026 – December 31, 2026

CPT code	CPT procedure code and description[1]	Medicare Work RVUs[2]	Medicare national average for physician services provided in:[†,3]	
			Office	Facility
Implant	**0816T** Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous	N/A	Carrier priced	Carrier priced
Revision/ Removal	**0818T** Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous	N/A	Carrier priced	Carrier priced
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 the local contractor or payer for interpretation of applicable policies.	**0589T** Electronic analysis with simple programming of implanted integrated neurostimulator system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, **1-3 parameters**[a]	N/A	Carrier priced	Carrier priced
	0590T Electronic analysis with complex programming of implanted integrated neurostimulator system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, **4 or more parameters**[a]	N/A	Carrier Priced	Carrier Priced

[†] 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.

HCPCS II device codes[4]

Device C-codes

Device	HCPCS II device codes	HCPCS II code description
Pulse generator (rechargeable)	**C1820**[b]	Generator, neurostimulator (implantable), rechargeable
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

Device	HCPCS II device codes	HCPCS II code description
Pulse generator	**L8679**[c]	Implantable neurostimulator pulse generator, any type
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

Hospital outpatient coding and payment

Effective January 1, 2026 – December 31, 2026

Procedure	CPT procedure code and description[a]	APC[5]	APC level	Status indicator[5,d]	Relative weight[5]	Medicare national average[5]
Implant	**0816T** Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (e.g., array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous	5464	Level 4	J1	216.8168	$19,820
Revision/ Removal	**0818T** Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous	5461	Level 1	J1	39.0727	$3,572

ASC coding and payment

Effective January 1, 2026 – December 31, 2026

Procedure	CPT procedure code and description[a]	Payment indicator[6,e]	Multiple procedure discounting[f]	Relative weight[6]	Medicare national average[6]
Implant	**0816T** Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (e.g., array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous	J8	Y	298.9652	$16,838
Revision/ Removal	**0818T** Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous	G2	Y	35.5707	$2,003

Annual references

1. CPT Copyright © 2025 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 the data contained or not contained herein.
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.
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. HCPCS 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. 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. By definition, analysis and programming are integral to insertion, replacement, and revision. Codes 0589T, 0590T are assigned only when performed on a different day. *CPT Assistant, July 2024, p. 4.*

b. Medicare designated CPT code 0816T as device intensive which requires hospital outpatient departments to report a device HCPCS code in addition to procedure code 0816T to identify the use and cost of the implantable neurostimulator pulse generator. Additional Medicare payment is not allowed but including a separate device code will ensure claims are not rejected for being incomplete. Assigning appropriate charges to the device code, based on your unique CCR, will help to protect future APC assignment and rate setting.

c. Commercial payers may process L8679 separately for payment.

d. 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.

e. The Payment Indicator shows how a code is handled for payment purposes. J8 = device-intensive procedure, payment amount adjusted to incorporate device cost.

f. 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. Procedures subject to discounting are marked "Y". However, procedures marked "N" are no subject to this discounting and are paid at 100% of the rate, regardless of whether they are submitted with other procedures.