Medtronic

Sacral nerve stimulation

2026 coding and payment guide

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Physician coding and payment

Effective January 1, 2026 – December 31, 2026

Procedure	CPT code and description[1]	Medicare work RVUs[2]	Medicare national average for physician service provided in:[†,3]	
			Physician office	Facility
Test stimulation[a,b,c]	FDA labeling for the InterStim™ system requires a test stimulation procedure prior to permanent implantation. Physicians are allowed to choose either an untined lead or a tined lead as an initial approach to test stimulation. If test stimulation using a percutaneous untined lead is inconclusive, then a percutaneous tined lead may be used for test stimulation. If test stimulation using a tined lead is inconclusive, test stimulation may be repeated, or the lead may be removed.			
	64561-50 Percutaneous implantation of neurostimulator electrode array, sacral nerve (transforaminal placement) including image guidance if performed[b,d,e]	7.95	$1,115	$407
Lead implantation[a,c,f]	**64561** Percutaneous implantation of neurostimulator electrode array, sacral nerve (transforaminal placement) including image guidance if performed[e]	5.30	N/A	$271
Generator implantation or replacement[c,g]	**64590** Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	4.97	N/A	$267
Revision or removal of lead or generator[c,f,g]	**64585** Revision or removal of peripheral neurostimulator electrode array	2.06	N/A	$136
	64595 Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array	3.70	N/A	$210
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.*	**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[h]	0.35	$20	$16

[†] 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 code and description[1]	Medicare work RVUs[2]	Medicare national average for physician service provided in:[3]	
			Physician office	Facility
Analysis/ programming (continued)	**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[i,j,k]	0.78	$50	$34
	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[i,j,k]	0.80	$60	$35

HCPCS II device codes[4]

Device C-codes

Device	HCPCS II device code	HCPCS II device code description
Test lead	**C1897**	Lead, neurostimulator test kit (implantable)
Lead	**C1778**	Lead, neurostimulator (implantable)
Pulse generator (rechargeable)	**C1820**	Generator, neurostimulator (implantable), with rechargeable battery and charging system
Pulse generator (non-rechargeable)	**C1767**	Generator, neurostimulator (implantable), non-rechargeable
Patient programmer	**C1787**	Patient programmer, neurostimulator
Extension	**C1883**	Adaptor/extension, pacing lead or neurostimulator lead (implantable)
External recharger	**L8689**	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only

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 A and L-codes

Device	HCPCS II device code	HCPCS II device code description
Test lead	**A4290**	Sacral nerve stimulation test lead, each
Lead[l]	**L8680**	Implantable neurostimulator electrode, each
Pulse generator[m]	**L8679**	Implantable neurostimulator pulse generator, any type
	L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
	L8686	Implantable neurostimulator pulse generator, single 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

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,n]	Relative weight[5]	Medicare national average[5]
Test stimulation[a,p]	FDA labeling for the InterStim™ system requires a test stimulation procedure prior to permanent implantation. Providers are allowed to choose either an untined lead or a tined lead as an initial approach to test stimulation. If test stimulation using a percutaneous untined lead is inconclusive, then a percutaneous tined lead may be used for test stimulation. If test stimulation using a tined lead is inconclusive, test stimulation may be repeated, or the lead may be removed.					
	64561 + 64561-59 Percutaneous implantation of neurostimulator electrode array, sacral nerve (transforaminal placement) including image guidance if performed[o,p]	5462	Level 2	J1	71.2250	$6,511
Lead Implantation[a,f,q]	**64561** Percutaneous implantation of neurostimulator electrode array, sacral nerve (transforaminal placement) including image guidance if performed	5462	Level 2	J1	71.2250	$6,511
Generator implantation or replacement[g,q]	**64590** Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode and pulse generator or receiver	5464	Level 4	J1	216.8168	$19,820
Revision or removal of lead or generator[f,g]	**64585** Revision or removal of peripheral neurostimulator electrode array	5461	Level 1	J1	39.0727	$3,572
	64595 Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array	5461	Level 1	J1	39.0727	$3,572
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 nor the 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 (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[h,r]	5734	Level 4	Q1	1.4870	$136
	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[i,j,k]	5742	Level 2	S	1.0625	$97

Hospital outpatient coding and payment (continued)

Procedure	CPT procedure code and description[1]	APC[5]	APC level	Status indicator[5,n]	Relative weight[5]	Medicare national average[5]
Analysis/ programming (continued)	**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[i,j,k]	5742	Level 2	S	1.0625	$97

ASC coding and payment

Effective January 1, 2026 – December 31, 2026

Procedure	CPT procedure code and description[1]	Payment indicator[6,s]	Multiple procedure discounting[t]	Relative weight[6]	Medicare national average[6]
Test stimulation[a]	FDA labeling for the InterStim™ system requires a test stimulation procedure prior to permanent implantation. Providers are allowed to choose either an untined lead or a tined lead as an initial approach to test stimulation. If test stimulation using a percutaneous untined lead is inconclusive, then a percutaneous tined lead may be used for test stimulation. If test stimulation using a tined lead is inconclusive, test stimulation may be repeated, or the lead may be removed.				
	64561 + 64561-59 Percutaneous implantation of neurostimulator electrode array, sacral nerve (transforaminal placement) including image guidance if performed[o,t]	J8	N	181.5604	$10,226
Lead implantation[a,f]	**64561** Percutaneous implantation of neurostimulator electrode array, sacral nerve (transforaminal placement) including image guidance if performed	J8	N	90.7802	$5,113
Generator implantation or replacement[g]	**64590** Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	J8	N	288.0622	$16,224
Revision or removal of lead or generator[f,g]	**64585** Revision or removal of peripheral neurostimulator electrode array	A2	Y	35.5707	$2,003
	64595 Revision or removal of peripheral, sacral or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array	A2	Y	35.5707	$2,003

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.
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. In 2022, the definition of related code 64581 was revised to say "open" to clarify that it involves surgical exposure of the sacrum, previously required to suture permanent sacral leads in place. In contrast, code 64561 should be used for all leads placed percutaneously without surgically exposing the sacrum, regardless of whether they are tined or untined leads, or test or permanent leads. *CPT Assistant, October 2021, p.7.*

b. The FDA has approved placing two temporary test stimulation leads during a single bilateral procedure. As defined and as published by the AMA *(CPT Assistant, December 2008, p.8-9)*, code 64561 represents a single lead, and when more than one lead is placed, each is coded separately. Medicare permits the use of bilateral modifier -50 with code 64561. To show placement of two test leads, submit 64561-50 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.*; see also *National Correct Coding Initiative (NCCI) Policy Manual 1/1/2024, Chapter I,V.3.a.ii*. Medicare's Medically Unlikely Edits (MUE) allow 1 unit for code 64561 on the same date of service.

c. Surgical procedures are subject to a "global period." The global period defines other physician services that are generally considered part of the surgery package and 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 days, treatment of complications unless they require a return visit to the operating room, and minor postoperative services such as dressing changes and suture removal.

d. NCCI policy and edits do not allow HCPCS II test lead code A4290 to be submitted with procedure code 64561, because code 64561 is already valued to include the test lead. *NCCI Policy Manual 1/1/2024, Chapter VIII, C.35.*

e. Because the definition of code 64561 includes image guidance, use of fluoroscopy is inherent and cannot be coded separately. NCCI edits prohibit use of fluoroscopy codes with 64561.

f. When an existing lead is removed and replaced by a new lead, only the lead implantation code 64561 may be assigned. For lead replacement, NCCI edits do not allow removal of the existing lead to be coded separately with implantation of the new lead.

g. 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 1/1/2024, Chapter VIII, C.16.*

h. 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.

Important information (continued)

i. Per CPT manual instructions, programming codes 95971 and 95972 may not be assigned to represent test stimulation during the implantation procedure. However, the instructions clarify that actual 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 95971 and 95972 with lead or generator implantation codes, but they allow an override in this scenario.

j. According to CPT manual instructions, "simple" programming involves changes to three or fewer parameters and "complex" programming involves changes to four or more parameters.

k. 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.*

l. Physicians should not submit codes A4290 or L8680 to Medicare for leads placed in the office, because the cost of the lead is already valued in the practice expense for 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 providers should check with the payer for specific coding and billing instructions.

m. Generator codes L8685 and L8686 are not recognized as valid 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 L8685 and L8686 remain available. However, all providers should check with the payer for specific coding and billing instructions.

n. 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; Q1 = STV packaged codes, not paid separately when billed with an S, T, or V procedure. See note 13 for more detailed information on the Status Indicator for code 95970.

o. If two procedures/surgeries are performed at separate patient encounters or at separate anatomic sites on the same date of service, modifier 59 may be appended to indicate that they are different procedures/surgeries on that date of service. NCCI Policy manual 1/1/2024, Chapter I, E) d.

p. When implantation of two leads is coded and billed, ie, code 64561 & 64561-59, the entire encounter continues to map to APC 5462. Because this is a C-APC and no complexity adjustment applies, there is no additional payment for the second lead.

q. When generator implantation is coded and billed together with lead implantation, ie. 64590 plus 64561, the entire encounter continues to map to APC 5464. Because this is a C-APC and no complexity adjustment applies, there is no additional payment for the lead.

r. The Status Indicator for code 95970 is Q1, indicating that this code is generally not paid separately when billed with other procedure codes. When billed alone, code 95970 is Status S.

s. 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.

t. 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 this discounting and are paid at 100% of the rate regardless of whether they are submitted with other procedures.