



Reclaim™

DBS Therapy for OCD

Hospital Commonly Billed Codes

February 2009

Medtronic provides this information for your convenience only. It is not intended as a recommendation regarding clinical practice. It is the responsibility of the provider to determine coverage and to submit appropriate codes, modifiers, and charges for the services that were rendered. Contact your Medicare contractor or other payer for interpretation of coverage, coding, and payment policies. Because Medtronic Reclaim™ Deep Brain Stimulation (DBS) Therapy for Obsessive Compulsive Disorder (OCD) is approved for use under a Humanitarian Device Exception (HDE), devices can only be implanted in facilities with institutional review board (IRB) approval.

Coverage and Authorization Services is available to respond to your coding questions toll-free at 800-292-2903.

ICD-9-CM Diagnosis Codes

Diagnosis codes are used by both physicians and hospitals to document the indication for the procedure. Reclaim DBS Therapy for OCD is intended to help manage the symptoms of the condition. Because the therapy may manage the symptoms, the principal diagnosis is coded to the underlying condition as shown in these examples.

Obsessive-Compulsive Disorders	300.3	Obsessive-compulsive disorders
Attention to Device¹	V53.02	Fitting and adjustment of neuropacemaker (brain, peripheral nerve, spinal cord)

1. Code V53.02 is used as the principal diagnosis when patients are seen for routine device replacement and maintenance. A secondary diagnosis code is then used for the underlying condition.

ICD-9-CM Procedure Codes

Hospitals use ICD-9-CM procedure codes for inpatient services.

Lead Insertion or Replacement	02.93	Implantation or replacement of intracranial neurostimulator lead(s)
Generator Implantation or Replacement	86.94	Insertion or replacement of single-array neurostimulator pulse generator, not rechargeable (Solettra®)
	86.95	Insertion or replacement of dual-array neurostimulator pulse generator, not rechargeable (Kinetra®)
Lead Removal	01.22	Removal of intracranial neurostimulator lead(s)
Generator Removal	86.05	Incision with removal of foreign body or device from skin and subcutaneous tissue

HCPCS II Device Codes

These codes are used by the entity that purchased and supplied the medical device, DME, drug, or supply to the patient. For implantable devices, that is typically the facility. For specific Medicare hospital outpatient billing instructions for medical devices, see the Device C-Codes for Medicare.

Pulse Generator, Soletra®	L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension
Pulse Generator, Kinetra®	L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
Lead (per electrode)	L8680	Implantable neurostimulator electrode, each
Access® Review Therapy Controller, Soletra®	L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
Access® Therapy Controller, Kinetra®	L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only

Device C-Codes (Medicare)

Hospitals assign C-codes when billing Medicare for medical devices in the outpatient setting. Although other payors may also accept C-codes, regular HCPCS II device codes are generally used for billing non-Medicare payors. For Medicare, billing C-codes is mandatory for medical devices utilized in the hospital outpatient setting. Unlike regular HCPCS II device codes, the extension is separately codable using C-codes.

Note: The C-code for the lead is not shown because intracranial leads are not implanted on an outpatient basis.

Pulse Generator, Soletra®	C1767	Generator, neurostimulator, implantable, non-rechargeable
Pulse Generator, Kinetra®	C1767	Generator, neurostimulator, implantable, non-rechargeable
Extension	C1883	Adaptor/extension, pacing lead or neurostimulator lead, implantable
Access® Review Therapy Controller, Soletra®	C1787	Patient programmer, neurostimulator
Access® Therapy Controller, Kinetra®	C1787	Patient programmer, neurostimulator

Device Edits (Medicare)

Medicare's Consolidated Device Edits require that when specific CPT® procedure codes for device implantation are billed, associated C-codes for the devices must also be billed.¹ When a hospital outpatient bill is received that contains one of the specific CPT procedure codes without one of the required C-codes, the claim is returned to the provider for correction. The edits also work in reverse; when a device C-code is present on the bill, the associated CPT procedure code must also be present.

CPT Procedure Code	CPT Code Description ²	Associated C-Codes	C-Code Description
61885³	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	C1767	Generator, neurostimulator, implantable, non-rechargeable
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays	C1767	Generator, neurostimulator, implantable, non-rechargeable

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1. Device edits can be found at: http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage. The edits are updated once a quarter.
2. Current Procedural Terminology (CPT) is copyright 2008 American Medical Association. All rights reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.
3. In edit logic, procedure code 61885 can also be paired with device code C1820, neurostimulator generator with rechargeable battery. As noted above, Soletra and Kinetra generators are non-rechargeable.

Hospital Outpatient Coding and Payment — Effective January 1, 2009 – December 31, 2009
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 about 820 ambulatory payment classes. Each APC has a relative weight that is then converted to a flat payment amount. Multiple APCs can be assigned for each claim depending on the number of procedures coded.

Note: Only procedures that can be performed in the hospital outpatient setting are shown. Intracranial lead implantation is not shown because it is not performed on an outpatient basis.

Procedure	CPT Code and Description ¹	APC ²	APC Title ²	SI ^{2,3}	Relative Weight ²	2009 Medicare National Average ^{2,4}
Bone Marker Fiducial Placement⁵	21499 Unlisted musculoskeletal procedure, head	0250	Level I ENT Procedures	T	1.1110	\$73
	64999 Unlisted procedure, nervous system	0204	Level I Nerve Injections	T	2.4871	\$164
Diagnostic Imaging and Planning^{6,8}	70450 CT, head or brain without contrast material ⁷	0332	Computed Tomography without Contrast	S	2.9426	\$194
	70551 MRI, brain, without contrast material ⁷	0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast	S	5.2689	\$348
	76376 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality, not requiring image postprocessing on an independent workstation ⁹	N/A	N/A	N	N/A	N/A
	76377 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality, requiring image postprocessing on an independent workstation ⁹	N/A	N/A	N	N/A	N/A
Generator Implantation or Replacement¹⁰	61885 (Soletra®) Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	0039	Level I Implantation of Neurostimulator	S	189.9087	\$12,545
	61886 (Kinetra®) Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays	0315	Level III Implantation of Neurostimulator	S	277.2288	\$18,313
	Bilateral stimulation can be carried out in three different configurations, as below. ¹¹ For implantation or replacement of : <ul style="list-style-type: none"> • two Soletra® pulse generators, one on either side, each connected to a single lead, use 61885-50 • one Kinetra® pulse generator, connected to two leads, use 61886 • two Kinetra® pulse generators, one on either side, each connected to a single lead, use 61885-50 					
Revision or Removal of Leads or Generator¹⁰	61880 Revision or removal of intracranial neurostimulator electrodes	0687	Revision/Removal of Neurostimulator Electrodes	T	19.6378	\$1,297
	61888 Revision or removal of cranial neurostimulator pulse generator or receiver	0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	29.5464	\$1,952

Chart continued on next page.

CPT Procedure Codes Continued

Procedure	CPT Code and Description ¹	APC ²	APC Title ²	SI ^{2,3}	Relative Weight ²	2009 Medicare National Average ^{2,4}
Analysis and Programming	95970 Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance, and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (i.e., cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming	0218	Level II Nerve and Muscle Tests	S	1.1853	\$78
	95978 Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance, and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming, first hour	0692	Level III Electronic Analysis of Devices	S	1.6537	\$109
	95979 each additional 30 minutes after first hour	0692	Level III Electronic Analysis of Devices	S	1.6537	\$109
Evaluation and Management Note: A clinic visit can only be billed separately when a full-scale, separately identifiable evaluation and management service takes place in addition to analysis and programming. The use of evaluation and management codes may require a -25 modifier and must meet separate coding requirements as well as documentation requirements.	99201 Office or other outpatient visit, new patient, problem focused	0604	Level 1 Hospital Clinic Visits	V	0.8277	\$55
	99202 Office or other outpatient visit, new patient, straightforward	0605	Level 2 Hospital Clinic Visits	V	1.0439	\$69
	99203 Office or other outpatient visit, new patient, low complexity	0606	Level 3 Hospital Clinic Visits	V	1.3585	\$90
	99204 Office or other outpatient visit, new patient, moderate complexity	0607	Level 4 Hospital Clinic Visits	V	1.7192	\$114
	99205 Office or other outpatient visit, new patient, high complexity ⁷	0608	Level 5 Hospital Clinic Visits	V	2.4477	\$162
	99211 Office or other outpatient visit, established patient, minimal	0604	Level 1 Hospital Clinic Visits	V	0.8277	\$55
	99212 Office or other outpatient visit, established patient, straightforward	0605	Level 2 Hospital Clinic Visits	V	1.0439	\$69
	99213 Office or other outpatient visit, established patient, low complexity	0605	Level 2 Hospital Clinic Visits	V	1.0439	\$69
	99214 Office or other outpatient visit, established patient, moderate complexity	0606	Level 3 Hospital Clinic Visits	V	1.3585	\$90
	99215 Office or other outpatient visit, established patient, high complexity ⁷	0607	Level 4 Hospital Clinic Visits	V	1.7192	\$114

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 - Federal Register, Volume 73, Number 223, November 18, 2008.
 - Status Indicator (SI) shows how a code is handled for payment purposes: 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; V = visit, paid at 100% of rate.
 - Medicare average payment is determined by multiplying the APC weight by the conversion factor (\$66.059 for 2009) as published in the Federal Register, Volume 73, Number 223, November 18, 2008. The payment is adjusted by the Wage Index for each hospital's specific geographic locality. Therefore, payment will vary from the stated national average Medicare payment levels.
 - Placement of implanted fiducials should generally be considered integral to lead implantation and should not be coded separately when performed on the same day as the lead implantation. Placement of implanted fiducials can be coded separately if performed during a different operative episode, for example, on a previous date. Note that medical necessity must be demonstrated and documented for staging the procedure.
- Footnotes continued on Page 6.

Hospital Inpatient Coding and Payment — Effective October 1, 2009 – September 30, 2009

MS-DRG Assignments

Under Medicare’s MS-DRG methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 745 diagnosis-related groups, based on the ICD-9-CM codes assigned to the diagnoses and procedures. Each MS-DRG has a relative weight that is then converted to a flat payment amount. Only one MS-DRG is assigned by inpatient stay, regardless of the number of procedures performed. The MS-DRGs shown are those typically assigned to the following scenarios.

Procedure	Scenario	MS-DRG ¹	MS-DRG Title ^{1,2}	Relative Weight ¹	2009 Medicare National Average ³
Implantation and Replacement	Entire system implant or replacement, generator (86.9X) plus lead(s) (02.93)	876	OR Procedure W Principal Diagnosis of Mental Illness	2.4834	\$13,789
	Lead(s) only implant or replacement (02.93)	876	OR Procedure W Principal Diagnosis of Mental Illness	2.4834	\$13,789
	Generator only implant or replacement (86.9X)	876	OR Procedure W Principal Diagnosis of Mental Illness	2.4834	\$13,789
Removal (without replacement)⁴	Entire system removal, generator (86.05) and lead (01.22)	025	Craniotomy and Endovascular Intracranial Procedures W MCC	5.0109	\$27,824
		026	Craniotomy and Endovascular Intracranial Procedures W CC	3.0058	\$16,690
		027	Craniotomy and Endovascular Intracranial Procedures W/O CC/MCC	2.1029	\$11,677
	Generator only removal (86.05)	This code is not considered a “significant procedure” for the purpose of DRG assignment. A non-surgical (i.e., medical) DRG is assigned to the stay according to the principal diagnosis.			
	Lead only removal (01.22)	025	Craniotomy and Endovascular Intracranial Procedures W MCC	5.0109	\$27,824
		026	Craniotomy and Endovascular Intracranial Procedures W CC	3.0058	\$16,690
		027	Craniotomy and Endovascular Intracranial Procedures W/O CC/MCC	2.1029	\$11,677

1. Federal Register, Volume 73, Number 161, August 19, 2008, 73 FR 48433-49084.

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/MCCs 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 are acquired in the hospital during the stay.

3. Payment is based on an average standardized operating amount (\$5,128.41), plus the capital standard amount (\$424.17) as published in the Federal Register, Volume 73, Number 193, 2008, CMS-1390-N. Note that CMS may subsequently revise these rates with the implementation of further legislation. The payment rate shown is the standardized amounts 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 your specific geographic locality. Therefore, payment for your area will vary from the stated Medicare national average payment levels shown.

4. Device removal without replacement is frequently performed as an outpatient. It is shown here for the occasional scenario where removal takes place due to a complication that requires inpatient admission. For device removal, the principal diagnosis is generally V53.02 or codes for complications of nervous system device. These result in assignment to Nervous System MS-DRGs.

Footnotes continued from Page 4.

6. This assumes the imaging is occurring in the hospital facility.
7. 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. For evaluation and management, status indicator Q3 shows that the higher level clinic visits may be part of a composite APC if billed with observation services. Otherwise, however, within the context of services related to Reclaim DBS Therapy for OCD, the codes will generally be paid separately under the APCs, status indicators, and rates shown.
8. Pre-operative CT and MRI imaging is separately codable when it represents full-scale diagnostic imaging and the interpretation is documented via a formal imaging report. Intra-operative imaging is part of surgical navigation and should not be coded separately.
9. 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.
10. In a replacement, National Correct Coding Initiative (NCCI) edits do not allow removal of the old device to be coded together with implantation of the new device.
11. Solettra® is a single array generator, designed with one port for connection to one lead. Kinetra® is a dual array generator, designed with two ports for connection to two leads. In some patients with very high energy needs, two Kinetra® generators are used; each is connected to one lead with the second port on the generator simply closed by a plug. Because the CPT generator codes are defined by the number of leads connected, code 61886 is used when a Kinetra® generator is connected to two leads, and 61885 is used when a Kinetra® generator is connected to one lead.

Hospital Commonly Billed Codes

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