



**Medtronic**

# Reclaim™

DBS Therapy for OCD

Physician Commonly Billed Codes

April 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 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) 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 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.

<b>Obsessive-Compulsive Disorders</b>	<b>300.3</b>	Obsessive-compulsive disorders
<b>Attention to Device<sup>1</sup></b>	<b>V53.02</b>	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.

## HCPCS II Device Codes

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 typically the facility. Physicians use HCPCS II codes when supplying the item in the office.

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

## Physician Coding and Payment – Effective January 1, 2009 – December 31, 2009

## 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, the relative value unit (RVU), which is then converted to a flat payment amount.

Procedure	CPT Code and Description <sup>1</sup>	2009 Medicare RVUs <sup>2</sup>		2009 Medicare National Average Payment <sup>3</sup>	
		For physician services provided in: <sup>4</sup>			
		Physician Office <sup>5</sup>	Facility	Physician Office <sup>5</sup>	Facility
<b>Bone Marker Fiducial Placement<sup>6</sup></b>	<b>21499</b> Unlisted musculoskeletal procedure, head	0	0	Carrier priced <sup>7</sup>	Carrier priced <sup>7</sup>
	<b>64999</b> Unlisted procedure, nervous system	0	0	Carrier priced <sup>7</sup>	Carrier priced <sup>7</sup>
<b>Diagnostic Imaging<sup>8</sup> and Planning<sup>9</sup></b>	<b>70450-26</b> CT, head or brain without contrast material <sup>10</sup>	–	1.21	–	\$44
	<b>70551-26</b> MRI, brain, without contrast material <sup>10</sup>	–	2.09	–	\$75
	<b>76376-26</b> 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 <sup>10</sup>	–	0.30	–	\$11
	<b>76377-26</b> 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality, requiring image postprocessing on an independent workstation <sup>10</sup>	–	1.16	–	\$42
<b>Lead Implantation<sup>11</sup></b>	<b>61863</b> Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray) without use of intraoperative microelectrode recording; first array	N/A	38.40	N/A	\$1,385
	<b>61864</b> Each additional array (List separately in addition to primary procedure.)	N/A	11.82	N/A	\$426
	<b>61867</b> Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray) with use of intraoperative microelectrode recording; first array	N/A	55.74	N/A	\$2,010
	<b>61868</b> Each additional array (List separately in addition to primary procedure.)	N/A	16.68	N/A	\$602
<b>Intraoperative Stimulation with Microelectrode Recording<sup>10,12</sup></b>	<b>95961-26</b> Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or depth electrodes, to provoke seizures or identify vital brain structures; initial hour of physician attendance	–	4.47	–	\$161
	<b>95962-26</b> Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of physician attendance (List separately in addition to code for primary procedure)	–	4.58	–	\$165
<b>Generator Implantation or Replacement<sup>11,13</sup></b>	<b>61885</b> Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	N/A	15.83	N/A	\$571

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## CPT Procedure Codes Continued

Procedure	CPT Code and Description <sup>1</sup>	2009 Medicare RVUs <sup>2</sup>		2009 Medicare National Average Payment <sup>3</sup>	
		For physician services provided in: <sup>4</sup>			
		Physician Office <sup>5</sup>	Facility	Physician Office <sup>5</sup>	Facility
<b>Generator Implantation or Replacement</b> <sup>11,13</sup>	<b>61886</b> Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays	N/A	19.95	N/A	\$720
<b>Revision or Removal of Leads or Generator</b> <sup>11,12</sup>	<b>61880</b> Revision or removal of intracranial neurostimulator electrodes	N/A	13.77	N/A	\$497
	<b>61888</b> Revision or removal of cranial neurostimulator pulse generator or receiver	N/A	10.10	N/A	\$364
<b>Analysis and Programming</b> <small>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 payor should not be billed for services rendered solely by the manufacturer's representative. Contact your local carrier or payer for interpretation of applicable policies.</small>	<b>95970</b> 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	1.36	0.61	\$49	\$22
	<b>95978</b> 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	5.56	4.81	\$201	\$173
	<b>95979</b> Each additional 30 minutes after first hour (List separately in addition to code for primary procedure)	2.49	2.26	\$90	\$82
<b>Evaluation and Management</b> <small>Note: An office 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.</small>	<b>99211 – 99215</b> Office or other outpatient visit	0.52 – 3.46	0.24 – 2.73	\$19 – \$125	\$9 – \$98
	<b>99217 – 99220</b> Observation care	N/A	1.85 – 4.04	N/A	\$67 – \$146
	<b>99221 – 99223</b> Initial hospital care	N/A	2.49 – 5.00	N/A	\$90 – \$180
	<b>99354 – 99355</b> Prolonged services, office	2.52 – 2.55	2.38 – 2.41	\$90 – \$91	\$86 – \$87
	<b>99356 – 99357</b> Prolonged service, inpatient	N/A	2.32 – 2.34	N/A	\$84

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Footnotes for Pages 2 and 3.

1. 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.
2. Federal Register, Volume 73, Number 224, November 19, 2008. The total RVU as shown here is the sum of three components: physician work RVU, 2009 transitioned practice expense RVU and malpractice RVU. Note that, unlike 2008, no CMS budget neutrality factor is applied in the formula for calculating Medicare payment.
3. Medicare national average payment is determined by multiplying the sum of the three component RVUs by the 2009 conversion factor of \$36.0666, as published in the Federal Register, Volume 73, Number 224, November 19, 2008. Final payment to the physician is adjusted by the Geographic Practice Cost Indices (GPCI). Because GPCI varies by area, each physician's specific reimbursement will vary from the national average payment shown. Also note that any applicable coinsurance, deductible and other amounts which are patient obligations are included in the national average 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 "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 (e.g., 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, per the Federal Register, Volume 73, Number 224, November 19, 2008, p. 69942.
6. 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 by the same physician. Placement of implanted fiducials can be coded separately if performed during a different operative episode on a previous date or by a different physician from the one who performed the lead implantation. Note that medical necessity must be demonstrated and documented for staging the procedure.
7. This is a carrier-priced code. Carriers establish the RVUs and the payment amount, usually on an individual case basis after review of the procedure report.
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. Note that although CPT code 61795 exists for computer-assisted surgical navigation, National Correct Coding Initiative (NCCI) edits do not allow this to be coded separately with lead implantation codes 61863 and 61867.
9. The 3D rendering codes are reported in addition to the code for the base CT or MRI procedure.
10. This assumes the service is occurring in the hospital facility, because the primary lead procedure must be performed in a facility. So the physician is providing the professional interpretation only (-26) and only facility RVUs and payments are displayed.
11. Surgical procedures are subject to a "global period." The global period defines other physician services that are generally considered part of the surgery package. The services 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 or 90 days depending on the specific procedure, treatment of complications unless they require a return visit to the operating room, and minor postoperative services such as dressing changes and suture removal.
12. Microelectrode recording is included in codes 61867 – 61868 and cannot be coded separately when performed by the operating surgeon. However, when another physician (e.g., neurologist or neurophysiologist) performs the cortical or subcortical mapping during the placement of the electrode array, that physician may report codes 95961 – 95962 separately.
13. 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.

## Physician Commonly Billed Codes

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