



**Medtronic**

# Reclaim™

Deep Brain Stimulation Therapy for  
Obsessive Compulsive Disorder

**Hospital Commonly Billed Codes**

October 2009

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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.

## ICD-9-CM Procedure Codes

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

<b>Lead Insertion or Replacement</b>	<b>02.93</b>	Implantation or replacement of intracranial neurostimulator lead(s)
<b>Generator Implantation or Replacement</b>	<b>86.94</b>	Insertion or replacement of single-array neurostimulator pulse generator, not rechargeable
	<b>86.95</b>	Insertion or replacement of dual-array neurostimulator pulse generator, not rechargeable
<b>Lead Removal</b>	<b>01.22</b>	Removal of intracranial neurostimulator lead(s)
<b>Generator Removal</b>	<b>86.05</b>	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.

<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>Patient Programmer</b>	<b>L8681</b>	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.

<b>Pulse Generator</b>	<b>C1767</b>	Generator, neurostimulator, implantable, non-rechargeable
<b>Extension</b>	<b>C1883</b>	Adaptor/extension, pacing lead or neurostimulator lead, implantable
<b>Patient Programmer</b>	<b>C1787</b>	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.<sup>1</sup> 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 <sup>2</sup>	Associated C-Codes	C-Code Description
61885 <sup>3</sup>	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](http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage). The edits are updated once a quarter.

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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 <sup>1</sup>	APC <sup>2</sup>	APC Title <sup>2</sup>	SI <sup>2,3</sup>	Relative Weight <sup>2</sup>	2009 Medicare National Average <sup>2,4</sup>
Bone Marker Fiducial Placement <sup>5</sup>	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

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CPT® Procedure Codes *continued*

Procedure	CPT Code and Description <sup>1</sup>	APC <sup>2</sup>	APC Title <sup>2</sup>	SI <sup>2,3</sup>	Relative Weight <sup>2</sup>	2009 Medicare National Average <sup>2,4</sup>
<b>Diagnostic Imaging and Planning</b> <sup>6,8</sup>	<b>70450</b> CT, head or brain without contrast material <sup>7</sup>	0332	Computed Tomography without Contrast	S	2.9426	\$194
	<b>70551</b> MRI, brain, without contrast material <sup>7</sup>	0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast	S	5.2689	\$348
	<b>76376</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>9</sup>	N/A	N/A	N	N/A	N/A
	<b>76377</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>9</sup>	N/A	N/A	N	N/A	N/A
<b>Generator Implantation or Replacement</b> <sup>10</sup>	<b>61885</b> 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
	<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	0315	Level III Implantation of Neurostimulator	S	277.2288	\$18,313
<b>Revision or Removal of Leads or Generator</b> <sup>10</sup>	<b>61880</b> Revision or removal of intracranial neurostimulator electrodes	0687	Revision/Removal of Neurostimulator Electrodes	T	19.6378	\$1,297
	<b>61888</b> Revision or removal of cranial neurostimulator pulse generator or receiver	0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	29.5464	\$1,952

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CPT® Procedure Codes *continued*

Procedure	CPT Code and Description <sup>1</sup>	APC <sup>2</sup>	APC Title <sup>2</sup>	SI <sup>2,3</sup>	Relative Weight <sup>2</sup>	2009 Medicare National Average <sup>2,4</sup>
<b>Analysis and Programming</b>	<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	0218	Level II Nerve and Muscle Tests	S	1.1853	\$78
	<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	0692	Level III Electronic Analysis of Devices	S	1.6537	\$109
	<b>95979</b> each additional 30 minutes after first hour	0692	Level III Electronic Analysis of Devices	S	1.6537	\$109
<b>Evaluation and Management</b> <b>Note:</b> 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.	<b>99201</b> Office or other outpatient visit, new patient, problem focused	0604	Level 1 Hospital Clinic Visits	V	0.8277	\$55
	<b>99202</b> Office or other outpatient visit, new patient, straightforward	0605	Level 2 Hospital Clinic Visits	V	1.0439	\$69
	<b>99203</b> Office or other outpatient visit, new patient, low complexity	0606	Level 3 Hospital Clinic Visits	V	1.3585	\$90
	<b>99204</b> Office or other outpatient visit, new patient, moderate complexity	0607	Level 4 Hospital Clinic Visits	V	1.7192	\$114
	<b>99205</b> Office or other outpatient visit, new patient, high complexity <sup>7</sup>	0608	Level 5 Hospital Clinic Visits	V	2.4477	\$162

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CPT® Procedure Codes *continued*

Procedure	CPT Code and Description <sup>1</sup>	APC <sup>2</sup>	APC Title <sup>2</sup>	SI <sup>2,3</sup>	Relative Weight <sup>2</sup>	2009 Medicare National Average <sup>2,4</sup>
<b>Evaluation and Management</b> 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.	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 <sup>7</sup>	0607	Level 4 Hospital Clinic Visits	V	1.7192	\$114

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2. Federal Register, Volume 73, Number 223, November 18, 2008.

3. 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.

4. 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.

5. 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.

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.

## Hospital Inpatient Coding and Payment — Effective October 1, 2009 – September 30, 2010

### 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 <sup>1</sup>	MS-DRG Title <sup>1,2</sup>	Relative Weight <sup>1</sup>	FY10 Medicare National Average <sup>3</sup>
<b>Implantation and Replacement</b>	Entire system implant or replacement, generator (86.9X) plus lead(s) (02.93)	876	OR Procedure W Principal Diagnosis of Mental Illness	2.5892	\$14,638
	Lead(s) only implant or replacement (02.93)	876	OR Procedure W Principal Diagnosis of Mental Illness	2.5892	\$14,638
	Generator only implant or replacement (86.9X)	876	OR Procedure W Principal Diagnosis of Mental Illness	2.5892	\$14,638
<b>Removal (without replacement)<sup>4</sup></b>	Entire system removal, generator (86.05) and lead (01.22)	025	Craniotomy and Endovascular Intracranial Procedures W MCC	4.8236	\$27,265
		026	Craniotomy and Endovascular Intracranial Procedures W CC	2.9421	\$16,630
		027	Craniotomy and Endovascular Intracranial Procedures W/O CC/MCC	2.0902	\$11,814
	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	4.8236	\$27,265
		026	Craniotomy and Endovascular Intracranial Procedures W CC	2.9421	\$16,630
		027	Craniotomy and Endovascular Intracranial Procedures W/O CC/MCC	2.0902	\$11,814

1. Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates, 74 Fed. Reg. 43754 – 44236 (finalized August 28, 2009).

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 the average standardized operating amount (\$5,223.14) plus the capital standard amount (\$429.26) as published in Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates, 74 Fed. Reg. 43754 – 44236 (finalized August 28, 2009), and corrected via Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates; Corrections, 74 Fed. Reg. 51496 – 51510 (finalized October 7, 2009). 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.

# Reclaim™ Deep Brain Stimulation for OCD

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