



Medtronic

Enterra® Therapy

For Gastroparesis

Hospital Commonly Billed Codes

October 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. This document provides assistance for FDA approved or cleared indications. Where reimbursement is requested for a use of a product that may be inconsistent or not expressly specified in the FDA cleared or approved labeling (e.g., instructions for use, operator’s manual or package insert) consult with your billing advisors or payers for advice on handling such billing issues. Some payers may have policies that make it inappropriate to submit claims for such items or related service. Contact your Medicare contractor or other payer for interpretation of coverage, coding, and payment policies. Because Enterra® 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.

Diabetic Gastroparesis¹	250.6X + 536.3	Diabetes with neurological manifestations, with gastroparesis
	249.6X + 536.3	Secondary diabetes with neurological manifestations, with gastroparesis ²
Idiopathic Gastroparesis	536.3	Gastroparesis
Attention to Device³	V53.02	Fitting and adjustment of neuropacemaker (brain, peripheral nerve, spinal cord)

1. Diabetic gastroparesis requires two codes, one for diabetes and one for gastroparesis. The diabetes code is always sequenced first, followed by the code for gastroparesis.
2. Secondary diabetes is caused by some other condition or event (e.g., diabetes due to cystic fibrosis, poisoning, pancreatic cancer, drug overdose, or long-term steroid use).
3. 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 Implantation or Replacement¹	04.92	Implantation or replacement of peripheral neurostimulator lead(s)
Lead Removal	04.93	Removal of peripheral neurostimulator lead(s)
Neurostimulator Generator Implantation or Replacement¹	86.95	Insertion or replacement of dual array neurostimulator pulse generator, non-rechargeable
Neurostimulator Generator Removal	86.05	Incision with removal of foreign body or device from skin and subcutaneous tissue

1. For a device replacement, coding guidelines do not allow removal of the old device to be coded together with implantation of the new device.

HCPCS II Device Codes (Non-Medicare)

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.

These HCPCS II device codes can be used by hospitals for billing outpatient services to non-Medicare payers and by ASCs for billing non-Medicare payers. Contact your local payer for specific billing instructions.

For Medicare billing instructions for medical devices, see the Device C-Codes (Medicare) below.

Lead (per electrode)¹	L8680	Implantable neurostimulator electrode, each
Pulse Generator	L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension

1. The system requires two leads, each containing one electrode.

Device C-Codes (Medicare)¹

Hospitals assign C-codes when billing Medicare for medical devices in the outpatient setting. Use of C-codes is mandatory for Medicare hospital outpatient bills.

ASCs, however, usually should *not* assign or report HCPCS II device codes for devices on claims sent to Medicare. Medicare generally does not make a separate payment for devices in the ASC. Instead, payment is “packaged” into the payment for the ASC procedure. ASCs are specifically instructed *not* to bill HCPCS II device codes to Medicare for devices that are packaged.²

Pulse Generator (non-rechargeable)	C1767	Generator, neurostimulator, implantable, non-rechargeable
Leads³	C1778	Lead, neurostimulator, implantable

1. Although other payers may also accept C-codes, regular HCPCS II device codes are generally used for billing non-Medicare payers.

2. ASCs should report all charges incurred. However, only charges for non-packaged items should be billed as separate line items. For example, the ASC should report its charge for the pulse generator. However, because the generator is a packaged item, the charge should not be reported on its own line. Instead, the ASC should bill a single line for the implantation procedure with a single total charge, including not only the charge associated with the operating room but also the charges for the generator and all other packaged items. Because of a Medicare requirement to pay the lesser of the ASC rate or the line-item charge, breaking these packaged charges out onto their own lines can result in incorrect payment to the ASC. (See the Medicare Claims Processing Manual, Chapter 14, section 40.)

3. The system requires two leads with one electrode each.

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
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	C1778	Lead, neurostimulator, implantable
64590 ³	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling	C1767	Generator, neurostimulator, implantable, non-rechargeable

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. CPT is a trademark of American Medical Association.

3. In edit logic, procedure code 64590 can also be paired with device code C1820, neurostimulator generator with rechargeable battery. As noted above, Enterra 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.

Procedure	CPT Code and Description ¹	APC ²	APC Title ²	SI ^{2,3}	Relative Weight ²	2009 Medicare National Average ^{2,4}
Laparoscopic Implantation or Replacement^{5,6}	43647 Laparoscopy, surgical, implantation or replacement of gastric neurostimulator electrodes, antrum	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes	S	82.9048	\$5,477
	64590 Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling	0039	Level I Implantation of Neurostimulator	S	189.9087	\$12,545
Laparoscopic Revision or Removal^{5,6}	43648 Laparoscopy, surgical, revision or removal of gastric neurostimulator electrodes, antrum	0130	Level I Laparoscopy	T	37.8887	\$2,503
	64595 Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver	0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	29.5464	\$1,952
Analysis/ Programming	95980 Electronic analysis of implanted neurostimulator pulse generator system, gastric neurostimulator pulse generator/transmitter, intraoperative, with programming	N/A	N/A	N	N/A	N/A
	95981 Electronic analysis of implanted neurostimulator pulse generator system, gastric neurostimulator pulse generator/transmitter, subsequent, without reprogramming	0218	Level II Nerve and Muscle Tests	S	1.1853	\$78
	95982 Electronic analysis of implanted neurostimulator pulse generator system, gastric neurostimulator pulse generator/transmitter, subsequent, with reprogramming	0692	Level III Electronic Analysis of Devices	S	1.6537	\$109
Endoscopy⁷	43235 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate, diagnostic, with or without collection of specimen(s) by brushing or washing	0141	Level I Upper GI Procedures	T	8.6526	\$572

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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}
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 ⁸	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 ⁸	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 into other services, not separately payable; 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. Medicare allows laparoscopic lead implantation or replacement to be performed in the hospital outpatient setting. However, open implantation or replacement of leads is permitted only as inpatient and is not payable to the hospital in the outpatient setting. If performed on an outpatient basis, the hospital will not be paid for this service.
6. For a device 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.
7. Upper GI endoscopy should not be coded separately when the implanting physician performs it during the same operative session to confirm successful placement of the leads. An endoscopy performed for distinct diagnostic purposes may be coded separately.
8. More broadly, these codes have status indicator Q3. 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 neurostimulation therapy, the codes will typically be paid separately under the APCs, status indicators, and rates shown.

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

Medicare 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 DRG has a relative weight that is then converted to a flat payment amount. Only one DRG is assigned by inpatient stay, regardless of the number of procedures performed. The DRGs shown are those typically assigned to the following scenarios. For Enterra, DRG assignment varies depending on the diagnosis and the specific procedures performed.

Procedure	Scenario	ICD-9-CM Procedure Codes	Principal Diagnosis	MS-DRG ¹	MS-DRG Title ^{1,2}	Relative Weight ¹	FY10 Medicare National Average ³
Implant or Replacement	Whole system (generator and leads)	Generator (86.95) plus leads (04.92)	Diabetic gastroparesis (250.6X or 249.6X) ⁴	040	Peripheral/cranial nerve and other nervous system procedures W MCC	3.9518	\$22,337
				041	Peripheral/cranial nerve and other nervous system procedures W CC or peripheral neurostimulators	2.1249	\$12,011
			Idiopathic gastroparesis (536.3) ⁵	981	Extensive OR procedure unrelated to principal diagnosis W MCC	5.0389	\$28,482
				982	Extensive OR procedure unrelated to principal diagnosis W CC	2.8954	\$16,366
				983	Extensive OR procedure unrelated to principal diagnosis W/O CC/MCC	1.8072	\$10,215

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Medicare MS-DRG Assignments *continued*

Procedure	Scenario	ICD-9-CM Procedure Codes	Principal Diagnosis	MS-DRG ¹	MS-DRG Title ^{1,2}	Relative Weight ¹	FY10 Medicare National Average ³
Other Procedures	Implant or replacement of leads only or generator only	Lead implantation only (04.92)	Diabetic gastroparesis (250.6X or 249.6X) ⁴	040	Peripheral/cranial nerve and other nervous system procedures W MCC	3.9518	\$22,337
		Generator implantation only (86.95)		041	Peripheral/cranial nerve and other nervous system procedures W CC or peripheral neurostimulator	2.1249	\$12,011
	Generator removal (86.05) ⁶ with lead removal (04.93)	042		Peripheral/cranial nerve and other nervous system procedures W/O CC/MCC	1.6448	\$9,297	
	Removal of whole system (leads and generator) or leads only	Lead removal only (04.93)	Idiopathic gastroparesis (536.3) ⁵	981	Extensive OR procedure unrelated to principal diagnosis W MCC	5.0389	\$28,482
				982	Extensive OR procedure unrelated to principal diagnosis W CC	2.8954	\$16,366
				983	Extensive OR procedure unrelated to principal diagnosis W/O CC/MCC	1.8072	\$10,215

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 were 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. There are three MS-DRGs for Enterra procedures with a diabetic gastroparesis as principal diagnosis: DRGs 040, 041, and 042. The difference is whether any secondary diagnoses are designated as MCCs or CCs. However, for full system neurostimulator implantation in which both the leads 04.92 and the generator 86.95 are coded, MS-DRG 042 cannot be assigned. Instead, MS-DRG 041 is automatically assigned for a full system implantation regardless of whether a CC is present or not. If an MCC is also present with a full system implantation, MS-DRG 040 is assigned. For other Enterra procedures, such as lead-only implantation 04.92, the full range of MS-DRGs 040, 041, and 042 can be assigned.

5. When used as the principal diagnosis, code 536.3 is designated as a digestive system diagnosis. However, because the Enterra procedure codes are designated as nervous system procedures, the “mismatch” DRGs of 981, 982, and 983 are assigned. The DRGs are valid and payable.

6. Code 86.05 for removal of the generator only is not considered a “significant procedure” for the purpose of DRG assignment. When this is the only procedure performed, a non-surgical (i.e., medical) DRG is assigned to the stay according to the principal diagnosis.

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