



Medtronic

Neurostimulation Therapy

For Chronic Pain—Trunk and/or Limbs

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.

Pain codes from the 338 series are used as the principal diagnosis when the encounter is for pain control or pain management, rather than for management of the underlying condition. Neurostimulation Therapy is directed at managing chronic, intractable pain rather than treating the underlying disorder. When a patient is admitted for insertion of a neurostimulator for pain control, the pain code is sequenced as the principal diagnosis. Additional codes may then be assigned to identify the underlying cause as well as to give more detail about the nature and location of the pain.

Note that when the encounter is for a procedure aimed at treating the underlying condition and a neurostimulator is also inserted for pain control, the underlying disorder is assigned as the principal diagnosis. However, an encounter specifically to insert a neurostimulator is most common.

Chronic Pain Disorders	338.0	Central pain syndrome
	338.29	Other chronic pain
	338.4	Chronic pain syndrome
Note: Pain must be specifically documented as “chronic” to use code 338.29. Similarly, the diagnostic term “chronic pain syndrome” must be specifically documented to assign code 338.4. If these terms are not documented, then other symptom codes for pain may be assigned instead. However, they cannot be sequenced as principal diagnosis. Rather, the underlying condition would ordinarily be used as the principal diagnosis in this circumstance.		

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ICD-9-CM Diagnosis Codes *continued*

Reflex Sympathetic Dystrophy and Causalgia	337.21	Reflex sympathetic dystrophy of the upper limb (complex regional pain syndrome type I)
	337.22	Reflex sympathetic dystrophy of the lower limb (complex regional pain syndrome type I)
	354.4	Causalgia of upper limb (complex regional pain syndrome type II)
	355.71	Causalgia of lower limb (complex regional pain syndrome type II)
	Note: Complex regional pain syndrome not specified by type defaults to type I, reflex sympathetic dystrophy. Codes from the 338 series should not be assigned with causalgia or reflex sympathetic dystrophy because pain is a known component of these disorders.	
Underlying Causes of Chronic Pain	322.2	Arachnoiditis, chronic
	322.9	Arachnoiditis, other and unspecified
	349.2	Epidural fibrosis
	354.9	Peripheral neuropathy of upper limb
	355.8	Peripheral neuropathy of lower limb
	722.10	Radiculitis due to herniated disc, lumbar
	722.52	Radiculitis due to degenerative disc disease, lumbar
	722.83	Postlaminectomy syndrome, lumbar region (failed back syndrome)
	723.4	Radicular syndrome of upper limbs
	724.4	Radicular syndrome of lower limbs
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	03.93	Implantation or replacement of spinal neurostimulator lead(s)
Generator Implantation or Replacement	86.94	Insertion or replacement of single-array neurostimulator pulse generator, not rechargeable
	86.95	Insertion or replacement of dual-array neurostimulator pulse generator, not rechargeable
	86.97	Insertion or replacement of single-array rechargeable neurostimulator pulse generator
	86.98	Insertion or replacement of dual-array rechargeable neurostimulator pulse generator
Lead Removal	03.94	Removal of spinal 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 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. For specific Medicare hospital outpatient billing instructions for medical devices, see the Device C-Codes for Medicare.

Lead (per electrode)	L8680	Implantable neurostimulator electrode, each
Pulse Generator	L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
	L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension
	L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
	L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
External Recharger	L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only
Patient Programmer	L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
Receiver	L8682	Implantable neurostimulator radiofrequency receiver
External Transmitter	L8683	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver

Device C-Codes (Medicare)

Hospitals assign C-codes when billing Medicare for medical devices in the outpatient setting. Although other payers may also accept C-codes, regular HCPCS II device codes are generally used for billing non-Medicare payers. 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.

Pulse Generator (non-rechargeable)	C1767	Generator, neurostimulator, implantable, non-rechargeable
Pulse Generator (rechargeable)	C1820	Generator, neurostimulator, implantable, with rechargeable battery and charging system
Extension	C1883	Adaptor/extension, pacing lead or neurostimulator lead, implantable
Leads	C1778	Lead, neurostimulator, implantable
	C1897	Lead, neurostimulator, test kit (implantable)
Patient Programmer	C1787	Patient programmer, neurostimulator
Receiver and Transmitter	C1816	Receiver and/or transmitter, neurostimulator, implantable

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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
63650	Percutaneous implantation of neurostimulator electrode array, epidural	C1778	Lead, neurostimulator, implantable
		C1897	Lead, neurostimulator, test kit (implantable)
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	C1778	Lead, neurostimulator, implantable
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	C1767	Generator, neurostimulator, implantable, non-rechargeable
		C1820	Generator, neurostimulator, implantable, with rechargeable battery and charging system

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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.

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}
Screening Test ⁵	63650 Percutaneous implantation of neurostimulator electrode array, epidural	0040	Percutaneous Implantation of Neurostimulator Electrodes	S	63.6772	\$4,206
	63655 Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	S	82.9048	\$5,477
Lead Implantation or Replacement ^{5,6}	63650 Percutaneous implantation of neurostimulator electrode array, epidural	0040	Percutaneous Implantation of Neurostimulator Electrodes	S	63.6772	\$4,206
	63655 Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	S	82.9048	\$5,477
Generator Implantation or Replacement ⁶	63685 Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	0222	Level II Implantation of Neurostimulator	S	235.6477	\$15,567
Revision or Removal of Lead or Generator ⁶	63660 Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)	0687	Revision/Removal of Neurostimulator Electrodes	T	19.6378	\$1,297
	63688 Revision or removal of implanted spinal 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 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
	95972 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 spinal cord or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour	0692	Level III Electronic Analysis of Devices	S	1.6537	\$109
	95973 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 spinal cord or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, each additional 30 minutes after first hour	0692	Level III Electronic Analysis of Devices	S	1.6537	\$109

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

3. Status Indicator (SI) shows how a code is handled for payment purposes: 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. As published by the AMA, these codes represent a single lead. When more than one lead is placed, each is coded separately. However, Medicare does not permit the use of bilateral modifier -50 or -LT/-RT on these codes. Some providers have been successful appending modifier -59 to the second lead insertion code to identify to payers that each code represents a distinct lead.

6. 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.

7. 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

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	FY10 Medicare National Average ³
Implantation or Replacement: Generator and Leads	Entire system implant or replacement generator (86.94 – 86.98) plus leads (03.93)	Pain disorder (338.X) or due to causalgia or RSD, and other nervous system disorders	028	Spinal Procedures W MCC ⁴	5.1090	\$28,878
			029	Spinal Procedures W CC or Spinal neurostimulators ⁴	2.7768	\$15,696
		Due to musculoskeletal disorders	490	Back and Neck Procedures Except Spinal Fusion W CC/MCC or Disc Device or Neurostimulators ⁵	1.7718	\$10,015
Implantation or Replacement: Generator Only	Generator only implant or replacement (86.94 – 86.98)	Pain disorder (338.X) or due to causalgia or RSD, and other nervous system disorders	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 Neurostimulator	2.1249	\$12,011
			042	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	1.6448	\$9,297
		Due to musculoskeletal disorders	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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MS-DRG Assignments *continued*

Procedure	Scenario		MS-DRG ¹	MS-DRG Title ^{1,2}	Relative Weight ¹	FY10 Medicare National Average ³
Implantation or Replacement: Leads Only^{4,5}	Lead only implant or replacement (03.93)	Pain disorder (338.X) or due to causalgia or RSD, and other nervous system disorders	028	Spinal Procedures W MCC	5.1090	\$28,878
			029	Spinal Procedures W CC or Spinal Neurostimulators	2.7768	\$15,696
			030	Spinal Procedures W/O CC/MCC	1.6019	\$9,055
	Due to musculoskeletal disorders	490	Back and Neck Procedures except Spinal Fusion W CC/MCC or Disc Device or Neurostimulators	1.7718	\$10,015	
		491	Back and Neck Procedures Except Spinal Fusion W/O CC/MCC	0.9522	\$5,382	
Removal (without replacement)^{4,6}	Entire system removal, generator (86.05) plus leads (03.94)		028	Spinal Procedures W MCC	5.1090	\$28,878
			029	Spinal Procedures W CC or Spinal Neurostimulators	2.7768	\$15,696
			030	Spinal Procedures W/O CC/MCC	1.6019	\$9,055
	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 (03.94)		028	Spinal Procedures W MCC	5.1090	\$28,878
			029	Spinal Procedures W CC or Spinal Neurostimulators	2.7768	\$15,696
			030	Spinal Procedures W/O CC/MCC	1.6019	\$9,055

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 spinal procedures with a nervous system principal diagnosis (DRGs 028, 029, and 030); the difference is whether secondary diagnoses are designated as MCCs or CCs. However, for full system neurostimulator implantation in which both the leads 03.93 and the generator 86.94 – 86.98 are coded, MS-DRG 030 cannot be assigned. Instead, MS-DRG 029 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 028 is assigned. For other spinal procedures, such as lead only implantation 03.93 or lead removal 03.94, the full range of MS-DRGs 028, 029, and 030 is available.

5. There are two MS-DRGs for back and neck procedures with a musculoskeletal system principal diagnosis (DRGs 490 and 491); the difference is whether secondary diagnoses are designated as CCs/MCCs. However, for full system neurostimulator implantation in which both the leads 03.93 and the generator 86.94 – 86.98 are coded, MS-DRG 490 is automatically assigned regardless of whether a CC or MCC is present. For other spinal procedures, such as lead only implantation 03.93, both MS-DRGs 490 and 491 are available.

6. Device removal without replacement is typically 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 coding purposes, a neurostimulator is classified as a nervous system device. When removed for complications or because it is no longer needed, the principal diagnosis is either various nervous system complication codes or code V53.02.

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www.medtronic.com

United States of America

Medtronic Neuromodulation
710 Medtronic Parkway
Minneapolis, MN 55432-5604
USA
Tel. 763-505-5000
Toll-free 1-800-328-0810

Europe

Medtronic International Trading Sàrl
Route du Molliau 31
Case Postale
CH-1131 Tolochenaz
Switzerland
Tel. +41-21-802-7000

Asia-Pacific

Medtronic International, Ltd.
Suite 1602 16/F
Manulife Plaza
The Lee Gardens, 33 Hysan Avenue
Causeway Bay
Hong Kong
Tel. 852-2891-4456

Australia

Medtronic Australasia Pty. Ltd.
97 Waterloo Road
North Ryde
NSW 2113
Australia
Tel. +61-2-9857-9000
www.medtronicneuro.com.au

Canada

Medtronic of Canada Ltd.
6733 Kitimat Road
Mississauga, Ontario L5N 1W3
Canada
Tel. 1-905-826-6020