

2010 Outpatient Hospital Coding and Payment Quick Reference for Spinal Cord Stimulation

GuidePoint

Simplifying Reimbursement

Neuromodulation

Reimbursement Coding and Medicare Payment Guide: This information pertains to the Centers for Medicare and Medicaid Services' (CMS) 2010 coding and national payment rates for spinal cord stimulator (SCS) procedures in the outpatient hospital. In the hospital outpatient prospective payment system (OPPS), Medicare bundles the reimbursement for the procedural and device components into an ambulatory payment classification (APC).

CPT Code ¹ Payment	Description	APC ²	Status Indicator	Medicare National Average Payment ^{3,4}
63650	Percutaneous implantation of neurostimulator electrode array; epidural (each)	0040	S ⁵	\$ 4,418
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle(s), epidural	0061	S	\$ 5,818
63661 ⁶	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	0687	T ⁷	\$ 1,320
63662 ⁶	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed			
63663 ⁶	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed			
63664 ⁵	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed			
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	0039 ⁸	S	\$ 13,858
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver	0688	T	\$ 1,927
95972	Electronic analysis of implanted neurostimulator pulse generator system; complex spinal cord, with intraoperative or subsequent programming, first hour	0692	S	\$ 108
95973	Electronic analysis of implanted neurostimulator pulse generator system; complex spinal cord, with intraoperative or subsequent programming, each additional 30 minutes after first hour	0692	S	\$ 108

When Billing Medicare: The following C-codes are required for billing Medicare outpatient procedures with the applicable CPT codes, but are not separately payable by Medicare.

C-Code ⁹	Description	CPT Code
C1778	Lead, neurostimulators (implantable)	63663, 63664 63650, 63655
C1787	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator	63685
C1820	Generator, neurostimulator (implantable) and external recharging system for battery (internal) for use with implantable neurostimulator	63685
C1883	Adapter/extension, pacing lead or neurostimulators lead (implantables)	63650

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² CMS 42 CFR Parts 410, 416, and 419 [CMS-1414-FC]. Available online at <http://edocket.access.gpo.gov/2009/pdf/E9-26499.pdf>

³ 2010 Medicare base reimbursement amounts are shown without geographic adjustment.

⁴ On March 23, 2010, President Obama signed into law the Affordable Care Act (ACA). Section 3401(i) of the ACA imposes a 0.25 percentage point reduction to the OPPS market basket for Calendar Year (CY) 2010, effective for services furnished on or after January 1, 2010.

⁵ Providers will begin seeing payments under this provision in the late May/early June time frame.

⁶ Significant procedure, not subject to multiple reduction rule.

⁷ AMA created four new CPT codes specific to removal and revision of both the percutaneous and laminectomy leads. The new 2010 CPT codes (63661-63664) are more specific; replacing CPT 63660

⁸ Significant procedure, multiple surgical reduction applies.

⁹ APC 0039 includes CPT codes 61885 (single-array cranial neurostimulators), 64590 (peripheral nerve stimulator), and 63685 as a result of 2010 Final OPPS/ASC Rule. APC 0222 has been discontinued as a result of the consolidation of 63685 into APC 0039.

⁹ CMS 42 CFR Parts 410, 416, and 419 [CMS-1404-FC; CMS-3887-F; CMS-3835-F-1]. Available online at <http://edocket.access.gpo.gov/2008/pdf/E8-26212.pdf>

2010 Outpatient Coding Scenarios for Spinal Cord Stimulation (Place of Service 22)

Important: The following are coding scenarios for commonly performed Spinal Cord Stimulator (SCS) procedures. Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

Trial Procedure: Single or Dual Percutaneous Lead

Code	Modifier	Units	Comments
63650		1	
63650		1	If dual lead procedure
95972		1	Use if performed
95973			Units determined by programming time
C1778		1	Use two units if dual lead procedure
C1883			Lead extension, if used (2 if dual leads)

Implant Procedure: Single or Dual Percutaneous Lead & IPG

Code	Modifier	Units	Comments
63685	58 ¹	1	Use if staged
63650	58	1	
63650	58	1	If dual lead procedure
95972		1	Use if performed
95973			Units determined by programming time
C1820		1	
C1778		1	Use two units if dual lead procedure
C1883			Lead extension, if used (2 if dual leads)

Implant Procedure: Laminectomy Lead & IPG

Code	Modifier	Units	Comments
63685	58	1	Use if staged
63655	58	1	Use if laminectomy lead placement
95972		1	Use if performed
95973			Units determined by programming time
C1820		1	
C1778		1	
C1883			Lead extension, if used

Note: Where revenue center coding is to be utilized, Revenue code 278: Medical/ surgical supplies - other implants applies to implantable SCS systems (including generator and leads).

CPT and Related HCPCS Association for Non-Medicare Payers²

CPT	HCPCS	Descriptor
63663, 63664 63650, 63655	L8680 ³	Implantable neurostimulator electrode, each
63685	L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
NA	L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
NA	L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only
NA	L8699	Prosthetic implant, not otherwise specified
NA	L9900	Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS "L" code

¹ Modifier 58: Indicates that it is a staged or related service by same physician during the post-operative period (use within global period).

² Please verify with local payers for specific device coding requirements.

³ On December 18, 2009, CMS issued a 2010 HCPCS Correction clarifying that the long code descriptor for L8680 will remain unchanged from the CY 2009 descriptor (see www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp).