

**GuidePoint**

Simplifying Reimbursement

**Neuromodulation**

**This document addresses common questions with regard to the CY 2010 changes in Neurostimulator Implantation reimbursement for outpatient hospitals in the Medicare Outpatient Prospective Payment System (OPPS) Final Rule.**

**1. What Medicare changes are taking place in 2010 hospital outpatient payments for neurostimulator implants?**

In 2009, there were three distinct ambulatory payment categories (APC) for classification of neurostimulator implant procedures. CMS adopted the 2010 proposal to combine SCS neurostimulators, peripheral neurostimulators, and single-array cranial neurostimulators into one single payment category (APC 0039) despite widespread national opposition. As a result of this change, there will now be two payment categories for Neurostimulator Implants: Level 1 (APC 0039) which involves SCS, peripheral, and single-array cranial neurostimulators and Level 2 (APC 0315) which involves only dual-array cranial neurostimulators. Table 1 below illustrates the APC reclassification.

**Table 1: Comparison of 2009 vs. 2010 APC Structure for Neurostimulator Implantation**

2009 APC	2009 Description	CPT Code <sup>1</sup>	CPT Description	2010 APC	2010 Description	CPT Code
0039	Level I Implantation of Neurostimulator	61885	Cranial neurostimulator, single-array	0039	Level I Implantation of Neurostimulator	61885
		64590	Peripheral and gastric neurostimulator			64590
0222	Level II Implantation of Neurostimulator	63685	Spinal neurostimulator (both rechargeable and non-rechargeable)			
0315	Level III Implantation of Neurostimulator	61886	Cranial neurostimulator, dual array	0315	Level II Implantation of Neurostimulator	61886

**2. What were the Medicare payment changes for SCS generator and SCS lead placements?**

Despite widespread national opposition and collaborative efforts by physicians and others, CMS finalized its proposal to move SCS generator implants into the lower payment category for neurostimulators which is reflected in the same payment classification (APC 0039) as peripheral nerve stimulators. In contrast, payments for both SCS percutaneous and laminectomy procedures have increased for 2010.

**3. Why did CMS make this change in reimbursement for spinal cord stimulator implant procedures?**

After reviewing public comments, CMS stated that consolidation of SCS, peripheral and single-array cranial neurostimulators payment categories was consistent with its policy goals of establishing broader payment categories and facility costs were sufficiently similar to merit recognition in the same payment category. Further, CMS concluded that facility cost differences are not sufficiently substantial for hospitals to deny access for patients who are clinical candidates for rechargeable SCS neurostimulators.

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We will continue to work aggressively on advocacy efforts with CMS and other payers to ensure patient access to rechargeable SCS neurostimulators in the future. Boston Scientific greatly appreciates the hundreds of comments that were submitted by physicians, administrators, and patients attesting to the value of rechargeable SCS neurostimulators.

**4. Do changes in the SCS implant reimbursement have any effect on the SCS lead reimbursement?**

No, the reassignment of APC 0222 into APC 0039 for SCS implant procedures does not affect lead reimbursement. Percutaneous lead (APC 0040) and laminectomy lead (APC 0061) placements are reported under separate CPT codes that are associated with different payment categories than the generator placements. In fact, Medicare increased these payment rates for both percutaneous and laminectomy lead placements as shown in the tables below.

**5. What is the overall impact on 2010 hospital outpatient payments for SCS trial and SCS permanent implant procedures?**

For 2010, overall Medicare facility reimbursement for SCS trial procedures with dual percutaneous leads will increase by 5.2% (\$8,966) in the outpatient hospital. Payments for permanent SCS implant procedures including both the generator and percutaneous leads will decline by 5.1% (\$22,858). Payments for permanent SCS implant procedures performed with laminectomy or paddle leads will decrease by 6.2% to \$19,832.

Tables 2, 3 and 4 provide details for common trial and permanent SCS implant scenarios. Appropriateness for CPT and HCPCS codes depend on actual services performed and may vary by payer. Please verify coding guidelines and requirements with your payer.

**Table 2: SCS Trial Procedure Payment with Placement of Dual Percutaneous Leads**

CPT Code	Descriptor	APC	2009 HOPPS National Avg. Payment	2010 HOPPS National Avg. Payment <sup>2</sup>	% Change
63650	Percutaneous implantation of electrode array(s)	0040	\$ 4,206	\$ 4,429	+5.3%
63650	Percutaneous implantation of electrode array(s)	0040	\$ 4,206	\$ 4,429	+5.3%
95972	Programming, complex, 1 <sup>st</sup> hour	0692	\$109	\$ 108	0%
<b>Total</b>			<b>\$ 8,521</b>	<b>\$ 8,966</b>	<b>+ 5.2%</b>

**Table 3: SCS Permanent Procedure Payment with Placement of Dual Percutaneous Leads**

CPT Code	Descriptor	APC	2009 HOPPS National Avg. Payment	2010 HOPPS National Avg. Payment <sup>2</sup>	% Change
63650	Percutaneous implantation of electrode array(s)	0040	\$ 4,206	\$ 4,429	+ 5.3%
63650	Percutaneous implantation of electrode array(s)	0040	\$ 4,206	\$ 4,429	+ 5.3%
63685	Insertion of SCS implantable pulse generator	0222/ 0039 <sup>3</sup>	\$ 15,567	\$ 13,892	- 10.8%
95972	Programming, complex, 1 <sup>st</sup> hour	0692	\$109	\$ 108	0%
<b>Total</b>			<b>\$ 24,088</b>	<b>\$ 22,858</b>	<b>- 5.1%</b>

**Table 4: SCS Permanent Procedure Payment with Placement of Laminectomy Lead**

CPT Code	Descriptor	APC	2009 HOPPS National Avg. Payment	2010 HOPPS National Avg. Payment <sup>2</sup>	% Change
63655	Laminectomy for implantation of electrodes, plate/paddle, epidural	0061	\$5,477	\$5,832	+ 6.5%
63685	Insertion of SCS implantable pulse generator	0222/ <b>0039</b> <sup>3</sup>	\$ 15,567	\$ 13,892	- 10.8%
95972	Programming, complex, 1 <sup>st</sup> hour	0692	\$109	\$ 108	0%
<b>Total</b>			<b>\$ 21,153</b>	<b>\$ 19,832</b>	<b>- 6.2%</b>

<sup>2</sup> 2010 Payment rates based on Medicare National Average, unadjusted for geographic wage index.

<sup>3</sup> APC 0039 includes CPT codes 61885 (single-array cranial neurostimulators), 64590 (peripheral nerve stimulator), and 63685 as a result of 2010 Final OPSS/ASC Rule. APC 0222 has been discontinued as a result of the consolidation of 63685 into APC 0039.

**6. What is the impact when the SCS trial and permanent implant procedures are both performed in the outpatient hospital?**

In facilities where both SCS trials and permanent implants are performed, the Medicare payment changes will be modest for outpatient hospitals.

- ◆ **SCS full system (trial and permanent) implants performed with percutaneous leads:** Medicare full system SCS percutaneous dual lead procedures will decrease by \$785 or 2.4%.
- ◆ **SCS full system (trial and permanent) implants performed with laminectomy/paddle lead:** Medicare full system paddle lead procedures, payments will decrease by \$876 or 3.0%.

**7. How does the above consolidation of payment categories for APC 0039 and APC 0222 affect how outpatient hospitals should code for spinal cord stimulator implant procedures?**

The CPT code for implantation of spinal cord stimulator procedures has not changed, so hospital coding practices should be unaffected by this CMS decision. The only change as a result of the 2010 Medicare OPSS Final Rule is the payment category for spinal cord stimulator implant procedures will be associated with payment category APC 0039. Outpatient hospitals and ambulatory surgery centers should continue to bill with the CPT and associated HCPCS codes related to these procedures. Please go to [www.controlyourpain.com/Reimbursement](http://www.controlyourpain.com/Reimbursement) for additional guidance for spinal cord stimulator implant procedures.

**8. Will Medicare’s reassignment of SCS generator implants into APC 0039 have an impact on commercial and/or workers’ compensation reimbursement for these procedures?**

This will be highly dependent on how the facility’s private pay and workers’ compensation contracts are negotiated. That said, many commercial and workers’ compensation payment rates are determined using methodologies that are unrelated to the Medicare OPSS payment system. Many facility contracts with commercial insurers include separate device carve-out payments for implantable medical devices where they are reimbursed using revenue center codes (e.g., Revenue code 278) based on a percentage of charges or cost plus a predetermined percentage amount. It is important that you contact your payer to determine whether Medicare payment changes have an impact on commercial or workers’ compensation payments for spinal cord stimulator implant procedures.

**9. I understand there are new AMA CPT procedure codes for 2010 that relate to removal and revision/replacement of neurostimulator leads. What are these new codes?**

The 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 and replace the existing general CPT code (63660) for revision or removal of a percutaneous or plate/paddle neurostimulator electrode array. That said, the new codes (63661-63664) are assigned to the same APC (APC 0687) as the predecessor CPT code (63660). Table 5 below reflects

the new CPT codes, descriptors and values. According to the 2010 AMA CPT guidance, do not report 63661 or 63663 when removing or replacing a temporary percutaneously placed array for an external generator.

**Table 5: 2010 CPT Codes Specific for Removal and Revision of Percutaneous or Paddle Lead**

CPT Code	Descriptor	APC	2009 HOPPS National Avg.	2010 HOPPS National Avg.	% Change
63660	Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)	0687	\$ 1,297		
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed				
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed				
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed			\$ 1,324	+ 2.1%
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed				

**10. If I have additional questions regarding Medicare changes in the 2010 OPSS/ASC Final Rule, who should I contact?**

Please feel free to contact your Boston Scientific Neuromodulation sales representative or the Pain Management Reimbursement Hotline if you have any additional questions and they will put you in touch with a Boston Scientific Neuromodulation Regional Reimbursement Manager. Additional details concerning the 2010 Medicare OPSS/ASC Final Rule can also be found on the CMS website at:

<http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1230047&intNumPerPage=10>.

**Pain Management Reimbursement Hotline**

Phone: (866) 287-0778 Monday – Friday

5:00 a.m. to 5:00 p.m. Pacific Time

Fax: (877) 835-2520

[www.controlyourpain.com/reimbursement](http://www.controlyourpain.com/reimbursement)

**Boston Scientific Corporation**

Neuromodulation

25155 Rye Canyon Loop

Valencia, CA 91355

[www.bostonscientific.com](http://www.bostonscientific.com)

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