



Neuromodulation Reimbursement

Spinal Cord Stimulation

Hospital Coding

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Spinal Cord Stimulation

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Topics

- Quick Overview of SCS
- Screening and Trial
- System Implantation
- Follow-Up and Maintenance
- Routine Generator Replacement
- Device Complications

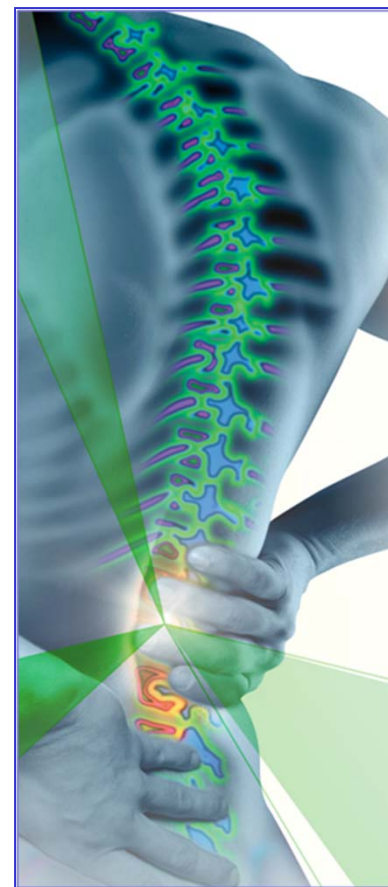
Quick Overview of SCS



What is SCS?

Spinal cord stimulation (SCS) is neurostimulation therapy for patients with chronic intractable pain.

- The chronic pain may result from a variety of underlying disorders such as:
 - ~ reflex sympathetic dystrophy (CRPS-I)
 - ~ causalgia
 - ~ failed back syndrome
- SCS is a “late resort” surgical treatment.
- For these patients, other treatment modalities including medication, physical therapy and prior surgery, have not provided adequate relief or are contraindicated.

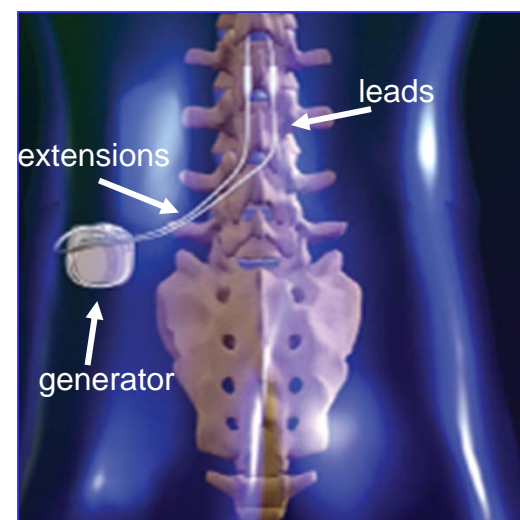
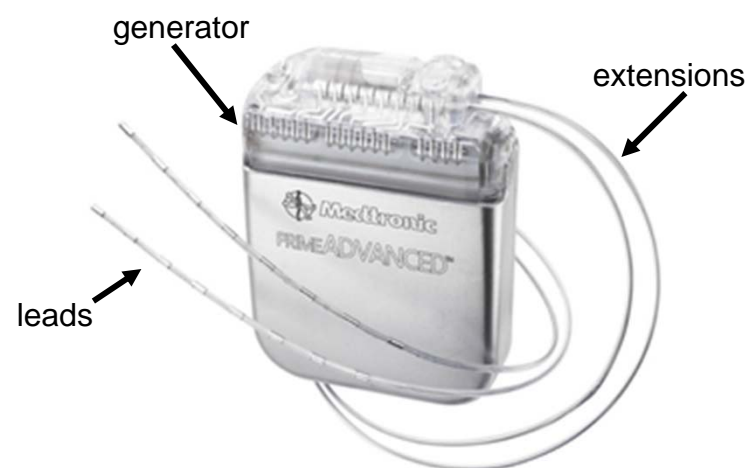


Implanted System Components

Spinal cord stimulation involves three implanted device components:

- Lead
- Generator
- Extension

One or two leads are placed within the epidural space of the spine and, as needed, connected by an extension to an implantable pulse generator (IPG) in a subcutaneous pocket. This allows programmed electrical stimulation to be delivered directly to the spine.



External System Components

Neurostimulator systems can have up to three external components as well. These components are integral to the system and are necessary for it to function properly.

- Clinician programmer
- Patient programmer
- Recharger

The clinician programmer is used by the physician to set the stimulation parameters. The patient programmer allows the patients to adjust the parameters within a pre-set range.

Some generators are rechargeable and need a recharger.

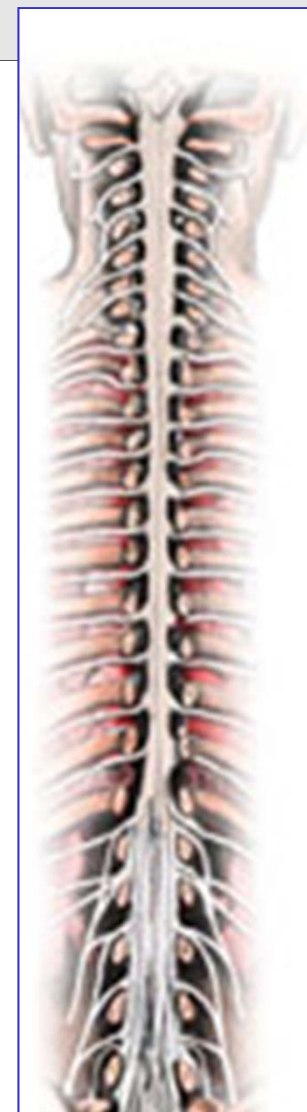


How Does SCS Act?

SCS is directed at managing the pain, not the underlying disorder itself.

- SCS is thought to block the sensation of pain.
- Stimulating certain nerve fibers in the spine is believed to inhibit pain signals before they reach the brain.
- Pain is replaced by a tingling sensation (paresthesia) that covers the areas where pain is felt.

SCS is most effective for chronic pain of the trunk and limbs caused by malfunctioning nervous pathways (neuropathic pain) as opposed to pain caused by tissue damage (nociceptive pain).



Screening and Trial



Screening Requirement

“Conditions for Coverage ... Patients have undergone careful screening, evaluation and diagnosis by a multidisciplinary team prior to implantation. (Such screening must include psychological, as well as physical evaluation.)”

Medicare National Coverage Determinations Manual, Chapter 1, section 160.7

- Most payers require extensive screening to ensure that the patient is an appropriate candidate for SCS.
- A psychological evaluation is required in addition to a physical evaluation.

Trial Requirement

“Conditions for Coverage ... Demonstration of pain relief with a temporarily implanted electrode precedes permanent implantation.”

Medicare National Coverage Determinations Manual, Chapter 1, section 160.7

- Most payers require that a preliminary trial of spinal cord stimulation be conducted prior to permanent implantation.
- The purpose of the trial is determine if SCS is effective in adequately relieving the patient’s pain and/or improving function.
- Many payer medical policies do not quantify a required level of pain relief, but a reduction in pain of 50% or more is a common clinical benchmark.

Trials are typically performed in the hospital outpatient setting.



Trial Procedure

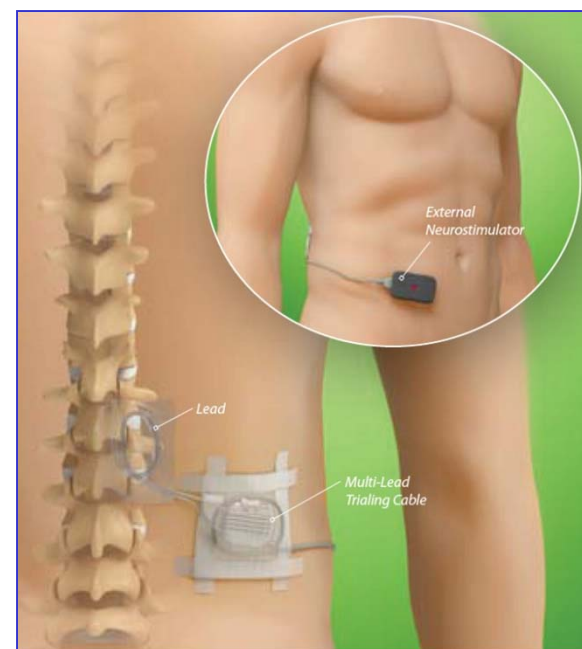
Under fluoroscopy, the physician inserts a trial lead into the epidural space.

The lead is connected to a cable and an *external* generator worn over the body.

Via the external generator, the physician tests various lead positions and stimulation parameters to identify optimal position and settings.

The patient is sent home with the temporary devices in place.

After a trial period of 3 to 7 days, the physician meets with the patient to assess the effect of spinal cord stimulation and determine if permanent implantation is appropriate.



CPT Codes: Trial

CPT	Description
63650	Percutaneous implantation of neurostimulator electrode array, epidural

- Leads can also be placed via laminectomy but this technique is much less common for the trial.
- Use of fluoroscopy is considered integral and is not coded separately.

CPT Issues: Trial

Issue: Coding for Programming

- Can programming be coded separately during the trial?

Coding Comment

- No. Do not code programming during the trial.

Discussion

- CPT manual instructions state that programming codes 95971 and 95972 refer to *implanted* neurostimulator generator systems, but the generator during the trial is *external*.
- The AMA has also published that impedance testing and stimulation to verify lead function is inherent to lead placement and does not constitute programming.

CPT Issues: Trial

Issue: Removal of Temporary Lead

- At the end of the trial, the temporary lead is usually removed by traction or pull. How is removal of the temporary lead coded?

Coding Comment

- It isn't. Removal of the temporary percutaneous lead is not separately codable.

Discussion

- The AMA has published that removal of a temporary SCS lead is not reportable because it is inherent to the insertion code.
- Although there is a code for removal of percutaneous lead, the AMA has published that this is assigned only for surgical removal of a permanent lead.

HCPCS II Codes: Trial Lead

In addition to the CPT procedure code, a HCPCS II code is submitted for the trial lead itself.

C Code : Medicare

HCPCS II	Description
C1897	Lead, neurostimulator, test kit (implantable)

- Although packaged under APCs, the device code is needed to pass Medicare's procedure-to-device edit.

L Codes : Non-Medicare Payers

HCPCS II	Description
L8680	Implantable neurostimulator electrode, each

- Some non-Medicare payers may allow separate payment.



System Implantation



Elements of System Implantation

From a coding perspective, there are six considerations in implanting a spinal cord neurostimulator system:

- ① *Principal diagnosis (ICD-9-CM)*
- ② *Lead implantation (CPT)*
- ③ *Generator implantation (CPT)*
- ④ *Devices (HCPCS II)*
- ⑤ *Analysis and programming (CPT)*

SCS systems are typically implanted in the hospital outpatient setting, although some are implanted during an inpatient stay.

- ⑥ *Inpatient coding (ICD-9-CM)*

Principal Diagnosis

1

There are multiple possibilities for principal diagnosis.

Pain Diagnosis Codes

- There are several codes for pain as a neurological disorder:
 - 338.0** central pain syndrome
 - 338.29** other chronic pain
 - 338.4** chronic pain syndrome
- Pain must be explicitly documented as “chronic” or as a specific syndrome to use codes from category 338.
- When the encounter is for neurostimulator placement for pain, a 338 code is sequenced as the principal diagnosis.
- The underlying cause, eg. failed back syndrome, is coded as a secondary diagnosis.



Principal Diagnosis

Complex Regional Pain Syndrome

- CRPS is coded as the principal diagnosis when it is the underlying cause of the pain.

337.21 reflex sympathetic dystrophy (CRPS I) of upper limb

337.22 reflex sympathetic dystrophy (CRPS I) of lower limb

354.4 causalgia (CRPS II) of upper limb

355.71 causalgia (CRPS II) of lower limb

- The pain codes from 338 are not assigned with these codes because pain is a known component of CRPS.
- CRPS not specified as type I or type II defaults to causalgia.

Principal Diagnosis

Other Underlying Disorders

- When documented generically, pain is a symptom code.
- Symptom codes cannot be assigned as the principal diagnosis, so the underlying condition is sequenced first.

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 (failed back syndrome)

723.4 radicular syndrome, upper limbs (not due to herniation or DDD)

724.4 radicular syndrome, lower limbs (not due to herniation or DDD)



Lead Implantation

2

Percutaneous Lead (Electrode Array, Catheter Lead)

Under fluoroscopy, a spinal needle is introduced into the epidural space.

The lead is then threaded through the needle and advanced to the optimal location within the epidural space.

Surgical Lead (Plate, Paddle)

The target vertebra is exposed by dissection and hemilaminectomy is performed to expose the epidural space.

The lead is placed into the epidural space and advanced to the optimal location.



Lead Configurations

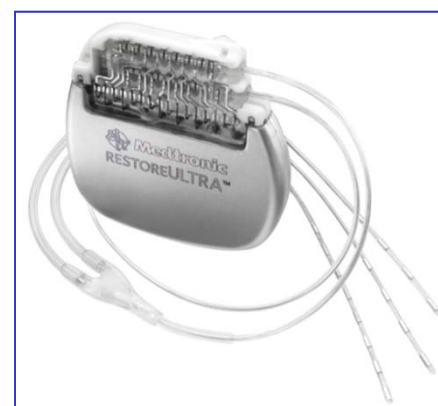
Most spinal neurostimulator systems involve more than one lead, to allow for a larger area of contact.

Bilateral Leads

- It is common to place one lead on the left side of the spinal column and one lead on the right.

Beyond Bilateral

- It is also becoming more common to place three or more leads, usually via a “splitter” to the extension.



CPT Codes: Lead Implantation

CPT	Description
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural

- Note that code 63650 is assigned for percutaneous insertion of both a temporary trial lead and a permanent lead.

CPT Issues: Lead Implantation

Issue: Bilateral Leads

- How is placement of bilateral leads coded?

Coding Comment

- Assign 63650 plus 63650-59 for percutaneous leads, or 63655 plus 63655-59 for leads placed via laminectomy.

Discussion

- The AMA has published that codes 63650 and 63655 represent a single lead, with each lead coded separately.
- Bilateral modifier -50 is not recognized with either of these codes and neither are anatomical modifiers –RT and –LT.
- Modifier -59 alerts the payer that each code represents a distinct lead, rather than an inadvertent duplicate.



CPT Issues: Lead Implantation

Issue: Approach ≠ Lead Type

- Sometimes the surgeon places a paddle lead by puncture or an electrode array via laminectomy. How is this coded?

Coding Comment

- Ultimately, codes 63650 and 63655 are defined and assigned by the approach used, not by the type of lead.

Discussion

- Conventionally, a correlation has existing between approach and type of lead and this is reflected in the CPT manual notes.
- However, as intended, code 63650 requires a percutaneous approach and code 63655 requires a laminectomy, because these are the key components in the physician work for each code.



CPT Issues: Lead Implantation

Issue: Removal of Trial Lead

- What codes are assigned when the temporary lead is removed and the permanent lead placed during the same operative episode?

Coding Comment

- Assign only 63650 or 63655 for placement of the permanent lead.
- Do *not* code removal of the temporary trial lead.
- Do *not* code this scenario as a lead revision or replacement.

Discussion

- Removal of the trial lead is inherent to its insertion, regardless of when or where it is removed.
- The AMA has published that the codes for lead revision and replacement are reserved for scenarios with permanent leads only.



CPT Issues: Lead Implantation

Issue: Conversion of Trial Lead to Permanent

- Sometimes the temporary lead from the trial is left in place and converted to a permanent lead by being tunneled and connected to the newly implanted generator. How is this coded?

Coding Comment

- Code only the generator implantation.
- Do *not* assign a code for lead revision.

Discussion

- The AMA has published that no code for the lead is assigned in this scenario.
- The work of tunneling and connection is included in the generator code.



Generator Implantation

The pulse generator is implanted in a subcutaneous pocket, usually on the back, flank or abdomen.

The lead is brought out, connected to an extension if used, tunneled under the skin to the pocket and connected to the generator.

No part of the system is visible externally.

The surgeon also usually programs the generator during the same encounter.



CPT Code: Generator Implantation

CPT	Description
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling

- The AMA has published that the generator code includes:
 - ~ creating the subcutaneous pocket
 - ~ tunneling the leads to the pocket
 - ~ connecting the leads to the generator

CPT Issues: Generator Implantation

Issue: Coding for the Extension

- What code is assigned for tunneling and implanting the extension?

Coding Comment

- None. In general, the extension is not separately codable.

Discussion

- In an analogous scenario for intracranial neurostimulators, *Coding Clinic for HCPCS* has published that lead extensions are captured in the generator code.

Devices

4

In addition to the CPT procedure codes, HCPCS II codes are submitted for the devices.

C Codes : Medicare

HCPCS II	Description
C1778	Lead, neurostimulator (implantable)
C1767	Generator, neurostimulator (implantable), non-rechargeable
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system
C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable)

- Separate C codes are assigned for the lead, the generator and the extension to capture the entire system.
- These codes are packaged under APCs; payment for the devices is included with the procedure codes.



Devices

L Codes : Non-Medicare Payers

HCPSC II	Description
L8680	Implantable neurostimulator electrode (each)
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

- Depending on the hospital's contract, some non-Medicare payers may allow separate payment for devices.

Note that C codes and L codes don't crosswalk one-for-one.



Device Code Editing

Medicare requires HCPCS II device codes and enforces its requirement with edits.

- When the CPT codes for lead and generator implantation are billed, associated HCPCS II device codes must be billed as well.
- The edits also work in reverse.
- If either the associated CPT procedure code or the HCPCS II device code is not present, the claim is returned to the provider for correction.



Lead Device Edits

Procedure-to-device edits are in place for both lead codes.

CPT Code	CPT Code Description	HCPCS II Device Code	HCPCS II Code Description
63650	Percutaneous implantation of neurostimulator electrode array, epidural	C1778	Lead, neurostimulator (implantable)
		L8680	Implantable neurostimulator electrode (each)

CPT Code	CPT Code Description	HCPCS II Device Code	HCPCS II Code Description
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	C1778	Lead, neurostimulator (implantable)
		L8680	Implantable neurostimulator electrode (each)

- Although C codes are required for Medicare, L codes will pass the edit as well.



Generator Device Edits

Procedure-to-device edits are also in place for the generator.

CPT Code	CPT Code Description	HCPSC II Device Code	HCPSC II Code Description
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
		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

- Again, both C codes and L codes will pass the edit.



Recharger

The recharger is an *external* device the hospital may supply to the patient at the time a rechargeable generator is implanted.



C Code

- There is no C code for the recharger; by definition, it is included with C1820 for the rechargeable generator.

L Code

- There is no L code for the *initial* recharger as this is considered an external component of the generator.
- A *replacement* is codable and may be separately payable.

HCPs II	Description
L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only



Analysis and Programming

5

Analysis and/or programming usually takes place during the same encounter as system implantation.

- Analysis is a device check to ensure the generator is operational.
- In programming, the physician determines and sets parameters to optimally generate the electrical pulses for stimulation.
- Programming is a *generator* service; leads are tested but can't be programmed per se.
- The hand-held clinician programmer delivers the programming instructions to the implanted generator through the skin by telemetry.



CPT Codes: Analysis/Programming

CPT	Description
95970	Electronic analysis of implanted neurostimulator pulse generator system, <i>simple or complex</i> brain, spinal cord, or peripheral pulse generator, <i>without</i> reprogramming
95971	Electronic analysis of implanted neurostimulator pulse generator system, <i>simple</i> spinal cord or peripheral neurostimulator generator, <i>with</i> intraoperative or subsequent programming
95972	Electronic analysis of implanted neurostimulator pulse generator system, <i>complex</i> spinal cord or peripheral neurostimulator generator, <i>with</i> intraoperative or subsequent programming, first hour
+ 95973	each additional 30 minutes after first hour

- Code 95970 is for generator check without programming.
- Code 95971 is for simple programming and codes 95972-95973 are for complex programming.
- Codes 95972-95973 for complex programming are also defined by time.



CPT Issues: Analysis

Issue: Coding for Device Check

- What code is assigned for the initial generator check immediately after generator implantation?

Coding Comment

- None. The initial device check is not separately coded.

Discussion

- The initial device check is integral to generator placement.
- CPT manual instructions state that the device check code 95970 is used for *subsequent* analysis of a *previously* implanted generator.
- Device check code 95970 is NCCI-edited with generator implantation code 63685.

CPT Issues: Programming

Issue: Programming with Generator Implantation

- Can programming be coded separately when performed during the same encounter as generator implantation?

Coding Comment

- Yes. Programming can be and should be coded separately.

Discussion

- Unlike a device check, programming is not integral to generator implantation.
- Programming is a distinct procedural service and is coded separately when performed.
- The programming codes are separately payable under APCs.



CPT Issues: Programming

Issue: Simple versus Complex Programming

- What's the difference between simple and complex programming?

Coding Comment

- Simple programming means changes to 3 or fewer parameters.
- Complex programming means changes to 4 or more parameters.

Discussion

- CPT manual instructions list 13 eligible parameters that “count”.
- Not all parameters listed apply to all neurostimulator models.
- Conversely, not all parameters that can be changed are eligible towards the count.
- The specific parameters that were programmed must be explicitly documented.

CPT Issues: Programming

Issue: Time Thresholds for Programming

- Complex programming code 95972 is defined as “first hour” and add-on code 95973 is defined as “each additional 30 minutes”. How long must programming last for either code to be assigned?

Coding Comment

- For 95972, programming must take at least 31 minutes.
- To add 95973, it must take at least an additional 16 minutes.

Discussion

- CPT manual instructions state that “a unit of time is attained when the midpoint is passed”.
- The total programming time must be explicitly documented.

CPT Issues: Programming

Issue: Programming of Less than 31 Minutes

- How is programming coded when it lasts less than 31 minutes?

Coding Comment

- Assign 95972-52.

Discussion

- CPT manual instructions state that modifier -52 should be appended to the programming code 95972 when the service lasts less than 31 minutes.
- Hospitals use modifier -52 to indicate when a service that does not require anesthesia has been partially reduced or discontinued.
- Codes with modifier -52 are paid at 50% of the rate under APCs.

MyStim Patient Programmer

The *patient* programmer is an external device that the hospital may supply to the patient at the time of generator implantation.

This hand-held device allows the patient to:

- Turn the generator on and off.
- Adjust certain settings within a range pre-set by the physician.
- Monitor the generator's battery life.



HCPCS II Code: Patient Programmer

C Code

- The patient programmer is coded separately, but is packaged under APCs and not paid separately.

HCPCS II	Description
C1787	Patient programmer, neurostimulator

L Code

- There is no L code for the *initial* patient programmer; it is considered an external component of the generator.
- A *replacement* is codable and may be separately payable.

HCPCS II	Description
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only



Inpatient Coding

6

Separate ICD-9-CM codes are assigned for implantation of the leads and implantation of the generator.

Leads

ICD-9-CM	Description
03.93	Implantation or replacement of spinal neurostimulator lead(s)

- ICD-9-CM does not make a distinction between leads placed percutaneously and those placed via laminectomy.
- Lead code 03.93 is a significant procedure for DRG assignment.

Inpatient Coding

Generator

ICD-9-CM	Description
86.94	Insertion and replacement of single array neurostimulator pulse generator, not specified as rechargeable
86.95	Insertion and replacement of multiple array neurostimulator pulse generator, not specified as rechargeable
86.96	Insertion and replacement of other neurostimulator pulse generator
86.97	Insertion and replacement of single array rechargeable neurostimulator pulse generator
86.98	Insertion and replacement of multiple array (two or more) rechargeable neurostimulator pulse generator

- All codes are significant procedures for DRG assignment.
- The practical way to differentiate single vs multiple array and non-rechargeable vs rechargeable is to check the generator model on the device sticker.

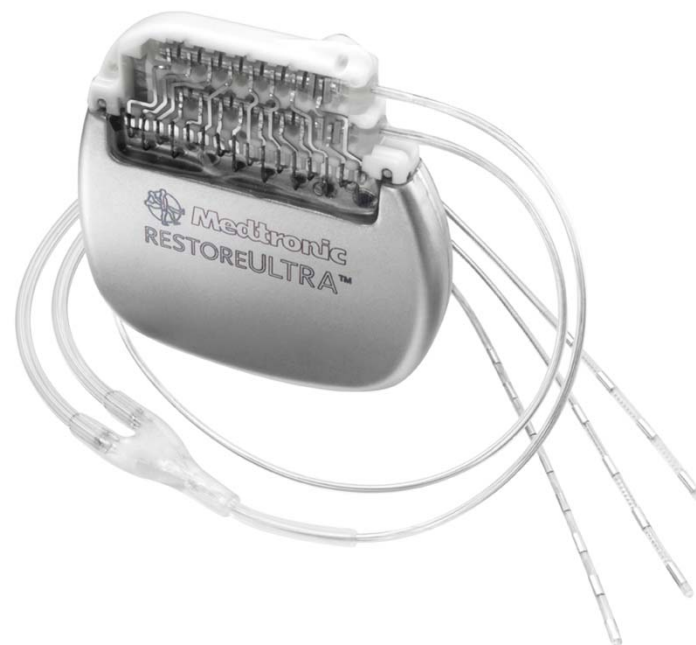


Single vs Multiple Array Generators

The term “array” in the generator code definitions refers to:
→ *the number of leads that can be connected to one generator.*

Generators are engineered with either one or more ports where a lead can be connected:

- *A single array generator has one port that can be connected to one lead.*
- *A multiple array generator has two or more ports that can be connected to two or more leads.*



ICD-9-CM Issues: Generator

Issue: Use of 86.96

- Code 86.96 is defined as “other” generator. When is 86.96 used?

Coding Comment

- Assigning code 86.96 is almost *never* appropriate.

Discussion

- Code 86.96 was assigned for neurostimulators with an implanted receiver and external transmitter, but these systems are rare today.
- Carotid sinus stimulators used to be assigned to 86.96 but code 38.93 for implantation of these devices was created in FY 2011.
- There is no reason to assign 86.96 when a device sticker is available.

DRG Assignment

For system implantation in which both leads and generator are coded, DRGs 029 or 490 are automatically assigned.

Nervous System (eg. pain, CRPS)

DRG	Description	FY 2012 Weight
028	Spinal Procedures W MCC	5.6476
029	Spinal Procedures W CC or Spinal Neurostimulator	2.8308
030	Spinal Procedures WO CC/MCC	1.6924

Musculoskeletal (eg. failed back syndrome)

DRG	Description	FY 2012 Weight
490	Back and Neck Proc Except Spinal Fusion W CC/MCC or Disc Device or Neurostimulators	1.7987
491	Back and Neck Proc Except Spinal Fusion WO CC/MCC	1.0067

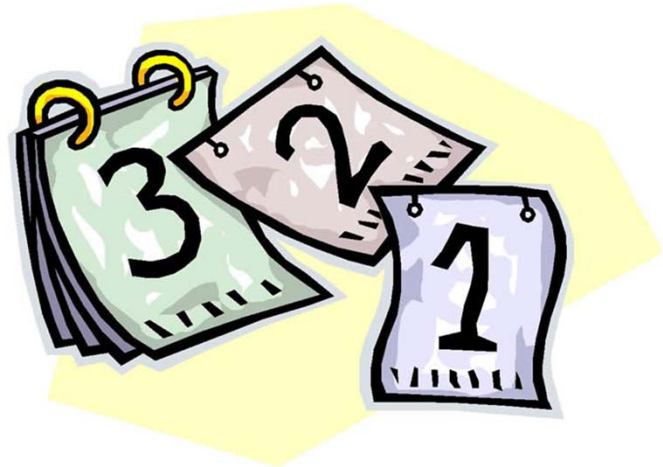
Follow-Up and Maintenance



Routine Follow-Up

After the initial post-implantation period, the patient continues to be seen periodically for routine device follow-up.

- Depending on physician judgment and each patient's need, these visits may take place once a month to once a quarter.
- At each visit, the physician performs a device check and may also perform reprogramming to adjust the stimulation parameters as needed.



Principal Diagnosis Code

Because the device is the specific focus of routine follow-up visits, the principal diagnosis is properly a V code.

V53.02 Fitting and adjustment of neuropacemaker
(brain) (peripheral nerve) (spinal cord)

- The underlying diagnosis, eg. chronic pain or CRPS, is coded as a secondary diagnosis.

Device Check vs Reprogramming

Device Check

- A device check, or interrogation, is an electronic analysis to recover stored data and review existing parameters.
- No settings are changed.

Reprogramming

- After assessing the effect of the current settings and any changes in the patient's clinical picture, the physician determines new parameters for optimal stimulation and adjusts the settings.
- Programming always includes a device check.

CPT Codes: Check/ Programming

CPT	Description
95970	Electronic analysis of implanted neurostimulator pulse generator system, <i>simple or complex</i> brain, spinal cord, or peripheral pulse generator, <i>without</i> reprogramming
95971	Electronic analysis of implanted neurostimulator pulse generator system, <i>simple</i> spinal cord or peripheral neurostimulator generator, <i>with</i> intraoperative or subsequent programming
95972	Electronic analysis of implanted neurostimulator pulse generator system, <i>complex</i> spinal cord or peripheral neurostimulator generator, <i>with</i> intraoperative or subsequent programming, first hour
+ 95973	each additional 30 minutes after first hour

- Code 95970 is used when only interrogation is performed.
- Codes 95971, 95972, and 95973 are used for reprogramming.

CPT Issues: Follow-Up

Issue: Clinic Visits with Programming

- When the patient comes to the clinic for programming after generator implantation, can a visit also be coded?

Coding Comment

- An E&M code for a clinic visit should usually *not* be coded separately. Only the programming code should be assigned.
- *If* a significant, separately identifiable E&M service is rendered in the clinic, append modifier -25 to the clinic visit (E&M) code.

Discussion

- CMS has published that “billing a visit code in addition to another service merely because the patient interacted with hospital staff or spent time in a room for that service is inappropriate”.



CPT Issues: Follow-Up

Issue: Adjustment with Resetting to Original Parameters

- What code is used when the physician re-sets the parameters but then decides to return the device to its original settings?

Coding Comment

- Assign programming codes 95972-95973 as usual.

Discussion

- In an analogous clinical scenario for pacemakers, the AMA has published that performing adjustments and ultimately restoring the original parameters should be coded as reprogramming.
- Although the original parameters were eventually restored, the physician has performed the work of adjusting the settings and assessing the effect.

CPT Issues: Follow-Up

Issue: Programming by the Manufacturer Representative

- Can the hospital report programming performed by the manufacturer representative?

Coding Comment

- The hospital should *not* report programming performed solely or largely by the manufacturer representative.

Discussion

- When performed by the representative, the hospital may not have incurred staff, equipment or supply expenses.
- A reasonable rule of thumb is that even with involvement by the manufacturer's representative, hospital staff should perform the majority of the work using hospital equipment and supplies.



Routine Generator Replacement



Principal Diagnosis Code

Every pulse generator has a battery sealed inside. When the battery wears out, as all electronic equipment eventually does, the entire generator must be replaced.

For routine 'end-of-life' generator replacement, the V code is the principal diagnosis.

V53.02 Fitting and adjustment of neuropacemaker
(brain) (peripheral nerve) (spinal cord)

- The underlying diagnosis, eg. chronic pain or CRPS, is coded as a secondary diagnosis.

Replacement Procedure

Routine generator replacement is a relatively straightforward procedure that typically takes place on an outpatient basis.

- The existing pocket is opened and the old generator is externalized.
- The existing leads are disconnected and examined.
- The existing leads are attached to the new generator.
- The new generator is returned to the existing pocket and the pocket is closed.
- The new generator is usually programmed during the same encounter.

CPT Code: Generator Replacement

CPT	Description
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling

- By definition, the same CPT code used for initial implantation of the generator is also used for replacement.
- If programming takes place during the same encounter as the generator replacement, it is coded separately.

CPT Issues: Generator

Issue: Removal of the Old Generator

- When a generator is replaced, can removal of the old generator be coded separately?

Coding Comment

- No. Assign only 61885 or 61886 for generator implantation.
- Do not assign a separate code for generator removal.
- This is true even when the pocket is relocated.

Discussion

- Effective January 2012, NCCI policy states that “if one pulse generator is removed and replaced with a different pulse generator into the same or another skin pocket, the ‘replacement’ CPT code may be reported. The ‘removal’ CPT code is not separately reportable”.



HCPCS II Issues: Generator

Issue: Device Code for New Patient Programmer

- When a generator is replaced, the patient typically receives a new patient programmer as well. Does this qualify as a “replacement” for use of L8681?

Coding Comment

- No. This scenario should be seen as provision of a new “initial” patient programmer.

Discussion

- CMS views the external components as integral to the generator.
- Under APCs, payment for devices is packaged and using L8681 could be perceived as an attempt to circumvent this.

Device Complications



Circumstances of Complications

Device complications may be suspected in some clinical situations, for example if the patient's symptoms increase or the patient becomes febrile.

- When other medical causes are ruled out, device issues may be at the root.
- If a complication is identified, the lead or the generator may need to be removed, revised, or replaced.

Procedures for lead and generator complications can be performed in either the outpatient or inpatient setting.

Principal Diagnosis Code

When device complications are the reason for the encounter, the principal diagnosis is usually one of three codes.

996.2 Mechanical complication of nervous system device

996.63 Infection due to nervous system device

996.75 Other complication of nervous system device

- The same codes are used regardless of whether the complication involves the lead or the generator.
- The underlying diagnosis, eg. chronic pain or CRPS, is coded as a secondary diagnosis.

Remove vs Revise vs Replace

Different complications call for different courses of action.

Removal

- Generator and lead removal may be performed to allow time for an infection to resolve or because the system is no longer effective in reducing the patient's pain.

Revision

- Revision includes: relocating the pocket, repositioning a twisted generator within the pocket, reconnecting a loosened extension, and repositioning a displaced lead.

Replacement

- Other than routine generator end-of-life, replacement is usually performed for mechanical issues, eg. lead fracture.



CPT Codes: Leads

Removal

CPT	Description
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

- These codes refer to *surgical* removal of a *permanent* lead.
- *Surgical* removal involves dissecting soft tissues to expose the lead before it is removed.
- Removal of a *temporary* percutaneous lead is inherent to its insertion and is not coded separately.
- Removal of a *permanent* lead by *simple pull or traction* is also not coded separately.

CPT Codes: Leads

Revision/Replacement

CPT	Description
63663	Revision, including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed
63664	Revision, including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy when performed

- The same code is used for lead revision and replacement.
- For replacements, codes 63663 and 63664 are used only:
 - ~ when a permanent lead is being replaced by another permanent lead, *and*
 - ~ the original lead and the new lead are the same type placed via the same approach at the same spinal level



CPT Issues: Lead Replacement

Issue: Same Type (Array), Same Level

- What code is assigned when a permanent percutaneous lead is removed and replaced by another percutaneous lead at the same spinal level?

Coding Comment

- Assign revision/replacement code 63663.
- Do *not* assign a separate code for removal of the old lead.

Discussion

- This is the clinical scenario that 63663 is intended to represent.
- Removal of the old lead is inherent to the replacement.

CPT Issues: Lead Replacement

Issue: Same Type (Paddle), Same Level

- What code is assigned when a permanent paddle lead is removed and replaced by a permanent paddle lead via the same laminectomy access site at the same spinal level?

Coding Comment

- Assign revision/replacement code 63664.
- Do *not* assign a separate code for removal of the old lead.
- Removal of scar tissue and additional bone at the prior laminectomy site is also included in 63664.

Discussion

- This is the clinical scenario that 63664 is intended to represent.
- Removal of the old lead is inherent to the replacement.



CPT Issues: Lead Replacement

Issue: Same Type (Array), Different Level

- What code is assigned when a permanent *percutaneous* lead is removed and replaced by a permanent *percutaneous* at a *different* spinal level?

Coding Comment

- Assign 63650 for implantation of the new percutaneous lead.
- Do *not* assign a code for removal of the old percutaneous lead.

Discussion

- Code 63661 for removal of percutaneous lead is NCCI-edited with 63650 with no override allowed as of 7-1-2011.

CPT Issues: Lead Replacement

Issue: Same Type (Paddle), Different Level

- What code is assigned when a permanent *paddle* lead is removed and replaced by another permanent *paddle* lead via a *fresh laminectomy* at a *different* spinal level?

Coding Comment

- Assign 63655 for implantation of the new paddle lead via laminectomy.
- Do *not* assign a code for removal of the old paddle lead.

Discussion

- Code 63662 for removal of paddle lead is NCCI-edited with 63655 with no override allowed as of 7-1-2011.

CPT Issues: Lead Replacement

Issue: Different Type, Different Level

- What code is assigned when a permanent *percutaneous* lead is removed and replaced by a permanent *paddle* lead via a *fresh laminectomy* at a *different* spinal level?

Coding Comment

- Assign 63655 for implantation of the new lead via laminectomy plus 63661-59 for removal of the old percutaneous lead.

Discussion

- Due to the different lead types and the fresh laminectomy, this is not considered a revision or replacement for coding purposes.
- There is currently no NCCI edit for this combination of codes.
- Modifier -59 is still useful to show the different anatomic sites.



CPT Issues: Lead Replacement

Issue: Different Type, Same Level

- What code is assigned when a permanent *percutaneous* lead is removed and replaced by a permanent *paddle* lead via a *fresh laminectomy* at the *same* spinal level?

Coding Comment

- Assign 63655 for implantation of the new lead via laminectomy plus 63661-59 for removal of the old lead

Discussion

- The AMA has published that use of 63661 “is appropriate regardless of whether the procedures were performed at the same or different spinal level(s)”.



CPT Codes: Generator

Revision/Removal

CPT	Description
63688	Revision or removal of implanted neurostimulator pulse generator or receiver

- The same code is used for generator revision and removal.

Replacement

- Replacement of the generator for complications uses the same code and follows the same guidelines as routine generator replacement.

ICD-9-CM Codes: Leads

Lead Removal

ICD-9-CM	Description
03.94	Removal of spinal neurostimulator lead(s)

- Because its definition specifies “lead(s)”, code 03.94 is assigned for removal of one or more leads.

Lead Revision

ICD-9-CM	Description
03.99	Other operations on spinal cord and spinal canal structures
86.09	Other incision of skin and subcutaneous tissue

- ICD-9-CM does not have a specific code for lead revision.
- Code 03.99 should be reserved for revision of leads within the spinal canal, eg. repositioning, while 86.09 should be used for subcutaneous revisions, eg. reconnecting.



ICD-9-CM Codes: Leads

Lead Replacement

ICD-9-CM	Description
03.93	Implantation or replacement of spinal neurostimulator lead(s)

- Code 03.93 is used for both initial insertion of leads and replacement of leads.
- Because its definition specifies “lead(s)”, code 03.93 is assigned for replacement of one or more leads.
- Removal of the old lead is not coded separately.

ICD-9-CM Codes: Generator

Generator Removal and Revision

ICD-9-CM	Description
86.05	Incision with removal of foreign body or device from skin and subcutaneous tissue
86.09	Other incision of skin and subcutaneous tissue

- Code 86.05 is used only for removal without replacement.
- Code 86.09 includes relocation of a device pocket as well as opening a pocket for device revision.

Generator Replacement

- Codes 86.94-86.95 and 86.97-86.98 are used for both initial insertion and replacement of the generator.
- Removal of the old generator is not coded separately.





Spinal Cord Stimulation

Hospital Coding

March 2012



Thank You for Participating!



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future...

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THANK YOU!

