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GUIDEPOINT
Reimbursement Resources

2018 Quick Reference Guide – Neuromodulation

Inpatient/Outpatient Hospital Reimbursement

CY 2018 Medicare Inpatient Prospective Payment System for Deep Brain Stimulation (DBS)

Inpatient Procedure Codes[1]	
ICD-10 PC[1]	**Description**
Implantation of Lead(s) only	
00H00MZ	Insertion of Neurostimulator Lead into Brain, Open Approach
00H03MZ	Insertion of Neurostimulator Lead into Brain, Percutaneous Approach
Implantation of IPG only	
0JH60DZ	Insertion of Multiple Array Stimulator Generator into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH80MZ	Insertion of Stimulator Generator into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH83MZ	Insertion of Stimulator Generator into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
Replacement of Lead(s) only	
00P00MZ	Removal of Neurostimulator Lead from Brain, Open Approach
00P03MZ	Removal of Neurostimulator Lead from Brain, Percutaneous Approach
Replacement of IPG only	
0JPT0MZ	Removal of Stimulator Generator from Trunk Subcutaneous Tissue and Fascia, Open Approach
0JPT3MZ	Removal of Stimulator Generator from Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach

Lead only Implant or Replacement

DRG[2]	Description	Relative Weight[3]	National Average Payment[4]
25	Craniotomy and Endovascular Intracranial Procedures W MCC	4.3064	**$25,959**
26	Craniotomy and Endovascular Intracranial Procedures W CC	2.9971	**$18,079**
27	Craniotomy and Endovascular Intracranial Procedures W/O CC/MCC	2.3665	**$14,253**
Whole System Implant			
23	Craniotomy with Major Device Implant/Acute Complex CNS Principal Diagnosis W MCC or Chemo Implant	5.4949	**$33,142**
24	Craniotomy with Major Device Implant/Acute Complex CNS Principal Diagnosis W/O MCC	3.8314	**$23,097**
Generator Only Implant or Replacement			
40	Peripheral/Cranial Nerve and Other Nervous System Procedures W MCC	3.8078	**$22,960**
41	Peripheral/Cranial Nerve and Other Nervous System Procedures W CC or Peripheral Neurostimulator	2.3311	**$14,051**
42	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	1.9105	**$11,511**

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CPT®[5]	Description	Status Indicator[6]	APC[7]	National Average Payment[8]
Pulse Generator Placement				
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays	J1	5464	**$27,890**
Revision of Pulse Generators				
61880	Craniotomy with Major Device Implant/Acute Complex CNS Principal Diagnosis W MCC or Chemo Implant	Q2	5461	**$2,879**
61888	Craniotomy with Major Device Implant/Acute Complex CNS Principal Diagnosis W/O MCC	J1	5462	**$6,055**
Programming Codes				
95970	Peripheral/Cranial Nerve and Other Nervous System Procedures W MCC	Q1	5734	**$105**
95978	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	S	5742	**$115**

HCPCS Level II Descriptors

HCPCS Code	Descriptor
L8679	Implantable neurostimulator pulse generator, any type
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only
C1767	Generator, neurostimulator (implantable), non-rechargeable
C1820	Generator, neurostimulator (implantable), non-high frequency with rechargeable battery and charging system
C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable)
C1787	Patient programmer, neurostimulator
L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only
L8699	Prosthetic implant, not otherwise specified
L9900	Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS "L" code

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Sequestration Disclaimer: Rates referenced in these guides do not reflect Sequestration; automatic reductions in federal spending that will result in a 2% across-the-board reduction to ALL Medicare rates as of January 1, 2018. (Budget Control Act of 2011)

1. ICD-10 Procedure Coding System (ICD-10-PCS) 2018 Tables and Index https://www.cms.gov/Medicare/Coding/ICD10/2017-ICD-10-PCS-and-GEMs.html
2. Most common MS-DRGs for SCS procedures based on Medicare claims data. Boston Scientific does not promote the use of its products outside FDA approved label.
3. FY 2018 IPPS Final Rule CMS-1677-P FY2017 Weight File, Table 5
4. Medicare National average base MS-DRG payment amounts (for urban areas) as of October 1, 2017 based on most common diagnoses for SCS. Academic teaching and disproportionate share hospitals may qualify for additional payment amounts in addition to the base MS-DRG.
5. CPT Copyright 2017 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.
6. J1: Hospital Part B services paid through a comprehensive APC
   Q1: Not paid separately when billed with a S,T,V, or X procedure
   S: Procedure or Service, Not Discounted When Multiple
   Q2: Not paid separately when billed with a T procedure (T packaged)
7. 42 CFR Parts 411, 412, 416, 419, 422, 423, and 424 [CMS-1613-FC]
8. 2018 Medicare National Average payment rates, unadjusted for wage. "National Average Payment" is the amount Medicare determines to be the maximum allowance for any Medicare covered procedure. Actual payment will vary based on the maximum allowance less any applicable deductibles, co-insurance etc.

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NM-455612-AB_JAN2018