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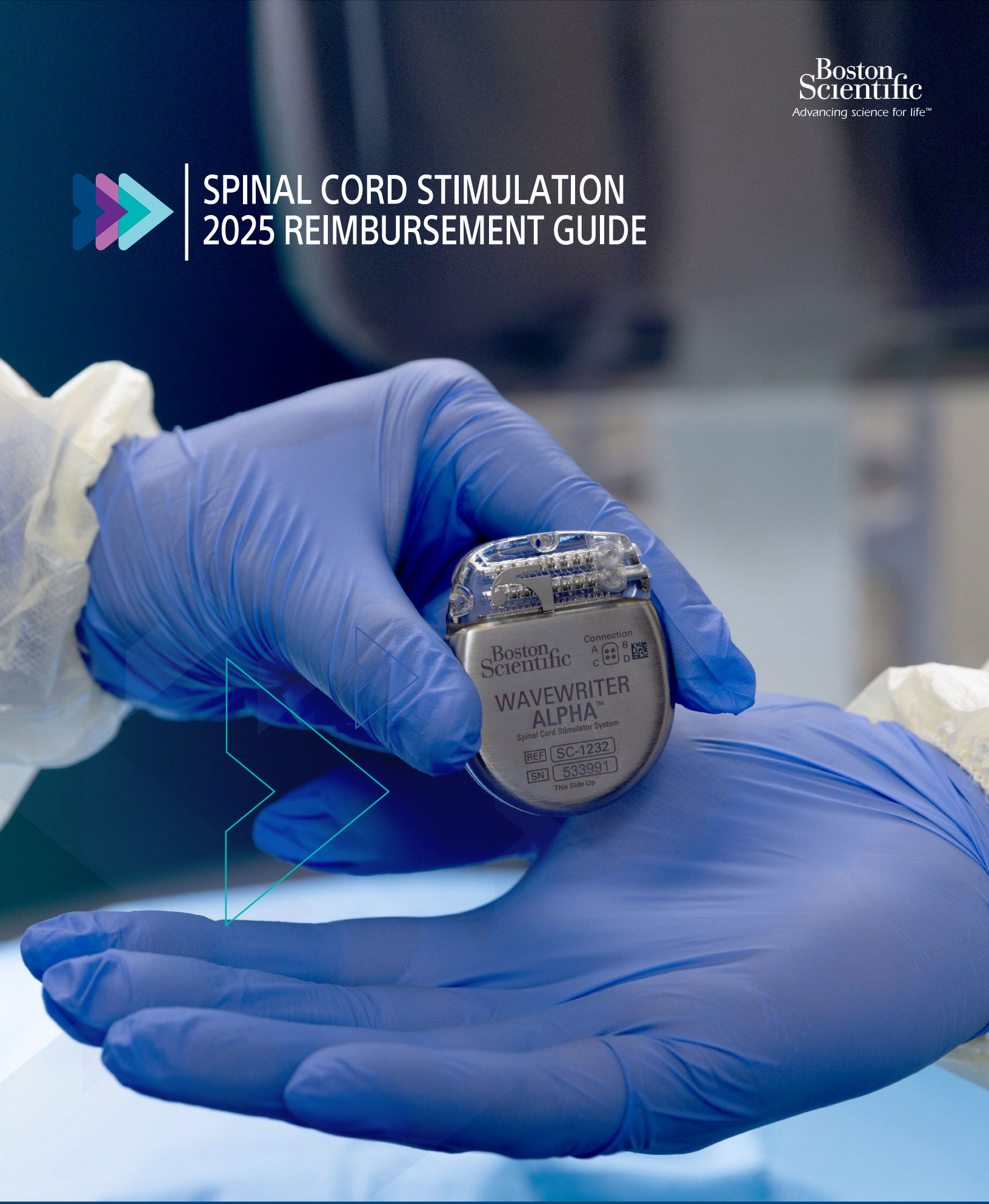
SPINAL CORD STIMULATION 2025 REIMBURSEMENT GUIDE



FOR MORE PROCEDURE PAYMENT GUIDES, CLICK HERE

This reimbursement guide, for Spinal Cord Stimulation provides coding and payment information for physicians and facilities to receive Medicare reimbursement. The Medicare payment amounts provided are national average payments. Actual reimbursement will vary based on different factors.

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.

This guide is intended to fully inform users. Sites of services must be based upon each patient's acuity of care needs.

INCLUDED IN THIS GUIDE:

Under each section in this guide are CPT codes and Medicare National Average Payments for Physicians, Ambulatory Surgical Centers, Hospital Outpatient, Neuromodulation Quick Reference Guide, and Spinal Cord Stimulation (SCS) Medical Necessity Documentation Recommendations Confirming Late or Last Resort for SCS Trials and Implants.

1. Spinal Cord Stimulation Medicare Coverage With NCD & LCD Reference
2. Spinal Cord Stimulation Physician Reimbursement 2025 (Medicare Coverage)
3. Spinal Cord Stimulation Ambulatory Surgical Center Reimbursement 2025 (Medicare Coverage)
4. Spinal Cord Stimulation Outpatient Hospital Reimbursement 2025 (Medicare Coverage)
5. Spinal Cord Stimulation Inpatient Hospital Reimbursement (Medicare Coverage)
6. Spinal Cord Stimulation Common ICD-10 CM Diagnosis Coding Reference
7. Spinal Cord Stimulation (SCS) Medical Necessity Documentation Recommendations Confirming Late or Last Resort for SCS Trials and Implants

SPINAL CORD STIMULATION MEDICARE COVERAGE WITH NCD & LCD REFERENCE

The information below represents Medicare National Coverage Determination and Local Coverage Determinations for Spinal Cord Stimulation (SCS) physician payment rates and SCS procedures performed in ambulatory surgical center (ASC), outpatient hospital, or inpatient hospital setting. Additionally, below represent HCPCS Level II codes and descriptors for SCS procedures performed in an ASC (L Codes) or outpatient hospital setting (C Codes).

MEDICARE NATIONAL COVERAGE DETERMINATION[7]

In the case of spinal cord stimulation, Medicare has a longstanding National Coverage Determination (NCD) for electrical nerve stimulators (160.7) that includes specific criteria for coverage, which are as follows:

- The implantation of the stimulator is used only as a late resort (if not a last resort) for patients with chronic intractable pain;
- With respect to item a, other treatment modalities (pharmacological, surgical, physical, or psychological therapies) have been tried and did not prove satisfactory, or are judged to be unsuitable or contraindicated for the given patient;
- 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);
- All the facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment training, and follow up of the patient (including that required to satisfy item c) must be available; and
- Demonstration of pain relief with a temporarily implanted electrode precedes permanent implantation.

MEDICARE LOCAL COVERAGE DETERMINATIONS[8]

Medicare has a long-standing NCD (160.7) for Electrical Nerve Stimulators (e.g., SCS). In addition to the NCD criteria, some Medicare contractors may require additional SCS coverage criteria through local coverage determinations (LCD). Please check with your local contractor. In the absence of an LCD, Medicare contractors will follow the NCD.

Palmetto GBA (AL, GA, TN, SC, VA, WV, NC)	http://www.palmettogba.com/medicare	LCD #L37632 LCA #A56876
Noridian JE (CA, NV, HI)	https://med.noridianmedicare.com/web/jeb/policies	LCD #L35136 LCA #A57791
Noridian JF (AK, ID, OR, WA, AZ, MT, ND, SD, UT, WY)	https://med.noridianmedicare.com/web/jfb/policies	LCD #L36204 LCA #A57792

HCPCS LEVEL II DESCRIPTORS[2,14,15,16]

HCPCS LEVEL II DESCRIPTORS	
HCPCS Code	**Descriptor**
L8679	Implantable neurostimulator pulse generator, any type
L8680	Implantable neurostimulator electrode, each
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688	Implantable neurostimulator pulse generator, dual array, non- rechargeable, includes extension
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
C1778	Lead, neurostimulator (implantable)
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system
C1767	Generator, neurostimulator (implantable), nonrechargeable
C1787	Patient programmer, neurostimulator
C1883	Adapter/ extension, pacing lead or neurostimulator lead (implantable)

SPINAL CORD STIMULATION PHYSICIAN REIMBURSEMENT 2025

2025 Coding and Payment Guide for Medicare Reimbursement: The following are the 2025 Medicare coding and national physician payment rates for spinal cord stimulation procedures. The 2025 conversion factor is 32.3465.

CPT®[2,3]	DESCRIPTION	GLOBAL PERIOD	WORK RVU[4]	TOTAL RVU[4]	NATIONAL AVERAGE PAYMENT[5]
Lead & Pulse Generator Placement Codes					
63650	Percutaneous implantation of neurostimulator electrode array, epidural	10	7.15	65.76 12.48	$2,127 (Non-Facility) $404 (Facility)
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	90	10.92	25.81	$835
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	10	5.19	10.28	$333
Revision of Lead and Pulse Generators					
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	10	7.75	26.58 13.58	$860 (Non-Facility) $439 (Facility)
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	90	11.52	27.24	$881
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array	10	4.35	9.10	$294
Removal of Leads and Pulse Generators					
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	10	5.08	20.34 10.01	$658 (Non-Facility) $324 (Facility)
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	90	11.00	26.13	$845
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver	10	4.35	9.10	$294

Neurostimulator Analysis & Programming: The AMA CPT® has defined simple intraoperative or subsequent programming of neurostimulator pulse generator with code 95971 when there are changes to three or fewer of the following parameters: rate, pulse amplitude, pulse duration, pulse frequency, eight or more electrode contacts, cycling, stimulation train duration, train spacing, number of programs, number of channels, alternating electrode polarities,dose time, or more than one clinical feature. Complex intraoperative Complex intraoperative or subsequent programming is defined as changes in more than three of the parameters above (code 95972).

CPT®[2,3]	DESCRIPTION	GLOBAL PERIOD	WORK RVU[4]	TOTAL RVU[4]	NATIONAL AVERAGE PAYMENT[5]
95970*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter, without programming	XXX[6]	0.35	0.56 0.55	$18 (Non-Facility) $18 (Facility)
95971*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	XXX[6]	0.78	1.43 1.15	$46 (Non-Facility) $37 (Facility)
95972*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/ transmitter programming by physician or other qualified health care professional	XXX[6]	0.80	1.70 1.18	$55 (Non-Facility) $38 (Facility)

SPINAL CORD STIMULATION AMBULATORY SURGICAL CENTER REIMBURSEMENT 2025

2025 Coding and Payment Guide for Medicare Reimbursement: The following are the 2025 Medicare coding and national payment rates for Spinal Cord Stimulation (SCS) procedures performed in an ambulatory surgical center.

CPT®[2]	DESCRIPTION	MULTIPLE SURGERY DISCOUNTING[10]	STATUS INDICATOR[11]	NATIONAL AVERAGE PAYMENT[5]
Lead & Pulse Generator Placement Codes				
63650	Percutaneous implantation of neurostimulator electrode array, epidural	N	J8	$5,084
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	N	J8	$18,105
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	N	J8	$26,282
Revision of Lead and Pulse Generators				
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	N	J8	$5,159
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	N	J8	$9,132
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array	Y	A2	$1,944
Removal of Leads and Pulse Generator				
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	N	G2	$925
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	Y	G2	$1,944
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array	Y	A2	$1,944

[11]ASC Status Indicators – J8: Device-intensive procedure; paid at adjusted rate, G2: Non office-based surgical procedure added in CY 2008 or later, payment based on OPPS relative payment weight, A2: Surgical procedure on ASC list in CY 2007; payment based on OPPS relative weight, subject to multiple reduction rule.

SPINAL CORD STIMULATION OUTPATIENT HOSPITAL REIMBURSEMENT 2025

2025 Coding and Payment Guide for Medicare Reimbursement: The following are the 2025 Medicare coding and national payment rates for Spinal Cord Stimulation (SCS) procedures performed in the outpatient hospital setting. Comprehensive Ambulatory Payment Classification (C-APCs) are effective for services performed in an Outpatient Hospital. A C-APC is a single all-inclusive payment for a primary device dependent service and all adjunct services provided to support the delivery of the primary service.

CPT®[2]	DESCRIPTION	APC[12]	STATUS INDICATOR[13]	NATIONAL AVERAGE PAYMENT[4]
Lead & Pulse Generator Placement Codes				
63650	Percutaneous implantation of neurostimulator electrode array, epidural	5462	J1	$6,563
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	5464	J1	$21,444
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	5465	J1	$30,474
Revision of Lead and Pulse Generators				
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	5462	J1	$6,563
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	5463	J1	$12,470
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array	5461	J1	$3,439
Removal of Leads and Pulse Generator				
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	5431	J1	$1,953
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	5461	J1	$3,439
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array	5461	J1	$3,439

[13] S: Procedure or service, not discounted when multiple, J1: Hospital Part B services paid through a comprehensive APC, Q2: Not paid separately when billed with a T procedure (T packaged).

Neurostimulator Analysis & Programming: The AMA CPT® has defined simple intraoperative or subsequent programming of neurostimulator pulse generator with code 95971 when there are changes to three or fewer of the following parameters: rate, pulse amplitude, pulse duration, pulse frequency, eight or more electrode contacts, cycling, stimulation train duration, train spacing, number of programs, number of channels, alternating electrode polarities, dose time, or more than one clinical feature. Complex intraoperative or subsequent programming is defined as changes to more than three of the parameters above (code 95972).[7]

CPT®[2]	DESCRIPTION	APC[12]	STATUS INDICATOR[13]	NATIONAL AVERAGE PAYMENT[5]
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter, without programming	5734	S	$129
95971	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	5742	S	$92
95972	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	5742	S	$92

SPINAL CORD STIMULATION INPATIENT HOSPITAL REIMBURSEMENT

INPATIENT HOSPITAL CODING AND PAYMENT GUIDE FOR SPINAL CORD STIMULATION OCTOBER 2024 – SEPTEMBER 2025

2025 Coding and Payment Guide for Medicare Reimbursement: The information below represents FY2025 Medicare coding and base payment rates for Spinal Cord Stimulator (SCS) procedures performed in the inpatient hospital setting. The inpatient system uses Medical Severity Diagnosis Related Groups (MS-DRGs) to align resources associated with the patient's diagnosis. The most common MS-DRGs for SCS procedures are outlined below. This does not represent an exhaustive list of SCS procedures.

ICD-10 PROCEDURE CODES ASSOCIATED WITH SCS

		ICD-10-PCS[17]	ICD-10-PCS DESCRIPTION
Leads	Paddle	00HU0MZ	Insertion of Neurostimulator Lead into Spinal Canal, Open Approach
	Percutaneous	00HU3MZ	Insertion of Neurostimulator Lead into Spinal Canal, Percutaneous Approach
IPG	Non-Rechargeable	0JH70DZ	Insertion of Multiple Array Stimulator Generator into Back Subcutaneous Tissue and Fascia, Open Approach
	Rechargeable	0JH70EZ	Insertion of Multiple Array Rechargeable Stimulator Generator into Back Subcutaneous Tissue and Fascia, Open Approach

MS-DRGS ASSOCIATED WITH SCS[18]

Implantation of SCS System – Lead(s) and Multi-Array Pulse Generator

MS-DRG	DESCRIPTION	BASE PAYMENT[19]
029	Spinal Procedures with CC or Spinal Neurostimulator	$23,955
518	Back and Neck Procedures Except Spinal Fusion with MCC or Disc Device/Neurostimulator	$25,577

IMPLANTATION OF SCS LEAD(S)

MS-DRG	DESCRIPTION	BASE PAYMENT[19]
028	Spinal Procedures with MCC	$43,387
029	Spinal Procedures with CC or Spinal Neurostimulator	$23,955
030	Spinal Procedures without CC/MCC	$15,882

IMPLANTATION OF MULTI-ARRAY PULSE GENERATOR

MS-DRG	DESCRIPTION	BASE PAYMENT[19]
40	Peripheral/Cranial Nerve and Other Nervous System Procedures with MCC	$26,920
41	Peripheral/Cranial Nerve and Other Nervous System Procedures with CC or Peripheral Neurostimulator	$16,116
42	Peripheral/Cranial Nerve and Other Nervous System Procedures without CC/MCC	$12,543

SPINAL CORD STIMULATION COMMON ICD-10 CM DIAGNOSIS CODING REFERENCE

Common ICD-10-CM diagnosis codes most closely associated with SCS procedures are provided for information only. Physicians and facility staff must ensure primary and secondary diagnosis codes most accurately reflect individual patient characteristics, and not be used solely for purposes of reimbursement. Some of these procedures are not indicated for use with the BSN SCS Systems. Please check the indications statement at the end for BSN SCS Systems Indications for Use. The following are Common ICD-10 CM Diagnosis Codes related to Spinal Cord Stimulation (SCS):

COMPLEX REGIONAL PAIN SYNDROME I AND II

ICD-10 CM DIAGNOSIS CODES[1]	DESCRIPTIONS
G90.50	Complex regional pain syndrome I, unspecified
G90.511	Complex regional pain syndrome I of right upper limb
G90.512	Complex regional pain syndrome I of left upper limb
G90.513	Complex regional pain syndrome I of upper limb, bilateral
G90.519	Complex regional pain syndrome I of unspecified upper limb
G90.521	Complex regional pain syndrome I of right lower limb
G90.522	Complex regional pain syndrome I of left lower limb
G90.523	Complex regional pain syndrome I of lower limb, bilateral
G90.529	Complex regional pain syndrome I of unspecified lower limb
G90.59	Complex regional pain syndrome I of other specified site
G56.40	Causalgia of unspecified upper limb
G56.41	Causalgia of right upper limb
G56.42	Causalgia of left upper limb
G56.43	Causalgia of bilateral upper limbs
G57.70	Causalgia of unspecified lower limb
G57.71	Causalgia of right lower limb
G57.72	Causalgia of left lower limb
G57.73	Causalgia of bilateral lower limbs

MONONEUROPATHY

ICD-10 CM DIAGNOSIS CODES[1]	DESCRIPTIONS
G57.91	Unspecified mononeuropathy of right lower limb
G57.92	Unspecified mononeuropathy of left lower limb
G58.8	Other specified mononeuropathies
G58.9	Mononeuropathy, unspecified

DIABETIC PERIPHERAL NEUROPATHY

ICD-10 CM DIAGNOSIS CODES[1]	DESCRIPTIONS
E08.40	Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified
E08.41	Diabetes mellitus due to underlying condition with diabetic mononeuropathy
E08.42	Diabetes mellitus due to underlying condition with diabetic polyneuropathy
E08.43	Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy
E08.49	Diabetes mellitus due to underlying condition with other diabetic neurological complication
E09.40	Drug or chemical induced diabetes mellitus with neurological complications with diabetic neuropathy, unspecified
E09.41	Drug or chemical induced diabetes mellitus with neurological complications with diabetic mononeuropathy
E09.42	Drug or chemical induced diabetes mellitus with neurological complications with diabetic polyneuropathy
E09.43	Drug or chemical induced diabetes mellitus with neurological complications with diabetic autonomic (poly)neuropathy
E09.49	Drug or chemical induced diabetes mellitus with other diabetic neurological complication
E10.40	Type 1 diabetes mellitus with diabetic neuropathy, unspecified
E10.41	Type 1 diabetes mellitus with diabetic mononeuropathy
E10.42	Type 1 diabetes mellitus with diabetic polyneuropathy
E10.43	Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy
E10.49	Type 1 diabetes mellitus with other diabetic neurological complication
E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unspecified
E11.41	Type 2 diabetes mellitus with diabetic mononeuropathy
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy

ICD-10 CM DIAGNOSIS CODES[1]	DESCRIPTIONS
E11.43	Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy
E11.49	Type 2 diabetes mellitus with other diabetic neurological complication
E13.40	Other specified diabetes mellitus with diabetic neuropathy, unspecified
E13.41	Other specified diabetes mellitus with diabetic mononeuropathy
E13.42	Other specified diabetes mellitus with diabetic polyneuropathy
E13.43	Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy
E13.49	Other specified diabetes mellitus with other diabetic neurological complication

DISC DISORDER

ICD-10 CM DIAGNOSIS CODES[1]	DESCRIPTIONS
M54.04	Intervertebral disc disorder with myelopathy, thoracic
M51.05	Intervertebral disc disorder with myelopathy, thoracolumbar
M51.06	Intervertebral disc disorder with myelopathy, lumbar
M51.15	Intervertebral disc disorders with radiculopathy, thoracolumbar region
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.25	Other intervertebral disc displacement, thoracolumbar region
M51.26	Other intervertebral disc displacement, lumbar region
M51.27	Other intervertebral disc displacement, lumbosacral region
M51.35	Other intervertebral disc degeneration, thoracolumbar region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region

SCIATICA AND RADICULOPATHY

ICD-10 CM DIAGNOSIS CODES[1]	DESCRIPTIONS
M54.30	Sciatica, unspecified side
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.14	Radiculopathy, thoracic region
M54.15	Radiculopathy, thoracolumbar region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M54.10	Radiculopathy, unspecified site

STENOSIS

ICD-10 CM DIAGNOSIS CODES[1]	DESCRIPTIONS
M48.00	Spinal stenosis, site unspecified
M48.04	Spinal stenosis, thoracic region
M48.05	Spinal stenosis, thoracolumbar region
M48.061	Spinal stenosis, lumbar region without neurogenic claudication
M48.062	Spinal stenosis, lumbar region with neurogenic claudication
M48.07	Spinal stenosis, lumbosacral region

SPONDYLOLISTHESIS AND SPONDYLOSIS

ICD-10 CM DIAGNOSIS CODES[1]	DESCRIPTIONS
M43.00	Spondylolysis, site unspecified
M43.04	Spondylolysis, thoracic region
M43.05	Spondylolysis, thoracolumbar region
M43.06	Spondylolysis, lumbar region

ICD-10 CM DIAGNOSIS CODES[1]	DESCRIPTIONS
M43.07	Spondylolysis, lumbosacral region
M43.08	Spondylolysis, sacral and sacrococcygeal region
M43.09	Spondylolysis, multiple sites in spine
M43.10	Spondylolisthesis, site unspecified
M43.14	Spondylolisthesis, thoracic region
M43.15	Spondylolisthesis, thoracolumbar region
M43.16	Spondylolisthesis, lumbar region
M43.17	Spondylolisthesis, lumbosacral region
M46.18	Spondylolisthesis, sacral and sacrococcygeal region
M43.19	Spondylolisthesis, multiple sites
M47.14	Other spondylosis with myelopathy, thoracic region
M47.15	Other spondylosis with myelopathy, thoracolumbar region
M47.16	Other spondylosis with myelopathy, lumbar region

PAIN

ICD-10 CM DIAGNOSIS CODES[1]	DESCRIPTIONS
G89.21	Chronic pain due to trauma
G89.29	Other chronic pain
G89.4	Chronic pain syndrome
M54.6	Pain in thoracic spine
M54.5	Low back pain
M54.50	Low back pain, unspecified
M54.59	Other low back pain
M79.2	Neuralgia and neuritis, unspecified
M79.604	Pain in right leg
M79.605	Pain in left leg

ICD-10 CM DIAGNOSIS CODES[1]	DESCRIPTIONS
M79.606	Pain in leg, unspecified
M79.609	Pain in unspecified limb
M79.651	Pain in right thigh
M79.652	Pain in left thigh
M79.659	Pain in unspecified thigh
M79.661	Pain in right lower leg
M79.662	Pain in left lower leg
M79.669	Pain in unspecified lower leg
M79.671	Pain in right foot
M79.672	Pain in left foot
M79.673	Pain in unspecified foot
M79.674	Pain in right toe(s)
M79.675	Pain in left toe(s)
M79.676	Pain in unspecified toe(s)

FAILED BACK

ICD-10 CM DIAGNOSIS CODES[1]	DESCRIPTIONS
M96.1	Postlaminectomy syndrome, NEC

SPINAL CORD STIMULATION (SCS) MEDICAL NECESSITY DOCUMENTATION RECOMMENDATIONS CONFIRMING LATE OR LAST RESORT FOR SCS TRIALS AND IMPLANTS

NOTE: Additional coverage criteria may be required based on the medical policy used by the insurance.

SUMMARY CAPTION	CONDITION

Pharmacology Management	Including, but not limited to:
	• OTC (Over the Counter) analgesics such as aspirin, Tylenol, NSAIDs (nonsteroidal anti-inflammatory drugs), topical creams, prescription opioids, etc.
	• Documentation should include:
	  • Date started/stopped or duration (include the reason(s) for stopping use if applicable)
	  • Dose
	  • Effectiveness

Medical Management / Conservative Treatment	Including, but not limited to:
	• Physician-directed Home Exercise Program (HEP), physical therapy, chiropractic, massage, acupuncture, epidural steroid injections (ESI), facet joint injections, medial branch blocks (MBB).
	• Documentation of a minimum of 6 consecutive months of tried/failed therapies and should include:
	  • Notes with dates and duration of treatment (how long)
	  • Measurable outcomes (effectiveness)
	  • Signature of treating physician on all office visit notes

Diagnostics (Imaging)	At least 1 of the following imaging reports should be included: • X-rays, CT scan, MRI, Myelogram, EMG/NCV, etc. • Image(s) taken within the last 12 months • Report must be legible

Psychological Evaluation	Must include the following:
	• Complete Psychological Evaluation report (all pages) including:
	  • Patient name
	  • Date of evaluation
	  • Signature of evaluator
	  • Clearance for SCS
	• Performed by a Psychologist, Psychiatrist (PsyD or PhD) or Licensed Clinical Social Worker (LCSW)
	• Evaluation completed within the last 12 months (6 months for AIM)

SUMMARY CAPTION	CONDITION
Surgical Consult	Must include: • Consult report from a neurosurgeon or orthopedic surgeon that specializes in spinal surgery (NOT the physician requesting SCS) with signature • Consultation completed within the last 12 months • Documentation noting patient had a previous surgery OR is not a surgical candidate • If the patient had prior surgery, need operative report • If the patient is not a surgical candidate, notes need to support why surgical intervention is not believed to resolve the patient's pain at this time
Physical Therapy (PT)	Documentation should include: • Notes from physical therapy office or discharge summary with duration of treatment,outcome or reason for discontinuation • Date started/stopped or duration (include the reason for stopping if applicable) • Minimum of 6-12 consecutive weeks of therapy sessions completed within the last 12months • Measurable outcomes (effectiveness) • If the patient has not participated in formal PT or HEP, provide documentation of contraindication, i.e., the patient is unable to tolerate formal PT/HEP due to extreme pain
Trial Documentation (Implant ONLY)	Must include: • Trial results documenting at least 50% pain relief from a 3-7 day trial • Improvement in function such as ADLs (Activities of Daily Living), sleep patterns, ability to walk more, and the reduced need for pain medication • Trial Operative Report

https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=240

1. ICD-10-CM Expert for Physicians: The Complete Official Code Set. Optum360, 2025.
2. CPT Copyright 2024 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. All trademarks are the property of their respective owners.
3. Multiple procedure reduction rules apply for procedures (excluding programming codes). Quantity of devices used in each procedure must be specified for appropriate payment. Payment rates provided are Medicare national average rates for each specified procedure with quantity = 1.
4. Department of Health and Human Services. Centers for Medicare and Medicaid Services. The 2025 National Average Medicare physician payment rates have been calculated using a revised 2025 conversion factor of 32.3465 which reflects changes effective as of calendar year 2025.
5. 2025 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
6. XXX: The global concept does not apply to the code.
7. AMA CPT® 2025 Professional Edition code book.
8. Medicare National Coverage Determination (NCD) for Electrical Nerve Stimulators (160.7) Publication Number 100-3, Manual Section Number 160.7, Benefit Category: Prosthetic Devices, NCD Link: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=240&ncdver=1&bc=0
9. List of local Medicare contractors is not an exhaustive list. LCD Link https://www.cms.gov/medicare-coverage-database/new-search/search.aspx
10. In the case that multiple procedures are billed and coded, payment is typically made at 100% of the rate for the first procedure, and 50% of the rate for the second and all succeeding procedures. Such procedures subject to this discounting are marked "Y". However, procedure marked "N" are not subject to discounting, and are paid at 100% in full, regardless of whether they are submitted with other procedures.
11. ASC Status Indicators:
J8: Device-intensive procedure; paid at adjusted rate.
G2: Non office-based surgical procedure added in CY 2008 or later, payment based on OPPS relative payment weight.
A2: Surgical procedure on ASC list in CY 2007; payment based on OPPS relative weight, subject to multiple reduction rule
12. . 42 CFR Parts 411, 412, 416, 419, 422, 423, and 424 [CMS-1786-FC]
13. S: Procedure or Service, Not Discounted When Multiple;
J1: Hospital Part B services paid through a comprehensive APC.
Q2: Not paid separately when billed with a T procedure (T packaged
14. Medicare device edits link: http://www.cms.gov/HospitalOutpatientPPS/02_device_procedure.asp. Please verify with local payers for specific device coding requirements.
15. Please verify with local payers for specific device coding requirements.
16. C-codes are required for billing Medicare outpatient procedures with the applicable CPT codes but are not separately payable by Medicare
17. 2025 CMS ICD-10-PCS Code Set Reference.
18. Most common MS-DRGs for SCS procedures based on Medicare claims data. Boston Scientific does not promote the use of its products outside PDA approval label.
19. Medicare National average base MS-DRG payment amounts (for urban areas) as of October 1, 2024 based on most common diagnosis for SCS. Academic teaching and disproportionate share hospitals may quality for additional payment amounts in addition to the base MS- DRG.

Indications for Use. The Boston Scientific Spinal Cord Stimulator Systems are indicated as an aid in the management of chronic intractable pain of the trunk and/or limbs including unilateral or bilateral pain associated with the following: failed back surgery syndrome, Complex Regional Pain Syndrome (CRPS) Types I and II, Diabetic Peripheral Neuropathy of the lower extremities, intractable low back pain and leg pain, radicular pain syndrome, radiculopathies resulting in pain secondary to failed back syndrome or herniated disc, epidural fibrosis, degenerative disc disease (herniated disc pain refractory to conservative and surgical interventions), arachnoiditis, multiple back surgeries. The Boston Scientific Spectra WaveWriter™, WaveWriter Alpha™ and WaveWriter Alpha™ Prime SCS Systems are also indicated as an aid in the management of chronic intractable unilateral or bilateral low back and leg pain without prior back surgery. Contraindications, warnings, precautions, side effects. The SCS Systems are contraindicated for patients who: are unable to operate the SCS System, have failed trial stimulation by failing to receive effective pain relief, are poor surgical candidates, or are pregnant. Refer to the Instructions for Use provided with the SCS System or Pain.com for potential adverse effects, warnings, and precautions prior to using this product.

Warning: Stimulation modes. Only paresthesia-based stimulation mode has been evaluated for effectiveness in the diabetic peripheral neuropathy (DPN) population.

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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

This coding information may include codes for procedures for which Boston Scientific currently offers no cleared or approved products. In those instances, such codes have been included solely in the interest of providing users with comprehensive coding information and are not intended to promote the use of any Boston Scientific products for which they are not cleared or approved. The Health Care Provider (HCP) is solely responsible for selecting the site of service and treatment modalities appropriate for the patient based on medically appropriate needs of that patient and the independent medical judgement of the HCP.

Information included herein is current as of November 2024 but is subject to change without notice. Rates for services are effective January 1, 2024.

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