



2026 Coding and Payment Guide – Sacral Neuromodulation (SNM)

The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. They are thought to be relevant to Sacral Neuromodulation procedures and are referenced throughout this document. We recommend consulting your relevant manuals for appropriate coding options. Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding, or site of service requirements.

All rates shown throughout this guide are 2026 Medicare unadjusted national average; actual rates will vary geographically and/or by individual facility. “Allowed Amount” 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.

To determine whether there are relevant C-codes for any Boston Scientific products, please visit our C-code finder at <https://www.bostonscientific.com/en-US/reimbursement/ccode-finder.html>. (See additional information on page 5).

CPT® codes with their respective long descriptions will be found on page 4.

Implant, Removal, Revision

Physician Payment – Medicare Unadjusted National Average

CPT 64561 may be used for either a temporary or permanent lead based on the surgical approach (percutaneously). (CPT updated guidance in 2019).

CPT® Code	Code Description	Global Days	Work RVUs	Total Facility Based RVUs (NF)	MD In-Facility Medicare Allowed Amount (NF)	Total Office Based RVUs	MD In-Office Medicare Allowed Amount
Electrode and Implantable Neurostimulator (INS) Implant							
64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including imaging guidance, if performed	10	5.30	8.12	\$271	22.25	\$743
64590	Insertion or replacement of peripheral or gastric neurostimulator or receiver, direct to inductive coupling	10	4.97	7.99	\$267	12.82	\$428
Revision or Removal							
64585	Revision or removal of peripheral neurostimulator electrode array	10	2.06	4.07	\$136	7.54	\$252
64595	Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver	10	3.70	6.28	\$210	10.42	\$348

CPT® Modifiers

Modifier	Description
-26	Professional component
-50	Bilateral procedures
-51	Multiple procedures
-53	Discontinued procedure
-58	Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period
-59	Distinct procedural service
-73	Discontinued outpatient procedure prior to anesthesia administration (facility reporting only)
-74	Discontinued outpatient procedure after anesthesia administration (facility reporting only)

Hospital Outpatient and ASC Payment – Medicare Unadjusted National Average

CPT® Code	Code Description	C-APC	SI	Outpatient Medicare National Average	PI	ASC Medicare National Average
Electrode and Implantable Neurostimulator (INS) Implant						
64561*	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including imaging guidance, if performed	5462	J1	\$6,511	J8	\$5,113
64590*	Insertion or replacement of peripheral or gastric neurostimulator or receiver, direct to inductive coupling	5464	J1	\$19,820	J8	\$16,224
Revision or Removal						
64585	Revision or removal of peripheral neurostimulator electrode array	5461	J1	\$3,572	A2	\$2,003
64595	Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver	5461	J1	\$3,572	A2	\$2,003

Total payment for all services reported is based on the primary procedure in the C-APC.
 *If performed in an ASC, these are not subject to multiple procedure discounting.

Programming

- Simple programming includes adjustment of one to three parameter(s)
- Complex Programming includes adjustment of more than three parameters
- Single parameter that is adjusted two or more times during a programming session counts as one parameter
- Electronic analysis of a device (95970) is not reported separately at the time of implantation

Physician Programming Payment – Medicare Unadjusted National Average

CPT® Code	Code Description	Global Days	Work RVUs	Total Facility Based RVUs	MD In-Facility Medicare Allowed Amount	Total Office Based RVUs	MD In-Office Medicare Allowed Amount
Programming							
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 brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	N/A	0.35	0.48	\$16	0.59	\$20
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	N/A	0.78	1.03	\$34	1.51	\$50
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	N/A	0.80	1.05	\$35	1.79	\$60

Programming, continued

Hospital Outpatient and ASC Payment – Medicare Unadjusted National Average

CPT® Code	Code Description	C-APC	SI	Outpatient Medicare National Average	PI	ASC Medicare National Average
Programming						
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 brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	5734	Q1	\$136	N/A	N/A
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	\$97	N/A	N/A
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	\$97	N/A	N/A

"N/A" indicates that Medicare has not deemed this procedure to be reimbursable in this setting.

OPPS Status Indicators (SI)

Status Indicator	Description†
J1	Hospital part B services paid through a comprehensive APC. Paid under OPSS; all covered part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPSS status indicator of "F", "G", "H", "L", and "U"; ambulance services, diagnostic and screen mammography, rehabilitation therapy services, services assigned to a new technology services, services assigned to a new technology APC, self-administered drugs, all preventive services, and certain part B inpatient services.
S	Procedure or service not subject to multiple procedure discounting. Paid under OPSS; separate APC payment.
Q1	STV-Packaged codes. Paid under OPSS; Addendum B displays APC assignments when services are separately payable. Packaged APC payment if billed on same date of service as a HCPCS assigned status indicator "S", "T", "V". In all other circumstances, payment is made through a separate APC payment.

ASC Payment Indicators (PI)

Payment Indicator	Description††
A2	Surgical procedure on ASC list in CY 2007; payment based on Outpatient Perspective Payment System (OPSS) relative payment weight.
J8	Device-intensive procedure; paid at adjusted rate

ICD-10 CM Diagnosis Codes

ICD-10 CM Diagnosis Code	Description
Overactive Bladder or Urinary Retention	
N32.81	Overactive bladder
N39.41	Urge incontinence
R33.8	Other retention of urine
R33.9	Retention of urine, unspecified
R35.0	Frequency of micturition
R39.14	Feeling of incomplete bladder emptying
Fecal Incontinence	
R15.9	Full incontinence of feces
Device Adjustment and Management	
Z45.42	Encounter for adjustment and management of neuropacemaker (brain) (peripheral nerve) (spinal cord)

CPT® Code with Long Descriptions

CPT® Code	Code Description
64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including imaging guidance, if performed
64590	Insertion or replacement of peripheral or gastric neurostimulator or receiver, direct to inductive coupling
64585	Revision or removal of peripheral neurostimulator electrode array
64595	Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver
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 brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming
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
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

Healthcare Common Procedure Coding System (HCPCS) II Device Codes

Medicare Device C-Codes for Hospital Outpatient Reporting

C-Code	Description
C1897	Lead neurostimulator test kit (implantable)
C1778	Lead, neurostimulator (implantable)
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system
C1767	Generator, neurostimulator(implantable), non-rechargeable
C1787	Patient programmer, neurostimulator
C1894	Introducer /sheath, other than guiding, other than intracardiac electrophysiological, non-laser
C1883	Adapter/extension, pacing lead or neurostimulator or lead (implantable)

Check with private payers if the "C" HCPCS codes are applicable.

C-Code Information

For all C-Code information, please reference the C-code Finder: <http://www.bostonscientific.com/en-US/reimbursement/ccode-finder.html>.

On claims for Medicare beneficiaries, hospitals should report not only the appropriate CPT® Code, but also all applicable C-Codes.

- C-Codes are tracking codes established by the Centers for Medicare & Medicaid Services (CMS) to assist Medicare in establishing future APC payment rates. C-Codes only apply to Medicare hospital outpatient claims. They do not trigger additional payment to the facility with the exception of designated transitional pass-through payment (TPT) devices.
- It's important that hospitals report C-Codes as well as the associated device costs as this will help inform and potentially increase future outpatient hospital payment rates.

Device A and L-codes

Code	Description
A4290	Sacral nerve stimulation test lead, each
L8679	Implantable neurostimulator, pulse generator, any type
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
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

Check with private payers if the "L" HCPCS codes are applicable.

Physician payment rates are 2026 Medicare national averages. Source: Centers for Medicare and Medicaid Services. CMS-1832-F, Physician Fee Schedule – Addendum B, Relative Value File October 2025 release, RVU24D file. <https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notice/cms-1832-f>

The 2026 National Average Medicare physician payment rates have been calculated using a 2026 conversion factor effective January 1, 2026, of \$33.4009. Rates subject to change.

Hospital outpatient payment rates are 2026 Medicare OPPS Addendum B national averages. Source: Centers for Medicare and Medicaid Services. CMS OPPS – November 2025 release, CMS-1834-FC file. <https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notice/cms-1834-fc>

ASC payment rates are 2026 Medicare ASC Addendum AA national averages. ASC rates are from the 2026 Ambulatory Surgical Center Covered Procedures List. Source: Centers for Medicare and Medicaid Services. CMS ASC November 2025 release, ASC Approved HCPCS Code and Payment Rates <https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and-notice/cms-1834-fc>

†OPPS Status Indicators; <https://med.noridianmedicare.com/web/jea/provider-types/opps/opps-payment-status-indicators>

††ASC Payment Indicators; ††<https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00261314>

Healthcare Common Procedure Coding System (HCPCS) Level II codes are maintained by the Centers for Medicare and Medicaid Services; <https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update>

Please note: 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.

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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.

Sequestration Disclaimer

Rates referenced in these guides do not reflect Sequestration or other reductions that may be implemented in 2026.

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