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®[1,2]	DESCRIPTION	GLOBAL PERIOD	WORK RVU[3]	TOTAL RVU[3]	NATIONAL AVERAGE PAYMENT[4]
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)[6].

CPT®[1,2]	DESCRIPTION	GLOBAL PERIOD	WORK RVU[3]	TOTAL RVU[3]	NATIONAL AVERAGE PAYMENT[4]	
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[5]	0.35	0.56 0.55	$18 $18	(Non-Facility) (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[5]	0.78	1.43 1.15	$46 $37	(Non-Facility) (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[5]	0.80	1.70 1.18	$55 $38	(Non-Facility) (Facility)

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.

Disclaimer: Health economic and reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules, and policies. This information is presented for illustrative purposes only and does not constitute reimbursement or legal advice. Boston Scientific encourages providers to submit accurate and appropriate claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services, and to submit appropriate codes, charges, and modifiers for services rendered. It is also always the provider's responsibility to understand and comply with Medicare national coverage determinations (NCD), Medicare local coverage determinations (LCD), and any other coverage requirements established by relevant payers which can be updated frequently. Boston Scientific recommends that you consult with your payers, reimbursement specialists, and/or legal counsel regarding coding, coverage, and reimbursement matters. Boston Scientific does not promote the use of its products outside their FDA- approved label. 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 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, 2025.

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2. 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.
3. 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 2024.
4. "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.
5. XXX: The global concept does not apply to the code.
6. AMA CPT® 2025 Professional Edition code book.

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