Program Memorandum Intermediaries/Carriers

Department of Health & Human Services (DHHS)
Centers For Medicare & Medicaid Services

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This Program Memorandum corrects Program Memorandum AB-02-182. The only changes are the discard date and the elimination of 22X and 23X bill type; all other material remains the same.

CHANGE REQUEST 2532

This Program Memorandum (PM) is being issued as a consolidation of Change Request 1936, PM AB-01-166, dated November 15, 2001 and Change Request 2098, PM A-02-020, dated March 21, 2002.

SUBJECT: Coverage and Billing of Sacral Nerve Stimulation

Coverage

A sacral nerve stimulator is a pulse generator that transmits electrical impulses to the sacral nerves through an implanted wire. These impulses cause the bladder muscles to contract, which gives the patient ability to void more properly.

Effective January 1, 2002, sacral nerve stimulation is covered for the treatment of urinary urge incontinence, urgency-frequency syndrome and urinary retention. Sacral nerve stimulation involves both a temporary test stimulation to determine if an implantable stimulator would be effective and a permanent implantation in appropriate candidates. Both the test and the permanent implantation are covered.

The following limitations for coverage apply to all indications:

o Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.

o Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) that are associated with secondary manifestations of the above three indications are excluded.

o Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50% or greater improvement through test stimulation. Improvement is measured through voiding diaries.

o Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.

Intermediary Billing Instructions

Applicable HCPCS Codes

- 64561 - Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)

- 64581 - Incision for implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)
- 64585 - Revision or removal of peripheral neurostimulator electrodes
- 64590 - Incision and subcutaneous placement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling
- 64595 - Revision or removal of peripheral neurostimulator pulse generator or receiver
- A4290 - Sacral nerve stimulation test lead, each
- E0752 - Implantable neurostimulator electrodes, each
- E0756 - Implantable neurostimulator pulse generator
- C1767 - Generator, neurostimulator (implantable)
- C1778 - Lead, neurostimulator (implantable)
- C1883 - Adaptor/extension, pacing lead or neurostimulator lead (implantable)
- C1897 - Lead, neurostimulator test kit (implantable)

NOTE: The "C" codes listed above are only applicable when billing under the hospital outpatient prospective payment system (OPPS). They should be reported in place of codes A4290, E0752 and E0756.

Payment Requirements for Test Procedures (HCPCS codes 64585, 64590, 64595)

Payment is as follows:

- Hospital outpatient departments - OPPS
- Critical Access Hospital (CAH) - Reasonable cost
- Comprehensive Outpatient Rehabilitation Facility - Medicare physician fee schedule (MPFS)
- Rural Health Clinics/Federally Qualified Health Centers (RHCs/FQHCs) - All inclusive rate, professional component only. The technical component is outside the scope of the RHC/FQHC benefit. Therefore, the provider of that technical service bills their carrier on Form HCFA-1500 and payment is made under the MPFS. For provider-based RHCs/FQHCs payment for the technical component is made as indicated above based on the type of provider the RHC/FQHC is based with.

Deductible and coinsurance apply.

Payment Requirements for Implantation Procedures (HCPCS codes 64561, 64581)

Payment is as follows:

- Hospital outpatient departments - OPPS
- Hospital inpatient - hospital prospective payment system (PPS)
- CAH - payment is made on a reasonable cost basis

Deductible and coinsurance apply.

Payment Requirements for Device Codes, A4290, E0752 and E0756

Payment is made on a reasonable cost basis when these devices are implanted in a CAH.

Payment Requirements for Codes C1767, C1778, C1883 and C1897

Only hospital outpatient departments report these codes. Payment is made under OPPS.

Applicable Bill Types

The applicable bill types for test stimulation procedures are 13X, 14X, 71X, 73X, 75X and 85X.

RHCs and FQHCs bill you under bill type 71X and 73X for the professional component. The technical component is outside the scope of the RHC/FQHC benefit. The provider of that technical service bills their carrier on Form CMS-1500 or electronic equivalent.

The technical component for a provider-based RHC/FQHC is typically furnished by the provider. The provider of that service bills you under bill type 13X, 14X, or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services.)

The applicable bill types for implantation procedures and devices are 11X, 13X, and 85X.

Applicable Revenue Codes

The applicable revenue code for the test procedures is 920 except for RHCs/FQHCs who report these procedures under revenue code 521.

Revenue codes for the implantation can be performed in a number of revenue centers within a hospital such as operating room (360) or clinic (510). Therefore, instruct your hospitals to report these implantation procedures under the revenue center where they are performed.

The applicable revenue code for the device codes C1767, C1778, C1883 and C1897, provided in a hospital outpatient department is 272, 274, 275, 276, 278, 279, 280, 289, 290 or 624 as appropriate. The applicable revenue code for device codes A4290, E0752 and E0756 provided in a CAH is 290.

Carrier Billing Instructions

HCPCS Coding

- 64555 - Percutaneous implantation of neurostimulator electrodes; peripheral nerve; (excludes sacral nerve). This code applies to services performed prior to January 1, 2002
- 64561 - Percutaneous implantation of neurostimulator electrodes; sacral nerve; (transforaminal placement). This code applies to services performed on or after January 1, 2002
- 64575 - Incision for implantantion of neurostimulator electrodes; peripheral nerve; (excludes sacral nerve). This code applies to services performed prior to January 1, 2002
- 64581- Incision for implantation of neurostimulator electrodes; sacral nerve; (transforaminal placement). This code applies to services performed on or after January 1, 2002

- 64585 - Revision or removal of peripheral neurostimulator electrodes
- 64590 - Incision and subcutaneous placement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling
- 64595 - Revision or removal of peripheral neurostimulator pulse generator or receiver
- A4290 - Sacral nerve stimulation test lead, each
- E0752 - Implantable neurostimulator electrodes
- E0756 - Implantable neurostimulator pulse generator

Ambulatory Surgical Centers (ASC) Procedures

Applicable HCPCS Codes

- 64575 - Incision for implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve). This code applies to services performed prior to January 1, 2002
- 64590 - Incision and subcutaneous placement of peripheral neurostimulator pulse generator or receiver; direct or inductive coupling
- 64595 - Revision or removal of peripheral neurostimulator pulse generator or receiver

Claims Requirements for Carriers

Follow the general instructions in §2010, purpose of health insurance claim Form CMS-1500, Medicare Carriers Manual (MCM) Part 4, chapter 2 for preparing claims. Claims for sacral nerve stimulation are to be submitted on health insurance claim Form CMS-1500 or electronic equivalent. Claims should be processed in accordance with §4020, Review of Health Insurance Claim Form – CMS-1500, of Part 3, Chapter IV of the Medicare Carriers Manual.

Payment Requirements for Carriers

Pay for sacral nerve stimulation on the basis of the Medicare physician fee schedule. Deductible and coinsurance apply. Claims from physicians, other practitioners, or suppliers where assignment was not taken are subject to the Medicare limiting charge (refer to MCM Part 3, chapter VII, §7555 for more information).

Code A4290 should be added to CWF categories 03 (prosthetics/orthotics) and 67 (local carrier jurisdiction). The local carriers are to gap-fill base fee schedule amounts for each carrier service area for code A4290 in accordance with instructions located in MCM §5102.2. However, base fee schedule amounts submitted to CMS central office may not be updated by any covered item update factors other than the 1.7 percent (1989) update factor for prosthetics and orthotics. The 2001 deflation factor for gap-filling purposes is .621 for prosthetic devices. The carriers are to submit the base fees for code A4290 to CMS central office by November 16, 2001. The fees are to be submitted in ASCII files via EMAIL to Mary Anne Stevenson (MStevenson@cms.hhs.gov) and Joel Kaiser (JKaiser@cms.hhs.gov).

Claims Editing

Nationwide claims processing edits for pre or post payment review of claim(s) for sacral nerve stimulation are not being required at this time. Contractors may develop local medical review policy and edits for such claim(s).

Provider Notification

Contractors should notify providers of this new national coverage in their next regularly scheduled bulletin, on their Web site, and in routinely scheduled training sessions.

The *effective date* for this PM is January 1, 2002.

The *implementation date* for this PM is January 1, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after January 1, 2004.

If you have any questions, contact the appropriate regional office. Providers and other interested parties should contact the appropriate carrier or intermediary.