
CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 125

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CHANGE REQUEST 2532

I. SUMMARY OF CHANGES: This change request manualizes Sacral Nerve Stimulation.

MANUALIZATION - EFFECTIVE/IMPLEMENTATION DATE: Not Applicable

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	32/40 – Sacral Nerve Stimulation
N	32/40.1 – Coverage Requirements
N	32/40.2 – Billing Requirements
N	32/40.2.1 - Healthcare Common Procedural Coding System (HCPCS)
N	32/40.2.2 – Payment Requirements for Test Procedures (HCPCS Codes 64585, 64590 and 64595)
N	32/40.2.3 – Payment Requirements for Device Codes A4290, E0752 and E0756
N	32/40.2.4 – Payment Requirements for Codes C1767, C1778, C1883 and C1897
N	32/40.3 – Bill Types
N	32/40.4 – Revenue Codes
N	32/40.5 – Claims Editing

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Medicare Claims Processing Manual

Chapter 32 – Billing Instructions for Special Services

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Crosswalk to Old Manuals

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40 – Sacral Nerve Stimulation

(Rev. 125, 03-26-04)

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.

40.1 – Coverage Requirements

(Rev. 125, 03-26-04)

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.*

40.2 – Billing Requirements

(Rev. 125, 03-26-04)

40.2.1 – Healthcare Common Procedural Coding System (HCPCS)

(Rev. 125, 03-26-04)

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.*

40.2.2 – Payment Requirements for Test Procedures (HCPCS Codes 64585, 64590 and 64595)

(Rev. 125, 03-26-04)

Payment is as follows:

- o Hospital outpatient departments - OPPS*
- o Critical Access Hospital (CAH) - Reasonable cost*
- o Comprehensive Outpatient Rehabilitation Facility - Medicare physician fee schedule (MPFS)*
- o 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 CMS-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.

40.2.3 – Payment Requirements for Device Codes A4290, E0752 and E0756

(Rev. 125, 03-26-04)

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

40.2.4 – Payment Requirements for Codes C1767, C1778, C1883 and C1897

(Rev. 125, 03-26-04)

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

40.3 – Bill Types

(Rev. 125, 03-26-04)

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.

40.4 – Revenue Codes

(Rev. 125, 03-26-04)

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.

40.5 – Claims Editing

(Rev. 125, 03-26-04)

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).