
Surgery: Nervous System

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This section contains information to assist providers in billing for surgical procedures related to the nervous system.

Nerve Block Injections

The following policy pertains to nerve block injection services.

Reimbursable CPT® Codes

CPT codes 64400 thru 64530 are for use in billing diagnostic or therapeutic injections of anesthetic agents only. These codes are not reimbursable for the administration of electrical current, electrons, microwaves or other energy forms into the body.

CPT codes 64493 thru 64495 (injection(s), diagnostic or therapeutic agent, paravertebral facet [zygapophyseal] joint [or nerves innervating that joint] with image guidance [fluoroscopy or CT], lumbar or sacral) require modifier 50 for bilateral procedures and are reimbursable only when billed in conjunction with one of the following ICD-10-CM diagnosis codes:

M47.16	M51.17	M99.33
M47.26 thru M47.28	M51.36	M99.43
M47.816 thru M47.818	M51.37	M99.53
M47.896 thru M47.898	M54.16	M99.63
M48.061	M54.17	M99.73
M48.062	M54.5	Q76.2
M48.07	M96.1	
M51.16	M99.23	

Spinal Percutaneous Decompression Procedure

CPT code 62287 (decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc) is not reimbursable with CPT code 62267, 62290, 77003, 77012 or 72295 when performed at the same spinal level. Providers must document when performed at a different spinal level.

Spinal Neurostimulators

The following policy pertains to spinal neurostimulator services.

Surgical Procedures

The following CPT codes are used to bill for implantation of epidural and intradural spinal neurostimulator electrodes:

CPT Code	Description
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver

TAR Requirements

Providers must submit a *Treatment Authorization Request* (TAR) for the surgical procedure (codes 63650, 63655 and 63685) and provide sufficient documentation of:

- Pathological basis for the pain (pain has been greater than six months in duration).
- Conventional medical treatments (drugs, surgery, physical and/or psychological) having failed or were clinically judged to be unsuitable or contraindicated. Spinal cord stimulation using implantable devices is felt to be the last resort.
- No existing contraindication to implantation, such as sepsis or coagulopathy.
- A multidisciplinary team's (neurosurgeon, physical therapist, psychiatrist, etc.) evaluation of the patient for the appropriateness of the spinal stimulator, and the patient screening for any untreated substance abuse disorder and psychiatric problems.
- The patient's demonstration that he or she is capable of operating the device.
- All the facilities, equipment, professional and support personnel required for the proper diagnosis, treatment training and follow-up of the patient are available.
- Further surgical intervention is not indicated.

Additionally for codes 63655 and 63685, providers must submit a TAR and provide sufficient documentation of:

- The patient's completion of a three- to seven-day trial of percutaneous spinal stimulation with a temporarily implanted electrode, with at least a 50 percent reduction in pain.

Implantable Generators

The following HCPCS codes are used to bill for spinal implant generators (codes C1767, C1820, C1822 and C1823) and the external recharging system (code L8695).

«Table of HCPCS Codes for Spinal Implant Generators»

HCPCS Code	Description
C1767	Generator, neurostimulator (implantable), non-rechargeable
C1820	Generator, neurostimulator (implantable), non high-frequency with rechargeable battery and charging system
C1822 *	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system
C1823	Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads
L8695	External recharging system for battery (external) for use with implantable neurostimulator

Providers also must submit a copy of the invoice for reimbursement.

Analysis and Reprogramming Codes

The following codes are used to bill for analysis and reprogramming for spinal neurostimulators.

«Table of CPT Codes for Analysis and Reprogramming»

CPT Code	Description
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter 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 by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, with simple spinal cord or peripheral nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional
95972	Electronic analysis of implanted neurostimulator pulse generator/transmitter by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, with complex spinal cord or peripheral nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional

Deep Brain Stimulation

The following policy pertains to services for Deep Brain Stimulation (DBS).

Reimbursable CPT Codes

The following CPT codes may be reimbursed for implantation of neurostimulator electrodes, subcutaneous insertion of the neurostimulator pulse generator, analysis and programming of the generator and revision of cranial neurostimulator electrodes.

«Table of CPT Codes for Neurostimulator Implantation»

CPT Code	Description
61867	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site, with use of intraoperative microelectrode recording; first array
61868	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site, with use of intraoperative microelectrode recording; each additional array

Pulse Generator Placement Codes:

The following codes are used to bill for pulse generator placement.

«Table of CPT Codes for Pulse Generator Placement»

CPT Code	Description
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays

Analysis and Reprogramming Codes:

The following codes are used to bill for analysis and/or reprogramming.

CPT Code	Description
95836	Electrocorticogram from an implanted brain neurostimulator pulse generator/transmitter, including recording, with interpretation and written report, up to 30 days
95970	Electronic analysis of implanted neurostimulator pulse generator system 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
95976	Electronic analysis of implanted neurostimulator pulse generator system by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional
95977	Electronic analysis of implanted neurostimulator pulse generator system by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, with complex cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional
95983	Electronic analysis of implanted neurostimulator pulse generator system by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional
95984	Electronic analysis of implanted neurostimulator pulse generator system by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional

CPT code 95836 has a frequency limitation of one per 30 days.

CPT code 95970 is also reimbursable for the revision of the neurostimulator electrodes and does not require an approved TAR.

Revision Codes

The following codes are used to bill for revision of cranial neurostimulator electrodes.

«Table of CPT Codes for Revision of Cranial Neurostimulator Electrodes»

CPT Code	Description
61880	Revision or removal of intracranial neurostimulator electrodes
61888	Revision or removal of cranial neurostimulator pulse generator or receiver

TAR Requirements

CPT codes 61867, 61868, 61880 and 61888 are reimbursable subject to *Treatment Authorization Request* (TAR) approval for recipients who meet one or more of the following conditions:

- Parkinson's Disease that is not adequately controlled by medication or that is resistant to medical therapy, where the tremor constitutes a significant functional disability

Note: The patient must not show evidence of chronic, advanced dementia or significant impairment from Alzheimer's disease.

- Essential tremor that is not adequately controlled with medication or that is resistant to medical therapy, where the tremor constitutes a significant functional disability
- Genetic torsion dystonia, acquired torsion dystonia and spasmodic torticollis

Dystonia

Surgery for unilateral or bilateral (including simultaneous bilateral) DBS is reimbursable for recipients with dystonia when medical necessity has been established as follows:

- Recipient is 7 years of age or older
- Recipient requires DBS as an aid in the management of primary dystonia that is chronic, intractable (drug refractory)
- The service is performed in an implant center that received Institutional Review Board (IRB) approval for the procedure

Providers must indicate on the TAR that the center has IRB approval for the procedure. Bilateral placement of implantable neurostimulator electrodes is reimbursable on the same date of service.

Parkinson's Disease

Surgery for unilateral or bilateral (including simultaneous bilateral) DBS is reimbursable for recipients with Parkinson's Disease when medical necessity has been established. Bilateral placement of implantable neurostimulator electrodes is reimbursable on the same date of service.

Essential Tremor

Surgery for unilateral DBS is reimbursable for recipients with essential tremor when the tremor is not adequately controlled with medication or has become refractory to medical therapy and significant functional disability exists.

ICD-10-CM Code Requirements

Claims submitted for DBS services require one of the following ICD-10-CM diagnosis codes, as appropriate:

«Table of ICD-10-CM Codes for DBS Services»

ICD-10-CM Code	Description
G20	Parkinson's Disease
G24.09	Other drug induced dystonia
G24.1	Genetic torsion dystonia
G24.3	Spasmodic torticollis
G24.8	Other dystonia
G25.0 thru G25.2	Other extrapyramidal and movement disorders
G80.3	Athetoid cerebral palsy

Activa Tremor Therapy Device

Claims for the Activa Tremor Therapy Device are separately reimbursable with the following HCPCS codes:

«Table of HCPCS Codes for the Activa Tremor Therapy Device»

HCPCS Code	Description
L8680	Implantable neurostimulator electrode (with any number of contact points), each
L8681	Patient programmer (external) for use with implantable programmer neurostimulator pulse generator
L8682	Implantable neurostimulator radiofrequency receiver
L8683	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension
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 implanted neurostimulator

Note: These items must be supplied by the hospital and are reimbursable only when contract hospitals have exclusions to their negotiated hospital contract to bill these codes separately.

Documentation Requirements

Documentation indicating the implantation of electrodes and/or insertion of the neurostimulator generator(s) must be included with the claim.

Medical necessity for implantation of two smaller pulse generators (codes L8685 and L8686), rather than one larger dual array pulse generator, must be documented in the *Remarks* field (Box 80) or *Additional Claim Information* field (Box 19) of the claim, or on a claim attachment.

Note: For invoice requirements, refer to the “Surgical Implantable Device Reimbursement” subsection in the *Surgery* section in the appropriate Part 2 manual.

Microelectrode Requirements

DBS procedures must be performed with microelectrode recording, which can improve accurate electrode placement and reduce neurosurgical complications.

Physician Qualifications

Implantation of the device for DBS should be performed only by a physician experienced in stereotactic neurosurgery and microelectrode recording.

Equipment Requirements

DBS procedures may be performed only with Federal Drug Administration approved devices, systems and equipment.

Hospital Stay

A minimum hospitalization of two days is usually authorized for an uncomplicated elective DBS procedure. Additional documentation is required for hospital stays longer than two days.

Magnetic Resonance and Computed Tomography Reimbursement

Providers may be separately reimbursed for performing magnetic resonance imaging (CPT codes 70551 thru 70553) or computed tomography (codes 70450 thru 70470) of the brain with or without contrast prior to the DBS procedure.

Vagal Nerve Stimulator

The following policy pertains to vagal nerve stimulator services.

Reimbursable CPT and HCPCS Codes

The following codes are used to bill for Vagal Nerve Stimulator (VNS) procedures.

«CPT Codes for Vagal Nerve Stimulator Procedures»

CPT Code	Description
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to with connection to two or more electrode arrays
64568	Incision for implantation of cranial nerve neurostimulator electrode array and pulse generator Note: This code is used for surgical implantation of the electrodes of both components and requires a TAR.

When performing the appropriate VNS procedures, providers also may bill CPT codes 61888, 64569, 64570, 95970 and 95971, as appropriate.

The following codes are used to bill for the VNS device and leads.

«Table of HCPCS Codes for the VNS Device»

HCPCS Code	Description
L8680	Implantable neurostimulator electrode (with any number of contact points), each
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension

Reimbursement

HCPCS codes L8680 and L8685 thru L8688 are reimbursable on an outpatient basis only. All procedures must be billed "By Report." Claims are reimbursed at invoice cost.

Treatment Authorization Request

A *Treatment Authorization Request* (TAR) is required when billing CPT codes 64568. CPT codes 61885 and 61886 no longer require a TAR. All of the following criteria must be met for authorization of a VNS procedure:

- Patient has a documented intractable seizure disorder and has had an appropriate trial period taking anticonvulsant medications.

Note: For the purposes of this benefit, an "intractable seizure" is defined as at least one seizure per month that results in unacceptable interference with the patient's ability to function despite use of appropriate anti-seizure medications and dosages for the patient's seizure type.

- Patient is not a good candidate for other more effective anti-seizure surgical therapy; or the patient refuses anti-seizure surgical therapy; or previous anti-seizure surgical therapy was unsuccessful for the patient.
- Patient's epileptologist/neurologist has recommended VNS implantation.
- The surgeon implanting the VNS device must have surgical privileges that allow insertion of this device.
- The surgeon requesting authorization to implant a VNS device must indicate on the TAR the name of the neurologist who will follow-up with the patient post-implantation, and this neurologist must be familiar with the settings and protocols for use of the device.

California Children's Services (CCS)-Eligible Recipients:

A request for implantation of a VNS device for a Medi-Cal recipient under 21 years of age who has a California Children's Services (CCS)-eligible medical condition related to the seizure disorder must be sent to the appropriate CCS Program Office. Individuals under 21 with seizure disorders who are eligible for the CCS program include those in whom the seizure disorder is secondary to another CCS-eligible condition, or in whom the seizure disorder is difficult to control according to any one of following criteria:

The frequency or duration of the seizures requires:

- More than four changes in dosage or type of medications
- Three or more types of seizure medication
- At least one medical office visit per month for assessment of the clinical status and periodic blood tests for medication levels or presence of blood dyscrasias

Non-CCS-Eligible Recipients:

For Medi-Cal recipients without a CCS-eligible medical condition related to the seizure disorder who are under 12 years of age, there must be a recommendation for the implantation from a Board Certified Pediatric Neurologist; and for those under 6 years of age, there must be a recommendation from two Board Certified Pediatric Neurologists. The neurologists must be familiar with the patient's seizure disorder and use of vagal nerve stimulation.

Note: For Medi-Cal program purposes, in order to be considered experienced, a neurologist must have successfully managed at least three patients with the device, including both programming the device and following the patient during the post-implantation period.

Stereotactic Radiosurgery: Cranial and Spinal

The following CPT codes are used to bill for stereotactic radiosurgery. Lesions successfully treated by this technique include arteriovenous malformations and central nervous system tumors such as acoustic schwannomas, pituitary adenomas, craniopharyngiomas, tumors of the pineal region and skull-base meningiomas.

«Table of CPT Codes for Stereotactic Radiosurgery»

CPT Code	Description
61796	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion
61797	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple
61798	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion
61799	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex
61800	Application of stereotactic headframe for stereotactic radiosurgery
63620	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion
63621	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion

Surgical procedures 61796 (stereotactic radiosurgery, 1 simple cranial lesion) and 61798 (stereotactic radiosurgery, 1 complex cranial lesion) may be reported only once per course of treatment (three months). Do not report these codes during the same surgical session.

Surgical procedures 61797 (stereotactic radiosurgery, each additional simple cranial lesion) and 61799 (stereotactic radio surgery, each additional complex cranial lesion) may not be reported more than four times in any combination, per course of treatment (three months).

Reimbursement Requirements

Stereotactic radiosurgery procedures no longer require a *Treatment Authorization Requirement* (TAR), but may be reimbursed only if all of the following conditions are met:

- Attending neurosurgeon is experienced in performing this technique
- Attending neurosurgeon documents that the lesion is inaccessible to more conventional neurosurgical techniques (surgical excision through craniotomy, or for vascular malformations, embolization by pellets and tissue adhesives)
- Facility has the experience and resources to perform the treatment

“By Report” Billing

CPT code 61796 thru 61800, 63620 or 63621 must be billed “By Report.” The “By Report” information may be entered in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim form or on an attachment.

Stereotactic Pallidotomy

CPT code 61720 (creation of lesion by stereotactic method, including burr hole[s] and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus) is used to bill for stereotactic pallidotomy in which the globus pallidus is ablated with radio frequency waves using stereotactic localization.

Reimbursement Requirements

CPT code 61720 no longer requires a TAR, but may be reimbursed only if all of the following conditions are met:

- A patient with Parkinson’s disease who has failed medical therapy and has intractable and disabling symptoms from this condition. In addition:
 - The patient must have historical evidence of response to dopaminergic replacement therapy.
 - The patient must have no evidence of dementia or Alzheimer’s disease.
- A patient with juvenile dystonia who is resistant or unresponsive to medical management
- A patient with focal torsion dystonia (spastic torticollis), who has failed therapy with botulinum toxin and continues to have disabling symptoms

Second Pallidotomy Procedure:

Patients may be approved for a second pallidotomy procedure on the opposite side (bilateral procedure) if documentation of disabling contralateral symptoms with significant interference in the activities of daily living is provided. A bilateral procedure will not be approved if requested within three months of the first procedure.

Microelectrode Requirements

In addition, stereotactic radio frequency pallidotomy must be performed using microelectrode mapping to reduce the risk of neurosurgical complications.

Magnetic Resonance Imaging

CPT code 70552 (magnetic resonance imaging, brain [including brain stem]; with contrast material) is usually performed prior to stereotactic pallidotomy and may be separately reimbursable.

Posterior Tibial Nerve Stimulation (PTNS)

CPT code 64566 (posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming) is used to bill for treatment of overactive bladder (OAB). PTNS is performed with the Urgent® PC Neuromodulation System. Treatment is once per week for 12 weeks. If improvement is shown additional treatments every three weeks have been shown to extend the effectiveness.

Requirements

CPT code 64566 is reimbursable when all of the following criteria are met:

- OAB symptoms for at least the last 12 months, consisting of urgency with or without urge incontinence, usually with frequency and/or nocturia
- Significant disability that limits daily activities
- Failure of behavioral and at least two pharmacotherapies
- Absence of pathologic or metabolic causes of OAB
- Patient without stress incontinence, interstitial cystitis, neurogenic bladder or obstructive urinary retention

Note: Documentation of all criteria must be included with the claim for reimbursement.

For reimbursement, one of the following ICD-10-CM diagnosis codes must appear on the claim:

«Table of ICD-10-CM Codes for Posterior Tibial Nerve Stimulation»

ICD-10-CM Code	Description
N39.41	Urge incontinence
N39.42	Incontinence without sensory awareness
N39.46	Mixed incontinence
N39.498	Other specified urinary incontinence
R35.0	Frequency of micturition
R39.15	Urgency of urination

Nerve Pedicle Transfer

CPT code 64905 (nerve pedicle transfer: first stage) is reimbursable for indications that include, but are not limited to, viral, traumatic and birth-related injuries.

Billing Requirements

The billing quantity limitation of one per date of service for CPT code 64905 may be overridden with documentation of medical necessity. In some cases, multiple concurrent nerve transfer procedures are performed on the same date of service. Quantities from two up to a maximum of six per day may be billed by documenting the indication in the *Remarks* field (Box 80) on the *UB-04* claim form, *Additional Claim Information* field (Box 19) on the *CMS-1500* claim form or on an attachment. No documentation is necessary when billing for a quantity of one per date of service.

<<Legend>>

<<Symbols used in the document above are explained in the following table.>>

Symbol	Description
<<	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
>>	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	"By Report" billing is required