2023 CODING AND REIMBURSEMENT GUIDE
SURGICAL ENCOUNTER

Vivistim® SYSTEM

MicroTransponder, Inc. offers reimbursement support and prior authorization assistance. Please contact the MicroTransponder Reimbursement Hotline at reimbursement@microtransponder.com.

Overview

This guide provides *hospital* and *physician* coding and reimbursement information for procedures associated with placement of the Vivistim® Paired VNS™ System (i.e. implant encounter) and device analysis and programming services.

The Vivistim® Paired VNS™ System is a PMA-approved (P210007), FDA Breakthrough Device (Q210050) intended to be used to stimulate the vagus nerve during rehabilitation therapy to reduce upper extremity motor deficits and improve motor function in chronic ischemic stroke patients with moderate to severe arm impairment.

MicroTransponder For questions about reimbursement please contact the MicroTransponder Reimbursement Hotline at reimbursement@microtransponder.com.

Table of Contents

Implant Encounter

ICD-10-CM Diagnosis Codes

Monoplegia describes a motor deficit affecting a single limb and hemiplegia describes a deficit affecting one side of the body. Code selection for monoplegia and hemiplegia requires the specification of the affected limb and limb dominance.

ICD-10-CM Code[1]	ICD-10-CM Description[1]
I69.33	**Monoplegia of upper limb following cerebral infarction**
I69.331	Monoplegia of upper limb following cerebral infarction affecting right dominant side
I69.332	Monoplegia of upper limb following cerebral infarction affecting left dominant side
I69.333	Monoplegia of upper limb following cerebral infarction affecting right non-dominant side
I69.334	Monoplegia of upper limb following cerebral infarction affecting left non-dominant side
I69.339	Monoplegia of upper limb following cerebral infarction affecting unspecified side
I69.35	**Hemiplegia and hemiparesis following cerebral infarction**
I69.351	Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
I69.352	Hemiplegia and hemiparesis following cerebral infarction affecting left dominant side
I69.353	Hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side
I69.354	Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side
I69.359	Hemiplegia and hemiparesis following cerebral infarction affecting unspecified side

Procedure Reporting

The following procedure code may be used to report the insertion of the Vivistim® Paired VNS™ System implantable pulse generator and stimulation lead. For device revision, removal, or replacement procedures, see the *Revision, Removal or Replacement Procedures* section.

CPT® Code[2]	Long Description[2]
64568	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator

Device Reporting

The following HCPCS Level II codes may be used to report the implantable pulse generator, stimulation lead and external controller of the Vivistim® Paired VNS™ System. The HCPCS Level II C-codes are typically reported to Medicare and some commercial insurers. The L-codes are used for specific commercial insurance plans and you should verify each payers' coding requirements prior to claim submission.

Level II HCPCS Crosswalk

Device	Device Description	Model Number	Medicare HCPCS	Alternate HCPCS
IPG	Vivistim® Paired VNS Implantable Pulse Generator Model 1001 IPG	VIV-IPG 29-MM11041	C1827	L8686
Lead – 2mm	Vivistim® Paired VNS Lead 2mm Model 3000 Lead	VIV-LEAD2MM 26-0012-0001	C1827	L8680
Lead – 3mm	Vivistim® Paired VNS Lead 3mm Model 3000 Lead	VIV-LEAD3MM	C1827	L8680

Level II HCPCS Long Descriptors

HCPCS[3]	Long Description[3]
C1827	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller
L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension
L8680	Implantable neurostimulator electrode, each

Physician Reimbursement

Medicare Physician Fee Schedule Status Indicators (SI), Relative Value Units (RVU) and Medicare payment amounts for the implant procedure are based upon hospital outpatient values, whereas device analysis and programming procedures are based upon a freestanding office site of service.

CPT® Code[2]	Long Description[2]	MPFS SI[4]	MPFS Total RVU[4]	2023 Medicare Physician Payment[4]
64568	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	A	18.14	$609.97

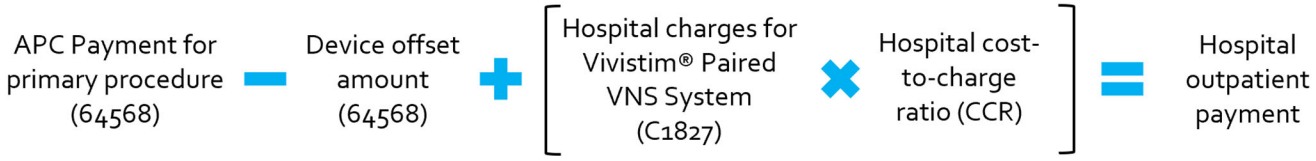
Hospital Outpatient Reimbursement (Facility)

The Vivistim® Paired VNS™ System was awarded transitional pass-through status by the Centers for Medicare and Medicaid Services (CMS) effective 1/1/2023.[5] The transitional pass-through program provides additional reimbursement to hospitals and ambulatory surgery centers (ASCs) for new, costly technologies that demonstrate a substantial clinical improvement to existing therapies.

CPT®/HCPCS Code[2,3]	Long Description[2,3]	OPPS APC[6]	OPPS Status Indicator[6]
64568	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	5465	J1
C1827	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller	2039	H

Under the transitional pass-through payment program, claims are reimbursed based on the reported charges for the implantable device. Payments are determined by converting the hospital's charges to costs using the

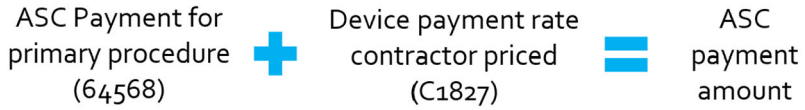
individual hospital's cost-to-charge (CCR) ratio for the cost center "implantable devices charged to patients", if available.



MicroTransponder can assist hospitals in estimating transitional pass-through payment amounts.

Ambulatory Surgery Center Reimbursement

Under the transitional pass-through payment program, ASC claims are reimbursed based on the invoice submitted to the local Medicare Administrative Contractor (MAC) for the implantable device. The invoice price should be entered in item 19 on the CMS-1500 claim form or its electronic equivalent.



MicroTransponder can assist hospitals in estimating transitional pass-through payment amounts.

Hospital Inpatient Coding & Reimbursement

Hospital inpatient coding requires the use of appropriate ICD-10-PCS procedure codes in addition to the diagnosis codes, CPT® procedure codes and HCPCS Level II device codes described above. Medicare and some other insurers use ICD-10-PCS codes and ICD-10-CM diagnosis codes to determine the appropriate diagnosis related group (DRG) assignment for admissions.

The Vivistim® Paired VNS System was granted New Technology Add-On Payment (NTAP) by the Centers for Medicare and Medicaid Services (CMS). Beginning on October 1, 2022, hospital inpatient claims for Medicare beneficiaries involving the use of the Vivistim® Paired VNS System are eligible to receive up to $23,400 in additional reimbursement.[7] The actual amount of NTAP reimbursement depends on several factors, including the hospital's reported charges and cost-to-charge ratios. Please reference the below ICD-10-PCS code when submitting inpatient hospital claims for Medicare beneficiaries beginning on October 1, 2022.

ICD-10-PCS Procedure Coding

The following ICD-10-PCS codes may be reported to describe admissions involving the insertion of the Vivistim® Paired VNS™ System.

ICD-10-PCS Procedure Code[8]	ICD-10-PCS Code Description[8]	Device Component
X0HQ3R8	Insertion of vagus nerve stimulation lead with paired stimulation system, percutaneous approach	Generator & Stimulation Lead

MS-DRG Assignment

The following MS-DRGs are assigned to ICD-10-PCS X0HQ3R8. Note that a concomitant diagnosis which qualifies as either a comorbidity or complication (CC) or a major comorbidity of complication (MCC) may affect final MS-DRG assignment.

MS-DRG[9]	MS-DRG Description[9]
040	Peripheral/Cranial Nerve and Other Nervous System Procedures W/MCC
041	Peripheral/Cranial Nerve and Other Nervous System Procedures W/CC or Peripheral Neurostimulator
042	Peripheral/Cranial Nerve and Other Nervous System Procedures WO/CC or MCC

Device Interrogation and Programming

ICD-10-CM Diagnosis Codes

The following ICD-10-CM diagnosis codes are used to report upper limb deficit in patients who may be eligible to receive treatment with the Vivistim® Paired VNS™ System. A secondary diagnosis code of Z45.42 (see below) should be reported for encounters for the purpose of interrogating or programming of the Vivistim® Paired VNS™ System.

ICD-10-CM Code[1]	ICD-10-CM Description[1]
Primary Diagnosis Code	
I69.331	Monoplegia of upper limb following cerebral infarction affecting right dominant side
I69.332	Monoplegia of upper limb following cerebral infarction affecting left dominant side
I69.333	Monoplegia of upper limb following cerebral infarction affecting right non-dominant side
I69.334	Monoplegia of upper limb following cerebral infarction affecting left non-dominant side
I69.339	Monoplegia of upper limb following cerebral infarction affecting unspecified side
I69.351	Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
I69.352	Hemiplegia and hemiparesis following cerebral infarction affecting left dominant side
I69.353	Hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side
I69.354	Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side
I69.359	Hemiplegia and hemiparesis following cerebral infarction affecting unspecified side
Secondary Diagnosis Code	
Z45.42	Encounter for adjustment and management of neuropacemaker (brain) (peripheral nerve) (spinal cord)

Encounters that are specifically for the purposes of device interrogation or programming, report ICD-10-CM Z45.42 as the primary diagnosis and report the applicable monoplegia/hemiplegia diagnosis code in the secondary position.

Procedure Reporting

The following procedures may be used to describe device analysis and programming. It is not appropriate to report these services during the operative encounter. Device analysis and programming services are reportable only after (e.g., subsequent to) the implant procedure. Simple programming describes the adjustment of 3 or fewer device parameters. Complex programming describes the adjustment 4 or more device parameters.[10]

CPT® Code[2]	Code Description	OPPS APC[6]	OPPS Indicator[6]	2023 Hospital Outpatient Payment[6]	Physician Indicator[4]	2023 Physician Payment[4]
Device Interrogation						
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., 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	$116.11	A	$18.98
Device Programming						
95976	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., 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 cranial nerve neurostimulator pulse generator/ transmitter programming by physician or other qualified health care professional.	5741	S	$35.00	A	$39.99
95977	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., 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 cranial nerve neurostimulator pulse generator/ transmitter programming by physician or other qualified health care professional.	5742	S	$99.81	A	$52.86

Revision, Removal and Replacement Procedures

In certain circumstances it may be necessary to perform a revision, removal or replacement of the Vivistim® Paired VNS™ System implantable pulse generator or stimulation lead. These procedures are separately reportable and are provided below.

CPT® Code[2]	Long Description[2]	Procedure Type *Device Component*
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	Insertion or Replacement *Generator Only*
61888	Revision or removal of cranial neurostimulator pulse generator or receiver	Revision or Removal *Generator Only*
64569	Revision or replacement of cranial nerve (e.g., vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	Revision or Replacement *Lead Only*
64570	Removal of cranial nerve neurostimulator electrode array and pulse generator	Removal Only *Generator and Lead*
64585	Revision or removal of peripheral neurostimulator electrode array	Revision or Removal *Lead Only*

Prior Authorization/Pre-Service Clearance

MicroTransponder has a complete prior authorization and pre-service clearance support program. Prior authorization is typically required for commercial insurances and some Medicare Advantage plans for the implantation of the Vivistim® Paired VNS™ System. MicroTransponder, Inc. provides prior authorization support services to physicians' groups and hospitals.

Please contact the MicroTransponder Reimbursement Hotline at reimbursement@microtransponder.com for assistance.

Billing and Claims Submission

Billing and claim submission requirements vary by payer and by State. Medicare billing guidelines require hospitals to accurately report costs for implantable devices. Charges for the Vivistim® Paired VNS™ System implantable components should reflect the hospital's implantable device charging policies and/or applicable Medicare cost to charge ratio. Implantable devices are reported under revenue code 0278.

Medicare Claims Processing

National Coverage Decision Edits: Medicare fee-for-service claims for the Vivistim® insertion procedure may result in an initial denial due to edits related to NCD 160.18 vagus nerve stimulation for epilepsy and treatment resistant depression. NCD edits are identified on remittance advice with an N386 remark code. An appeal to your local Medicare Administrative Contractor will be needed to bypass the NCD edit. If you receive a denial for the Vivistim® insertion procedure, please contact the MicroTransponder Reimbursement Hotline at reimbursement@microtransponder.com for assistance.

Device to Procedure Edits: Hospitals and ASCs need to report the implantable components of the Vivistim® Paired VNS™ System (e.g, HCPCS C1827) to prevent potential device to procedure edits.

Commercial Insurance/Medicare Advantage Claims Submission

Prior authorization is typically required for commercial insurances and Medicare Advantage plans for the insertion of the Vivistim® Paired VNS™ System. Please remember to include the Prior Authorization number on all claims submitted to avoid unnecessary claim denials.

Physician Claim Form (i.e., CMS-1500)

- Paper Claims: Box 23 – Prior Authorization Number
- Electronic Claims: 837P Loop 2300, Segment REF02 (if REF01 is G1)

Hospital Claim Form (i.e., UB-04, CMS-1450)

- Paper Claims: Box 63 (A, B, C) – Treatment Authorization Code(s)
- Electronic Claims: 837I Loop 2300, Segment REF02 (if REF01 is G1)

IMPORTANT:
If you experience a denied claim, underpayment, or receive a remittance advice or explanation of benefits that does not show a fully adjudicated claim, please contact the MicroTransponder Reimbursement Hotline at reimbursement@microtransponder.com for assistance.

References

1. CMS 1771-F, FY 2023 IPPS Final Rule ICD-10-CM Diagnosis Tabular Index
2. CPT® is a registered trademark of the American Medical Association © 2022. All Rights Reserved.
3. CMS CY 2023 HCPCS Alphanumeric Index
4. CMS 1770-FC – CY 2023 MPFS Final Rule Addendum B RBRVS with MPFS CY 2023 corrected conversion factor ($33.8872).
5. CMS 1772-FC. Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs. 42 CFR Vol. 87, No. 225 (71895-71899). Nov. 23, 2022.CPT® code reporting must be supported by medical record documentation
6. CMS-1772-F, CY 2023 OPPS Final Rule with Comment Period (NFRM). Addendum B.
7. CMS-1771-F. Hospital Inpatient Prospective Payment System Final Rule. FR 87. No. 153 (pg. 48780-49499) Aug. 10, 2022.
8. CMS 1771-F, FY 2023 IPPS Final Rule ICD-10-PCS Tabular Index
9. CMS 1771-F, FY 2023 IPPS Final Rule Table 5 MS-DRG
10. CPT Coding Update: Neurostimulator Analysis & Programming. Jul 2016 (7).