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Part B Insider (Multispecialty) Coding Alert

Neurostimulator Coding: Neurostimulator Trial, but No Error

Treat the trial and final implantation as staged procedures

A patient comes in with chronic intractable pain, and the physician has tried other treatment methods, including drugs. What do you do?

These days, Medicare covers spinal neurostimulator implantation for last-ditch pain relief. But the Part B carriers require you to test the leads on the patient to see if they reduce the pain, before doing a final implantation. Many coders aren't sure how to bill for the test and final implantation without falling afoul of a 90-day global period.

The best approach is to treat the test and final implantation as a staged procedure, using modifier -58 (Staged or related procedure or service by the same physician during the postoperative period), says **Devona Slater**, president of Auditing for Compliance & Education in Leawood, Kan. For example, the physician may perform a percutaneous placement (63650) for trial purposes. Then two weeks later, the physician does the permanent placement. In that case, **bill 63650** again, using modifier -58, along with 63685 (Incision and subcutaneous placement of spinal neurostimulator pulse generator or receiver).

Don't use modifier -59 (Distinct procedural service) unless the later implantation is on a different site on the body, says **Rhonda Petruzillo**, director of revenues and reimbursement for medical operations with Metro Health Medical Center in Cleveland. Since the physician knows in advance she's going to have to implant a permanent neurostimulator after the test, it's more like a staged procedure than a separate and unrelated procedure.

The physician's operative note for the first procedure should mention that this is a staged procedure and that the final implantation will happen later. Unless the op notes for the first procedure mention that the physician expects a follow-up, some carriers may not pay for the later procedure even with modifier -58.

Don't forget that you can bill per electrode for multiple electrodes, Slater says. "Coders miss [out on] billing that code multiple times," she says. You don't necessarily need a modifier if you bill 63685 multiple times. But if the carrier questions it, Slater advises using modifier -51 (Multiple procedures).

If you're doing a bilateral neurostimulator placement, use modifier -50 (Bilateral procedure), Petruzillo says. With Medicare, you should only bill on one line item, using 63685 with modifier -50 in a quantity of one. The carrier will automatically add the extra reimbursement for the bilateral procedure. Some other payers, such as Blue Cross/Blue Shield plans, want to see 63685 billed twice, with modifier -50 attached to the second instance. And some payers want to see 63685 on one line, with a quantity of two and modifier -50.

If you provide the neurostimulators in the office setting instead of the hospital, you'll need a durable medical equipment supplier number to bill for the equipment and supplies, Slater says.

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