



Medtronic

Spinal Cord Stimulation

Medicare Physician Fee Schedule (MPFS)

Final Rule Highlights 11/27/2013



Medtronic provides this information for your convenience only. It is not intended as a recommendation regarding clinical practice. It is the responsibility of the provider to determine coverage and to submit appropriate codes, modifiers, and charges for the services rendered. This document provides assistance for FDA approved or cleared indications. Where reimbursement is requested for a use of a product that may be inconsistent or not expressly specified in the FDA cleared or approved labeling (e.g., instructions for use, operator's manual, or package insert) consult with your billing advisors or payers for advice on handling such billing issues. Some payers may have policies that make it inappropriate to submit claims for such items or related service. Contact your Medicare contractor or other payer for interpretation of coverage, coding, and payment policies.

Spinal Cord Stimulation Office Trialing

CMS published the Final Rule for the Medicare Physician Fee Schedule (MPFS) on November 27, 2013. Effective January 1, 2014, spinal cord stimulation (SCS) trials furnished in a physician's office will continue to be reimbursed under Medicare; however, the payment mechanisms will change.

What is remaining the same?

- SCS trials furnished in a physician's office will continue to be reimbursed under Medicare
- CPT code 63650 will continue to be reported for each lead insertion procedure in the trial

What is changing?

- CMS established non-facility practice expense (PE) relative value units (RVUs) for CPT 63650 that are valued to include payment for the lead(s) and other practice expenses associated with office based trials
- HCPCS code L8680 will no longer be reported for the device component in conjunction with office based SCS trials

The following provides additional background and details around these changes:

Historically, CPT code 63650 (Percutaneous implantation of neurostimulator electrode array, epidural) has not had non-facility RVUs assigned to it under the Medicare System. This means practice expense values were never established for this procedure, the majority of which would be the cost of the trial lead. Despite the lack of non-facility (NF) RVUs, most Medicare Administrative Contractors (MACs) have been willing to reimburse physicians for trials conducted in their office setting using the facility based RVUs, which do not factor in the practice expense component. This has been accomplished by having physicians report CPT code 63650 (Percutaneous implantation of neurostimulator electrode array, epidural) for the lead insertion procedure and HCPCS code L8680 (Implantable neurostimulator electrode, each) for the lead itself.

In the 2013 MPFS Proposed Rule published on July 30, 2012 and the Final Rule published on November 16, 2012, CMS recognized that CPT code 63650 is frequently furnished in the physician office setting but is not priced in that setting. In addition, CMS stated that the disposable leads shouldn't be reimbursed using the Durable Medical Equipment, Prosthetic/Orthotic, and Supplies (DMEPOS) fee schedule as they are not considered prosthetic devices covered under this fee schedule. Consequently, CMS indicated they would establish non-facility practice expense (PE) RVUs for CPT 63650 that would be valued to include payment for the lead(s) and other practice expenses associated with office based trials. In addition, CMS recognized that the leads comprise a significant resource cost for the service, therefore, CMS requested recommendations from the

AMA RUC (American Medical Association Relative Value Scale Update Committee) and other public commenters on the appropriate facility and NF direct PE inputs for the service.

In the 2014 Final Rule for Physicians, CMS finalized this proposal, although no specific commentary was included in the CMS Final Rule about this change. As a result of these changes, physicians will no longer report the device component (L8680) in conjunction with office based SCS trials. The disposable lead expense will now be factored in under the NF practice expense RVU newly developed for 2014, so the physician fee schedule amount for the lead insertion procedure (CPT 63650) furnished in the office setting will be significantly higher in 2014. The following table provides the Medicare physician fee schedule RVUs and national average payment rates for 63650 that will be effective 1/1/14:

CPT ^{® 4} code	2014 Medicare RVUs For Physician Services Provided in ^{1 2} :		2014 Medicare National Average Estimated Fee Schedule Amount For Physician Services Provided in ³ :	
	Non-Facility (Physician Office)	Facility	Non- Facility (Physician Office)	Facility
63650	37.67	11.93	\$1,281.65	\$405.89

Please note that if two leads are placed during a trial, payment for the second lead is reduced by 50% pursuant to the CMS multiple surgery reduction provision. Therefore, total payment for a dual lead trial will be 1,281.65 x 1.5 = \$1,922.47.

Link to the Medicare Final Rule for physician services: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1600-FC.html>

If you have questions about how these Medicare changes impact your facility and/or practice, please contact your local Medtronic Health Economics Manager.

If you would like to submit electronic comments on CMS-1600-FC, you may do so by accessing <http://www.regulations.gov>. Follow the instructions for "submitting a comment." Comments must be received no later than 5 pm on January 27, 2014

¹ Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2014 Final Rule 42 CFR Parts 405, 410, 411, 414, 423, and 425 CMS-1600-FC, RIN 0938-AR56 finalized on November 27, 2014.

² The RVUs shown are for the physician's services and payment is made to the physician. However, there are different RVUs and payments depending on the setting in which the physician rendered the service. "Facility" includes physician services rendered in hospitals, ASCs, and SNFs. Physician RVUs and payments are generally lower in the "Facility" setting because the facility is incurring the cost of some of the supplies and other materials. Physician RVUs and payments are generally higher in the "Physician Office" setting because the physician incurs all costs.

³ Medicare National Average is determined by multiplying the sum of the three RVUs: physician work, practice expense, and malpractice, by the CY 2013 conversion factor of \$34.0230. Payment rates reflect policies adopted in Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2013 Final Rule 77 Fed. Reg. 68891-69380 (finalized November 16, 2012), and subsequently corrected by a CY 2013 Medicare Physician Fee Schedule Final Rule Correction Notice. These rates also reflect the zero percent update for calendar year 2013 adopted by section 601(a) of the American Taxpayer Relief Act of 2012. Final payment to the physician is adjusted by the Geographic Practice Cost Indices (GPCI). If congress doesn't act to eliminate the sustainable growth rate (SGR) decrease as proposed, the conversion factor in 2014 will decrease to \$26.8199. This information does not take into effect Medicare payment reductions resulting from Sequestration associated with the Budget Control Act of 2011. Sequestration reductions went into effect on April 1, 2013. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the payment amount shown.

⁴ CPT copyright 2012 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.