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SPINAL CORD STIMULATION

2026 Hospital Outpatient Reimbursement Guide



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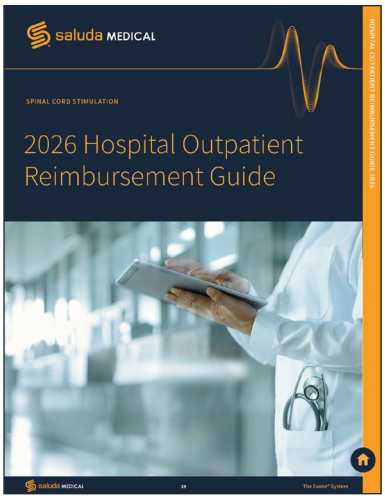
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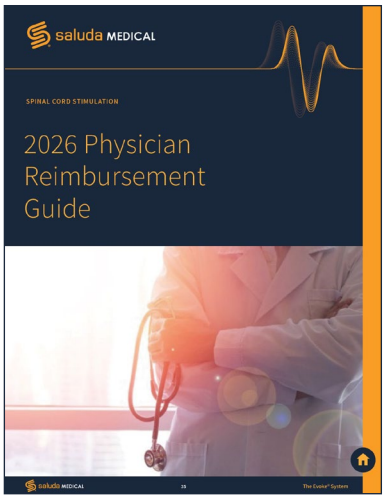
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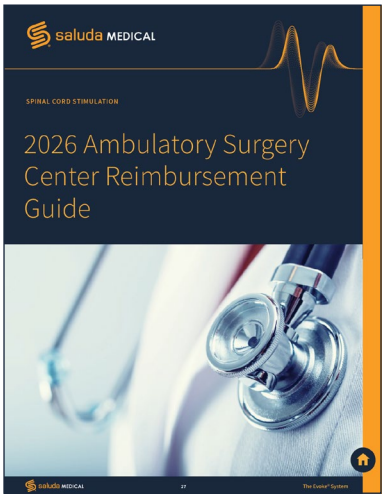
Saluda Medical offers several resources for coding, coverage, and payment information for spinal cord stimulation



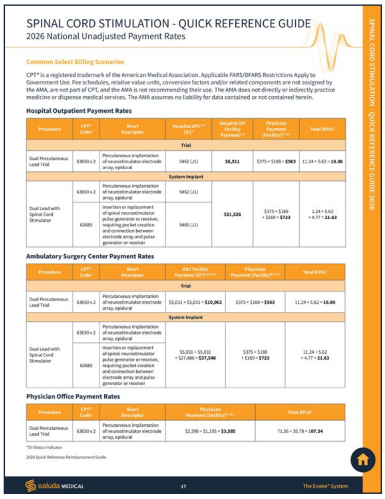
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Spinal Cord Stimulation Physician Reimbursement Guide



Spinal Cord Stimulation Ambulatory Surgery Center (ASC) Reimbursement Guide



Spinal Cord Stimulation Quick Reference Guide

SALUDA MEDICAL REIMBURSEMENT CENTER

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Please allow 24 hours for a response.

Hospitals bill using HCPCS codes for outpatient services. Under Medicare's Ambulatory Payment Classification (APC) methodology of hospital outpatient services, each HCPCS code is assigned to one APC. Each APC has a relative weight that is converted to a flat payment amount. For APCs which are designated as Comprehensive APCs (C-APC), Medicare provides a single payment for all services on the claim. A primary service is identified by the status indicator J1, and all other procedures and services coded on the bill are considered adjunctive to the primary service resulting in a single APC payment for the entire hospital outpatient encounter. The payment level for the C-APC is calculated to include the costs of the primary service and all adjunctive services. Spinal Cord Stimulation procedures subject to the C-APC are identified by status indicator J1.

Trial & System Implant

Procedure	CPT® Code[1]	Short Descriptor	Hospital APC[2]	Status Indicator[3]	Hospital Outpatient Medicare National Payment[2,4]
Trial					
Single Percutaneous Lead Trial	63650	Percutaneous implantation of neurostimulator electrode array, epidural	5462	J1	$6,511
Dual Percutaneous Lead Trial	63650	Percutaneous implantation of neurostimulator electrode array, epidural	5462	J1	$6,511
	63650	Percutaneous implantation of neurostimulator electrode array, epidural	5462	J1	
System Implant					
Single Lead with Spinal Cord Stimulator	63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	5465	J1	$31,526
	63650	Percutaneous implantation of neurostimulator electrode array, epidural	5462	J1	
Dual Lead with Spinal Cord Stimulator	63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	5465	J1	$31,526
	63650	Percutaneous implantation of neurostimulator electrode array, epidural	5462	J1	
	63650	Percutaneous implantation of neurostimulator electrode array, epidural	5462	J1	
Paddle Lead with Spinal Cord Stimulator	63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	5465	J1	$31,526
	63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	5464	J1	

*SI=Status Indicator

Revision, Removal & Replacement

Procedure	CPT® Code[1]	Short Descriptor	Hospital APC[2]	Status Indicator[3]	Hospital Outpatient Medicare National Payment[2,4,6]
Removal Percutaneous Lead	63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	5431	Q2	$1,995
Revision or Replacement Percutaneous Lead	63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	5462	J1	$6,511
Revision or Removal–Spinal Cord Stimulator	63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver	5461	J1	$3,572

Neurostimulator Analysis & Programming

CPT® Code[1]	Short Descriptor	Hospital APC[2]	Status Indicator[3]	Hospital Outpatient Medicare National Payment[4]
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, 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	$136
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, 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 spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/ transmitter programming by physician or other qualified health care professional	5742	S	$97
95972	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, 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 spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	5742	S	$97

*SI=Status Indicator

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HCPCS Level II Descriptions

The following codes are utilized by the entity that purchased the device, DME or supply and provided it to the patient. For implantable devices, the entity is usually the facility. Device L-Codes are utilized by non-Medicare payers and device C-Codes are used by hospitals for billing medical devices to Medicare in the hospital outpatient setting.

HCPCS Code	Descriptor
C1778	Lead, neurostimulator (implantable)
C1897	Lead, neurostimulator test kit (implantable)
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system
C1826	Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system
C1787	Patient programmer, neurostimulator
C1883	Adapter/ extension, pacing lead or neurostimulator lead (implantable)
L8679*	Implantable neurostimulator pulse generator, any type
L8680	Implantable neurostimulator electrode, each
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only
L8699	Prosthetic implant, not otherwise specified
L9900	Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS “L” code

*In 2014 a new HCPCS level II code was established: L8679–“Implantable neurostimulator pulse generator, any type”. However, L8687 - “Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension” may still be an active code on the fee schedule for some payers.

ICD-10-CM Diagnoses

ICD-10-CM diagnosis codes are used by providers to report the indication or reason for the procedure and patient conditions. List all diagnoses on the claim form and code to the highest available level of specificity based on the documentation in the patient's medical record. The following ICD-10-CM codes describe chronic, intractable pain conditions commonly managed with spinal cord stimulation. Other codes may apply based on the patient condition. For a complete list of codes and descriptions, consult the current ICD-10-CM manual.

ICD-10-CM Code[5]	Descriptor
Causalgia (CRPS II)	
G56.40	Causalgia of unspecified upper limb
C1897	Lead, neurostimulator test kit (implantable)
G56.41	Causalgia of right upper limb
G56.42	Causalgia of left upper limb
G56.43	Causalgia of bilateral upper limbs
G57.70	Causalgia of unspecified lower limb
G57.71	Causalgia of right lower limb
G57.72	Causalgia of left lower limb
G57.73	Causalgia of bilateral lower limbs
Arachnoiditis	
G03.1	Chronic meningitis
G03.9	Meningitis, unspecified
Peripheral Neuropathy	
G56.90	Unspecified mononeuropathy of unspecified upper limb
G56.91	Unspecified mononeuropathy of right upper limb
G56.92	Unspecified mononeuropathy of left upper limb
G56.93	Unspecified mononeuropathy of bilateral upper limbs
G57.90	Unspecified mononeuropathy of unspecified lower limb
G57.91	Unspecified mononeuropathy of right lower limb
G57.92	Unspecified mononeuropathy of left lower limb
G57.93	Unspecified mononeuropathy of bilateral lower limbs
Chronic Pain Disorders	
G89.0	Central pain syndrome
G89.29	Other chronic pain
G89.4	Chronic pain syndrome

ICD-10-CM Code[5]	Descriptor
Reflex Sympathetic Dystrophy (CRPS I)	
G90.511	Complex regional pain syndrome I of right upper limb
G90.512	Complex regional pain syndrome I of left upper limb
G90.513	Complex regional pain syndrome I of upper limb, bilateral
G90.519	Complex regional pain syndrome I of unspecified upper limb
G90.521	Complex regional pain syndrome I of right lower limb
G90.522	Complex regional pain syndrome I of left lower limb
G90.523	Complex regional pain syndrome I of lower limb, bilateral
G90.529	Complex regional pain syndrome I of unspecified lower limb
Epidural Fibrosis	
G96.12	Meningeal adhesions (spinal) (cerebral)
Radiculopathy	
M50.10	Cervical disc disorder with radiculopathy, unspecified cervical region
M50.11	Cervical disc disorder with radiculopathy, high cervical region
M50.121	Cervical disc disorder at C4-C5 level with radiculopathy
M50.122	Cervical disc disorder at C5-C6 level with radiculopathy
M50.123	Cervical disc disorder at C6-C7 level with radiculopathy
M50.13	Cervical disc disorder with radiculopathy, cervicothoracic region
M51.14	Intervertebral disc disorders with radiculopathy, thoracic region
M51.15	Intervertebral disc disorders with radiculopathy, thoracolumbar region
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M54.12	Radiculopathy, cervical region
M54.13	Radiculopathy, cervicothoracic region
M54.14	Radiculopathy, thoracic region
M54.15	Radiculopathy, thoracolumbar region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
Post Laminectomy Syndrome	
M96.1	Post laminectomy syndrome, not elsewhere classified

References

1. CPT Copyright 2023 American Medical Association (AMA). All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

2. Center for Medicare and Medicaid Services. CY 2025 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule. December 2025.

3. Status Indicators: S: Procedure or Service, Not Discounted When Multiple; J1: Hospital Part B services paid through a comprehensive APC. Q2: Not paid separately when billed with a T procedure (T packaged) Q1: STV -packaged codes. H: Pass-through device.

4. The Medicare National Average Payment is determined by multiplying the APC weight by the conversion factor of $91.42 for 2026. The payment will also be adjusted by the wage index for specific geographic localities. Therefore, payment will vary by hospital from the stated Medicare National Payment levels. Applicable co-insurance, deductibles and other amounts that are patient obligations are included in the Medicare National Payment levels shown.

5. Centers for Disease Control and Prevention, National Center for Health Statistics. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). https://www.cdc.gov/nchs/icd/icd-10-cm.htm. Updated October 17, 2022.

6. Assignment of a CPT® procedure code to a C-APCs is considered a primary procedure. All other services and procedures reported on the claim would be considered adjunctive to the primary procedure. CMS will make a single APC payment for the entire hospital outpatient encounter. There is no additional payment for the adjunctive services or procedures. When procedures performed in an episode of care map to multiple C-APCs, the entire episode will map to the highest paying C-APC.

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