enterra medical®

Gastric Electrical Stimulation

2025 CODING AND PAYMENT GUIDE

Humanitarian Device: The Enterra® Therapy System for gastric electrical stimulation is authorized by Federal law for use in treatment of chronic intractable (drug refractory) nausea and vomiting secondary to gastroparesis of diabetic or idiopathic etiology. The effectiveness of this device for this use has not been demonstrated.

The Enterra System must be implanted in an IRB-approved facility.

TABLE OF CONTENTS

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This document provides reimbursement information for FDA-approved indications only. For off-label use, consult payers or billing advisors, as some may restrict such claims.

Payment estimates do not reflect the 2% Medicare sequestration reduction under the Budget Control Act of 2011, effective April 1, 2013.

For questions please contact Enterra Medical at 1-855-768-3772 or email reimbursement@enterramedical.com.

ICD-10-CM[1] Diagnosis Codes

Diagnosis codes are used by both physicians and hospitals to document the indication for the procedure. Enterra Medical Gastrointestinal Electronic Stimulation (GES) is intended to treat the symptoms of chronic intractable nausea and vomiting secondary to gastroparesis of diabetic or idiopathic etiology. Because symptom codes are generally not acceptable as the principal diagnosis, the principal diagnosis is coded to the underlying conditions as shown.

Diabetic Gastroparesis[2]	**Diabetic Gastroparesis**	
	E10.43	Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy
	E11.43	Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy
	E13.43	Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy[3]
	plus	
	K31.84	Gastroparesis
	Gastroparesis due to Secondary Diabetes[4]	
	E08.43	Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy
	E09.43	Drug or chemical induced diabetes mellitus with neurological complications with diabetic autonomic (poly)neuropathy
	plus	
	K31.84	Gastroparesis
Idiopathic Gastroparesis	**K31.84**	Gastroparesis
Attention to Device[5]	**Z45.42**	Encounter for adjustment and management of neurostimulator
Neurostimulator Status[6]	**Z96.82**	Presence of neurostimulator

1. Centers for Disease Control and Prevention, National Center for Health Statistics. International Classification of Diseases, Tenth Comprehensive Listing ICD-10-CM Files, 2025 Release of ICD-10-CM, https://www.cdc.gov/nchs/icd/icd-10-cm/files.html.
2. Diabetic gastroparesis involves two codes, one for diabetes and one for gastroparesis. The diabetes code is always sequenced before the code for gastroparesis.
3. "Other specified" types of diabetes include diabetes mellitus due to genetic defects in insulin action and post-pancreatectomy diabetes mellitus, as well as diabetes mellitus "type 1.5". Coding Clinic, 3rd Q 2018, p.4-5.
4. Secondary diabetes is caused by some other condition or event. ICD-10-CM manual notes provide code sequencing instructions. In diabetes due to an underlying condition, e.g., cystic fibrosis or pancreatic cancer, the other condition is coded separately and sequenced before the code for diabetes. In drug or chemical induced diabetes, e.g., diabetes due to long-term steroid use, sequencing depends on whether diabetes resulted from poisoning or overdose or was the result of an adverse effect of the drug.
5. Code Z45.42 is used as the primary diagnosis when patients are seen for routine device maintenance, such as periodic device checks and programming, as well as routine device replacement.
   A secondary diagnosis code is then used for the underlying condition. ICD-10-CM Official Guidelines for Coding and Reporting FY 2025, I.C.21.c.7.
6. Code Z96.82 is a status code, assigned to indicate that the patient currently has an implanted neurostimulator that was placed during a prior encounter. This code is not assigned during the same encounter in which the neurostimulator is implanted, replaced, removed, revised, interrogated, or programmed. ICD-10-CM Official Guidelines for Coding and Reporting FY 2025. I.C.21.c.3.

Hospital Outpatient Coding and Payment

CPT Procedure Codes

Under Medicare's APC methodology for hospital outpatient payment, each CPT code is assigned to an ambulatory payment class (APC) and each APC is assigned a payment and a Status Indicator (SI) in the Outpatient Prospective Payment System (OPPS). If a CPT is assigned the J1 status indicator, it is assigned to a Comprehensive APC (C-APC), and therefore all other services reported on the claim are packaged into the payment for the highest ranked J1 service.

Procedure	CPT Code and Description[1]	APC[2]	SI[2,3]	Medicare National Rate[2]
Generator Implantation or Replacement	**64590** Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	5464	J1	$21,444
Generator Revision or Removal	**64595** Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array	5461	J1	$3,439
Lead Implantation or Replacement, Laparoscopic	**43647** Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	5463	J1	$12,470
Lead Revision or Removal, Laparoscopic	**43648** Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	5362	J1	$10,411
Endoscopy (EGD)	**43235** Esophagogastroduodenoscopy, flexible, transoral, diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)	5301	T	$938
Analysis/ Programming	**95980** Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/ transmitter, intraoperative, with programming	N/A	N	Packaged
	95981 Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter, subsequent, without reprogramming	5733	Q1	$59
	95982 Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/ transmitter, subsequent, with reprogramming	5741	Q1	$37

Note: According to CPT manual instructions, test stimulation during an implantation procedure is considered integral and cannot be coded separately as electronic analysis or programming. In addition, programming codes may be assigned as long as iterative adjustments to the parameters are made and assessed, regardless of whether the final settings are ultimately changed. See also CPT Assistant, February 2019, p.6. In the office, analysis, and programming may be furnished by a physician, practitioner with an "Incident to" benefit, or auxiliary personnel under the direct supervision of the physician (or other practitioner), with or without support from a manufacturer's representative. The patient or payer should not be billed for services rendered by the manufacturer's representative. Contact your local contractor or payer for interpretation of applicable policies.

1. CPT copyright 2024 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.
2. Centers for Medicare and Medicaid Services. CMS-1809-FC: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems . . . Final Rule and Related Addenda. FR DOC #2024-25521 (89 FR 93912). https://www.federalregister.gov/documents/2024/11/27/2024-25521/medicare-and-medicaid-programs-hospitaloutpatient-prospective-payment-and-ambulatory-surgical. Published November 27, 2024.
3. Status Indicator (SI) shows how a code is handled for payment purposes. J1 = paid under comprehensive APC, single payment based on primary service without separate payment for other adjunctive services; N = packaged service, no separate payment; S = always paid at 100% of rate; T = paid at 50% of rate when billed with another higher-weighted T procedure; Q1 = STV packaged codes, not paid separately when billed with an S, T, or V procedure.

HCPCS Level II C-Codes and L-Codes

Healthcare Common Procedure Coding System (HCPCS) Level II codes represent items and nonphysician services that are not represented by Level I CPT codes. Below are two types of HCPCS Level II device codes: C-codes, which are used on Medicare outpatient facility claims, and L-codes, primarily used by commercial insurance providers.

These codes are utilized by the entity that purchased and supplied the medical device to the patient. For implantable devices, that is generally the facility. Medicare requires hospitals to document C-codes on their outpatient claims when reporting devices used in device-intensive procedures. Although the L-codes are generally reported by non-Medicare payers, some payers request the use of the device C-Codes. Facilities should verify which code set is required with each payer. The facility claim may also qualify for a separate reimbursement payment with some commercial payors, commonly called an "implant carve-out", in addition to the reimbursement for the procedure billed.

ASCs usually do not report HCPCS II device codes for devices on claims sent to Medicare. While they are supposed to submit the charges, they are specifically instructed not to report HCPCS II device codes to Medicare on a separate line for devices that are packaged.[1]

Device	HCPCS Code[2]	Code Description
Medicare Hospital Outpatient Payment System C-Codes		
Pulse Generator (non-rechargeable)	**C1767**	Generator, neurostimulator (implantable), non-rechargeable
Lead[3]	**C1778**	Lead, neurostimulator (implantable)
L Codes for Orthotics & Devices (often used by Commercial Payers, not Medicare)		
Pulse Generator	**L8679**	Implantable neurostimulator pulse generator, any type
	L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
Lead[3]	**L8680**	Implantable neurostimulator electrode, each

1. ASCs should report all charges incurred. However, only charges for non-packaged items should be billed as separate line items. For example, the ASC should report its charge for the generator but because the generator is a packaged item, the charge should not be reported on its own line. Instead, the ASC should bill a single line for the implantation procedure with a single total charge, including not only the charge associated with the operating room but also the charges for the generator device and all other packaged items. Because of a Medicare requirement to pay the lesser of the ASC rate or the line-item charge, breaking these packaged charges out onto their own lines can result in incorrect payment to the ASC. Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual, Chapter 14—Ambulatory Surgical Centers, Section 40. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf.
2. Healthcare Common Procedure Coding System (HCPCS) Level II codes, including device C-codes, are maintained by the Centers for Medicare and Medicaid Services. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.
3. A complete implant of the Enterra System requires two leads, each containing one electrode.

ASC Coding and Payment (Medicare)

CPT Procedure Codes

Medicare payment for procedures performed in an ambulatory surgery center is based on the payment assigned to each CPT code on the ASC fee schedule. Multiple procedure discounting may apply. Only certain procedures are payable in the ASC.

Procedure	CPT Code and Description[1]	Multiple Procedure Discounting[2]	Medicare National Rate[3]
Generator Implantation or Replacement[4]	**64590** Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	N	$19,672
Generator Revision or Removal[4]	**64595** Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array	Y	$2,478
Endoscopy[5] (EGD)	**43235** Esophagogastroduodenoscopy, flexible, transoral, diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)	Y	$503

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2. When multiple procedures are reported, payment is usually made at 100% for the first procedure and 50% for the second and all subsequent procedures that are subject to multiple procedure discounting. Procedures with a "N" in this column are not subject to multiple procedure discounting. Those marked "Y" are.
3. Centers for Medicare and Medicaid Services. CMS-1809-FC: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems . . . Final Rule and Related Addenda. FR DOC #2024-25521 (89 FR 93912). https://www.federalregister.gov/documents/2024/11/27/2024-25521/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical. Published November 27, 2024.
4. For CY 2025, only Enterra® generator procedures are designated as "ASC-Covered Surgical Procedures" for Medicare. Lead procedures, open and laparoscopic, are not on Medicare's list of covered ASC procedures. Medicare Program: If lead procedures are performed in an ASC, Medicare makes no payment to the facility and the beneficiary is personally liable for the facility charges. Medicare Claims Processing Manual, Chapter 14—Ambulatory Surgical Centers, section 10.2. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf.
5. An EGD performed for distinct diagnostic purposes or performed at a separate encounter from lead implantation may be coded separately. However, according to NCCI policy, an EGD should not be coded separately when performed during the same operative episode as lead implantation to assess the surgical field and anatomic landmarks, to ensure no intraoperative injury occurred, or to verify successful lead placement. NCCI Policy Manual, Effective 1/1/2025, Chapter I, B-Surgical-3 and Chapter VI, C.6.

ICD-10-PCS[1] Procedure Codes

Procedure	ICD-10-PCS Code	Description
Neurostimulator Generator Implantation[2,3,4]	**0JH80DZ**	Insertion of multiple array stimulator generator into abdomen subcutaneous tissue and fascia, open approach
Neurostimulator Generator Removal[4]	**0JPT0MZ**	Removal of stimulator generator from trunk subcutaneous tissue and fascia, open approach
	0JPT3MZ	Removal of stimulator generator from trunk subcutaneous tissue and fascia, percutaneous approach
Generator Replacement	Two codes are required to identify a device replacement: one code for implantation of the new device and one code for removal of the old device.[3]	
Generator Revision[5,6]	**0JWT0MZ**	Revision of stimulator generator in trunk subcutaneous tissue and fascia, open approach
	0JWT3MZ	Revision of stimulator generator in trunk subcutaneous tissue and fascia, percutaneous approach
Lead Implantation[7]	**0DH60MZ**	Insertion of stimulator lead into stomach, open approach
	0DH64MZ	Insertion of stimulator lead into stomach, percutaneous endoscopic approach
Lead Removal[7]	**0DP60MZ**	Removal of stimulator lead from stomach, open approach
	0DP64MZ	Removal of stimulator lead from stomach, percutaneous endoscopic approach
Lead Replacement	Two codes are required to identify a device replacement: one code for implantation of the new device and one code for removal of the old device.[8]	
Lead Revision[7,9]	**0DW60MZ**	Revision of stimulator lead in stomach, open approach
	0DW64MZ	Revision of stimulator lead in stomach, percutaneous endoscopic approach

1. U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS). https://www.cms.gov/medicare/coding-billing/icd-10-codes. 2025 ICD-10-PCS files.
2. Body part value 8-Abdomen is shown because the Enterra® generator is typically placed into the subcutaneous tissue of the abdomen. Other body part values are also available for sites such as subcutaneous tissue of chest and subcutaneous tissue of back.
3. Device value D-Multiple Array Stimulator Generator is shown because Enterra® is a dual array non-rechargeable generator. See also the ICD-10-PCS Device Key. "Multiple array" includes dual array neurostimulator generators for which two leads are connected to one generator. Do not assign default value M-Stimulator Generator.
4. Placement of a neurostimulator generator is shown with the approach value 0 Open because creating the pocket requires surgical dissection and exposure. Removal also usually requires surgical dissection to free the device.
5. The ICD-10-PCS codes shown can be assigned for opening the pocket for generator revision, as well as reshaping or relocating the pocket while re-inserting the same generator. However, there are no ICD-10-PCS codes specifically defined for revising the subcutaneous portion of a lead. Because these services usually involve removing and re-inserting the generator as well, they can also be represented by the ICD-10-PCS generator revision codes.
6. Approach value X-External is also available for external generator manipulation without opening the pocket, e.g.. to correct a flipped generator.
7. Approach value 0-Open is used when lead procedures are performed via laparotomy and approach value 4 -Percutaneous Endoscopic is used when lead procedures are performed via laparoscopy.
8. Coding Clinic, 3rd Q 2014, pp.19-20.
9. For Lead Revision, the ICD-10-PCS codes refer to surgical revision of leads within the intra-abdominal space or gastric tissue, e.g.. repositioning. For revision of the subcutaneous portion of the lead, see Generator Revision.

Hospital Inpatient Coding and Payment

Medicare MS-DRG Assignments

Under Medicare's MS-DRG methodology for hospital inpatient payment, each inpatient stay is assigned to one diagnosis-related group (DRG), based on the ICD-10-CM diagnosis codes reported and ICD-10-PCS codes assigned to the procedures.

Only one MS-DRG is assigned for each inpatient stay, regardless of the number of procedures performed. The MS-DRGs shown are those typically assigned to the following scenarios.

Procedure	Scenario		MS- DRG[1]	MS-DRG Title[1,2]	Medicare National Rate[1]
Implantation or Replacement: Whole System	Generator plus leads	Diabetic gastroparesis	040	Peripheral/Cranial Nerve and Other Nervous System Procedures W MCC	$26,920
			041	Peripheral/Cranial Nerve and Other Nervous System Procedures W CC or Peripheral Neurostimulator	$16,116
			042	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	$12,543
		Idiopathic gastroparesis	981	Extensive OR Procedure Unrelated to Principal Diagnosis W MCC	$33,926
			982	Extensive OR Procedure Unrelated to Principal Diagnosis W CC	$17,472
			983	Extensive OR Procedure Unrelated to Principal Diagnosis W/O CC/ MCC	$11,905
Implantation or Replacement: Leads Only or Generator Only	Leads only (one or more) (either approach) or Generator only	Diabetic gastroparesis	040	Peripheral/Cranial Nerve and Other Nervous System Procedures W MCC	$26,920
			041	Peripheral/Cranial Nerve and Other Nervous System Procedures W CC or Peripheral Neurostimulator	$16,116
			042	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	$12,543
		Idiopathic gastroparesis	981	Extensive OR Procedure Unrelated to Principal Diagnosis W MCC	$33,926
			982	Extensive OR Procedure Unrelated to Principal Diagnosis W CC	$17,472
			983	Extensive OR Procedure Unrelated to Principal Diagnosis W/O CC/ MCC	$11,905
Removal (without replacement)	Whole system (generator plus leads) or Leads only (one or more)		040	Peripheral/Cranial Nerve and Other Nervous System Procedures W MCC	$26,920
			041	Peripheral/Cranial Nerve and Other Nervous System Procedures W CC or Peripheral Neurostimulator	$16,116
			042	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	$12,543
	Generator only		These codes are not considered "significant procedures" for the purpose of DRG assignment. A non-surgical (i.e., medical) DRG is assigned to the stay according to the principal diagnosis.		
Revision	Leads only (one or more)		981	Extensive OR Procedure Unrelated to Principal Diagnosis W MCC	$33,926
			982	Extensive OR Procedure Unrelated to Principal Diagnosis W CC	$17,472
			983	Extensive OR Procedure Unrelated to Principal Diagnosis W/O CC/MCC	$11,905
	Generator only		These codes are not considered "significant procedures" for the purpose of DRG assignment. A non-surgical (i.e., medical) DRG is assigned to the stay according to the principal diagnosis.		

1. Centers for Medicare and Medicaid Services. CMS 1808-CN and CMS-1808-IFC: Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals Final Rule, Correction Notice and Interim Final Action and Related Addenda. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-final-rule-home-page.
2. W MCC = with Major Complications and Comorbidities; W CC = with Complications and Comorbidities; W/O CC/MCC = without Complications and Comorbidities or without Major Complications and Comorbidities.

Physician Coding and Payment

CPT Procedure Codes

Under Medicare's Resource-Based Relative Value Scale (RBRVS) methodology for physician payment, each CPT code is assigned a point value, known as the relative value unit (RVU), which is then converted to a flat payment amount.

Procedure	CPT Code and Description[1]	Medicare Total RVUS[2]		Medicare National Rate[3]		Global Days Indicator[2-4]
		For Physician Services Provided In:[5]				
		Physician Office[6]	Facility	Physician Office[6]	Facility	
Generator Implantation or Replacement	**64590** Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	See note 8	8.87	See note 8	$287	010
Generator Revision or Removal	**64595** Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array	See note 8	6.94	See note 8	$224	010
Lead Implantation or Replacement, Laparoscopic	**43647** Laparoscopy, surgical, implantation or replacement of gastric neurostimulator electrodes, antrum[7]	—	Contractor Priced	—	Contractor Priced	YYY
Lead Revision or Removal, Laparoscopic	**43648** Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum[7]	—	Contractor Priced	—	Contractor Priced	YYY
Lead Implantation or Replacement, Open	**43881** Implantation or replacement of gastric neurostimulator electrodes, antrum, open[7]	—	Contractor Priced	—	Contractor Priced	YYY
Lead Revision or Removal, Open	**43882** Revision or removal of gastric neurostimulator electrodes, antrum, open[7]	—	Contractor Priced	—	Contractor Priced	YYY
Endoscopy (EGD)	**43235** Esophagogastroduodenoscopy, flexible, transoral, diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)[9]	8.54	3.65	$276	$118	000
Analysis/ Programming	**95980** Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter, intraoperative, with programming	N/A	1.34	N/A	$43	XXX
	95981 Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter, subsequent, without reprogramming	1.19	0.53	$38	$17	XXX
	95982 Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter, subsequent, with reprogramming	1.80	1.10	$58	$36	XXX

Note: According to CPT manual instructions, test stimulation during an implantation procedure is considered integral and cannot be coded separately as electronic analysis or programming. In addition, programming codes may be assigned as long as iterative adjustments to the parameters are made and assessed, regardless of whether the final settings are ultimately changed. See also CPT Assistant, February 2019, p.6. In the office, analysis and programming may be furnished by a physician, practitioner with an "Incident to" benefit, or auxiliary personnel under the direct supervision of the physician (or other practitioner), with or without support from a manufacturer's representative. The patient or payer should not be billed for services rendered by the manufacturer's representative. Contact your local contractor or payer for interpretation of applicable policies.

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2. Centers for Medicare and Medicaid Services. CMS-1807-F and CMS-4201-F5: Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule . . . Final Rule and Related Addenda. FR DOC # 2024-25382 (89 FR 97710). https://www.federalregister.gov/documents/2024/12/09/2024-25382/medicare-and-medicaid-programs-cy-2025-paymentpolicies-under-the-physician-fee-schedule-and-other. Published December 9, 2024.
3. Medicare national average payment is determined by multiplying the sum of the total RVUs by the conversion factor. The conversion factor for CY 2025 is $32.3465 per the current 2024 release of the PFS Relative Value File at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files. Final payment to the physician is adjusted by the Geographic Practice Cost Indices (GPCI). Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the payment amount shown.
4. Global Days Indicator shows either the length of the code's global period (0, 10, or 90 days) or how the global period may apply differently (XXX = the global concept does not apply; YYY = the global period is to be set by the contractor [for example, unlisted surgery codes]; ZZZ = code related to another service that is always included in the global period of the other service.)
5. 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 there.
6. "N/A" shown in Physician Office setting indicates that Medicare has not developed RVUs in the office setting because the service is typically performed in a facility (e.g., in a hospital). However, if the local Medicare contractor determines that it will cover the service in the office, then it is paid using the facility RVUs at the facility rate.
7. For Medicare, this is a contractor-priced code. Contractors establish the RVUs and the payment amount, as well as the global period, usually on an individual basis after review of the procedure report.
8. RVUs exist for this code in the office setting. However, the RVUs are not displayed because generator implantation and replacement customarily take place in the facility setting.
9. An EGD performed by a different physician, performed for distinct diagnostic purposes, or performed at a separate encounter from lead implantation may be coded separately. However, according to NCCI policy, an EGD should not be coded separately when performed during the same operative episode as lead implantation to assess the surgical field and anatomic landmarks, to ensure no intraoperative injury occurred, or to verify successful lead placement. NCCI Policy Manual, Effective 1/1/2025, Chapter I, B-Surgical-3 and Chapter VI, C.6.

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