Neuro Navigation System
2022 Coding and Reimbursement Guide

2022 CLEARPOINT® NAVIGATION SYSTEM CODING GUIDE

The ClearPoint® System is intended to provide stereotactic guidance for the placement and operation of instruments or devices during planning and operation of neurological procedures within the MRI environment and in conjunction with MR imaging. The ClearPoint System is intended as an integral part of procedures that have traditionally used stereotactic methodology. These procedures include biopsies, catheter and electrode insertion, including deep brain stimulation (DBS) lead placement. The System is intended for use only with 1.5 and 3.0 Tesla MRI scanners.

The coding information provided in this guide represent some of the more common CPT, ICD-10, and Diagnosis Related Groups (DRGs) that may be reported or assigned when procedures that have traditionally used stereotactic methodology are performed. It is not intended to be exhaustive list. The information provided is educational and not meant to be construed as a guarantee of coverage or payment.

Diagnosis Coding

ICD-10-CM	Descriptor
C71.0- C71.9	Malignant neoplasm of brain
D32.X	Benign neoplasm of meninges
D33.X	Benign neoplasm of brain and other parts of the central nervous system
D43.X	Neoplasm of uncertain behavior of brain and other parts of the central nervous system
D49.6	Neoplasm of unspecified behavior of brain
G12.20 – G12.29	Motor neuron disease
G20	Parkinson’s disease
G24.9	Dystonia, unspecified
G40.XXX	Epilepsy and recurrent seizures

Note: The place holder “X” is used to indicate that additional characters may be used to report a higher level of disease specificity. Providers should code to the highest level of specificity

For additional reimbursement support, please contact ClearPoint@thepinnaclehealthgroup.com or 866-369-9290

Procedure coding should be based upon medical necessity and procedures and supplies provided to the patient. All coding, coverage, billing, and payment information provided by ClearPoint Neuro, Inc. or The Pinnacle Health Group is gathered from third party sources and is subject to change without notice. This information is intended to serve as a general reference guide and does not constitute reimbursement or legal advice. For all coding, coverage and reimbursement matters or questions about the information contained in these materials, it is recommended that you consult with your payers, certified coders, reimbursement specialists, and/or legal counsel for further guidance. ClearPoint Neuro, Inc. and The Pinnacle Health Group do not guarantee that the use of any particular codes will result in coverage or payment. Coverage for procedures may vary by payor. It is recommended that providers verify coverage prior to date of service. This information may include some codes for procedures for which ClearPoint Neuro, Inc. currently offers no cleared or approved products. In those instances, such codes have been included solely in the interests of providing users with comprehensive coding information and are not intended to promote the use of any products. ClearPoint Neuro, Inc. does not promote the use of its products outside of their FDA-approved label.

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CPT Coding

CPT	Descriptor	MPFS Facility
61736	LITT of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion	$924.67
61737	LITT of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)	$1,101.52
61751	Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computed tomography and/or magnetic resonance guidance	$1,428.54
61850	Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical	$1,017.77
61860	Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral, cortical	$1,610.57
61863	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array	$1,550.36
61864	; each additional array (List separately in addition to primary procedure)	$288.27
64999	Unlisted procedure, nervous system	By Report
76498	Unlisted magnetic resonance procedure (e.g., diagnostic, interventional)	By Report
77290	Therapeutic radiology simulation-aided field setting; complex	$83.40
77334	Treatment devices, design and construction; complex	$60.91

Inpatient Procedure Coding

ICD-10-PCS	Descriptor
D0Y0KZZ	Laser Interstitial Thermal Therapy of Brain
D0Y6KZZ	Laser Interstitial Thermal Therapy of Brain Stem
00H00MZ	Insertion of Neurostimulator Lead into Brain, Open Approach
00H60MZ	Insertion of Neurostimulator Lead into Cerebral Ventricle, Open Approach
009 Series	Medical & Surgical, CNS & Cranial Nerves, Drainage
00K Series	Medical & Surgical, CNS & Cranial Nerves, Map
3E0Q — — —	Administration, Physiological Systems and Anatomical Regions, Cranial Cavity and Brain

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Inpatient Reimbursement

Diagnosis Related Group (DRG) assignment will be based upon principal diagnosis, specific secondary diagnoses (ICD-10-CM), procedures provided (ICD-10-PCS), sex, and discharge status reported to payer. LITT of the brain or brain stem may map to DRG 040, 041, or 042 depending on the combination of diagnoses and procedures reported.

DRG	Description	Payment
040	Peripheral, Cranial Nerve & Other Nervous System Procedures with CC Or Peripheral Neurostimulator with MCC	$25,172.27
041	Peripheral, Cranial Nerve & Other Nervous System Procedures with CC Or Peripheral Neurostimulator with CC	$15,304.10
042	Peripheral, Cranial Nerve & Other Nervous System Procedures with CC Or Peripheral Neurostimulator without CC/MCC	$12,382.92

References:

- CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; (CMS-1751-F); Addendum B. All MPFS Fee Schedules calculated using CF of $34.6062 effective January 1, 2022.
- DRG values calculated using a base rate of $6,040.63 and Capital Standard Payment of $472.59. The national average hospital Medicare base rate is an average of the sum of eight categories: For hospitals with a wage index above 1 and hospitals with a wage index below 1: Hospital Submitted Quality Data and is a Meaningful EHR User, Hospital Did NOT Submit Quality Data and is a Meaningful EHR User, Hospital Submitted Quality Data and is NOT a Meaningful EHR User, Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (see 2nd tab of this worksheet). This information is provided as a benchmark reference only. There is no official publication of the average hospital base rate; therefore, the national average payments provided are approximate. Actual reimbursement will vary by geographic region, status as a teaching facility, share of low-income patients, status of submitting quality data, status as a meaningful electronic health user, participation in the Hospital Value-Based Purchasing (VBP), and Hospital Readmissions Reduction Program (HRRP). Calculations were based on data provided in FY 2022 IPPS Final Rule CN (Tables 1A, 1D, and 5CN). ICD-10-CM Expert for Physicians 2021, ©2020 Optum360, LLC. All rights reserved
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