Vivistim®
by MicroTransponder Inc.

2026 Rehabilitation Billing Guide

MicroTransponder, Inc. offers reimbursement support and prior authorization assistance. Please contact the MicroTransponder Reimbursement Hotline at claims@microtransponder.com. The Vivistim® Paired VNS™ System is a PMA-approved (P210007), FDA Breakthrough Device (Q210050). The Vivistim® Paired VNS™ System is intended to be used to stimulate the vagus nerve during rehabilitation therapy in order to reduce upper extremity motor deficits and improve motor function in chronic ischemic stroke patients with moderate to severe arm impairment.1 This guide is for FDA approved indications only. Disclaimer: This document provides reimbursement information from third party sources, including the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS), and is for illustrative purposes only. Reimbursement regulations, laws and policies are updated frequently, which may or may not be reflected in this document. As a result, MicroTransponder, Inc. claims no liability or responsibility for the completeness or accuracy of the information contained in this document or any consequences that may result from its use. The information contained herein does not replace advice from insurers and/or from qualified coding staff. Responsibility for correct coding lies with the provider of services. Please contact your local payer(s) and/or qualified coding staff for interpretation of the appropriate codes to use for specific procedures.

Table of contents

Vivistim® Paired VNS™ Therapy Overview

This guide provides hospital and office-based coding and reimbursement information for rehabilitation services that are frequently provided to patients who have been implanted with the Vivistim® Paired VNS™ System, as well as device analysis and programming services.

The Vivistim® Paired VNS™ System is intended to be used to stimulate the vagus nerve during rehabilitation therapy to reduce upper extremity motor deficits and improve motor function in chronic ischemic stroke patients with moderate to severe arm impairment. The Vivistim® Paired VNS™ System when used as intended, provides a drug-free way to treat upper extremity motor deficits associated with a stroke by pairing rehabilitation movements with Vagus Nerve Stimulation.

Vivistim® Paired VNS™ Therapy

Upper Extremity Evaluation

- Fugl-Meyer Assessment
- Upper Extremity (FMA-UE)
- Assessment of ADLs/IADLs
- Evaluation of sensation, spasticity, other factors

Pre-Surgical Consultation

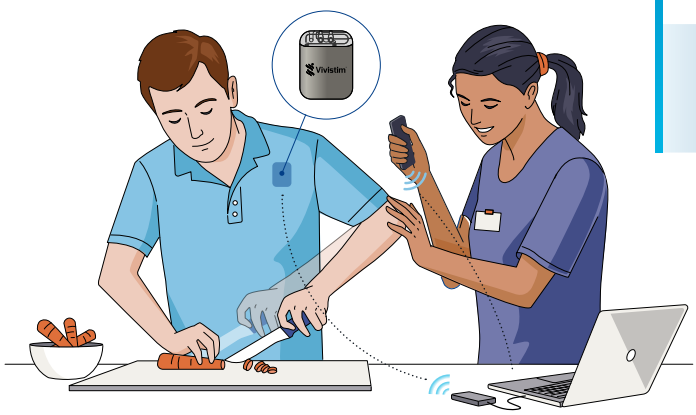
- History of present illness, medical and evaluation of comorbidities
- Stroke etiology, type and date
- Review of Upper Extremity Evaluation

Prior Authorization (if required)

- Secure prior authorization, predetermination, precertification.
- Verify rehabilitation benefits

Surgical Scheduling

- Approximately 60-minute procedure (typically same-day/outpatient surgery)
- Hospital or Ambulatory Surgery Center



Rehabilitation with Paired VNS™

- Establish therapy goals, create plan of care
- Approximately 18 outpatient therapysessions over 6 weeks
- Patients continue therapy at home, as prescribed

Typical Patient Encounter Overview

The following table lists the typical patient encounters required to complete Vivistim® Paired VNS Therapy and a description of some of the services that are commonly rendered during those encounters. Neither the list of patient encounters, nor the description of services commonly rendered are intended to be prescriptive. All services provided to patients should be medically necessary, meet standards of clinical practice and meet applicable State and Federal law.

1. Initial Upper Extremity Diagnostic Visit (Pre-Implant)

Initial visit to evaluate the extent of the patient's upper limb impairment and suitability for various treatment options.

- Fugl-Meyer Upper Extremity (FMA-UE)
- ADL and IADL documentation
- Physical therapy evaluation of upper limb function. Evaluation may include evaluation of spasticity, dysphasia, cognition, gait and/or balance.
- Patient personal history since stroke including level of disability, functional limitations,occupational limitations, assessment of activities of daily living
- History of motor recovery since stroke: Time since stroke and rehab history including (inpatient care, skilled nursing care, outpatient rehab, home health services, home modifications, durablemedical equipment, etc.)

2. In-Clinic Rehabilitation (Post Implant)

Example of Services Commonly Rendered

On the first visit after surgery, the therapist will typically conduct an evaluation following the patient's surgical change in status. This evaluation will utilize any standardized assessment tools, will establish treatment goals with the patient and will results in a plan of care, including the estimated duration and timing of therapy (18 sessions over 6 weeks for 90-mintues per session)

The therapy that is delivered during the plan of care will vary based on the patients' objectives, capabilities and progress. Therapy visits will often include the following:

- Therapeutic rehabilitation activities (neuromuscular reeducation, therapeutic activities, etc.) toimprove dynamic function, including proximal and/or distal functional tasks (i.e. reach and grasp, flip objects, gross movement tasks, strength training, endurance, etc.)
- Training and education toward home therapy including prescribed activities, duration, etc.
- Documentation of progress toward patient plan of care and/or modification of plan of care

Paired VNS™ Rehabilitation Therapy Coding

ICD-10-CM Diagnosis Codes

The following ICD-10-CM diagnosis codes are used to report upper limb deficit in patients who may be eligible to receive treatment with the Vivistim® Paired VNS™ System.

ICD-10-CM Code[1]	ICD-10-CM Description
I69.33	**Monoplegia of upper limb following cerebral infarction**
I69.331	Monoplegia of upper limb following cerebral infarction affecting right dominant side
I69.332	Monoplegia of upper limb following cerebral infarction affecting left dominant side
I69.333	Monoplegia of upper limb following cerebral infarction affecting right non-dominant side
I69.334	Monoplegia of upper limb following cerebral infarction affecting left non-dominant side
I69.339	Monoplegia of upper limb following cerebral infarction affecting unspecified side
I69.35	**Hemiplegia and hemiparesis following cerebral infarction**
I69.351	Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
I69.352	Hemiplegia and hemiparesis following cerebral infarction affecting left dominant side
I69.353	Hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side
I69.354	Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side

1. CMS CY2026 ICD-10-CM- Index.

Occupational Therapy Evaluation Coding

Patient screening and evaluation services may include both a physician therapy evaluation of a patient's upper limb deficit, as well as evaluation and management services to better understand a patient's personal and medical history. Occupational therapy evaluations and management services must be medically necessary and supported by medical record documentation.

CPT®Code[1]	Description
97165	**Occupational therapy evaluation, low complexity, requiring these components:** An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97166	**Occupational therapy evaluation, moderate complexity, requiring these components:** An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97167	**Occupational therapy evaluation, high complexity, requiring these components:** An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.
97168	**Re-evaluation of occupational therapy established plan of care, requiring these components:** An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.

Physical Therapy Evaluation Coding

Patient screening and evaluation services may include both a physician therapy evaluation of a patient's upper limb deficit, as well as evaluation and management services to better understand a patient's personal and medical history. Physical therapy evaluations and management services must be medically necessary and supported by medical record documentation.

CPT®Code[1]	Description
97161	**Physical therapy evaluation:** low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97162	**Physical therapy evaluation:** moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97163	**Physical therapy evaluation:** high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97164	**Re-evaluation of physical therapy established plan of care, requiring these components:** An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.

In-Clinic Rehabilitation Therapy (Post-Implant)

The following services are commonly performed during in-clinic Paired VNS™ rehabilitation therapy. Note that most rehabilitation therapy services are provided in 15-minute increments and require the use of modifiers to denote the type of therapy provided. Additional information about time-increment reporting and modifiers is provided in the section 'Billing for Timed Codes'.

CPT®Code[1]	Description
97110*	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112*	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97530*	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97535*	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes

*Time-based code reported in 15-minute increments.
1. CPT® is registered trademark of the american Medical associaton © 2026. all rights reserved.

In-Clinic Rehabilitation Therapy – Task Examples (Post-Implant)

Task Examples	Applicable Code(S)	Rationale
Reach, grasp, and release	**97110** **97112** **97535**	If exercise is intended to develop strength and endurance, code 97110. If exercise is intended to retrain motor control/coordination, code 97112. If exercise is tied to a functional activity (i.e., grasping for utensils), code 97535.
Simulated feeding activities	**97535**	Task aims to train and improve an activity of daily living.
Open/close container	**97535**	Task is tied to a functional activity.
Typing	**97535**	Task aims to train and improve an activity of daily living.
Putting on jewelry	**97530**	Task aims to train and improve an activity of daily living.
Removing & placing tape/sticky notes on a vertical surface	**97110**	Task aims to strengthen elbow and improve ROM.

Billing for Timed and Untimed Codes

When reporting services that are not defined by a specific timeframe (“untimed” codes), a unit of 1 is reported on the claim. For timed codes, services are reported based on the number of times the procedure is performed.

Counting Minutes for Timed Codes

Many rehabilitation sessions involve only a single timed service. In these cases, for any single timed service to be reported, it should be performed for equal to or greater than 8 minutes. The table below describes the rounding of reportable units based upon the total minutes of a single timed unit.

Billing Units	Procedure Times
1 Unit	≥ 8 minutes through 22 minutes
2 Unit	≥ 23 minutes through 37 minutes
3 Unit	≥ 38 minutes through 52 minutes
4 Unit	≥ 53 minutes through 67 minutes
5 Unit	≥ 68 minutes through 82 minutes
6 Unit	≥ 83 minutes through 97 minutes
7 Unit	≥ 98 minutes through 112 minutes
8 Unit	≥ 113 minutes through 127 minutes

Medically Unlikely Edits (MUEs)

MUEs represents the maximum number of units that are reported on a typical case; the Medicare Administrative Contractors use these edits to identify and deny claims with inappropriate number of units reported.

It is important to note that the absence of a published MUE does not mean that one does not exist.

CPT®Code[1]	MUE	
	Practitioner	Hospital
In-Clinic Visits		
97110	6	8
97112	4	6
97530	6	6
97535	8	8

1. CPT® is registered trademark of the american Medical associaton © 2026. all rights reserved

Therapy Modifier Reporting

Rehabilitation therapy services require the use of modifiers to denote the type of therapy service performed, therapy provided in whole or in part by a therapy assistant, and in circumstances when beneficiaries have reached their therapy thresholds for a calendar year. The following section provides a description of modifiers used in rehabilitation therapy for Vivistim® patients.

Therapy Modifiers – GO, GP

Therapy modifiers indicate the type of therapy service being provided and are required by Medicare to be reported. Therapy modifiers may be reported in any order. Therapeutic modalities may be combined throughout a plan of care, based on the individual needs of the patient.

Therapy Modifier	Services Delivered Under Outpatient Plan of Care
GO	Occupational Therapy
GP	Physical Therapy

Therapy Assistant Modifiers – CO/CQ
In some cases, patients are treated in whole or in part by an occupational therapy assistant (OTA) or physical therapy assistant (PTA). On these cases CMS has specific reporting rules and has reduced payments for physician and occupational therapy services furnished in whole or in part by an occupational therapy assistant (OTA) or physical therapy assistant (PTA). These services are denoted on claims with the CO or CQ modifier (see table below).

CMS requires these payment modifiers to be appended on claims for therapy services, alongside the GP and GO therapy modifiers which are used to indicate the services are furnished under a physical therapy or occupational therapy plan of care, respectively. Services are deemed to be provided in whole or in part when more than 10 percent of a service – whether timed or untimed – is furnished by the PTA or OTA. In these cases, the CO and CQ modifier are to be reported alongside the GO/GP modifiers.

Therapy Modifier	Services Delivered Under Outpatient Plan of Care
CO	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
CQ	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant

Section 53107 of the Bipartisan Budget Act of 2018 that requires CMS to make a reduced payment at 85 percent of the otherwise applicable payment amount based on the physician fee schedule (PFS) for physical therapy and occupational therapy services when they are furnished in whole or in part by a PTA or OTA for dates of service on and after January 1, 2022.

Medicare Outpatient Therapy Thresholds - Per-Beneficiary KX Modifier Thresholds

The Centers for Medicare and Medicaid Services (CMS) eliminated annual “therapy caps” on rehabilitation in 2018 through the Bipartisan Budget Act (BBA) of 2018.

Going forward, CMS established therapy thresholds for medically necessary therapy services. Medically necessary services provided above the thresholds, should be justified by appropriate documentation in the medical record and billed with the KX modifier. Note that there are separate annual thresholds for PT/SLP and for OT services provided in a calendar year.

Therapy Type	2025 Threshold	2026 Threshold
Physical and Speech Therapy (PT and SLP) Combined	$2,410	$2,480
Occupational Therapy (OT)	$2,410	$2,480

Medicare will deny claims for therapy services above these amounts without the KX modifier.

Targeted Medical Review

In addition to the modifier KX outpatient therapy thresholds, CMS has established a Targeted Medical Review process when per-beneficiary outpatient therapy exceeds $3,000 in a calendar year. Targeted Medical Review is intended to reduce improperpayments for services that are not medically necessary. Not all claims over the $3,000 threshold will be reviewed.

Targeted Medical Review is performed on a claim-by-claim basis, typically through an Additional Documentation Request (ADR). If an ADR is requested under a Targeted Medical Review, providers are instructed to submit medical record documentation, which will include the plan of care and last progress note with a justification for why the therapy threshold exception.

Noridian Healthcare Solutions, Inc. was selected as the supplemental medical review contractor to initiate Targeted Medical Review for outpatient therapy services. When submitting documentation under an ADR, be sure to include the rationale for medical necessity, including:

- A summary of the patient's level of disability and diagnoses, including impacts to activities of dailyliving, employment and quality of life
- A description of the services provided, including their type, frequency, and duration.
- An explanation of why the services have exceeded pre-determined thresholds and why the additional services are necessary to improve the patient’s upper limb function.

In general, targeted medical review is intended to prospectively verify the medical necessity for patients whose per-beneficiary outpatient therapy has exceeded $3,000 in a calendar year. Proper medical record documentation and a clear rationale for the reasonable and necessary services provided that exceed that amount will be sufficient.

Device Analysis and Programming Reporting

In some cases, it may be necessary for an occupational or rehabilitation therapist to perform interrogation and/or programming of the Vivistim® Paired VNS™ System. The following section provides commonly reported billing codes for interrogation and/or programming of the Vivistim® System.

ICD-10-CM Diagnosis Codes

The following ICD-10-CM diagnosis codes are used to report upper limb deficit in patients who may be eligible to receive treatment with the Vivistim® Paired VNS™ System. A secondary diagnosis code of Z45.42 (see below) should be reported for encounters for the purpose of interrogating or programming of the Vivistim® Paired VNS™ System.

ICD-10-CM Code[1]	ICD-10-CM Description
Primary Diagnosis Code	
I69.33	**Monoplegia of upper limb following cerebral infarction**
I69.331	Monoplegia of upper limb following cerebral infarction affecting right dominant side
I69.332	Monoplegia of upper limb following cerebral infarction affecting left dominant side
I69.333	Monoplegia of upper limb following cerebral infarction affecting right non-dominant side
I69.334	Monoplegia of upper limb following cerebral infarction affecting left non-dominant side
I69.339	Monoplegia of upper limb following cerebral infarction affecting unspecified side
I69.35	**Hemiplegia and hemiparesis following cerebral infarction**
I69.351	Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
I69.352	Hemiplegia and hemiparesis following cerebral infarction affecting left dominant side
I69.353	Hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side
I69.354	Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side
Primary Diagnosis Code	
Z45.42	Encounter for adjustment and management of neurostimulator

1. CMS CY2026 ICD-10-CM- Index

Device Analysis and Programming Reporting

The following procedures may be used to describe device analysis and programming. It is not appropriate to report these services during the operative encounter.

Device analysis and programming services are reportable only after (e.g., subsequent to) the implant procedure. Device programming is described as either simple (95976) or complex (95977). Simple programming describes the adjustment of 3 or fewer device parameters. The Vivistim® Paired VNS™ System will only be programmed using 3 or fewer parameters.

CPT® Code[1]	Code Description
Device Analysis	
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., 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
Device Programming	
95976	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., 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 cranial nerve neurostimulator pulse generator/ transmitter programming by physician or other qualified health care professional.

1. CPT® is registered trademark of the american Medical associaton © 2026. all rights reserved

Billing for Device Analysis and Programming

Device interrogation and programming services are reportable by therapist providers who bill under their individual National Provider Identifier. Therapists billing under a group practice NPI will be denied payment.

Medicare Payment Amounts for Therapy Services

The following section includes Medicare Physician Fee Schedule (MPFS) payment amounts for therapy services commonly provided to Vivistim® Paired VNS™ Therapy patients, with payment amounts listed for each unit of service.

		Status Indicator and RVU			Freestanding Clinic
CPT® Code[1]	CPT Short Description	MPFS SI	Work RVU	Total RVU	2026 Medicare National Average Payment[2]
Occupational Therapy Evaluation Visits					
97165	Occupational therapy evaluation, low complexity	A	1.54	3.01	$101
97166	Occupational therapy evaluation, moderate complexity	A	1.54	3.01	$101
97167	Occupational therapy evaluation, high complexity	A	1.54	3.01	$101
97168	Re-evaluation of occupational therapy established plan of care	A	0.96	2.05	$69
Physical Therapy Evaluation Visit(s)					
97161	PT eval – low complexity (20 min)	A	1.54	2.94	$99
97162	PT eval – moderate complexity (30 min)	A	1.54	2.94	$99
97163	PT eval – high complexity (45 min)	A	1.54	2.94	$99
97164	PT re-evaluation (20 min)	A	1.54	2.02	$68
In-Clinic Therapy Visits Services					
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	A	0.45	0.87	$29
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	A	0.50	0.98	$33
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	A	0.44	1.05	$35
97535	Self-care/home management training (eg, activities of daily living and compensatory training, meal preparation, safety procedures, and instruction in the use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes.	A	0.45	0.97	$33
Device Analysis & Programming					
95970	Device analysis only, without programming (not at the time of generator implantation)	A	0.35	0.59	$20
95976	Device analysis and simple programming	A	0.71	1.14	$38.27

1. CMS CY2026 MPFS Final Rule Addendum B and RBRVS. 2. Payment calculated using 2026 qualifying APM CF $33.57.
Please note: Hospital reimbursement rates vary depending on if provider is hospital outpatient based

If you experience a denied claim, underpayment, or receive a remittance advice or explanation of benefits that does not show a fully adjudicated claim, **please contact the MicroTransponder Reimbursement Hotline at claims@microtransponder.com for assistance.**

Vivistim®
by MicroTransponder Inc.