



CODMAN® 3000

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CONTINUOUS QUALITY

CODING SHEETS

CHRONIC INTRACTABLE PAIN MANAGEMENT

Effective January 1, 2009

CODMAN® 3000 NEUROMODULATION AND ONCOLOGY REIMBURSEMENT HOTLINE



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CHRONIC INTRACTABLE PAIN MANAGEMENT

PHYSICIAN SERVICES – CY 2009 MEDICARE REIMBURSEMENT¹

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NOTE: Physicians have a code to use for implantable pump refills: 95991 [Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); **administered by physician**]. This code is **specific to a physician** performing the services, in contrast to 95990 [Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular)] for which a professional other than a physician is expected to perform the services. As with other infusion pump refill and maintenance codes, this code is not payable when performed in an ASC.

Note: When performing multiple procedures, review current correct coding guidelines carefully. Services that are considered a component of another procedure cannot always be coded and billed separately. Medicare's Correct Coding Initiative is reviewed and updated several times a year. Commercial payer policies vary and should be consulted and reviewed thoroughly on a regular basis.

SCREENING TRIAL²

Code	Code Description	Medicare Phys Fee Schedule ³		Global Days ⁴
		Non-Facility (Phys Office)	Facility (Non-Phys Office)	
62310	Injection, single (not via indwelling catheter), not including neurolytic substances, w/ or w/o contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, other solution), epidural or subarachnoid; cervical or thoracic	\$199.09	\$95.22	000
62311	Injection, single (not via indwelling catheter), not including neurolytic substances, w/ or w/o contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)	\$175.64	\$78.99	000
Non-Tunneled Catheter				
62318	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic	\$212.79	\$95.58	000
62319	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)	\$192.60	\$89.45	000
Tunneled Catheter				
62350	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; w/o laminectomy	Not typically performed in this site of service	\$364.63	010
62351	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump w/ laminectomy		\$770.02	090

PHYSICIAN SERVICES (continued)

SCREENING TRIAL (continued)²

Code	Code Description	Medicare Phys Fee Schedule ³		Global Days ⁴
		Non-Facility (Phys Office)	Facility (Non-Phys Office)	
Other Services				
64999	Unlisted procedure, nervous system	Carrier Determined		
72275-26*	Epidurography, radiological supervision and interpretation	\$104.59 (Global)	\$36.43 (-26, Professional)*	N/A
72265-26*	Myelography, lumbosacral, radiological supervision and interpretation	\$147.15 (Global)	\$42.20 (-26, Professional)*	N/A
77003-26*	Fluoroscopic guidance & localization of needle or catheter tip for spine of paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal, epidural, subarchnoid, paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint), including neurolytic agent destruction	\$59.15 (Global)	\$28.13 (-26, Professional)*	N/A

*Modifier -26 (aka –PC) should be used when billing for the professional component of a service.

IMPLANTATION OF PUMP⁵

Code	Code Description	Medicare Phys Fee Schedule ³		Global Days ⁴	
		Non-Facility (Phys Office)	Facility (Non-Phys Office)		
Implanted Catheter					
62350	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter... w/o laminectomy	Not typically performed in this site of service	\$364.63	010	
62351	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter...with laminectomy		\$770.02	090	
Non-Programmable Pump					
62361	Implantation or replacement of device for intrathecal or epidural drug infusion; non-programmable pump		\$360.67	010	
Programmable Pump					
62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming		\$384.47	010	
Other Services					
76000-26*	Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)	\$8.66 (-26, Professional)*	N/A		
76001-26*	Fluoroscopy, physician time more than one hour, assisting a non-radiologic physician	\$34.98 (-26, Professional)*	N/A		
72265-26*	Myelography, lumbosacral, radiological supervision and interpretation	\$42.20 (-26, Professional)*	N/A		

*Modifier -26 (aka –PC) should be used when billing for the professional component of a service.

PHYSICIAN SERVICES (continued)

REFILL AND MAINTENANCE

Code	Code Description	Medicare Phys Fee Schedule ³		Global Days ⁴
		Non-Facility (Phys Office)	Facility (Non-Phys Office)	
Non-Programmable Pump Only				
64999	Unlisted procedure code, nervous system (e.g., bolus injections)	Carrier Determined		
Programmable Pump Only				
62367	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming	\$35.71	\$22.72	N/A
62368	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming	\$51.21	\$35.71	N/A
Refill and Maintenance of Implanted Pump				
95990	Refilling & maintenance of implantable pump...for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular);	\$58.43	\$58.43	N/A
95991	Refilling & maintenance of implantable pump...for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); administered by physician	\$86.56	\$36.43	N/A
A4220 ⁶	Refill kit for implantable infusion pump	Refer to Carrier-specific policies	N/A	N/A
J2275 -KD ^{7,8}	Injection, Morphine Sulfate (preservative free), per 10 mg	\$4.39/10 mg	N/A	N/A
J3490 -KD ^{7,7}	Unclassified Drugs	Based on Invoice		N/A
J7799-KD ^{7,7}	NOC drugs, other than inhalation drugs, administered through DME	Refer to Carrier-specific policies		N/A

EXPLANTATION OF PUMP OR CATHETER

Code	Code Description	Medicare Phys Fee Schedule ³		Global Days ⁴
		Non-Facility (Phys Office)	Facility (Non-Phys Office)	
62355	Removal of previously implanted intrathecal or epidural catheter	\$273.02	\$273.02	010
62365	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion	\$302.96	\$302.96	010

CHRONIC INTRACTABLE PAIN MANAGEMENT

OUTPATIENT FACILITIES

CY 2009 OUTPATIENT HOSPITAL AND CY 2009 ASC MEDICARE REIMBURSEMENT

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SCREENING TRIAL		OUTPATIENT HOSPITAL ⁹				AMBULATORY SURGERY CENTER ⁹	
Code	Code Description	APC Group	APC Descriptor	APC Payment	*Status Indicator	*Payment Indicator	ASC Payment Rate
62310	Injection, single (not via indwelling catheter), not including neurolytic substances, w/ or w/o contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, other solution), epidural or subarachnoid; cervical or thoracic	0207	Level III Nerve Injections	\$473.78	T	A2	\$307.09
62311	Injection, single (not via indwelling catheter), not including neurolytic substances, w/ or w/o contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)	0207	Level III Nerve Injections	\$473.78	T	A2	\$307.09
Non-Tunneled Catheter							
62318	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic	0207	Level III Nerve Injections	\$473.78	T	A2	\$307.09
62319	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)	0207	Level III Nerve Injections	\$473.78	T	A2	\$307.09

***Status/Payment Indicator Key:** A2= ASC payment based on OPSS rate; H8= Device-intensive procedure; K& K2= Drug/biological paid separately; N & N1= Packaged item/service, not separately paid; Q1 & Q2= Conditionally paid; S= Significant procedure, not discounted when multiple; T= Procedure discounted when multiple; X= Ancillary service; Y= Not implantable Durable Equipment – not paid under OPSS

January 2009

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OUTPATIENT FACILITIES (continued)

SCREENING TRIAL		OUTPATIENT HOSPITAL ⁹				AMBULATORY SURGERY CENTER ⁹	
Code	Code Description	APC Group	APC Descriptor	APC Payment	*Status Indicator	*Payment Indicator	ASC Payment Rate
Tunneled Catheter							
62350	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; w/o laminectomy	0224	Implantation of Catheter / Reservoir / Shunt	\$2,777.19	T	A2	\$1,065.88
62351	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump w/ laminectomy	0208	Laminotomies & Laminectomies	\$3,210.92	T	N/A	Not payable in the ASC
Other Services							
64999	Unlisted procedure, nervous system	0204	Level I Nerve Injections	\$164.30	T	N/A	Not payable in the ASC
72275	Epidurography, radiological supervision and interpretation	N/A	N/A	N/A	N	N1	Not Separately Paid
72265	Myelography, lumbosacral, radiological supervision and interpretation	0274	Not separately paid if performed at the same time as another T status procedure; see below if payable		Q2		
			Myelography	\$475.26			
77003	Fluoroscopic guidance & localization of needle or catheter tip for spine of paraspinal diagnostic or therapeutic injection procedures (epidural, transforaminal, epidural, subarchnoid, paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint), including neurolytic agent destruction	N/A	N/A	N/A	N		
E0781	Ambulatory infusion pump... worn by pt (external)	N/A	N/A	N/A	Y	N/A	Submit invoice with claim ¹⁰
J2275-KD ^{7,7}	Injection, Morphine Sulfate (preservative-free), per 10 mg	N/A	N/A	N/A	N	N1	Not Separately Paid
J3490-KD ^{7,7}	Unclassified Drugs	N/A	N/A	N/A	N	N/A	Not payable in the ASC
J7799-KD ^{7,7}	NOC drugs, other than inhalation drugs, administered through DME	N/A	N/A	N/A	N		

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OUTPATIENT FACILITIES (continued)

IMPLANTATION OF PUMP AND CATHETER ⁵		OUTPATIENT HOSPITAL ⁹				AMBULATORY SURGERY CENTER ⁹	
Code	Code Description	APC Group	APC Descriptor	APC Payment	*Status Indicator	*Payment Indicator	ASC Payment Rate
Implanted Catheter							
62350	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; w/o laminectomy	0224	Implantation of Catheter / Reservoir / Shunt	\$2,777.19	T	A2	\$1,065.88
62351	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump w/ laminectomy	0208	Laminotomies/ Laminectomies	\$3,210.92	T	N/A	Not payable in the ASC
Non-Programmable Pump							
62361	Implantation or replacement of device for intrathecal or epidural drug infusion; non-programmable pump	0227	Implantation of Drug Infusion Device	\$12,282.40	T	H8	\$10,941.40
Programmable Pump							
62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming	0227	Implantation of Drug Infusion Device	\$12,282.40	T	H8	\$10,941.40
Other Services							
76000	Fluoroscopy (separate procedure), up to 1 hr physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)	0272	Not separately paid if performed at the same time as another S, T, V, or X status procedure; see below if payable		Q1	N1	Not Separately Paid
			Level I Fluoroscopy	\$83.21			
76001	Fluoroscopy, physician time more than one hour, assisting a non-radiologic phys (eg,.. ERCP, transbronchial biopsy)	N/A	N/A	N/A	N		
72265	Myelography, lumbosacral, radiological supervision and interpretation	0274	Not separately paid if performed at the same time as another T status procedure; see below if payable		Q2		
			Myelography	\$475.26			
E0782-KF ¹¹ (C1891 & C1755 if OPPS ¹²)	Infusion pump, implantable, non-programmable (includes all components, e.g., pump, catheter, connectors, etc.)	N/A	N/A	N/A	N	N1	Not Separately Paid ¹⁰

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OUTPATIENT FACILITIES (continued)

IMPLANTATION OF PUMP AND CATHETER ⁵		OUTPATIENT HOSPITAL ⁹				AMBULATORY SURGERY CENTER ⁹	
Code	Code Description	APC Group	APC Descriptor	APC Payment	*Status Indicator	*Payment Indicator	ASC Payment Rate
Other Services (cont)							
J2275-KD ^{7.7}	Injection, Morphine Sulfate (preservative-free), per 10 mg	N/A	N/A	N/A	N	N1	Not Separately Paid
J3490-KD ^{7.7}	Unclassified Drugs	N/A	N/A	N/A	N	N/A	Not payable in the ASC
J7799-KD ^{7.7}	NOC drugs, other than inhalation drugs, administered through DME	N/A	N/A	N/A	N		

REFILL AND MAINTENANCE		OUTPATIENT HOSPITAL ⁹				AMBULATORY SURGERY CENTER ⁹	
Code	Code Description	APC Group	APC Descriptor	APC Payment	*Status Indicator	*Payment Indicator	ASC Payment Rate
95990	Refilling & maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular);	0440	Level V Drug Administration	\$187.96	S	N/A	Not payable in the ASC
95991	Refilling & maintenance of implantable pump or reservoir for drug delivery, spinal...; administered by physician	0440	Level V Drug Administration	\$187.96	S		
A4220 ⁶	Refill kit for implantable infusion pump	N/A	N/A	N/A	N		
J2275-KD ^{7.7}	Injection, Morphine Sulfate (preservative-free), per 10 mg	N/A	N/A	N/A	N		
J3490-KD ^{7.7}	Unclassified Drugs	N/A	N/A	N/A	N		
J7799-KD ^{7.7}	NOC drugs, other than inhalation drugs, administered through DME	N/A	N/A	N/A	N		

EXPLANTATION OF PUMP OR CATHETER		OUTPATIENT HOSPITAL ⁹				AMBULATORY SURGERY CENTER ⁹	
Code	Code Description	APC Group	APC Descriptor	APC Payment	*Status Indicator	*Payment Indicator	ASC Payment Rate
62355	Removal of previously implanted intrathecal or epidural catheter	0203	Level IV Nerve Injections	\$949.39	T	A2	\$507.49
62365	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion	0221	Level II Nerve Procedures	\$2,375.49	T	A2	\$943.17

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CHRONIC INTRACTABLE PAIN MANAGEMENT

INPATIENT HOSPITAL – FY2009 MEDICARE REIMBURSEMENT

COMMON MS-DRGS FOR TRIALING & IMPLANTATION OF INFUSION PUMP TO TREAT CHRONIC PAIN

MS DRG	MS-DRG Description MCC= Major Complication/Comorbidity CC= Complication/Comorbidity	FY 2009 Medicare Natl Avg MS-DRG Payment ¹³
028	Spinal Procedures with MCC	\$26,606
029	Spinal Procedures with CC or Spinal Neurostimulator	\$14,319
030	Spinal Procedures without CC/MCC	\$7,884
040	Peripheral & Cranial Nerve & Other Nervous System Procedures with MCC	\$20,316
041	Peripheral & Cranial Nerve & Other Nervous System Procedures with CC or Peripheral Neurostimulator	\$11,027
042	Peripheral & Cranial Nerve & Other Nervous System Procedure without CC/MCC	\$8,583
073	Cranial & Peripheral Nerve Disorders with MCC	\$6,702
074	Cranial & Peripheral Nerve Disorders without MCC	\$4,314
515	Other Musculoskeletal System & Connective Tissue O.R. Procedure with MCC	\$15,716
516	Other Musculoskeletal System & Connective Tissue O.R. Procedure with CC	\$9,265
517	Other Musculoskeletal System & Connective Tissue O.R. Procedure without CC/MCC	\$6,810
551	Medical Back Problems with MCC	\$7,850
552	Medical Back Problems without MCC	\$3,920
490	Back and Neck Procedures Except Spinal Fusion with CC/MCC or Disc Device / Neurostimulator	\$8,815
491	Back and Neck Procedures Except Spinal Fusion without CC/MCC	\$4,806

ICD-9-CM PROCEDURE CODES THAT SUPPORT TRIALING AND IMPLANTATION OF INFUSION PUMP AND CATHETER

ICD-9-CM Procedure Code ¹⁴	Description
86.06	Insertion of totally implantable infusion pump (code also any associated catheterization)
03.90	Insertion of catheter into spinal canal for infusion of therapeutic or palliative substances (code also any implantation of infusion pump)
03.92	Injection of other agent into spinal cord

REFERENCES

- ¹ Non-Medicare payment rates may vary from the Medicare Physician Fee Schedule and will be based on the physician's negotiated contract with the payer. For specific reimbursement rates, we recommend contacting the patient's payer.
- ² Medicare considers 62310 – 62319 to be component procedures of the 62350 and 62351 and therefore cannot be separately coded; third party payers should be contacted for their rules.
- ³ Physician national reimbursement levels are based on the Medicare Physician Fee Schedule as published in the Medicare Program: Revisions to Payment Policies, etc.; Final Rule *Federal Register*, November 29, 2008, Medicare Program; Payment Policies under the Physician Fee Schedule, and Other Revisions to Part B for CY 2009.
- ⁴ Physician Global Period is based on the Medicare Physician Fee Schedule as published in the Medicare Program: Revisions to Payment Policies, etc.; Final Rule *Federal Register*, November 29, 2008, Medicare Program; Payment Policies under the Physician Fee Schedule, and Other Revisions to Part B for CY 2009.
- ⁵ In addition to reporting codes 62350 or 62351, the provider(s) must also report 62361 (non-programmable pump) or 62362 (programmable pump). Provider(s) may also report the 62361 or 62362 separately if the procedure involves the replacement or implantation of a pump or reservoir, or if the procedure is performed by a separate provider.
- ⁶ Many Medicare policies state that a refill kit for the refill of an implanted infusion pump (A4220) is not separately payable to any provider in any place of service. Payment for A4220 is bundled into 95990 or 95991. Patients may not be billed for this service, even with a properly completed Advance Beneficiary Notice (ABN). Third-party payers should be contacted for their rules.
- ⁷ Drugs (e.g. morphine sulfate) provided by provider must represent a cost to the provider and be incident to the services provided to be considered for reimbursement. If provided to a Medicare beneficiary in the hospital setting, the hospital must be the entity to bill Medicare.
- ⁸ Effective January 1, 2004, the "KD" modifier should be added to the codes for drugs that are not paid on a cost or prospective payment basis and are infused through Durable Medical Equipment (DME) as posted in the 2004 Quarterly Update from the National HCPCS Panel, 1/23/2004, CMS Transmittal 54 dated December 24, 2003, and Medlearn Matters Number MM3105 dated January 30, 2004.
- ⁹ Outpatient Hospital and Ambulatory Surgery Center national reimbursement levels are based on the Medicare Outpatient Prospective Payment System and Ambulatory Surgery Center Payment System as published in the Medicare Program—Changes to the Hospital Outpatient Prospective Payment System and CY 2009 Payment Rates; Changes to the Ambulatory Surgical Payment System and CY 2009 Payment Rates...Final Rule *Federal Register*, November 18, 2008.
- ¹⁰ Certain Hospitals or ASCs that are enrolled as Durable Medical Equipment providers with the Medicare program may be able to bill separately for specific Durable Medical Equipment items such as the trial catheter and external infusion pump. We recommend the Hospital or ASC contact their Local Medicare Contractors (Part B Carrier and the DME Regional Carrier [DMERC]) to clarify if benefits will be provided separate from and in addition to the base Hospital or ASC payment schedule. The Hospital or ASC payment for the implantation of a pump is all inclusive (including the implanted pump and associated supplies), with the exception of physician professional services, which are reimbursed separately to the physician. Payment for the implanted pump and supplies is packaged into the Hospital or ASC's payment for the implantation procedure.
- ¹¹ The -KF Modifier indicates an item designated by FDA as Class III Device and must be used, if appropriate, on all Medicare claims with dates of service on or after January 1, 2004. For additional information see CMS One-Time Notification R350TN, dated December 24, 2003 with an implementation date of April 1, 2004.
- ¹² Based upon the OPPTS Final Rule for CY2005 (*Federal Register* November 15, 2004), hospitals must use "C" codes on Medicare claims for outpatient procedures.
- ¹³ Inpatient national reimbursement levels are based on the Medicare Inpatient Prospective Payment System as published in the 08/19/07 *Federal Register* (Medicare Program: Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates; Final Rule...). National payment estimates are determined using the book *DRG Expert, 2009 Edition*, published by Ingenix, Inc. The following information is directly cited from *DRG Expert, 2009 Edition, Appendix E*, "The national average payment for each DRG is calculated by multiplying the current relative weight of the DRG by the ESTIMATED national average hospital Medicare base rate. That estimated average hospital base rate is adjusted annually using information gathered by Ingenix, Inc. and the information published in the *Federal Register* ('Medicare Program; Changes to the Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates; Final Rule'). 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 in this table are approximate".
- ¹⁴ 2009 ICD-9-CM Expert for Hospitals Volumes 1, 2, and 3; published by Ingenix, Inc.