



Medtronic

Intrathecal Drug Delivery

For Chronic Pain

Hospital Commonly Billed Codes

October 2009

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Coverage and Authorization Services is available to respond to your coding questions at 800-292-2903.

ICD-9-CM Diagnosis Codes

Diagnosis codes are used by both physicians and hospitals to document the indication for the procedure. Intrathecal drug delivery is directed at managing chronic, intractable pain. Pain can be coded and sequenced several ways depending on the documentation and the nature of the encounter.

Codes from the 338 series can be used as the principal diagnosis when the encounter is for pain control or pain management, rather than for management of the underlying condition. Additional codes may then be assigned to give more detail about the nature and location of the pain and its underlying cause.

When a specific pain disorder is not documented or the encounter is to manage the cause of the pain, the underlying condition is coded and sequenced as the principal diagnosis.

Chronic Pain Disorders	338.0	Central pain syndrome
	338.29	Other chronic pain
	338.3	Neoplasm-related pain (cancer pain)
	338.4	Chronic pain syndrome
Note: Pain must be specifically documented as “chronic” to use code 338.29. Similarly, the diagnostic term “chronic pain syndrome” must be specifically documented to assign code 338.4. If these terms are not documented, then other symptom codes for pain may be assigned instead. However, they cannot be sequenced as principal diagnosis. Rather, the underlying condition would ordinarily be used as the principal diagnosis in this circumstance.		
Reflex Sympathetic Dystrophy and Causalgia	337.22	Reflex sympathetic dystrophy of the lower limb (complex regional pain syndrome type I)
	355.71	Causalgia of the lower limb (complex regional pain syndrome type II)
Note: Complex regional pain syndrome not specified by type defaults to type I, reflex sympathetic dystrophy. Codes from the 338 series should not be assigned with causalgia or reflex sympathetic dystrophy because pain is a known component of these disorders.		

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ICD-9-CM Diagnosis Codes *continued*

Underlying Causes of Chronic Non-Cancer Pain	053.12 – 053.13	Postherpetic neuralgia
	322.2	Arachnoiditis, chronic
	322.9	Arachnoiditis, other and unspecified
	353.6	Phantom limb syndrome
	355.8	Peripheral neuropathy of lower limb
	722.10	Radiculitis due to herniated disc, lumbar
	722.52	Radiculitis due to degenerative disc disease, lumbar
	722.83	Postlaminectomy syndrome, lumbar region (failed back syndrome)
	724.4	Radicular syndrome of lower limbs
	733.13 plus 733.0X	Collapsed vertebra (pathologic fracture) due to osteoporosis
Underlying Causes of Cancer Pain	150.0 – 150.9	Esophageal cancer
	151.0 – 151.9	Stomach cancer
	153.0 – 154.8, 197.5	Colon and rectal cancer
	155.0, 197.7	Liver cancer
	157.0 – 157.9	Pancreatic cancer
	162.0 – 162.9, 197.0	Lung cancer
	170.0 – 170.9, 198.5	Bone cancer
	174.0 – 174.9	Breast cancer
	180.0 – 180.9	Cervical cancer
	182.0 – 182.8	Uterine cancer
	183.0, 198.6	Ovarian cancer
	185	Prostate cancer
	186.0 – 186.9	Testicular cancer
	188.0 – 188.9, 198.1	Bladder cancer
	189.0 – 189.1, 198.0	Kidney cancer
	191.0 – 192.9, 198.3	Brain and spinal cord cancer
733.13 plus 170.X or 198.5	Pathological fracture due to bone cancer	
Attention to Device¹	V53.09	Fitting and adjustment of devices related to nervous system

1. Code V53.09 is used as the principal diagnosis when patients are seen for routine device replacement and maintenance. A secondary diagnosis code is then used for the underlying condition.

ICD-9-CM Procedure Codes

Hospitals use ICD-9-CM procedure codes for inpatient services.

Catheter Insertion	03.90	Insertion of catheter into spinal canal for infusion of therapeutic or palliative substances
Intrathecal Injection	03.92	Injection of other agent into spinal canal
Pump Implantation	86.06	Insertion of totally implantable pump
Pump Removal	86.05	Incision with removal of foreign body or device from skin or subcutaneous tissue
Catheter Removal (surgical)	03.99	Other operation on spinal cord and spinal canal structures

HCPCS II Device and Drug Codes

These codes are used by the entity that purchased and supplied the medical device, DME, drug, or supply to the patient. For implantable devices, that is typically the facility. For specific Medicare hospital outpatient billing instructions for Medicare devices, see the Device C-Codes for Medicare.

Entire System (Catheter and Programmable Pump)	E0783	Infusion pump system, implantable, programmable (includes all components, e.g., pump, catheters, connectors, etc.)
Entire System (Catheter and Non-programmable Pump)	E0782	Infusion pump system, implantable, non-programmable (includes all components, e.g., pump, catheters, connectors, etc.)
Programmable Pump only (replacement)	E0786	Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter)
Intraspinal Catheter only (replacement)	E0785	Implantable intraspinal (epidural/intrathecal) catheter used with implantable infusion pump, replacement
Preservative-Free Morphine Sulphate	J2275	Injection, morphine sulfate (preservative-free sterile solution), 10 mg
Prialt® (ziconotide intrathecal infusion)	J2278	Injection, Ziconotide, 1 mcg
Refill Kit	A4220	Refill kit for implantable infusion pump
Personal Therapy Manager (myPTM), SynchroMed® II¹	A9900	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code, for replacement only

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1. The CMS HCPCS Workgroup maintains that the PTM is included as a component of E0783 when the system is initially implanted. If the PTM must later be replaced, code A9900 is assigned.

Device C-Codes (Medicare)

Hospitals assign C-codes when billing Medicare for medical devices in the outpatient setting. Although other payers may also accept C-codes, regular HCPCS II device codes are generally used for billing non-Medicare payers. For Medicare, billing C-codes is mandatory for medical devices utilized in the hospital outpatient setting.

Infusion Pump	C1772	Infusion pump, programmable, implantable
	C1891	Infusion pump, non-programmable, permanent, implantable
Intrathecal Catheter	C1755	Catheter, intraspinal

Device Edits (Medicare)

Medicare's Consolidated Device Edits require that when specific CPT® procedure codes for device implantation are billed, associated C-codes for the devices must also be billed.¹ When a hospital outpatient bill is received that contains one of the specific CPT procedure codes without one of the required C-codes, the claim is returned to the provider for correction.

CPT Procedure Code	CPT Code Description ²	Associated C-Codes	C-Code Description
62361	Implantation or replacement of device for intrathecal or epidural drug infusion; non-programmable pump	C1891	Infusion pump, non-programmable, permanent, implantable
62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming	C1772	Infusion pump, programmable, implantable

CPT® is a trademark of American Medical Association.

1. Device edits can be found at: http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage. The edits are updated once a quarter.

2. Current Procedural Terminology (CPT) is copyright 2008 American Medical Association. All rights reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

Hospital Outpatient Coding and Payment — Effective January 1, 2009 – December 31, 2009

CPT® Procedure Codes

Hospitals use CPT codes for outpatient services. Under Medicare's APC methodology for hospital outpatient payment, each CPT code is assigned to one of about 820 ambulatory payment classes. Each APC has a relative weight that is then converted to a flat payment amount. Multiple APCs can be assigned for each claim depending on the number of procedures coded.

Procedure	CPT Code and Description ¹	APC ²	APC Title ²	SI ^{2,3}	Relative Weight ²	2009 Medicare National Average ^{2,4}
Screening Test ⁵	62311 Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrasts (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	T	7.1721	\$474
	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	T	7.1721	\$474
	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; without laminectomy	0224	Implantation of Catheter/Reservoir/Shunt	T	42.0410	\$2,777

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Intrathecal Drug Delivery

CPT® Procedure Codes *continued*

Procedure	CPT Code and Description ¹	APC ²	APC Title ²	SI ^{2,3}	Relative Weight ²	2009 Medicare National Average ^{2,4}
Implantation, Revision, or Replacement of Catheter⁶	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; without laminectomy	0224	Implantation of Catheter/Reservoir/Shunt	T	42.0410	\$2,777
	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; with laminectomy	0208	Laminotomies and Laminectomies	T	48.6069	\$3,211
Implantation or Replacement of Pump⁶	62361 Implantation or replacement of device for intrathecal or epidural drug infusion; non-programmable pump	0227	Implantation of Drug Infusion Device	T	185.9307	\$12,282
	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	T	185.9307	\$12,282
Removal of Catheter or Pump⁶	62355 Removal of previously implanted intrathecal or epidural catheter	0203	Level IV Nerve Injections	T	14.3718	\$949
	62365 Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion	0221	Level II Nerve Procedures	T	35.9602	\$2,375
Fluoroscopy for Catheter Placement and Injection⁷	77003 Fluoroscopic guidance and localization of needle or catheter tip for diagnostic or therapeutic injection procedures (epidural, subarachnoid)	N/A	N/A	N	N/A	N/A
Drug⁸ (ASP Drug Pricing Updated Quarterly—See Footnote)	J2275 Injection, morphine sulfate (preservative-free sterile solution), 10 mg	N/A	N/A	N	N/A	N/A
	J2278 Ziconotide, injection, 1 mcg	1694	Ziconotide Injection	K	N/A	ASP+4%
Refill/Analysis/Programming⁹	95990 Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular)	0440	Level V Drug Administration	S	2.8454	\$188
	95991 Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), administered by physician	0440	Level V Drug Administration	S	2.8454	\$188
	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 ¹⁰	0692	Level III Electronic Analysis of Devices	S	1.6537	\$109

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CPT® Procedure Codes *continued*

Procedure	CPT Code and Description ¹	APC ²	APC Title ²	SI ^{2,3}	Relative Weight ²	2009 Medicare National Average ^{2,4}
Refill/ Analysis/ Programming⁹	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 ¹⁰	0691	Level IV Electronic Analysis of Devices	S	2.4647	\$163
Catheter Dye Study¹¹	61070 Puncture of reservoir for injection procedure	0121	Level I Tube or Catheter Changes and Repositioning	T	4.5958	\$304
	75809 Shuntogram for investigation of previously placed indwelling non-vascular shunt (indwelling infusion pump) ¹²	N/A	N/A	Q2	N/A	N/A
Pump Rotor Study	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	0691	Level IV Electronic Analysis of Devices	S	2.4647	\$163
	76000 Fluoroscopy ¹³	N/A	N/A	Q1	N/A	N/A
Evaluation and Management Note: A clinic visit can only be billed separately when a full-scale, separately identifiable evaluation and management service takes place in addition to refilling, analyzing, and programming the pump. The use of evaluation and management codes may require a -25 modifier and must meet separate coding requirements as well as documentation requirements.	99201 Office or other outpatient visit, new patient, problem focused	0604	Level 1 Hospital Clinic Visits	V	0.8277	\$55
	99202 Office or other outpatient visit, new patient, straightforward	0605	Level 2 Hospital Clinic Visits	V	1.0439	\$69
	99203 Office or other outpatient visit, new patient, low complexity	0606	Level 3 Hospital Clinic Visits	V	1.3585	\$90
	99204 Office or other outpatient visit, new patient, moderate complexity	0607	Level 4 Hospital Clinic Visits	V	1.7192	\$114
	99205 Office or other outpatient visit, new patient, high complexity ¹⁴	0608	Level 5 Hospital Clinic Visits	V	2.4477	\$162
	99211 Office or other outpatient visit, established patient, minimal	0604	Level 1 Hospital Clinic Visits	V	0.8277	\$55
	99212 Office or other outpatient visit, established patient, straightforward	0605	Level 2 Hospital Clinic Visits	V	1.0439	\$69
	99213 Office or other outpatient visit, established patient, low complexity	0605	Level 2 Hospital Clinic Visits	V	1.0439	\$69
	99214 Office or other outpatient visit, established patient, moderate complexity	0606	Level 3 Hospital Clinic Visits	V	1.3585	\$90
	99215 Office or other outpatient visit, established patient, high complexity ¹⁴	0607	Level 4 Hospital Clinic Visits	V	1.7192	\$114

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CPT® Procedure Codes *continued*

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2. Federal Register, Volume 73, Number 223, November 18, 2008.
3. Status Indicator (SI) shows how a code is handled for payment purposes. K = non-pass-through drugs, paid under separate APC; N = packaged into other services, not separately payable; S = always paid at 100% of rate; T = paid at 50% of rate when billed with another higher-weighted T procedure; V = visit, paid at 100% of rate. See notes 11 and 12 for status indicators Q1 and Q2.
4. Medicare average payment is determined by multiplying the APC weight by the conversion factor (\$66.059 for 2009) as published in the Federal Register, Volume 73, Number 223, November 18, 2008. The payment is adjusted by the Wage Index for each hospital's specific geographic locality. Therefore, payment will vary from the stated national average Medicare payment levels.
5. When epidural or intrathecal injection is performed without a catheter, code 62311 is used. When a trial catheter is placed and is not tunneled, code 62319 is used. However, when the trial catheter is tunneled, it is unclear whether to use 62319 or 62350. By definition, 62350 captures a tunneled catheter and an external pump; it can be further argued that a tunneled catheter meets the requirement for "long-term" because it anticipates a successful trial in which medication will eventually be administered through the pump. Alternately, it can be argued that a trial is temporary by nature and 62319 indicates a temporary catheter. Check with the payer for specific guidelines.
6. In a replacement, National Correct Coding Initiative (NCCI) edits do not allow removal of the old device to be coded together with implantation of the new device.
7. It is questionable if fluoroscopy can be coded separately with injections and catheter implantation. According to guidelines by the American Association of Neurological Surgeons, use of fluoroscopy to place the catheter is inherent to 62350 and should not be coded separately, although National Correct Coding Initiative (NCCI) edits do not prohibit use of fluoroscopy code 77003 with 62350. Similarly, NCCI edits prohibit use of fluoroscopy codes 76000, 76001, and 77002 with injection codes 62311 and 62319, but there is no edit for fluoroscopy code 77003. Check with the payer for specific coding guidelines. If fluoroscopy is coded, it is designated as packaged and is not separately payable.
8. J2275 is packaged and not separately payable. However, J2278 is designated as a "specific covered outpatient drug." It is assigned to an APC and generates separate payment. CMS updates Average Sales Price (ASP) drug pricing on a quarterly basis. ASP values are publicly available at <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice>. For 2009, the payment amount is based on ASP plus 4% per the Federal Register, Volume 73, Number 223, November 18, 2008; CMS-1404-FC.
9. Use the Refill/Analysis/Programming codes only for follow-up services. Do not assign these codes at the time of implantation. NCCI edits do not allow these codes to be assigned at the time of pump implantation. Also note that according to published material from the AMA, it is appropriate to code both 62367 – 62368 for device analysis with 95990 – 95991 for refilling when performed at the same encounter.
10. Code 62367 is used for pump interrogation only (e.g., determining the current programming, assessing the device's functions such as its battery voltage and settings, and retrieving or downloading stored data for review). Code 62368 is used when the pump is both interrogated and reprogrammed. In the context of a refill, the AMA has published material indicating that pumps require reprogramming at the time of refilling and that it is appropriate to use 62368 for resetting the pump to its original parameters after a refill.
11. The AMA has published material confirming the use of 61070 and 75809 for implanted pump catheter dye studies. However, use of 64999 (unlisted procedure, nervous system) or code 95999 (unlisted neurological diagnostic procedure) may be preferred by some payers.
12. Status Q2 indicates that code 75809 is conditionally packaged. Although separately payable in certain circumstances, code 75809 is designated as "packaged" into the primary service when submitted with another code with status indicator "T." In a catheter dye study, its companion code is 61070. Because code 61070 is status "T," code 75809 is packaged and not separately payable in this scenario.
13. Status Q1 indicates that code 76000 is conditionally packaged. Although payable in a separate APC in certain unusual circumstances, it is designated as "packaged" into the primary service when submitted with another code with status indicator "S," "T," "V," or "X." In a pump rotor study, its companion code is 62368. Because code 62368 is status "S," code 76000 is "packaged" and not separately payable in this scenario.
14. More broadly, these codes have status indicator Q3. Status indicator Q3 shows that the higher level clinic visits may be part of a composite APC if billed with observation services. Otherwise, however, within the context of services related to neurostimulation therapy, the codes will typically be paid separately under the APCs, status indicators, and rates shown.

Hospital Inpatient Coding and Payment — Effective October 1, 2009 – September 30, 2010

MS-DRG Assignments — Non-Cancer Pain

Under Medicare's MS-DRG methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 745 diagnosis-related groups, based on the ICD-9-CM codes assigned to the diagnoses and procedures. Each MS-DRG has a relative weight that is then converted to a flat payment amount. Only one MS-DRG is assigned by 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}	Relative Weight ¹	FY10 Medicare National Average ³
Screening Test ⁴	Pain disorder (338.0, 338.29, 338.4)	091	Other Disorders of Nervous System W MCC	1.5465	\$8,743
		092	Other Disorders of Nervous System W CC	0.9167	\$5,182
		093	Other Disorders of Nervous System W/O CC/MCC	0.6691	\$3,783

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MS-DRG Assignments — Non-Cancer Pain *continued*

Procedure	Scenario		MS-DRG ¹	MS-DRG Title ^{1,2}	Relative Weight ¹	FY10 Medicare National Average ³	
Screening Test ⁴	Causalgia, reflex sympathetic dystrophy, postherpetic neuralgia, phantom limb syndrome, and peripheral neuropathy		073	Cranial and Peripheral Nerve Disorders W MCC	1.2939	\$7,315	
			074	Cranial and Peripheral Nerve Disorders W/O MCC	0.8380	\$4,737	
	Arachnoiditis		097	Non-Bacterial Infections of the Nervous System Except Viral Meningitis W MCC	3.0233	\$17,092	
			098	Non-Bacterial Infections of the Nervous System Except Viral Meningitis W CC	1.7985	\$10,168	
			099	Non-Bacterial Infections of the Nervous System Except Viral Meningitis W/O CC/MCC	1.2084	\$6,831	
	Collapsed vertebrae		542	Pathological Fractures and Musculoskeletal Malignancy W MCC	1.9540	\$11,047	
			543	Pathological Fractures and Musculoskeletal Malignancy W CC	1.1211	\$6,338	
			544	Pathological Fractures and Musculoskeletal Malignancy W/O CC/MCC	0.7717	\$4,363	
	Failed back syndrome, radicular syndrome, and radiculitis due to disc disease		551	Medical Back Problems W MCC	1.5442	\$8,730	
			552	Medical Back Problems W/O MCC	0.7937	\$4,487	
	Implantation or Replacement Pump and Catheter	Entire system implant or replacement, pump (86.06) plus catheter (03.90)	Pain disorder (338.0, 338.29, 338.4), causalgia, RSD, arachnoiditis, and other nervous system disorders	040	Peripheral/Cranial Nerve and Other Nervous System Procedures W MCC	3.9518	\$22,337
				041	Peripheral/Cranial Nerve and Other Nervous System Procedures W CC or Peripheral Neurostimulator	2.1249	\$12,011
				042	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	1.6448	\$9,297
Collapsed vertebrae and other musculoskeletal disorders		515	Other Musculoskeletal System OR Procedure W MCC	3.0414	\$17,194		
		516	Other Musculoskeletal System OR Procedure W CC	1.8355	\$10,377		
		517	Other Musculoskeletal System OR Procedure W/O CC/MCC	1.3640	\$7,711		

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MS-DRG Assignments — Non-Cancer Pain *continued*

Procedure	Scenario		MS-DRG ¹	MS-DRG Title ^{1,2}	Relative Weight ¹	FY10 Medicare National Average ³
Implantation or Replacement Pump Only	Pump only implant or replacement (86.06)	Pain disorder (338.0, 338.29, 338.4), causalgia, RSD, arachnoiditis, and other nervous system disorders	040	Peripheral/Cranial Nerve and Other Nervous System Procedures W MCC	3.9518	\$22,337
			041	Peripheral/Cranial Nerve and Other Nervous System Procedures W CC or Peripheral Neurostimulator	2.1249	\$12,011
			042	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	1.6448	\$9,297
		Pain due to collapsed vertebrae and other musculoskeletal disorders	515	Other Musculoskeletal System OR Procedure W MCC	3.0414	\$17,194
			516	Other Musculoskeletal System OR Procedure W CC	1.8355	\$10,377
			517	Other Musculoskeletal System OR Procedure W/O CC/MCC	1.3640	\$7,711
Implantation or Replacement Catheter Only	Catheter only implant or replacement (03.90)		This code is not considered a significant procedure for the purpose of DRG assignment. A non-surgical (i.e., medical) DRG is assigned to the stay according to the principal diagnosis.			
Removal (without replacement) ⁵	Entire system removal, pump (86.05) and catheter (03.99) ⁶		028	Spinal Procedures W MCC	5.1090	\$28,878
			029	Spinal Procedures W CC or Spinal Neurostimulator	2.7768	\$15,696
			030	Spinal Procedures W/O CC/MCC	1.6019	\$9,055
	Pump only removal (86.05)		This code is not considered a significant procedure for the purpose of DRG assignment. A non-surgical (i.e., medical) DRG is assigned to the stay according to the principal diagnosis.			
	Catheter only removal (03.99) ⁶		028	Spinal Procedures W MCC	5.1090	\$28,878
			029	Spinal Procedures W CC or Spinal Neurostimulator	2.7768	\$15,696
030			Spinal Procedures W/O CC/MCC	1.6019	\$9,055	

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MS-DRG Assignments — Non-Cancer Pain *continued*

1. Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates, 74 Fed. Reg. 43754 – 44236 (finalized August 28, 2009).
2. W MCC in MS-DRG titles refers to secondary diagnosis codes that are designated as major complications or comorbidities. MS-DRGs W MCC have at least one major secondary complication or comorbidity. Similarly, W CC in MS-DRG titles refers to secondary diagnosis codes designated as other (non-major) complications or comorbidities, and MS-DRGs W CC have at least one other (non-major) secondary complication or comorbidity. MS-DRGs W/O CC/MCCs have no secondary diagnoses that are designated as complications or comorbidities, major or otherwise. Note that some secondary diagnoses are only designated as CCs or MCCs when the conditions were present on admission, and do not count as CCs or MCCs when the conditions were acquired in the hospital during the stay.
3. Payment is based on the average standardized operating amount (\$5,223.14) plus the capital standard amount \$429.26 as published in Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates, 74 Fed. Reg. 43754 – 44236 (finalized August 28, 2009), and corrected via Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates; Corrections, 74 Fed. Reg. 51496 – 51510 (finalized October 7, 2009). Note that CMS may subsequently revise these rates with the implementation of further legislation. The payment rate shown is the standardized amounts for facilities with a wage index greater than one. The average standard amounts shown also assume facilities receive the full quality update. The payment will also be adjusted by the Wage Index for your specific geographic locality. Therefore, payment for your area will vary from the stated Medicare national average payment levels shown.
4. The ICD-9-CM procedure codes for screening injections are not considered “significant procedures” for the purpose of MS-DRG assignment. As shown, a non-surgical (i.e., medical) DRG is assigned to the stay according to the principal diagnosis.
5. Device removal without replacement is typically performed as an outpatient. It is shown here for the occasional scenario where removal takes place due to a complication that requires inpatient admission. For coding purposes, an intrathecal pain pump is classified as a nervous system device. When it is removed for complications or because it is no longer needed, the principal diagnosis is either various nervous system complication codes or code V53.09.
6. To use 03.99, removal of the catheter must be surgical (i.e., by incision).

Hospital Inpatient Coding and Payment — Effective October 1, 2009 – September 30, 2010

MS-DRG Assignments — Cancer Pain

Under Medicare’s MS-DRG methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 745 diagnosis-related groups, based on the ICD-9-CM codes assigned to the diagnoses and procedures. Each MS-DRG has a relative weight that is then converted to a flat payment amount. Only one MS-DRG is assigned by 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}	Relative Weight ¹	FY10 Medicare National Average ³
Screening Test ⁴	Neoplasm-related pain (338.3)	947	Signs and Symptoms W MCC	1.0922	\$6,175
		948	Signs and Symptoms W/O MCC	0.6689	\$3,782
	Bone cancer and pathological fracture due to bone cancer	542	Pathological Fractures and Musculoskeletal Malignancy W MCC	1.9540	\$11,047
		543	Pathological Fractures and Musculoskeletal Malignancy W CC	1.1211	\$6,338
		544	Pathological Fractures and Musculoskeletal Malignancy W/O CC/MCC	0.7717	\$4,363
	Esophageal, stomach, colon, and rectal cancer	374	Digestive Malignancy W MCC	2.0149	\$11,391
		375	Digestive Malignancy W CC	1.2631	\$7,141
		376	Digestive Malignancy W/O CC/MCC	0.8883	\$5,022
	Liver and pancreatic cancer	435	Malignancy of Hepatobiliary System or Pancreas W MCC	1.7293	\$9,776
		436	Malignancy of Hepatobiliary System or Pancreas W CC	1.1831	\$6,688
		437	Malignancy of Hepatobiliary System or Pancreas W/O CC/MCC	0.8780	\$4,964
	Lung cancer	180	Respiratory Neoplasms W MCC	1.7263	\$9,759
		181	Respiratory Neoplasms W CC	1.2062	\$6,819
		182	Respiratory Neoplasms W/O CC/MCC	0.8159	\$4,613
	Breast cancer	597	Malignant Breast Disorders W MCC	1.6302	\$9,216
		598	Malignant Breast Disorders W CC	1.0650	\$6,021
		599	Malignant Breast Disorders W/O CC/MCC	0.6102	\$3,450
	Uterine, cervical, and ovarian cancer	754	Malignancy, Female Reproductive System W MCC	1.8829	\$10,645
		755	Malignancy, Female Reproductive System W CC	1.1184	\$6,323
		756	Malignancy, Female Reproductive System W/O CC/MCC	0.5883	\$3,326

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MS-DRG Assignments — Cancer Pain *continued*

Procedure	Scenario	MS-DRG ¹	MS-DRG Title ^{1,2}	Relative Weight ¹	FY10 Medicare National Average ³	
Screening Test⁴	Bladder and kidney cancer	686	Kidney and Urinary Tract Neoplasms W MCC	1.5362	\$8,685	
		687	Kidney and Urinary Tract Neoplasms W CC	1.0260	\$5,800	
		688	Kidney and Urinary Tract Neoplasms W/O CC/MCC	0.6852	\$3,874	
	Prostate and testicular cancer	722	Malignancy, Male Reproductive System W MCC	1.4962	\$8,459	
		723	Malignancy, Male Reproductive System W CC	0.9732	\$5,502	
		724	Malignancy, Male Reproductive System W/O CC/MCC	0.6288	\$3,555	
	Brain and spinal cord cancer	054	Nervous System Neoplasms W MCC	1.5637	\$8,840	
		055	Nervous System Neoplasms W/O MCC	1.0613	\$6,000	
	Implantation or Replacement	Neoplasm-related pain (338.3)	939	OR Procedure W Diagnosis of Other Contact W Health Services W MCC	2.8593	\$16,165
940			OR Procedure W Diagnosis of Other Contact W Health Services W CC	1.6821	\$9,509	
941			OR Procedure W Diagnosis of Other Contact W Health Services W/O CC/MCC	1.1298	\$6,387	
Entire system implant or replacement, pump (86.06) plus catheter (03.90)		Bone cancer and pathological fracture due to bone cancer	515	Other Musculoskeletal System OR Procedure W MCC	3.0414	\$17,194
			516	Other Musculoskeletal System OR Procedure W CC	1.8355	\$10,377
			517	Other Musculoskeletal System OR Procedure W/O CC/MCC	1.3640	\$7,711
or		Esophageal, stomach, colon, and rectal cancer	356	Other Digestive System OR Procedures W MCC	3.9597	\$22,386
			357	Other Digestive System OR Procedures W CC	2.1160	\$11,962
			358	Other Digestive System OR Procedures W/O CC/MCC	1.3008	\$7,354
Pump only implant or replacement (86.06)		Liver and pancreatic cancer	423	Other Hepatobiliary or Pancreas OR Procedures W MCC	4.2255	\$23,888
			424	Other Hepatobiliary or Pancreas OR Procedures W CC	2.2105	\$12,497
			425	Other Hepatobiliary or Pancreas OR Procedures W/O CC/MCC	1.4477	\$8,184
Lung cancer			166	Other Respiratory System OR Procedure W MCC	3.7227	\$21,046
			167	Other Respiratory System OR Procedure W CC	2.0068	\$11,345
			168	Other Respiratory System OR Procedure W/O CC/MCC	1.3026	\$7,364

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MS-DRG Assignments — Cancer Pain *continued*

Procedure	Scenario	MS-DRG ¹	MS-DRG Title ^{1,2}	Relative Weight ¹	FY10 Medicare National Average ³	
Implantation or Replacement Entire system implant or replacement, pump (86.06) plus catheter (03.90) or Pump only implant or replacement (86.06)	Breast cancer	579	Other Skin, Subq and Breast OR Procedure W MCC	2.8556	\$16,144	
		580	Other Skin, Subq and Breast OR Procedure W CC	1.3997	\$7,913	
		581	Other Skin, Subq and Breast OR Procedure W/O CC/MCC	0.8589	\$4,856	
	Uterine, cervical, and ovarian cancer	749	Other Female Reproductive System OR Procedures W CC/MCC	2.4378	\$13,782	
		750	Other Female Reproductive System OR Procedures W/O CC/MCC	1.0159	\$5,743	
	Bladder and kidney cancer	673	Other Kidney and Urinary Tract Procedures W MCC	2.9192	\$16,503	
		674	Other Kidney and Urinary Tract Procedures W CC	2.0576	\$11,632	
		675	Other Kidney and Urinary Tract Procedures W/O CC/MCC	1.3129	\$7,422	
	Prostate and testicular cancer	715	Other Male Reproductive System OR Procedures for Malignancy W CC/MCC	1.7460	\$9,871	
		716	Other Male Reproductive System OR Procedures for Malignancy W/O CC/MCC	1.0053	\$5,683	
	Brain and spinal cord cancer	040	Peripheral/Cranial Nerve and Other Nervous System Procedures W MCC	3.9518	\$22,337	
		041	Peripheral/Cranial Nerve and Other Nervous System Procedures W CC or Peripheral Neurostimulator	2.1249	\$12,011	
		042	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	1.6448	\$9,297	
	Implantation or Replacement	Catheter only implant or replacement (03.90)	This code is not considered a significant procedure for the purpose of DRG assignment. A non-surgical (i.e., medical) DRG is assigned to the stay according to the principal diagnosis.			

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MS-DRG Assignments — Cancer Pain *continued*

Procedure	Scenario	MS-DRG ¹	MS-DRG Title ^{1,2}	Relative Weight ¹	FY10 Medicare National Average ³
Removal (without replacement) ⁵	Entire system removal, pump (86.05) and catheter (03.99) ⁶	028	Spinal Procedures W MCC	5.1090	\$28,878
		029	Spinal Procedures W CC or Spinal Neurostimulator	2.7768	\$15,696
		030	Spinal Procedures W/O CC/MCC	1.6019	\$9,055
	Pump only removal (86.05)	This code is not considered a significant procedure for the purpose of DRG assignment. A non-surgical (i.e., medical) DRG is assigned to the stay according to the principal diagnosis.			
	Catheter only removal (03.99) ⁶	028	Spinal Procedures W MCC	5.1090	\$28,878
		029	Spinal Procedures W CC or Spinal Neurostimulator	2.7768	\$15,696
		030	Spinal Procedures W/O CC/MCC	1.6019	\$9,055

1. Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates, 74 Fed. Reg. 43754 – 44236 (finalized August 28, 2009).

2. W MCC in MS-DRG titles refers to secondary diagnosis codes that are designated as major complications or comorbidities. MS-DRGs W MCC have at least one major secondary complication or comorbidity. Similarly, W CC in MS-DRG titles refers to secondary diagnosis codes designated as other (non-major) complications or comorbidities, and MS-DRGs W CC have at least one other (non-major) secondary complication or comorbidity. MS-DRGs W/O CC/MCCs have no secondary diagnoses that are designated as complications or comorbidities, major or otherwise.

3. Payment is based on the average standardized operating amount (\$5,223.14) plus the capital standard amount (\$429.26) as published in Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates, 74 Fed. Reg. 43754 – 44236 (finalized August 28, 2009), and corrected via Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates; Corrections, 74 Fed. Reg. 51496 – 51510 (finalized October 7, 2009). Note that CMS may subsequently revise these rates with the implementation of further legislation. The payment rate shown is the standardized amounts for facilities with a wage index greater than one. The average standard amounts shown also assume facilities receive the full quality update. The payment will also be adjusted by the Wage Index for your specific geographic locality. Therefore, payment for your area will vary from the stated Medicare national average payment levels shown.

4. The ICD-9-CM procedure codes for screening injections are not considered “significant procedures” for the purpose of MS-DRG assignment. As shown, a non-surgical (i.e., medical) DRG is assigned to the stay according to the principal diagnosis.

5. Device removal without replacement is typically performed as an outpatient. It is shown here for the occasional scenario where removal takes place due to a complication that requires inpatient admission. For coding purposes, an intrathecal pain pump is classified as a nervous system device. When it is removed for complications or because it is no longer needed, the principal diagnosis is either various nervous system complication codes or code V53.09.

6. To use 03.99, removal of the catheter must be surgical (i.e., by incision).

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