



Medtronic

External Pump Trialing System

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 show 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.

Cancer Pain¹	338.3	Neoplasm-related pain (cancer pain)
Underlying Causes of Cancer Pain¹	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

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ICD-9-CM Diagnosis Codes *continued*

Underlying Causes of Cancer Pain¹	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
Other Chronic Pain Disorders	338.0	Central pain syndrome
	338.29	Other chronic 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.	
Underlying Causes of Non-Cancer Pain: 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.	
Other 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)
	733.13 plus 733.0X	Collapsed vertebra (pathologic fracture) due to osteoporosis
	724.4	Radicular syndrome of lower limbs
Attention to Device²	V53.09	Fitting and adjustment of devices related to nervous system

1. Medicare National Coverage Decision for Infusion Pumps (280.14) covers morphine infusion via an external infusion pump when used in the treatment of intractable pain caused by cancer. Refer to http://www.cms.gov/mcd/viewncd.asp?ncd_id=@80.148&basket=ncd%3A280%2E14%3A2%3AInfusion+pumps for complete policy and other indications. Check with local carrier or payer for non-cancer pain.

2. 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.

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.

External Pump	E0781 RR¹	Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient
Preservative-Free Morphine Sulphate	J2275	Injection, morphine sulfate (preservative-free sterile solution), 10 mg
Supplies	A4221	Supplies for maintenance of drug infusion catheter, per week
	A4222	Infusion supplies for external drug infusion pump, per cassette or bag

1. RR modifier indicates "rental" and is used when the DME is rented. Code E0781 is classified on the DMEPOS fee schedule in the "capped rental" category. Medicare routinely pays a monthly rental fee that is not to exceed 15 months. However, if the supplier charges for only part of a month, or the DMERC's carrier is aware that the equipment is only needed for part of the month, payment will be on a prorated basis (Medicare Program Integrity Manual, Chapter 5, section 5.13). For guidance, contact your local contractor or DMERC.

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}
Trial	Procedure ⁵	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
	Imaging ⁶	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

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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}
Trial	Equipment, Supplies, Drugs	E0781-RR-KH^{7,8} Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient, per month	DMEPOS fee schedule: \$278.11 — ceiling; \$236.39 — floor				
		J2275 Injection, morphine sulfate (preservative-free sterile solution), 10 mg	N/A	N/A	N	N/A	N/A
		A4221⁷ Supplies for maintenance of drug infusion catheter, per week	DMEPOS fee schedule: \$23.77 — ceiling; \$20.20 — floor				
		A4222⁷ Infusion supplies for maintenance of drug infusion pump, per cassette or bag	DMEPOS fee schedule: \$49.07 — ceiling; \$41.71 — floor				
Follow-Up During Trial Period	Pump Refill	96521 Refilling and maintenance of portable pump	0440	Level V Drug Administration	S	2.8454	\$188
	Drug	J2275 Injection, morphine sulfate (preservative-free sterile solution), 10 mg	N/A	N/A	N	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	604	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 ⁹	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 ⁹	0607	Level 4 Hospital Clinic Visits	V	1.7192	\$114		

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CPT® Procedure Codes *continued*

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1. 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.
2. Federal Register, Volume 73, Number 223, November 18, 2008.
3. Status Indicator (SI) shows how a code is handled for payment purposes. 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.
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 the trial catheter 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. 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.
7. These services are not payable to the hospital under the APC methodology. Instead, they are separately payable under the DMEPOS fee schedule. Non-implantable DME furnished by a hospital is billed to the DMERC. In order to bill Medicare and receive payment, a hospital must be a Medicare-certified DMEPOS supplier. Note that if a hospital uses a third-party DMEPOS supplier to obtain the external pump, the DMEPOS supplier bills and receives the payment. Payment reflected is per the January 2009 release of the 2009 DMEPOS Fee Schedule. Medicare DMEPOS Fee Schedule is available at: <http://www.cms.hhs.gov/DMEPOSFeeSched/LSDMEPOSFEE/list.asp#TopOfPage>
8. RR modifier indicates "rental" and is used when the DME is rented. Code E0781 is classified on the DMEPOS fee schedule in the "capped rental" category. Medicare routinely pays a monthly rental fee that is not to exceed 15 months. However, if the supplier charges for only part of a month, or the DMERC's carrier is aware that the equipment is only needed for part of the month, payment will be on a prorated basis (Medicare Program Integrity Manual, Chapter 5, section 5.13). For guidance, contact your local DMERC or local payer. The KH modifier indicates first month of rental.
9. 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.

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