FLOWONIX

Targeted Drug Delivery

SEVERE SPASTICITY CODING AND PAYMENT GUIDE 2022

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The Reimbursement Support Program is available to answer any of your coding and reimbursement inquiries at reimbursementsupport@flowonix.com.

ICD-10-CM Diagnosis Codes for Spasticity

Diagnosis codes are used by both physicians and hospitals to document the indication for the procedure. Targeted Drug Delivery includes Intrathecal Baclofen (ITB) Therapy, which is directed at reducing the symptom of severe spasticity. Because symptom codes are generally not acceptable as the principal diagnosis, the principal diagnosis is coded to the underlying condition as shown.

Category	Code	Code Description
Multiple Sclerosis	G35	Multiple sclerosis
Cerebral Palsy	G80.0	Spastic quadriplegic cerebral palsy
	G80.1	Spastic diplegic cerebral palsy
	G80.2	Spastic hemiplegic cerebral palsy
	G80.3	Athetoid cerebral palsy
	G80.4	Ataxic cerebral palsy
	G80.8	Other cerebral palsy
	G80.9	Cerebral palsy, unspecified
Paralytic Syndromes	G81.00-G81.04	Flaccid hemiplegia (choose side, dominant or nondominant)
	G81.10-G81.14	Spastic hemiplegia (choose side, dominant or nondominant)
	G81.90-G81.94	Hemiplegia, unspecified (choose side, dominant or nondominant)
	G82.20-G82.22	Paraplegia (choose unspecified, complete or incomplete)
	G82.50-G82.54	Quadriplegia (choose unspecified, level, complete or incomplete)
	G83.0	Diplegia of upper limbs
	G83.10-G83.14	Monoplegia of lower limb (choose side, dominant or nondominant)
	G83.20-G83.24	Monoplegia of upper limb (choose side, dominant or nondominant)
	G83.30-G83.34	Monoplegia, unspecified (choose side, dominant or nondominant)
	G83.8	Other specified paralytic syndrome
	G83.9	Paralytic syndrome, unspecified

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ICD-10-CM Diagnosis Codes for Spasticity (continued)

Category	Code	Code Description
Sequela (Late Effect) of Prior Injury	S06.0X0S-S06.9X9S S14.101S-S14.159S S24.101S-S24.159S S34.101S-S34.139S	Intracranial injury (traumatic brain injury), sequela Spinal cord injury, sequela
Sequela of Cerebrovascular Disease	I69.059, I69.159 I69.259, I69.359	Hemiplegia and hemiparesis following nontraumatic subarachnoid, intracerebral or intracranial hemorrhage or cerebral infarction affecting unspecified side
	I69.051, I69.052 I69.151, I69.152 I69.251, I69.252 I69.351, I69.352	Hemiplegia and hemiparesis following nontraumatic subarachnoid, intracerebral or intracranial hemorrhage or cerebral infarction affecting dominant side
	I69.053, I69.054 I69.153, I69.154 I69.253, I69.254 I69.353, I69.354	Hemiplegia and hemiparesis following nontraumatic subarachnoid, intracerebral or intracranial hemorrhage or cerebral infarction affecting nondominant side
	I69.851, I69.852 I69.853, I69.854 I69.859	Hemiplegia and hemiparesis following other cerebrovascular disease affecting dominate, nondominant or unspecified side
	I69.951, I69.952 I69.953, I69.954 I69.959	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting dominate, nondominant or unspecified side
	I69.039, I69.139 I69.239, I69.339	Monoplegia of upper limb following nontraumatic subarachnoid, intracerebral or intracranial hemorrhage or cerebral infarction affecting unspecified side
	I69.031, I69.032 I69.131, I69.132 I69.231, I69.232 I69.331, I69.332	Monoplegia of upper limb following nontraumatic subarachnoid, intracerebral or intracranial hemorrhage or cerebral infarction affecting dominant side
	I69.033, I69.034 I69.133, I69.134 I69.233, I69.234 I69.333, I69.334	Monoplegia of upper limb following nontraumatic subarachnoid, intracerebral or intracranial hemorrhage or cerebral infarction affecting nondominant side

ICD-10-CM Diagnosis Codes for Spasticity (continued)

Category	Code	Code Description
Sequela of Cerebrovascular Disease	I69.049, I69.149 I69.249, I69.349	Monoplegia of lower limb following nontraumatic subarachnoid, intracerebral or intracranial hemorrhage or cerebral infraction affecting unspecified side
	I69.041, I69.042 I69.141, I69.142 I69.241, I69.242 I69.341, I69.342	Monoplegia of lower limb following nontraumatic subarachnoid, intracerebral or intracranial hemorrhage or cerebral infarction affecting dominant side
	I69.043, I69.044 I69.143, I69.144 I69.243, I69.244 I69.343, I69.344	Monoplegia of lower limb following nontraumatic subarachnoid, intracerebral or intracranial hemorrhage or cerebral infarction affecting non-dominant side
	I69.065, I69.165 I69.265, I69.365	Other paralytic syndrome nontraumatic subarachnoid, intracerebral or intracranial hemorrhage or cerebral infraction. **Use additional code to identify type of paralytic syndrome**
	I69.093, I69.193 I69.293, I69.393	Ataxia following nontraumatic subarachnoid, intracerebral or intracranial Hemorrhage or cerebral infarction
Device Complications	T85.610A T85.615A T85.620A T85.625A T85.630A T85.635A T85.690A T85.695A T85.735A T85.738A T85.830A T85.840A T85.890A	Breakdown (mechanical) of cranial or spinal infusion catheter Breakdown (mechanical) of other nervous system device, implant or graft Displacement of cranial or spinal infusion catheter Displacement of other nervous system device, implant or graft Leakage of cranial or spinal infusion catheter Leakage of other nervous system device, implant or graft Other mechanical complication of cranial or spinal infusion catheter Other mechanical complication of other nervous system device, implant or graft Infection and inflammatory reaction due to cranial or spinal infusion catheter Infection and inflammatory reaction due to other nervous system device, implant or graft Hemorrhage due to nervous system prosthetic devices, implants and grafts Pain due to nervous system prosthetic devices, implants and grafts Other specified complication of nervous system prosthetic devices, implants and grafts
Attention to Device	Z45.49	Encounter for adjustment and management of other implanted nervous system device

ICD-10-PCS Procedure Codes

Hospitals use ICD-10-PCS procedure codes for inpatient services.

Trial Procedure	Code	Code Description
Catheter Implantation	00HU33Z	Insertion of infusion device into spinal canal, percutaneous approach
Intrathecal Injection	3E0R3NZ	Introduction of analgesics, hypnotics, sedatives into spinal canal, percutaneous approach

Catheter Procedures	Code	Code Description
Catheter Implantation	00HU33Z	Insertion of infusion device into spinal canal, percutaneous approach
Intrathecal Injection	3E0R3GC	Introduction of other therapeutic substance into spinal canal, percutaneous approach
Catheter Removal	00PU03Z	Removal of infusion device from spinal canal, open approach
	00PU33Z	Removal of infusion device from spinal canal, percutaneous approach
Catheter Replacement	Two codes are required to identify a device replacement; one code for implantation of the new device and one code for the removal of the old device.	
Catheter Revision	00WU03Z	Revision of infusion device in spinal canal, open approach
	00WU33Z	Revision of infusion device in spinal canal, percutaneous approach
	0JWT03Z	Revision of infusion device in trunk subcutaneous tissue and fascia, open approach
	0JWT33Z	Revision of infusion device in trunk subcutaneous tissue and fascia, percutaneous approach
Pump Implantation	0JH80VZ	Insertion of infusion pump into abdomen subcutaneous tissue and fascia, open approach
Pump Removal	0JPT0VZ	Removal of infusion pump from trunk subcutaneous tissue and fascia, open approach
	0JPT3VZ	Removal of infusion pump from trunk subcutaneous tissue and fascia, percutaneous approach
Pump Replacement	Two codes are required to identify a device replacement; one code for implantation of the new device and one code for the removal of the old device.	
Pump Revision	0JWT0VZ	Revision of infusion pump in trunk subcutaneous tissue and fascia, open approach
	0JWT3VZ	Revision of infusion pump in trunk subcutaneous tissue and fascia, percutaneous approach

Physician Coding and Payment – CPT® Procedure Codes

The 2022 Medicare national average payment for common pain procedures and intrathecal pain pump management are shown in the table below. The Medicare national average payment is calculated by multiplying the sum of RVUs by the 2022 conversion factor. Specific reimbursement will vary from the national average based on the wage index of the geographical area in which the services are rendered. The complete Medicare Physician Fee Schedule (MPFS) payment rates are available on the CMS website in the downloads section of the CY 2022 Physician Fee Schedule final rule (CMS-1751-F) webpage. The finalized changes are effective January 1, 2022. Specific payments will vary depending on the place of service where the physician rendered the service. Physician payments are generally higher if they are performed in the physician's office. Procedures performed in a facility setting (ASC's or hospitals) generally have a lower payment because the facility is incurring the cost of some of the supplies and materials. Also note, that applicable coinsurance, deductible and other amounts that are the patient obligation are included in the national payments shown below.

			2022 Medicare National Average	
Procedure	Code	Code Description	Physician Office	Facility
Trial	62322	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance	$144	$82
	62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	$270	$101
	62326	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance	$144	$87
	62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	$276	$106
Implantation or Revision of 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; without laminectomy	N/A	$407

CPT® Procedure Codes (continued)

Procedure	Code	Code Description	2022 Medicare National Average: Physician Office	2022 Medicare National Average: Facility
Implantation, or Replacement of Pump	62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming	N/A	$394
Removal of Catheter or Pump	62355	Removal of previously implanted intrathecal or epidural catheter	N/A	$279
	62365	Removal of subcutaneous reservoir or pump previously implanted for intrathecal or epidural infusion	N/A	$303
Revision of Pump Pocket	64999	Unlisted procedure nervous system	N/A	Contractor Pricing
Drug/Refill Kit	J0475	Injection, baclofen, 10 mg	ASP+6%	—
	A4220	Refill kit for implantable infusion pump		
Analysis/ Reprogramming/ Refill	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 or refill	$32	$26
	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	$45	$36
	62369	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill	$95	$36
	62370	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional)	$96	$47
Catheter Dye Study	61070	Puncture of shunt tubing or reservoir for aspiration or injection procedure	N/A	$58
	75809	Shuntogram for investigation of previously placed indwelling non vascular shunt (eg, indwelling infusion pump)	— TC 26	$85

HCPCS II Device and Drug Codes

Commonly billed HCPCS II Device and Drug Codes are used by the entity that purchased and supplied the medical device, which is usually the facility. Physicians may report drug charges when the drug is provided in the office. HCPCS II codes should only be billed for outpatient hospital procedures. They may also be reported with device C-codes when billing Medicare.

Device/Drug	Code	Code Description
Programmable Pump and Catheter	E0783	Infusion pump system, implantable, programmable (includes all components, e.g., pump, catheter, connectors, etc.)
Programmable Pump Only (Replacement)	E0786	Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter)
Intraspinal Implantable Catheter Only	E0785	Implantable intraspinal (epidural/intrathecal) catheter used with implantable infusion pump, replacement
Refill Kit	A4220	Refill Kit for implantable infusion pump
Intrathecal baclofen	J0475	Injection, baclofen, 10 mg
Intrathecal baclofen	J0476	Injection, baclofen, 50 mcg for intrathecal trial

Device C-Codes

Hospitals assign C-codes in the outpatient hospital setting only when billing Medicare. Although other payers may also accept C-codes, regular HCPCS-II device codes are generally used for billing non-Medicare carriers.

Device/Drug	Code	Code Description
Infusion Pump	C1772	Infusion pump, programmable, implantable
Intrathecal Catheter	C1755	Catheter, Intraspinal

Device Edits (Medicare)

Medicare's Consolidated Device Edits require that when certain CPT procedure codes for device implantation are billed, associated device category C-codes must also be billed. These are only used in the outpatient hospital setting.

CPT® Procedure Code	CPT Code Description	Associated C-Codes	C-Code Description
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

Hospital Outpatient Coding and Payment

Hospitals use CPT codes for outpatient services. Under Medicare's APC methodology for hospital outpatient payment, each CPT code is assigned to APCs based on similar clinical characteristics and similar costs. Each APC has a relative weight that is then converted into a flat payment amount. Multiple APCs can be assigned for each claim depending on the number of procedures coded and whether any of them map to a Comprehensive APCs (C-APCs). Each CPT procedure code assigned to one of these C-APCs is considered a primary service. All other procedures and services coded on the bill are considered adjunctive to delivery of the primary service. This results in a single APC payment and a single beneficiary copayment for the entire outpatient encounter, based solely on the primary service. Separate payment is not made for the other adjunctive services. Instead, the payment level for the C-APC is calculated to include the costs of the other adjunctive services, which are packaged into the payment for the primary service.

As shown on the following tables, TDD therapy is subject to C-APCs specifically for implantation/replacement of the pump. C-APCs are identified by status indicator J1.

The following table gives information on procedures, codes, APC, status indicator and payment based on the Medicare national average. The complete 2022 CPPS/ASC Payment System final rule is available on the CMS website (CMS-1753-FC) webpage. The finalized changes are effective January 1, 2022.

Procedure	Code	Code Description	APC	APC Descriptor	Status Indicator	Relative Weight	2022 Medicare National Average
Trial	62322	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance	5442	Level II Nerve Injections	T	7.7043	$648
	or 62323	With imaging guidance (ie, fluoroscopy or CT)	5442	Level II Nerve Injections	T	7.7043	$648
Baseline Evaluation and Periodic Assessment During Screening Test when performed by a Hospital-employed Physical Therapist	97161	Physical therapy evaluation, low complexity	—	—	A	—	—

Procedure	Code	Code Description	APC	APC Descriptor	Status Indicator	Relative Weight	2022 Medicare National Average
Baseline Evaluation and Periodic Assessment During Screening Test when performed by a Hospital-employed Physical Therapist	97162	Physical therapy evaluation, moderate complexity	—	—	A	—	—
	97163	Physical therapy evaluation, high complexity	—	—	A	—	—
	97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes	—	—	A	—	—
Implantation or Revision of 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; without laminectomy	5432	Level III Nerve Procedure	J1	69.1869	$5,824
Implantation or Replacement of Pump	62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming	5471	Implantation of drug infusion device	J1	206.7704	$17,405
Pump Pocket Revision	64999	Unlisted procedure, nervous system	5441	Level 1 Nerve Procedure	T	3.1699	$267
Removal of Catheter or Pump	62355	Removal of previously implanted intrathecal or epidural catheter	5431	Level I Nerve Procedure	Q2	21.304	$1,793
	62365	Removal of subcutaneous reservoir or pump previously implanted for intrathecal or epidural infusion	5432	Level II Nerve Procedure	Q2	69.1869	$5,824

Hospital Outpatient Coding and Payment (continued)

Procedure	Code	Code Description	APC	APC Descriptor	Status Indicator	Relative Weight	2022 Medicare National Average
Drug	J0475	Injection, baclofen, 10 mg	9032	N/A	K2	N/A	N/A
Refill/Analysis/ Reprogramming	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 or refill	5743	Level III Electronic Analysis of Devices	S	3.3128	$279
	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	5743	Level III Electronic Analysis of Devices	S	3.3128	$279
	62369	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill	5743	Level III Electronic Analysis of Devices	S	3.3128	$279
	62370	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional)	5743	Level III Electronic Analysis of Devices	S	3.3128	$279

Hospital Outpatient Coding and Payment (continued)

Procedure	Code	Code Description	APC	APC Descriptor	Status Indicator	Relative Weight	2022 Medicare National Average
Catheter Dye Study	61070	Puncture of shunt tubing or reservoir for aspiration or injection procedure	5442	Level II Nerve Injections	T	7.7043	$648
	75809	Shuntogram for investigation of previously placed indwelling non vascular shunt (eg, indwelling infusion pump)	5522	Level II Imaging Without Contrast	Q2	1.3209	$111

Hospital Inpatient Coding and Payment MS-DRG Assignments

Under Medicare's DRG methodology for hospital inpatient payment, each inpatient stay is assigned to a diagnosis related group (DRG), based on the ICD-10-CM codes assigned to the diagnoses and procedure. Only one DRG is assigned by inpatient stay, regardless of the number of procedures performed.

The following table shows MS-DRG assignments to specific procedures and diagnosis along with national Medicare average payments for spasticity treatment in an inpatient hospital setting.

Procedure	Scenario	MS-DRG	MS-DRG Title	Relative Weight	2022 Medicare National Average
Screening Test	The screening test codes for catheter implantation and intrathecal injection are not considered significant procedures for the purpose of DRG assignment. A non-surgical DRG is assigned according to the principal diagnosis.				
Implantation	Whole system implant (pump plus catheter) or Pump only implant	040	Peripheral/Cranial Nerve and Other Nervous System Procedures with MCC	3.8648	$23,346
		041	Peripheral/Cranial Nerve and Other Nervous System Procedures with CC	2.3497	$14,194
		042	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	1.9012	$11,484
	Catheter only implant	This code is not considered a significant procedure for the purpose of DRG assignment. A non-surgical (ie, medical) DRG is assigned to the stay according to the principal diagnosis. The DRGs displayed for the screening trial are common.			

Hospital Inpatient Coding and Payment (continued)

Procedure	Scenario	MS-DRG	MS-DRG Title	Relative Weight	2022 Medicare National Average
Replacement	Whole system replacement (pump plus catheter)	028	Spinal Procedures with MCC	5.8231	$35,175
		029	Spinal Procedures with CC	3.2968	$19,915
		030	Spinal Procedures W/O CC/MCC	2.3568	$14,237
	Pump only replacement	040	Peripheral/Cranial Nerve and Other Nervous System Procedures with MCC	3.8648	$23,346
		041	Peripheral/Cranial Nerve and Other Nervous System Procedures with CC	2.3497	$14,194
		042	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	1.9012	$11,484
Removal (without replacement)	Whole system removal (pump plus catheter)	028	Spinal Procedures with MCC	5.8231	$35,175
		029	Spinal Procedures with CC	3.2968	$19,915
		030	Spinal Procedures W/O CC/MCC	2.3568	$14,237
	Pump only removal	These codes are considered significant procedures for the purpose of DRG assignment. A non-surgical (ie, medical) DRG is assigned to the stay according to the principal diagnosis.			
	Catheter only removal	028	Spinal Procedures with MCC	5.8231	$35,175
		029	Spinal Procedures with CC	3.2968	$19,915
		030	Spinal Procedures W/O CC/MCC	2.3568	$14,237
Revision	Catheter revision (intrathecal portion)	028	Spinal Procedures with MCC	5.8231	$35,175
		029	Spinal Procedures with CC	3.2968	$19,915
		030	Spinal Procedures W/O CC/MCC	2.3568	$14,237
	Catheter revision (subcutaneous portion)	These codes are not considered significant procedures for the purpose of DRG assignment. A non-surgical (ie, medical) DRG is assigned to the stay according to the principal diagnosis.			
	Pump revision	These codes are not considered significant procedures for the purpose of DRG assignment. A non-surgical (ie, medical) DRG is assigned to the stay according to the principal diagnosis.			

ASC Coding and Payment - CPT® Procedure Codes

The Payment Indicator in the chart below shows how a code is handled for payment purposes. A2 = surgical procedure, payment based on hospital outpatient rate adjusted for ASC; J8 = device-intensive procedure, payment amount adjusted to incorporate device cost; K2 = drugs paid separately when provided integral to a surgical procedure on ASC list, payment based on hospital outpatient rate; N1 = packaged service, no separate payment; P3 = office-based procedure, payment based on physician fee schedule. G2 = Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight. When multiple procedures are coded and billed, payment is usually made at 100% of the rate for the first procedure and 50% of the rate for the second and all subsequent procedures. Procedures marked with a Y in the chart below are subject to the multiple procedure rule.

Procedure	Code	Code Description	Payment Indicator	Multiple Procedure Discount	2022 Medicare National Average
Trial	62322	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance	G2	Y	$329
	62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	G2	Y	$329
	62326	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance	G2	Y	$426

ASC Coding and Payment – CPT® Procedure Codes (continued)

Procedure	Code	Code Description	Payment Indicator	Multiple Procedure Discount	2022 Medicare National Average
Trial	62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	G2	Y	$426
Implantation or Revision, of 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; without laminectomy	J8	Y	$3,613
Implantation or Replacement of Pump	62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming	J8	Y	$14,469
Pump Pocket Revision	64999	Unlisted procedure, nervous system	IO	N	per contract
Removal of Catheter or Pump	62355	Removal of previously implanted intrathecal or epidural catheter	A2	N	$826
	62365	Removal of subcutaneous reservoir or pump previously implanted for intrathecal or epidural infusion	A2	N	$2,498
Drug	J0475	Injection, baclofen, 10 mg	K2	N/A	per fee schedule

ASC Coding and Payment – CPT® Procedure Codes (continued)

Procedure	Code	Code Description	Payment Indicator	Multiple Procedure Discount	2022 Medicare National Average
Analysis/ Reprogramming Refill (used for followup services)	62367	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation or reservoir status, alarm status, drug prescription status); without reprogramming or refill	P3	N	$13
	62368	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation or reservoir status, alarm status, drug prescription status); with reprogramming	P3	N	$18
	62369	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation or reservoir status, alarm status, drug prescription status); with reprogramming or refill	P3	N	$67
	62370	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation or reservoir status, alarm status, drug prescription status); with reprogramming or refill (requiring skill of a Physician or other qualified health care professional)	P3	N	$60

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Sources: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index