FLOWONIX

Targeted Drug Delivery

ASC AND PHYSICIAN CODING AND PAYMENT GUIDE 2022

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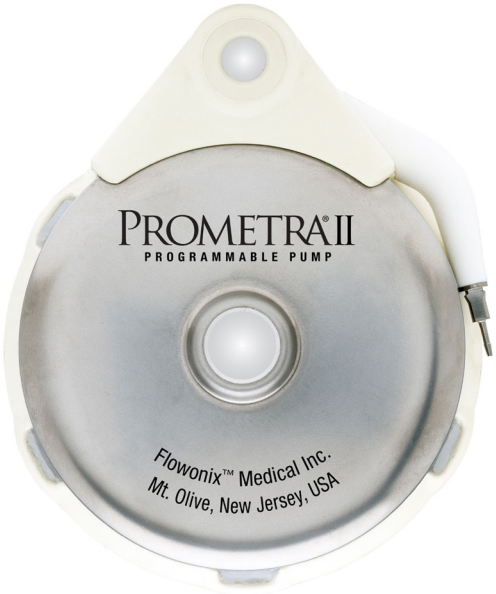
The Reimbursement Support Program is available to answer any of your coding and reimbursement inquiries at reimbursementsupport@flowonix.com.

ICD-10-CM Diagnosis Code Options

ICD-10-CM codes are to be used to document the patient's condition. Diagnosis codes are used by both physicians and facilities 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 G89 category may be used as the principal diagnosis when the encounter is for pain control or pain management, rather than for management of the underlying conditions. Additional codes may then be assigned to give more detail about the nature and location of the pain and the 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. It is the physician's responsibility to code the appropriate diagnosis code(s) based on the patient's condition and presenting symptoms.



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Commonly billed ICD-10-CM diagnosis codes used in all settings.

Category	Code	Code Description
Chronic Pain Disorders	G89.0 G89.2 - G89.29 G89.3 G89.4	Central pain syndrome Chronic pain Neoplasm related pain (acute)(chronic) Chronic pain syndrome
	Note: Pain must be specifically documented as "chronic" to use codes G89.2 - G89.29. Similarly, the diagnostic term "chronic pain syndrome" must be specifically documented to assign code G89.4. If these terms are not documented, then symptom codes for pain may be assigned instead, although 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 (Complex Regional Pain Syndrome I) and Causalgia (Complex Regional Pain Syndrome II)	G90.521 - G90.529 G57.70 - G57.73	Complex regional pain syndrome I of lower limb(s) Causalgia of unspecified lower limb(s)
	Note: ICD-10-CM does not have a default code for "Complex Regional Pain Syndrome"; type I or II must be specified. Codes from the G89 series in ICD-10-CM should not be assigned with causalgia or reflex sympathetic dystrophy because pain is a known component of these disorders.	
Underlying Causes of Chronic Pain (Non-Cancer)	**Postherpetic Neuropathy**	
	B02.21 B02.22 B02.23 B02.29	Postherpetic geniculate ganglionitis Postherpetic trigeminal neuralgia Postherpetic polyneuropathy Other Postherpetic nervous system indocement
	Arachnoiditis	
	G03.1 G03.9	Chronic meningitis Meningitis, unspecified
	Phantom Limb Pain	
	G54.6	Phantom limb syndrome with pain

ICD-10-CM diagnosis codes used in all settings (continued).

Category	Code	Code Description
Underlying Causes of Chronic Pain (Non-Cancer)	**Peripheral Neuropathy**	
	G57.90	Unspecified mononeuropathy of unspecified lower limb
	G57.91	Unspecified mononeuropathy of right lower limb
	G57.92	Unspecified mononeuropathy of left lower limb
	G57.93	Unspecified mononeuropathy of bilateral lower limbs
	Radiculopathy	
	M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
	M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
	M54.12	Radiculopathy, cervical region
	M54.13	Radiculopathy, cervicothoracic region
	M54.14	Radiculopathy, thoracic region
	M54.15	Radiculopathy, thoracolumbar region
	M54.16	Radiculopathy, lumbar region
	M54.17	Radiculopathy, lumbosacral region
	Osteoporosis-Related Fracture, Vertebra	
	M80.08XA	Age-related osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture
	M80.88XA	Other osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture
	Postlaminectomy Syndrome	
	M96.1	Postlaminectomy syndrome, not elsewhere classified
Underlying Causes of Chronic Pain (Cancer)	C00-C14	Malignant neoplasms of lip, oral cavity and pharynx
	C15-C26	Malignant neoplasms of digestive organs
	C30-C39	Malignant neoplasms of respiratory and intrathoracic organs
	C40-C41	Malignant neoplasms of bone and articular cartilage
	C43-C44	Melanoma and other malignant neoplasms of skin
	C45-C49	Malignant neoplasms of mesothelial and soft tissue
	C50-C50	Malignant neoplasms of breast
	C51-C58	Malignant neoplasms of female genital organs
	C60-C63	Malignant neoplasms of male genital organs

ICD-10-CM diagnosis codes used in all settings (continued).

Category	Code	Code Description
Underlying Causes of Chronic Pain (Cancer)	C64-C68	Malignant neoplasms of urinary tract
	C69-C72	Malignant neoplasms of eye, brain and other parts of central nervous system
	C73-C75	Malignant neoplasms of thyroid and other endocrine glands
	C76-C80	Malignant neoplasms of ill-defined, other secondary and unspecified sites
	C7A-C7A	Malignant neuroendocrine tumors
	C7B-C7B	Secondary neuroendocrine tumors
	C81-C96	Malignant neoplasms of lymphoid, hematopoietic and related tissue
Device Complications	T85.610A	Breakdown (mechanical) of cranial or spinal infusion catheter
	T85.615A	Breakdown (mechanical) of other nervous system device, implant or graft
	T85.620A	Displacement of cranial or spinal infusion catheter
	T85.625A	Displacement of other nervous system device, implant or graft
	T85.630A	Leakage of cranial or spinal infusion catheter
	T85.635A	Leakage of other nervous system device, implant or graft
	T85.690A	Other mechanical complication of cranial or spinal infusion catheter
	T85.695A	Other mechanical complication of other nervous system device, implant or graft
	T85.735A	Infection and inflammatory reaction due to cranial or spinal infusion catheter
	T85.738A	Infection and inflammatory reaction due to other nervous system device, implant or graft
	T85.830A	Hemorrhage due to nervous system prosthetic devices, implants and grafts
	T85.840A	Pain due to nervous system prosthetic devices, implants and grafts
	T85.890A	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

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	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	J2274	Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 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 used in all settings. However, in the outpatient hospital setting these codes are used in conjunction 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)
Implantable Intraspinal Catheter Only	E0785	Implantable intraspinal (epidural/intrathecal) catheter used with implantable infusion pump, replacement
Infumorph™ (preservative-free morphine sulfate sterile solution)	J2274	Injection, morphine sulfate, perservative-free for epidural or intrathecal use, 10 mg
Anesthetic Drug Administered Through IV	J7799	NOC drugs, other than inhalation drugs, administered through DME
Personal Therapy Controller	A9900	Misc. DME supply, accessory and/or service component of another HCPCS Code (used for replacement only).
Refill Kit	A4220	Refill Kit for implantable infusion pump

Ambulatory Surgery Centers (ASC) Coding a Payment - CPT® Procedure Codes

ASC's offers outpatient surgical services to patients that do not require hospitalization. They utilize ICD-10-CM diagnosis codes and CPT procedural codes to bill for their services. It is important to distinguish that payment for procedures performed at an ASC are completely different than those for the same surgical procedures performed as outpatient at a hospital.
The Centers for Medicare & Medicaid Services (CMS) have special rules and a separate payment system for ASC payment. Each service is given a relative weight equal to the Outpatient Prospective Payment System (OPPS) for the same services. It's relative payment weight is then adjusted using the ASC conversion factor (CF) to set a standard payment for each separately payable procedure or service. Ancillary services considered integral to the surgical procedure may be paid separately, however, drugs and DME are usually considered as packaged in the procedure payment and are not separately reimbursable. The 2022 Medicare national average payment for common pain procedures and intrathecal pain pump management performed at an ASC are shown in the table below. The complete 2022 OPPS/ASC Payment System final rule is available on the CMS website (CMS-1753-FC) webpage. The finalized changes are effective January 1, 2022.

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
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	J2274	Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg	N1	N/A	N/A

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

Sources: https://www.cms.gov/medicare/medicare-fee-for-service-payment/feeschedulegeninfo/index