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The Customer Care Support Program is available to answer any of your coding and billing inquiries at 855-356-9666.

ICD-10-CM Diagnosis Code Options

Effective October 1, 2015, ICD-10-CM codes are to be used to document the patient's condition. Just like with the ICD-9-CM diagnosis coding, it is the physician's responsibility to select and report the appropriate diagnosis codes that pertain to the patient's symptoms or conditions. 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. **Regardless of the place of service, ICD-10-CM diagnosis codes do not change.**

Codes from the "G89" series 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. It is the physician's responsibility to code the appropriate diagnosis code(s) based on the patient's condition and presenting symptoms.

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.

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The table below gives a breakdown of commonly billed ICD-10-CM¹ diagnosis codes used in all settings.

Category	Code	Code Description
Chronic Pain Disorders	G89.0 G89.29 G89.3 G89.4	Central pain syndrome Other chronic pain Neoplasm related pain (acute)(chronic) Chronic pain syndrome
	Note: Pain must be specifically documented as “chronic” to use code 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 G90.522 G90.523 G90.529 G57.70 G57.71 G57.72	Complex regional pain syndrome I of right lower limb Complex regional pain syndrome I of left lower limb Complex regional pain syndrome I of lower limb, bilateral Complex regional pain syndrome I of unspecified lower limb Causalgia of unspecified lower limb Causalgia of right lower limb Causalgia of left lower limb
	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	
	B02.22 B02.23	Postherpetic trigeminal neuralgia Postherpetic polyneuropathy
	Arachnoiditis	
	G03.1 G03.9	Chronic meningitis Meningitis, unspecified
	Phantom Limb Pain	
G54.6	Phantom limb syndrome with pain	

ICD-10-CM¹ 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
	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)	C15.3-C15.9	Malignant neoplasm of esophagus
	C16.0-C16.9	Malignant neoplasm of stomach
	C18.0-C18.9, C19, C20, C21.0-C21.8, C78.5	Malignant neoplasm of colon, rectosigmoid junction, rectum, and anus
	C22.0-C22.9, C78.7	Malignant neoplasm of liver
	C25.0-C25.9	Malignant neoplasm of pancreas
	C33, C34.00-C34.92	Malignant neoplasm of lung, bronchus and trachea
	C78.00-C78.02	

ICD-10-CM¹ diagnosis codes used in all settings (continued).

Category	Code	Code Description
Underlying Causes of Chronic Pain (Cancer)	C40.00-C40.92	Malignant neoplasm of bones
	C41.0-C41.9, C79.51	
	C50.011-C50.929	Malignant neoplasm of breast
	C53.0-C53.9	Malignant neoplasm of cervix
	C54.0-C54.9, C55	Malignant neoplasm of uterus
	C56.1-C56.9	Malignant neoplasm of ovary
	C79.60-C79.62	
	C61	Malignant neoplasm of prostate
	C62.00-C62.92	Malignant neoplasm of testis
	C64.1-C64.9, C65.1-C65.9, C79.00-C79.02	Malignant neoplasm of kidney
	C67.0-C67.9, C79.11	Malignant neoplasm of bladder
	C71.0-C71.9	Malignant neoplasm of brain, spinal cord, and other central nervous system structures
	C72.0-C72.9	
	C79.31-C79.32	
	C79.40-C79.49	
M84.58xA	Pathological fracture in neoplastic disease, other specified site (vertebrae), initial encounter for fracture	
Attention to Device ²	Z45.49	Encounter for adjustment and management of other implanted nervous system device

¹Centers for Disease Control and Prevention, National Center for Health Statistics. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). <https://www.cms.gov/Medicare/Coding/ICD10/2017-ICD-10-PCS-and-GEMs.html>.

²ICD-10-CM code Z45.49 is used as the principal diagnosis when patients are seen for routine device maintenance, such as periodic device checks and programming, as well as routine device replacement. A secondary diagnosis code is then used for the underlying condition.

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)
Intraspinal Implantable 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
Refill Kit	A4220	Refill kit for implantable infusion pump

Physician Coding and Payment

Physician Office

Medicare varies specific reimbursement from the national average based on the geographical area in which the services are rendered, for this reason, national averages are shown, but each specific payment to physicians will vary by geography. Also note that any applicable coinsurance, deductible and other amounts that are patient obligations are included in the national average payment shown.

Different amounts are paid depending on the place of service in which the physician rendered the services. “Facility” includes physician services rendered in hospitals and ASCs. Physician payments are generally lower in the “facility” setting because the facility is incurring the cost of some of the supplies and other materials. Physician payments are generally higher in the “office” setting because the physician incurs all costs there.

CPT® Procedure Codes

Procedure	Code ¹	Code Description ¹	2017 Medicare National Average ²	
			Physician Office ³	Facility ³
Trial ^{4,5}	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	\$159	\$91
	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	\$159	\$91
	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	\$156	\$94
	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	\$156	\$94

CPT® Procedure Codes (continued)

			2017 Medicare National Average ²	
Procedure	Code ¹	Code Description ¹	Physician Office ³	Facility ³
Implantation or Revision of Catheter ^{6,7}	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	\$413
Implantation, or Replacement of Pump ^{6,7}	62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming	N/A	\$399
Removal of Catheter or Pump ^{6,7}	62355	Removal of previously implanted intrathecal or epidural catheter	N/A	\$277
	62365	Removal of subcutaneous reservoir or pump previously implanted for intrathecal or epidural infusion	N/A	\$309
Drug/Refill Kit	J2274	Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg ⁸	ASP+6%	—
	A4220	Refill kit for implantable infusion pump ⁹		
Refill/Analysis/Repro-gramming ¹⁰	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 ¹¹	\$42	\$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 ¹¹	\$57	\$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 ¹²	\$120	\$37
	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) ¹²	\$127	\$48

CPT® Procedure Codes (continued)

			2017 Medicare National Average ²	
Procedure	Code ¹	Code Description ¹	Physician Office ³	Facility ³
Catheter Dye Study ¹³	61070	Puncture of shunt tubing or reservoir for aspiration or injection procedure	N/A	\$59
	75809	Shuntogram for investigation of previously placed indwelling non vascular shunt (eg, indwelling infusion pump) ¹⁴	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	57.42	\$36
	76000	Fluoroscopy, up to one hour	1.33	N/A
	76000-26	Fluoroscopy, up to one hour—professional component ¹⁴	–	0.25

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²Medicare national average payment is determined by multiplying the sum of the three RVUs by the conversion factor. The conversion factor for CY 2017 is \$35.8887 through December 31, 2017 per Federal Register /Vol. 81, No. 220 page 80543. <https://www.gpo.gov/fdsys/pkg/FR-2016-11-15/pdf/2016-26668.pdf>. Published November 16, 2016. See also the January 2017 release of the PFS Relative Value File RVU17A at <https://www.gpo.gov/fdsys/pkg/FR-2016-11-15/pdf/2016-26668.pdf>. Final payment to the physician is adjusted by the Geographic Practice Cost Indices (GPCI). Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the payment amount shown.

³“N/A” shown in Physician Office setting indicates that Medicare has not developed RVUs in the office setting because the service is typically performed in a facility (eg, in a hospital). However, if the local contractor determines that it will cover the service in the office, then it is paid using the facility RVUs at the facility rate. “N/A” shown in the Facility setting indicates that the service is not paid to the physician in a hospital or ASC, because the service is expected to be performed by employees of the hospital or ASC instead. Centers for Medicare & Medicaid Services. Details for Title: CMS-1631-FC. CY 2016 PFS Final Rule Addenda. Addendum A: Explanation of Addendum B and C. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1631-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending>. Updated November 5, 2015.

⁴According to CPT® manual instructions, injection codes 62322 and 62326 both include temporary catheter placement. Code 62322 is used for needle injection or when a catheter is placed to administer one or more injections on a single calendar day. Code 62326 is used when the catheter is left in place to deliver the agent continuously or intermittently for more than a single calendar day.

⁵Check with the payer for specific guidelines on coding a tunneled trial catheter. Options may include 62350, although the code definition specifies “long-term” and the trial is temporary, or 62326 with modifier -22 to indicate that tunneling substantially increases the work.

⁶Surgical procedures are subject to a “global period.” The global period defines other physician services that are generally considered part of the surgery package. The services are not separately coded, billed, or paid when rendered by the physician who performed the surgery. These services include: preoperative visits the day before or the day of the surgery, postoperative visits related to recovery from the surgery for 10 days, treatment of complications unless they require a return visit to the operating room, and minor postoperative services such as dressing changes and suture removal.

CPT® Procedure Codes (continued)

⁷For pump and catheter replacement, NCCI edits do not allow removal of the existing device to be coded separately with implantation of the new device.

⁸Payer interpretations on coding, billing and payment for the drug may vary. For coding and billing, some contractors instruct that modifier -KD, defined “drug or biological infused through DME”, be appended to the drug code when the drug is infused via an implanted pump. However, other contractors instruct the modifier -KD is reserved for external pumps and should not be appended for drugs infused via an implanted pump. For payment, some contractors make payment for the drug at 95% of AWP and others make payment at ASP + 6%. ASP and AWP values are available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html> and are updated quarterly. Providers should check with the local Medicare contractor or other payers for their specific coding, billing and payment instructions.

⁹Medicare generally does not pay for supplies separately. However, other payers may make a separate payment depending on the provider contract and their payment methodology.

¹⁰Use the Refill/Analysis/Reprogramming codes only for follow-up services. NCCI edits do not allow these codes to be assigned at the time of pump implantation.

¹¹Code 62367 is assigned for pump interrogation only (eg, determining the current programming, assessing the device’s functions such as battery voltage and settings, and retrieving or downloading stored data for review). Code 62368 is assigned when the pump is both interrogated and reprogrammed.

¹²Code 62369 is assigned when the pump is interrogated, reprogrammed and refilled by ancillary staff, eg. nurse under physician supervision in the office. Although RVUs exist for code 62369 in the facility setting, they are not displayed because the service is typically provided by facility staff, eg. hospital nurse. As defined, code 62370 is used when the pump is interrogated, reprogrammed, and refilled by a physician or “other qualified health care professional”. The AMA defines “other qualified health care professional” as an individual who performs professional services within their scope of practice and is able to bill their services independently, eg. nurse practitioner.

¹³The AMA has published material (CPT Assistant, September 2008, p.10) confirming the use of 61070 and 75809 for implanted pump catheter dye studies.

¹⁴RVUs exist for this code in the office setting. However, they are not displayed because the professional component –26 is customarily provided in the facility setting.

Note: The payment amounts indicated are based upon data elements published in the Federal Register dated 11/15/2016, and subsequent legislation and updates issued by CMS. These changes are effective for services provided from 1/1/16 through 12/31/17. CMS may make adjustments to any or all of the data inputs from time to time. All CPT codes are copyright AMA.