Medtronic

# Targeted drug delivery for chronic pain and severe spasticity

## 2026 coding and payment guide

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# Physician coding and payment

## January 1, 2026 – December 31, 2026



| Procedure | CPT procedure code and description[1] | Medicare work RVUs[2] | Medicare national average for physician services provided in:[†,3] | |
|---|---|---|---|---|
| | | | Office | Facility |
| **Screening test for chronic pain**[a,b,c,d] | **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 | 1.51 | $146 | $74 |
| | **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) | 1.76 | $273 | $89 |
| | **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 | 1.74 | $153 | $82 |
| | **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) | 1.85 | $275 | $93 |
| **Implantation or revision of catheter**[e] | **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 | 5.90 | NA | $378 |
| **Implantation or replacement of pump**[e] | **62362** Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming | 5.46 | NA | $372 |
| **Revision of pump**[f] | **64999** Unlisted procedure, nervous system | Contractor priced | – | Contractor priced |
| **Removal of catheter or pump**[e] | **62355** Removal of previously implanted intrathecal or epidural catheter | 3.46 | N/A | $281 |
| | **62365** Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion | 3.83 | N/A | $296 |

[†] Rates shown reflect the CY 2026 Medicare Physician Fee Schedule for clinicians who did not qualify as participants in Advanced Alternative Payment Model (APM). Physicians and other eligible clinicians who qualify as participants in an Advanced APM under the Quality Payment Program may receive higher payment rates.

## Physician coding and payment - continued

| Procedure | CPT procedure code and description[1] | Medicare work RVUs[2] | Medicare national average for physician services provided in:[3] | |
|---|---|---|---|---|
| | | | Office[5] | Facility |
| **Drug / refill kit**[g] | **J2274** Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg | – | ASP + 6% | – |
| | **J2278** Injection, ziconotide, 1 microgram | – | ASP + 6% | – |
| | **J0475** Injection, baclofen, 10 mg | – | ASP + 6% | – |
| | **J0476** Injection, baclofen, 50 mcg for intrathecal trial | – | ASP + 6% | – |
| | **A4220** Refill kit for implantable infusion pump[h] | – | – | – |
| **Refill / analysis / reprogramming**[i,j] | **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[k] | 0.47 | $33 | $21 |
| | **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[k] | 0.65 | $46 | $29 |
| | **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[l] | 0.65 | $97 | $30 |
| | **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)[l] | 0.88 | $97 | $39 |
| **Catheter dye study**[m,n] | **61070** Puncture of reservoir for injection procedure | 0.87 | NA | $51 |
| | **75809** Shuntogram for investigation of previously placed indwelling non-vascular shunt (eg, indwelling infusion pump) - professional component[o] | 0.46 | $85 | NA |
| **Evaluation & Management (E/M)** *Note: An office visit can only be billed in addition to pump interrogation/ programming/ refill visit separately when a significant, separately identifiable E/M service takes place. Modifier -25 should be appended to the E/M code and documentation requirements must be met. Please note: modifier -25 cannot be "reported" with CPT 99211.* | **99211** Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional | 0.18 | $24 | $8 |
| | **99212** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded. | 0.70 | $59 | $31 |
| | **99213** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded. | 1.30 | $95 | $57 |
| | **99214** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded. | 1.92 | $136 | $85 |

| | | | | |
|---|---|---|---|---|
| | **99215** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded. | 2.80 | $192 | $126 |

# HCPCS II device and drug codes

## Device C-codes

| Device | HCPCS II device codes[4,p] | HCPCS II code description |
|---|---|---|
| **Infusion pump** | C1772 | Infusion pump, programmable (implantable) |
| **Intrathecal catheter** | C1755 | Catheter, intraspinal |

The device C-codes above are applicable to this therapy. To determine if there is a C-code for a particular Medtronic device, click here for a C-code finder to search by model number, product name, C-code, C-code description, or product category.

## Device E-codes

| Device | HCPCS II device codes[4] | HCPCS II code description |
|---|---|---|
| **Entire system (catheter and programmable pump)** | E0783 | Infusion pump system, implantable, programmable (includes all components, eg, pump, catheter, connectors, etc) |
| **Programmable pump only (replacement)** | E0786 | Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter) |
| **Intrathecal catheter only (replacement)** | E0785 | Implantable intraspinal (epidural/intrathecal) catheter used with implantable infusion pump, replacement |
| **External patient programmer[q]** | A9900 | Miscellaneous DME supply, accessory, and/or service component of another HCPCS code (used for replacement only) |

## Drug and supply codes

| Drug / supply[r] | HCPCS II codes[4] | HCPCS II code description |
|---|---|---|
| **Morphine sulfate, preservative-free** | J2274 | Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg |
| **Ziconotide, preservative-free** | J2278 | Injection, ziconotide, 1 microgram |
| **Intrathecal baclofen** | J0475 | Injection, baclofen, 10 mg |
| | J0476 | Injection, baclofen, 50 mcg for intrathecal trial |
| **Refill kit[s]** | A4220 | Refill kit for implantable infusion pump |

# Hospital outpatient coding and payment

## Effective January 1, 2026 – December 31, 2026

| Procedure | CPT procedure code and description[1] | APC[5] | APC level | Status indicator[5,t] | Relative weight[5] | Medicare national average[5] |
|---|---|---|---|---|---|---|
| **Screening test**[a,b,c] | **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 | 5443 | Level 3 | T | 9.8849 | $904 |
| | **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) | 5442 | Level 2 | T | 7.8890 | $721 |
| | **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 | 5443 | Level 3 | T | 9.8849 | $904 |
| | **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) | 5443 | Level 3 | T | 9.8849 | $904 |
| **Implantation or revision of catheter**[e] | **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 | 5433 | Level 3 | J1 | 98.0794 | $8,966 |
| **Implantation or replacement of pump**[e] | **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 | 201.4356 | $18,414 |
| **Revision of pump**[f] | **64999** Unlisted procedures, nervous system | 5441 | Level 1 | T | 3.4305 | $314 |
| **Removal of catheter or pump**[e,u] | **62355** Removal of previously implanted intrathecal or epidural catheter | 5431 | Level 1 | Q2 | 21.8238 | $1,995 |
| | **62365** Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion | 5432 | Level 2 | Q2 | 38.1791 | $3,490 |
| **Drug / refill kit**[v] | **J2274** Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg | N/A | N/A | N | N/A | N/A |
| | **J2278** Injection, ziconotide, 1 microgram | 1694 | Ziconotide Injection | K | N/A | ASP + 6% |
| | **J0475** Injection, baclofen, 10 mg | 9032 | Baclofen 10 mg Injection | K | N/A | ASP + 6% |
| | **J0476** Injection, baclofen, 50 mcg for intrathecal trial | N/A | N/A | N | N/A | N/A |
| | **A4220** Refill kit for implantable infusion pump | N/A | N/A | N | N/A | N/A |

## Hospital outpatient coding and payment - continued

| Procedure | CPT procedure code and description[1] | APC[5] | APC level | Status indicator[5,t] | Relative weight[5] | Medicare national average[5] |
|---|---|---|---|---|---|---|
| **Refill / analysis / Reprogramming** [i,j,k] | **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 3 | S | 3.4326 | $314 |
| | **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 3 | S | 3.4326 | $314 |
| | **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 3 | S | 3.4326 | $314 |
| | **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 3 | S | 3.4326 | $314 |
| **Catheter dye study**[m,n] | **61070** Puncture of reservoir for injection procedure | 5442 | Level 2 | T | 7.8890 | $721 |
| | **75809** Shuntogram for investigation of previously placed indwelling non- vascular shunt (eg, indwelling infusion pump)[w] | 5522 | Level 2 | Q2 | 1.1684 | $107 |
| **Evaluation & Management** *Note: This may only be billed in addition to a pump interrogation / programming / refill visit when a significant, separately identifiable assessment and management service takes place. Modifier -25 modifier should be appended to G0463 and documentation requirements must be met.* | **G0463** Hospital outpatient clinic visit for assessment and management of a patient | 5012 | Clinic Visit | J2 | 1.4879 | $136 |
| **Intrathecal baclofen therapy screening test (baseline evaluation & periodic assessment)** when performed by a hospital-employed physical therapist[x] | **97161** Physical therapy evaluation, low complexity[y] | – | – | A | – | – |
| | **97162** Physical therapy evaluation, moderate complexity[y] | – | – | A | – | – |
| | **97163** Physical therapy evaluation, high complexity[y] | – | – | A | – | – |
| | **97750** Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes[z] | – | – | A | – | – |

# ASC coding and payment

## January 1, 2026 – December 31, 2026

| Procedure | CPT procedure code and description[1] | Payment indicator[6,aa] | Multiple procedure discounting[bb] | Relative weight[6] | Medicare national average[6] |
|---|---|---|---|---|---|
| **Screening test**[a,b,c] | **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 | 8.6202 | $486 |
| | **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 | 6.8793 | $387 |
| | **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 | 8.6202 | $486 |
| | **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 | 8.6202 | $486 |
| **Implantation or revision of catheter**[e] | **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 | 101.0365 | $5,691 |
| **Implantation or replacement of pump**[e] | **62362** Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming | J8 | Y | 274.6836 | $15,471 |
| **Removal of catheter or pump**[e,cc] | **62355** Removal of previously implanted intrathecal or epidural catheter | A2 | N | 16.8435 | $949 |
| | **62365** Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion | A2 | N | 38.6613 | $2,177 |

## ASC coding and payment - continued

| Procedure | CPT procedure code and description[1] | Payment indicator[6,aa] | Multiple procedure discounting[bb] | Relative weight[6] | Medicare national average[6] |
|---|---|---|---|---|---|
| **Drug**[dd] | **J2274** Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg | N1 | N/A | N/A | N/A |
| | **J2278** Injection, ziconotide, 1 microgram | K2 | N/A | N/A | ASP + 6% |
| | **J0475** Injection, baclofen, 10 mg | K2 | N/A | N/A | ASP + 6% |
| | **J0476** Injection, baclofen, 50 mcg for intrathecal trial | N1 | N/A | N/A | N/A |
| **Refill / analysis / reprogramming**[i,j] | **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 | P3 | N | N/A | $16 |
| | **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 | P3 | N | N/A | $22 |
| | **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 | P3 | N | N/A | $74 |
| | **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) | P3 | N | N/A | $65 |
| **Catheter dye study**[m,n] | **61070** Puncture of reservoir for injection procedure | A2 | Y | 6.8793 | $387 |
| | **75809** Shuntogram for investigation of previously placed indwelling non-vascular shunt (eg, indwelling infusion pump) | N1 | N/A | N/A | N/A |

# Hospital inpatient coding and payment

## Effective October 1, 2025 – September 30, 2026

| Procedure | ICD-10-PCS[7] procedure codes | ICD-10-PCS procedure code description |
|---|---|---|
| **Trial and catheter procedures** | | |
| **Catheter implantation**[ee,ff] | 00HU33Z | Insertion of infusion device into spinal canal, percutaneous approach |
| **Intrathecal injection** | 3E0R3GC | Introduction of other therapeutic substance into spinal canal, percutaneous approach (used for baclofen) |
| | 3E0R3NZ | Introduction of analgesics, hypnotics, sedatives into spinal canal, percutaneous approach (used for morphine, ziconotide) |
| **Catheter procedures** | | |
| **Catheter implantation**[ee,ff] | 00HU33Z | Insertion of infusion device into spinal canal, percutaneous approach |
| **Intrathecal injection** | 3E0R3GC | Introduction of other therapeutic substance into spinal canal, percutaneous approach (used for baclofen) |
| | 3E0R3NZ | Introduction of analgesics, hypnotics, sedatives into spinal canal, percutaneous approach (used for morphine, ziconotide) |
| **Catheter removal**[gg] | 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 removal of the old device.[hh] | |
| **Catheter revision**[i,j] | 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 procedures** | | |
| **Pump implantation**[jj,kk] | 0JH80VZ | Insertion of infusion pump into abdomen subcutaneous tissue and fascia, open approach |
| **Pump removal**[jj,kk] | 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 removal of the old device.[hh] | |
| **Pump revision**[ll,mm] | 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 |

## MS-DRG assignments: Non-cancer pain

Note: For certain procedures, DRG assignment varies depending on the primary diagnosis.

- Nervous system disorders include: chronic pain disorders, reflex sympathetic dystrophy (CRPS I), causalgia (CRPS II), postherpetic neuralgia/neuropathy, arachnoiditis, and peripheral neuropathy of lower extremities, as well as device complications and attention to device.
- Musculoskeletal system disorders include: radiculopathy of lower extremities, osteoporosis-related vertebral fracture, and postlaminectomy syndrome.

| Procedure | MS-DRG[8] | MS-DRG title[nn] | Relative weight[9] | Medicare national average[9] |
|---|---|---|---|---|
| **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 (ie, medical) DRG is assigned to the stay according to the principal diagnosis. | | | |

## Hospital inpatient coding and payment: MS-DRG assignment Non-cancer pain - continued

| Procedure | | MS-DRG[8] | MS-DRG title[nn] | Relative weight[9] | Medicare national average[9] |
|---|---|---|---|---|---|
| **Implantation: Whole system implantation (pump plus catheter)[oo]** | Nervous system disorders | 040 | Peripheral/Cranial nerve and other nervous system Procedures W MCC | 3.8612 | $28,097 |
| | | 041 | Peripheral/Cranial nerve and other nervous system Procedures W CC | 2.1987 | $15,999 |
| | | 042 | Peripheral/Cranial nerve and other nervous system procedures W/O CC/MCC | 1.7277 | $12,572 |
| | Musculoskeletal system disorders | 515 | Other musculoskeletal system and connective tissue OR procedures W MCC | 3.1869 | $23,190 |
| | | 516 | Other musculoskeletal system and connective tissue OR procedures W CC | 2.0781 | $15,122 |
| | | 517 | Other musculoskeletal system and connective tissue OR procedures W/O CC/MCC | 1.5367 | $11,182 |
| **Implantation: Pump only** | Nervous system disorders | 040 | Peripheral/Cranial nerve and other nervous system procedures W MCC | 3.8612 | $28,097 |
| | | 041 | Peripheral/Cranial nerve and other nervous system procedures W CC | 2.1987 | $15,999 |
| | | 042 | Peripheral/Cranial nerve and other nervous system procedures W/O CC/MCC | 1.7277 | $12,572 |
| | Musculoskeletal system disorders | 515 | Other musculoskeletal system and connective tissue OR procedures W MCC | 3.1869 | $23,190 |
| | | 516 | Other musculoskeletal system and connective tissue OR procedures W CC | 2.0781 | $15,122 |
| | | 517 | Other musculoskeletal system and connective tissue OR procedures W/O CC/MCC | 1.5367 | $11,182 |
| **Implantation: Catheter only** | | 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. | | | |
| **Replacement: Whole system replacement (pump plus catheter)[pp,qq,rr]** | Nervous system disorders | 028 | Spinal procedures W MCC | 6.0083 | $43,721 |
| | | 029 | Spinal procedures W CC | 3.4116 | $24,825 |
| | | 030 | Spinal procedures W/O CC/MCC | 2.1952 | $15,974 |
| **Replacement: Pump only[pp]** | Nervous system disorders | 040 | Peripheral/Cranial nerve and other nervous system procedures W MCC | 3.8612 | $28,097 |
| | | 041 | Peripheral/Cranial Nerve and Other Nervous System Procedures W CC | 2.1987 | $15,999 |
| | | 042 | Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC | 1.7277 | $12,572 |

## Hospital inpatient coding and payment: MS-DRG assignment Non-cancer pain - continued

| Procedure | | MS-DRG[8] | MS-DRG title[nn] | Relative weight[9] | Medicare national average[9] |
|---|---|---|---|---|---|
| **Replacement: Catheter only**[pp,qq] | Nervous system disorders | 028 | Spinal procedures W MCC | 6.0083 | $43,721 |
| | | 029 | Spinal procedures W CC | 3.4116 | $24,825 |
| | | 030 | Spinal procedures W/O CC/MCC | 2.1952 | $15,974 |
| **Removal (without replacement) Whole system removal (pump plus catheter)**[pp,qq,ss,tt] | Nervous system disorders | 028 | Spinal procedures W MCC | 6.0083 | $43,721 |
| | | 029 | Spinal procedures W CC | 3.4116 | $24,825 |
| | | 030 | Spinal procedures W/O CC/MCC | 2.1952 | $15,974 |
| **Removal (without replacement) Pump only**[ss] | | 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. | | | |
| **Removal (without replacement) Catheter only**[pp,qq,ss] | Nervous system disorders | 028 | Spinal procedures W MCC | 6.0083 | $43,721 |
| | | 029 | Spinal procedures W CC | 3.4116 | $24,825 |
| | | 030 | Spinal procedures W/O CC/MCC | 2.1952 | $15,974 |
| **Revision: Catheter (intrathecal portion)**[pp,ss] | Nervous system disorders | 028 | Spinal procedures W MCC | 6.0083 | $43,721 |
| | | 029 | Spinal procedures W CC | 3.4116 | $24,825 |
| | | 030 | Spinal procedures W/O CC/MCC | 2.1952 | $15,974 |
| **Revision: Catheter (subcutaneous portion)**[ss] | | 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. | | | |
| **Revision: Pump**[ss] | | 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. | | | |

## MS-DRG assignments: Cancer pain

| Procedure | | MS-DRG[8] | MS-DRG title[nn] | Relative weight[9] | Medicare national average[9] |
|---|---|---|---|---|---|
| **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 (ie, medical) DRG is assigned to the stay according to the principal diagnosis. | | | | |
| **Implantation: Whole system implantation (pump plus catheter)**[oo] | Neoplasm- related pain | 939 | OR Procedures W Diagnoses of Other Contact W Health Services W MCC | 3.6285 | $26,404 |
| | | 940 | OR Procedures W Diagnoses of Other Contact W Health Services W CC | 2.3369 | $17,005 |
| | | 941 | OR Procedures W Diagnoses of Other Contact W Health Services W/O CC/MCC | 2.0277 | $14,755 |
| | Esophageal, stomach, colon, rectal and anal cancer | 356 | Other Digestive System OR Procedures W MCC | 4.3928 | $31,965 |
| | | 357 | Other Digestive System OR Procedures W CC | 2.3255 | $16,922 |
| | | 358 | Other Digestive System OR Procedures W/O CC/MCC | 1.3979 | $10,172 |

## Hospital inpatient coding and payment: MS-DRG assignment cancer pain - continued

| Procedure | | MS-DRG[8] | MS-DRG title[nn] | Relative weight[9] | Medicare national average[9] |
|---|---|---|---|---|---|
| **Implantation: Whole system implantation (pump plus catheter)[oo] (continued)** | Liver and pancreatic cancer | 423 | Other Hepatobiliary or Pancreas OR Procedures W MCC | 4.1530 | $30,220 |
| | | 424 | Other Hepatobiliary or Pancreas OR Procedures W CC | 2.1879 | $15,921 |
| | | 425 | Other Hepatobiliary or Pancreas OR Procedures W/O CC/MCC | 1.5003 | $10,917 |
| | Lung, bronchus and trachea cancer | 166 | Other Respiratory System OR Procedures W MCC | 3.7377 | $27,198 |
| | | 167 | Other Respiratory System OR Procedures W CC | 1.8034 | $13,123 |
| | | 168 | Other Respiratory System OR Procedures W/O CC/MCC | 1.3664 | $9,943 |
| | Breast cancer | 579 | Other Skin, Subcutaneous Tissue and Breast Procedures W MCC | 3.2385 | $23,566 |
| | | 580 | Other Skin, Subcutaneous Tissue and Breast Procedures W CC | 1.7280 | $12,574 |
| | | 581 | Other Skin, Subcutaneous Tissue and Breast Procedures W/O | 1.4431 | $10,501 |
| | Uterine, cervical, and ovarian cancer | 749 | Other Female Reproductive System OR Procedures W | 2.5676 | $18,684 |
| | | 750 | Other Female Reproductive System OR Procedures W/O CC/ | 1.4758 | $10,739 |
| | Prostate and testicular cancer | 715 | Other Male Reproductive System OR Procedures for Malignancy W CC/MCC | 2.2373 | $16,280 |
| | | 716 | Other Male Reproductive System OR Procedures for Malignancy W/O CC/MCC | 1.4710 | $10,704 |
| | Kidney and bladder cancer | 673 | Other Kidney and Urinary Tract Procedures W MCC | 4.2016 | $30,574 |
| | | 674 | Other Kidney and Urinary Tract Procedures W CC | 2.3386 | $17,017 |
| | | 675 | Other Kidney and Urinary Tract Procedures W/O CC/MCC | 1.6414 | $11,944 |
| | Brain and spinal cord cancer | 040 | Peripheral/Cranial Nerve and Other Nervous System Procedures W MCC | 3.8612 | $28,097 |
| | | 041 | Peripheral/Cranial Nerve and Other Nervous System Procedures W CC | 2.1987 | $15,999 |
| | | 042 | Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC | 1.7277 | $12,572 |
| | Bone cancer and pathological fracture due to bone cancer | 515 | Other Musculoskeletal System and Connective Tissue OR Procedures W MCC | 3.1869 | $23,190 |
| | | 516 | Other Musculoskeletal System and Connective Tissue OR Procedures W CC | 2.0781 | $15,122 |
| | | 517 | Other Musculoskeletal System and Connective Tissue OR Procedures W/O CC/MCC | 1.5367 | $11,182 |

## Hospital inpatient coding and payment: MS-DRG assignment cancer pain - continued

| Procedure | | MS-DRG[8] | MS-DRG title[nn] | Relative weight[9] | Medicare national average[9] |
|---|---|---|---|---|---|
| **Pump only implantation** | | The same DRGs are assigned for pump only implantation as for whole system implantation (see above). | | | |
| **Catheter only implantation** | | 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. | | | |
| **Replacement: Whole system replacement (pump and catheter)**[pp,qq,rr] | Nervous system disorders | 028 | Spinal Procedures W MCC | 6.0083 | $43,721 |
| | | 029 | Spinal Procedures W CC | 3.4116 | $24,825 |
| | | 030 | Spinal Procedures W/O CC/MCC | 2.1952 | $15,974 |
| **Replacement: Pump only**[pp] | Nervous system disorders | 040 | Peripheral/Cranial Nerve and Other Nervous System Procedures W MCC | 3.8612 | $28,097 |
| | | 041 | Peripheral/Cranial Nerve and Other Nervous System Procedures W CC | 2.1987 | $15,999 |
| | | 042 | Peripheral/Cranial Nerve and Other Nervous System dures W/O CC/MCC | 1.7277 | $12,572. |
| **Replacement: Catheter only**[pp,qq] | Nervous system disorders | 028 | Spinal Procedures W MCC | 6.0083 | $43,721 |
| | | 029 | Spinal Procedures W CC | 3.4116 | $24,825 |
| | | 030 | Spinal Procedures W/O CC/MCC | 2.1952 | $15,974 |
| **Removal (without replacement) Whole system removal (pump plus catheter)** [pp,qq,ss,tt] | Nervous system disorders | 028 | Spinal Procedures W MCC | 6.0083 | $43,721 |
| | | 029 | Spinal Procedures W CC | 3.4116 | $24,825 |
| | | 030 | Spinal Procedures W/O CC/MCC | 2.1952 | $15,974 |
| **Removal (without replacement) Pump only** [pp,ss] | | 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. | | | |
| **Removal (without replacement) Catheter only**[pp,qq,ss] | Nervous system disorders | 028 | Spinal Procedures W MCC | 6.0083 | $43,721 |
| | | 029 | Spinal Procedures W CC | 3.4116 | $24,825 |
| | | 030 | Spinal Procedures W/O CC/MCC | 2.1952 | $15,974 |
| **Revision Catheter (intrathecal portion)** [pp,ss] | Nervous system disorders | 028 | Spinal Procedures W MCC | 6.0083 | $43,721 |
| | | 029 | Spinal Procedures W CC | 3.4116 | $24,825 |
| | | 030 | Spinal Procedures W/O CC/MCC | 2.1952 | $15,974 |
| **Revision Catheter (subcutaneous portion)** [ss] | | 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. | | | |
| **Revision Pump**[ss] | | 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. | | | |

## MS-DRG assignments: spasticity conditions

| Procedure | | MS-DRG[8] | MS-DRG title[nn] | Relative weight[9] | Medicare national average[9] |
|---|---|---|---|---|---|
| **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 (ie, medical) DRG is assigned to the stay according to the principal diagnosis | | | | |
| **Implantation: Whole system implantation (pump plus catheter)[oo]** | Nervous system disorders | 040 | Peripheral/cranial nerve and other nervous system procedures W MCC | 3.8612 | $28,097 |
| | | 041 | Peripheral/cranial nerve and other nervous system procedures W CC | 2.1987 | $15,999 |
| | | 042 | Peripheral/cranial nerve and other nervous system procedures W/O CC/MCC | 1.7277 | $12,572 |
| **Implantation: Pump only** | Nervous system disorders | 040 | Peripheral/cranial nerve and other nervous system procedures W MCC | 3.8612 | $28,097 |
| | | 041 | Peripheral/cranial nerve and other nervous system procedures W CC | 2.1987 | $15,999 |
| | | 042 | Peripheral/cranial nerve and other nervous system procedures W/O CC/MCC | 1.7277 | $12,572 |
| **Implantation: Catheter only** | | 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. | | | |
| **Replacement: Whole system replacement (pump plus catheter)[qq,rr]** | Nervous system disorders | 028 | Spinal procedures W MCC | 6.0083 | $43,721 |
| | | 029 | Spinal procedures W CC | 3.4116 | $24,825 |
| | | 030 | Spinal procedures W/O CC/MCC | 2.1952 | $15,974 |
| **Replacement: Pump only** | Nervous system disorders | 040 | Peripheral/cranial nerve and other nervous system procedures W MCC | 3.8612 | $28,097 |
| | | 041 | Peripheral/cranial nerve and other nervous system procedures W CC | 2.1987 | $15,999 |
| | | 042 | Peripheral/cranial nerve and other nervous system procedures W/O CC/MCC | 1.7277 | $12,572 |
| **Replacement: Catheter only[qq]** | Nervous system disorders | 028 | Spinal procedures W MCC | 6.0083 | $43,721 |
| | | 029 | Spinal procedures W CC | 3.4116 | $24,825 |
| | | 030 | Spinal procedures W/O CC/MCC | 2.1952 | $15,974 |
| **Removal (without replacement) Whole system removal (pump plus catheter)[qq,ss,tt]** | Nervous system disorders | 028 | Spinal procedures W MCC | 6.0083 | $43,721 |
| | | 029 | Spinal procedures W CC | 3.4116 | $24,825 |
| | | 030 | Spinal procedures W/O CC/MCC | 2.1952 | $15,974 |
| **Removal (without replacement): Pump only[ss]** | | 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. | | | |

**Hospital inpatient coding and payment: MS-DRG assignment spasticity conditions - continued**

| Procedure | | MS-DRG[8] | MS-DRG title[nn] | Relative weight[9] | Medicare national average[9] |
|---|---|---|---|---|---|
| **Removal (without replacement): Catheter only** [qq,ss] | Nervous system disorders | 028 | Spinal Procedures W MCC | 6.0083 | $43,721 |
| | | 029 | Spinal Procedures W CC | 3.4116 | $24,825 |
| | | 030 | Spinal Procedures W/O CC/MCC | 2.1952 | $15,974 |
| **Revision Catheter (intrathecal portion)**[ss] | Nervous system disorders | 028 | Spinal Procedures W MCC | 6.0083 | $43,721 |
| | | 029 | Spinal Procedures W CC | 3.4116 | $24,825 |
| | | 030 | Spinal Procedures W/O CC/MCC | 2.1952 | $15,974 |
| **Revision Catheter (subcutaneous portion)**[ss] | | 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. | | | |
| **Revision Pump**[ss] | | 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 | | | |

## Annual references


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2. PFS 2026 Final Rule CMS-1832-F Addenda. Cms.gov. Published October 31, 2025. https://www.cms.gov/files/zip/cy-2026-pfs-final-rule-addenda.zip. Although the total RVU consists of three components, only the physician work RVU is shown.
3. PFS 2026 Final Rule CMS-1832-F | CMS. Cms.gov. Published October 31, 2025. https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-f. Local physician rates will vary based on location specific factors not reflected in this document.
4. HCPCS 2025 Level II Professional Edition. American Medical Association; 2024.These codes are used by the entity that purchased and supplied the medical device. For Medicare hospital outpatient claims, C codes are required. For Medicare ASC claims, C codes are not reported unless the device is eligible for transitional pass-through payment. For non-Medicare hospital or ASC claims, please consult payer specific contracts for whether C or L codes would be billed.
5. OPPS 2026 Final Rule CMS-1834-FC | CMS. Cms.gov. Published November 21, 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1834-fc. Rates shown reflect the unadjusted OPPS payment rates. Actual reimbursement may vary based on hospital-specific factors, such as wage index, geographic adjustments, and other CMS payment modifiers.
6. ASC 2026 Final Rule CMS-1834-FC | CMS. Cms.gov. Published November 21, 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and-notices/cms-1834-fc. Rates shown reflect the unadjusted ASC payment rates. Actual reimbursement may vary based on hospital-specific factors, such as wage index, geographic adjustments, and other CMS payment modifiers.
7. AAPC. ICD-10-PCS Code Book 2026. AAPC; 2025.
8. CMS. ICD-10-CM/PCS MS-DRG v43.0 Definitions Manual. Cms.gov. Published 2025. https://www.cms.gov/icd10m/FY2026-fr-v43-fullcode-cms/fullcode_cms/P0001.html
9. FY 2026 IPPS Final Rule Home Page | CMS. Cms.gov. Published July 31, 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps-final-rule-home-page. Rates shown reflect the unadjusted IPPS payment rates. Actual reimbursement may vary based on hospital-specific factors, such as wage index, geographic adjustments, and other CMS payment modifiers.


## Important Information

a. Codes 62322-62323 are used for needle injection or when a temporary catheter is placed to administer one or more injections on a single calendar day. Codes 62322-62327 are assigned based on the region of the body where the needle is injected. CPT Assist, Sept 2023 p.46. Codes 62326-62327 are used when the catheter is left in place to deliver the agent continuously or intermittently for more than a single calendar day. According to CPT manual instructions, placement of the temporary or indwelling catheter is integral and not coded separately.

b. Codes 62322 and 62326 are defined for injection or catheter placement without imaging guidance. Codes 62323 and 62327 are defined for injection or catheter placement with imaging guidance. Because imaging is included in the definitions of codes 62323 and 62327, no additional codes should be assigned for use of imaging. According to CPT manual instructions, fluoroscopy and injection of contrast are included in codes 62323 and 62327 and should not be coded separately.

c. Check 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 62326-62327 with modifier -22 to indicate that tunneling substantially increases the work.

d. Check with the payer for specific guidelines on submitting additional codes for significant patient monitoring and assessment performed by the physician as part of the screening trial in the office setting. Options may include appending modifier -22 to the injection code to indicate the substantially increased work, or use of a separate E&M code to represent a significant, separately identifiable service above and beyond routine post-injection work.

e. For pump and catheter replacement, NCCI edits do not allow removal of the existing device to be coded separately with implantation of the new device. See also 2022 AANS Guide to Coding, p.79. When a catheter revision is performed where no device was inserted, the CG modifier may be appended to CPT 62350 to bypass the device edit. The CG modifier is not required for critical access hospitals. Medicare Claims Processing Manual Chapter 4, section 20.6.19.

f. Pump revision includes procedures such as reshaping the pocket, relocating the pocket, or opening the pocket to correct a flipped pump or to reconnect the catheter, all while re-inserting the existing pump without replacing it with a new pump. There is no CPT code specifically defined for pump revision so an unlisted code is used. For Medicare, the unlisted code is contractor-priced. Contractors establish the RVUs and the payment amount, usually on an individual basis after review of the procedure report.

g. The payment amount is based on the ASP methodology and payment to the providers is made at 106 percent of the ASP. Medicare Claims Processing Manual, Chapter 17-Drugs and Biologicals, Section 20.1.2. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf. This also lists exceptions to the general rule. The ASP methodology uses quarterly drug pricing data submitted to the CMS by drug manufacturers. Average Sales Price (ASP) values are publicly available at: https://www.cms.gov/medicare/medicare-fee-for-service-part-b-drugs/mcrpartbdrugavgsalesprice. CMS updates ASP drug pricing on a quarterly basis.

h. For Medicare, this code is designated as bundled into the physician's primary service when pump refill is performed in the office and is not separately payable. However, other payers may make a separate payment depending on the provider contract and their payment methodology.

i. Use 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.

j. The AMA has published that when a pump is refilled and the pump is reprogrammed in any way, either 62369 or 62370 is assigned. However, when a pump is refilled but no changes were made to any of the parameters for the pump's operation (eg, changing the drug rate or dose), either 95990 or 95991 is assigned. CPT Assistant, May 2022, p.15; see also 2022 AANS Guide to Coding, p.80. Medtronic programmable pumps always require reprogramming of the reservoir volume at the time of refill and may or may not require changes to other parameters.

k. Code 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.

l. Code 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, eg. nurse practitioner.

m. The AMA has published that codes 61070 and 75809 are assigned for implanted pump catheter dye studies. CPT Assistant, September 2008, p.10.

n. Some pump models may also undergo a pump rotor study. When performed, this is coded 62368 for pump analysis with reprogramming plus 76000 for fluoroscopy.

o. RVUs exist for this code in the office setting. However, payment is not displayed because the associated puncture code 61070 and professional component –26 are customarily provided in the facility setting.

p. ASCs should report all charges incurred. However, only charges for non-packaged items, eg, device codes eligible for pass-through payment, should be billed as separate line items. For example, the ASC should report its charge for the pump but because the pump is a packaged item, the charge should not be reported on its own line. Instead, the ASC should bill a single line for the implantation procedure with a single total charge, including not only the charge associated with the operating room but also the charges for the pump, catheter, and all other packaged items. Because of a Medicare requirement to pay the lesser of the ASC rate or the line-item charge, breaking these packaged charges out onto their own lines can result in incorrect payment to the ASC. Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual, Chapter 14–Ambulatory Surgical Centers, Section 40. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf. Accessed November 30, 2022.

q. The CMS HCPCS Workgroup maintains that the external patient programmer is included as a component of E0783 when the system is initially implanted, regardless of whether it is provided to the patient at that time. See Medicare Pricing Data Analysis and Coding (PDAC) database at https://www4.palmettogba.com/pdac_dmecs/searchProductClassificationResults.do?aciotnPath=search, under Medtronic (Personal Therapy Manager). If the external patient programmer must later be replaced, code A9900 can be assigned.

r. ASCs should report all charges incurred. However, only charges for non-packaged items should be billed as separate line items, eg, drugs eligible for separate payment. For example, the ASC should report its charge for preservative-free morphine sulfate but because J2274 is a packaged drug, the charge should not be reported on its own line. Instead, the ASC should bill a single line for the implantation procedure with a single total charge, including not only the charge associated with the operating room but also the charges for the pump, catheter, morphine, supplies and all other packaged items. Because of a Medicare requirement to pay the lesser of the ASC rate or the line-item charge, breaking these packaged charges out onto their own lines can result in incorrect payment to the ASC. In contrast, J2278 and J0474 are not packaged drugs. The charges associated with these codes should be broken out and billed as their own line item with HCPCS II code J2278 or J0475. See Medicare Claims Processing Manual, Chapter 14–Ambulatory Surgical Centers, Section 40. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf. Accessed November 30, 2022.

s. HCPCS II supply code A4220 for the refill kit cannot be reported to Medicare together with CPT codes for the service of refilling the pump, eg, 62369, 62370. National Correct Coding Initiative (NCCI) Policy Manual, 1/1/2023, Chapter XII.C.7. Some non-Medicare payers may recognize the code for separate payment.

t. Status Indicator (SI) shows how a code is handled for payment purposes. J1 = paid under comprehensive APC, single payment based on primary service without separate payment for other adjunctive services; S = always paid at 100% of rate; T = paid at 50% of rate when billed with another higher-weighted T procedure; N = packaged service, no separate payment. See notes 11 and 19 for status indicator Q2. See note 12 for status indicator K.

u. Status Q2 indicates that device removal codes 62355 and 62365 are conditionally packaged and are usually not separately payable. However, a device removal code is separately payable when it is the only procedure performed. Or when both device removal codes 62355 and 62365 are performed together, with no other procedures, then status J1 applies and only higher-ranked code 62365 is paid.

v. Although most drugs, including J2274 andf J0476, are packaged and not separately payable, codes J2278 and J0475 are designated as a "specified covered outpatient drug" with status indicator K = non-pass-through drugs, paid under separate APC unless submitted with J1. Code J2278 and J0475 are not paid separately when the pump is filled during the same encounter as when the pump is implanted because pump implantation code 62362 maps to a C-APC and is status J1. Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual, Chapter 4—Part B Hospital, Section 10.2.3. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf. Accessed November 30, 2022.

w. Status Q2 indicates that code 75809 is conditionally packaged. Although separately payable in certain unusual circumstances, it 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.

x. The physician performs the injection itself. The hospital-employed physical therapist performs the baseline evaluation and periodic assessments over the course of 6 to 8 hours to gauge the effectiveness of the ITB therapy, outside of standard evaluation for any complications and routine recovery from the injection. Under APCs, physical therapy services billed by a hospital are status A = services furnished to a hospital outpatient that are paid separately under a different fee schedule. Physical therapy services billed by a hospital are paid to the hospital using fees from the Physician Fee Schedule.

y. Use of physical therapy evaluation codes 97161-97163 for the ITB screening test assumes that prior evaluation had not been performed. The PT must document the impairment as well as all conditions and complexities that may impact the treatment, the current functional status, objective measurements, clinical judgments, a determination of whether or not the therapy could be useful, and a prognosis for benefit. The evaluation must also meet the requirements for "low", "moderate" and "high" complexity as outlined in the CPT manual.

z. Use of code 97750 for the periodic assessments reflects additional objective documentation of a patient's condition or status, usually performed every two hours after the injection. Observational assessment may be included but hands-on measurement is required. These types of tests include isokinetic testing, functional capacity evaluation, and gait and balance assessments, including the Ashworth scale. A distinct report is required, documenting the specific test performed, the time spent, and the test results as well as how results could impact treatment planning. Note that code 97750 for periodic assessment is NCCI-edited with codes 97161-97163 for the evaluation when performed during the same encounter, with no override allowed. Code 97750 can be reported when initial evaluation is not being reported for thecurrent encounter, for example when an evaluation was previously performed. NCCI Policy Manual, 1/1/2023, Chapter XI.P.8.

aa. The Payment Indicator shows how a code is handled for payment purposes. J8 = device-intensive procedure, payment amount adjusted to incorporate device cost; A2 = surgical procedure, payment based on hospital outpatient rate adjusted for ASC; G2 = surgical procedure, non-office- based, payment based on hospital outpatient rate adjusted for ASC; 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.

bb. When multiple procedures are coded and billed, payment is usually made at 100% of the rate for the first procedures and 50% of the rate for the second and all subsequent procedures. These procedures are marked "Y." However, procedures marked "N" are not subject to this discounting and are paid at 100% of the rate regardless of whether they are submitted with other procedures.

cc. Code 64999 for pump revision is not shown because Medicare does not cover unlisted codes in the ASC setting. However, other payers may make a separate payment depending on the provider contract and their payment methodology.

dd. Although most drugs, including J2274, are packaged and not separately payable, codes J2278 and J0475 are designated as an "ASC covered ancillary service integral to covered surgical procedures for CY 2024" and generates separate payment.

ee. Approach value 3-Percutaneous is used because the catheter is placed by spinal needle via puncture or minor incision.

ff. The Ascenda intrathecal catheter uses device value 3-Infusion Device per the ICD-10-PCS Device Key.

gg. Approach value 0-Open is used when the catheter is removed by dissection to free the device. Approach value 3-Percutaneous is used when the catheter is removed by puncture or minor incision. Only the ICD-10-PCS codes for surgical removal of the catheter are displayed. Approach value X-External is also available for removal of catheter by simple pull.

hh. CMS ICD-10-PCS Reference Manual 2016, p.67. See also Coding Clinic, 3rd Q 2014, p.19.

ii. For catheter revision, the ICD-10-PCS codes using body part value U-Spinal Canal refer to surgical revision of the catheter, eg, repositioning, within the spinal intrathecal space. The ICD-10-PCS codes using body part value T-Subcutaneous Tissue and Fascia refer to revision of the subcutaneous portion of the catheter. See also Coding Clinic, 3rd Q 2022, p.24-25.

jj. Placement of the pump is shown with approach value 0-Open because creating the pocket requires surgical dissection and exposure. Removal also usually requires surgical dissection to free thedevice.

kk. The SynchroMed pump uses device value V-Infusion Device, Pump per the ICD-10-PCS Device Key.

ll. For Pump Revision, the ICD-10-PCS codes shown can be assigned for opening the pocket for pump revision, as well as reshaping or relocating the pocket while reinserting the same pump. A code for repair of subcutaneous tissue may be assigned for significant reshaping of the pocket, eg, soft tissue flaps. Coding Clinic, 3rd Q 2022, p.24-25.

mm. Approach value X-External is also available for external pump manipulation without opening the pocket, eg. to correct a flipped pump.

nn. 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/MCC 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.

oo. When the pump and catheter are implanted together as a whole system, the pump implantation code is the "driver" and groups to the DRGs shown.

pp. Pumps and catheters may be replaced, removed, or revised for diagnoses involving device complications or attention to device. Because these diagnoses are classified as nervous system disorders, procedures involving replacement, removal and revision are generally assigned to Nervous System MS-DRGs in these scenarios.

qq. Removal of the catheter, either without replacement or together with catheter insertion as a component of catheter replacement, is usually performed via an open approach by dissecting through the subcutaneous tissue or fascia to expose and free the catheter for extraction. When coded to open approach, catheter removal impacts DRG assignment as shown. However, percutaneous removal via puncture or minor incision is not considered a significant procedure and other DRGs may be assigned.

rr. When the pump and catheter are replaced as a whole system, the code for open catheter removal as a component of its replacement is the "driver" and groups to the DRGs shown.

ss. Procedures involving device removal without replacement and device revision are typically performed as an outpatient. They are shown here for the occasional scenario where removal or revision requires inpatient admission.

tt. When the pump and catheter are removed as a whole system without replacement, the code for open catheter removal is the "driver" and groups to the DRGs shown.