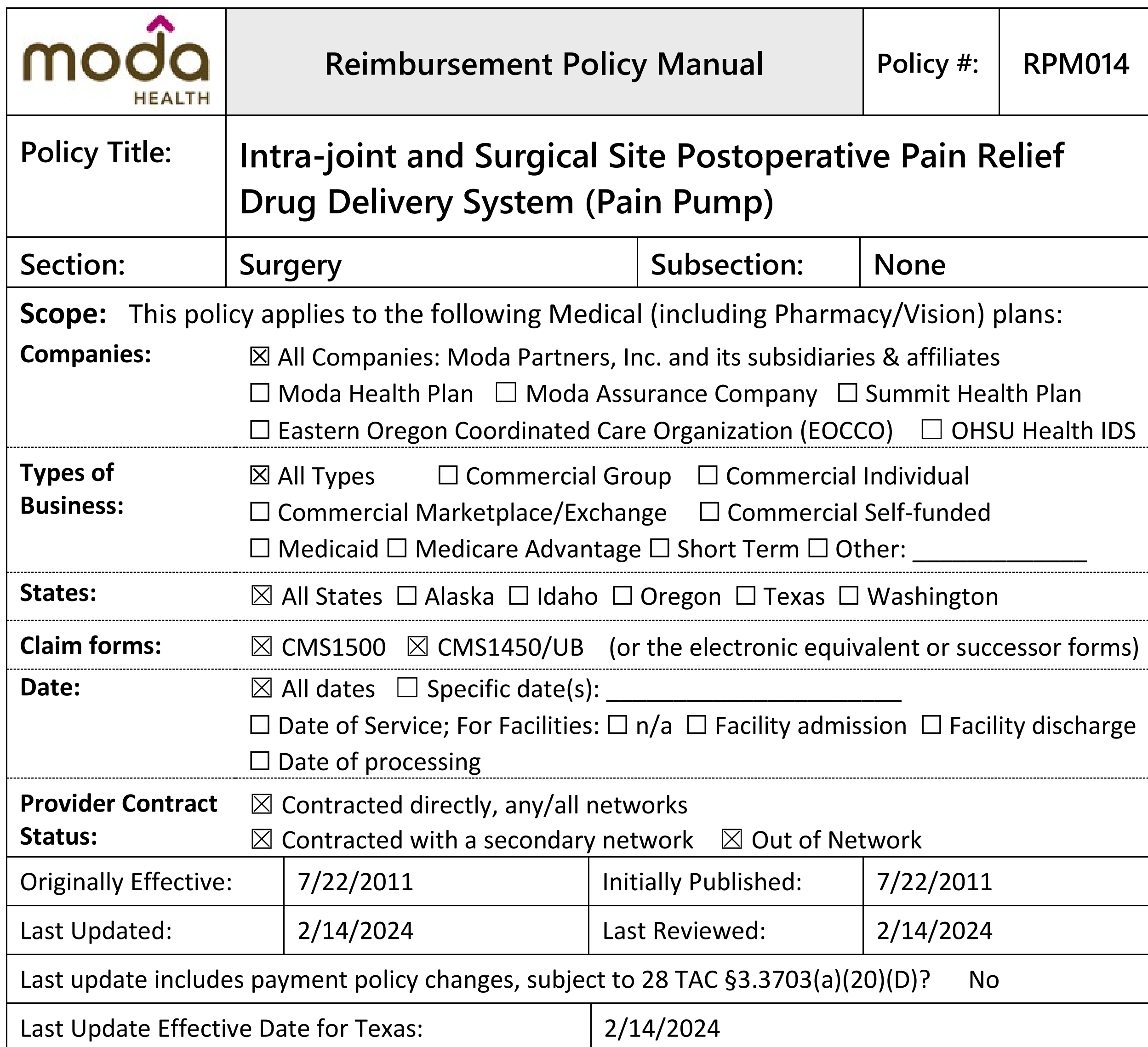

moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM014
Policy Title:	Intra-joint and Surgical Site Postoperative Pain Relief Drug Delivery System (Pain Pump)		
Section:	Surgery	Subsection:	None

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____________
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): ______________________ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	7/22/2011	Initially Published:	7/22/2011
Last Updated:	2/14/2024	Last Reviewed:	2/14/2024
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)?	No		
Last Update Effective Date for Texas:	2/14/2024		

Reimbursement Guidelines

Placement of a pain pump catheter(s) for postoperative pain control is not eligible for separate reimbursement, regardless of the procedure code used to identify this service. Payment for the work involved is considered included in the allowance for the definitive and/or primary surgical procedure code(s) (e.g., knee surgery, shoulder surgery).

The CPT or HCPCS code(s) used to describe a surgical procedure includes all services integral to accomplishing the procedure (CMS[1]), including but not limited to:

1. Insertion and removal of drains, suction devices, and pumps into same site. (CMS[1])
2. Topical or regional anesthetic administered by the physician performing the procedure. (CMS[2, 3])
3. Application, management, and removal of postoperative dressings including anesthetic devices (peri-incisional). (CMS[1])
4. The management of postoperative pain by the surgeon who performed the procedure, including epidural or subarachnoid drug administration, is included in the global period services associated with the operative procedure. (CMS[5])

Disposable drug delivery systems (included but not limited to A4305, A4306, A9274) do not meet the Medicare definition of durable medical equipment (DME). Disposable drug delivery systems are

considered surgical supplies for the definitive and/or primary surgical procedure code(s) and are not eligible for separate reimbursement. Drugs and supplies used with disposable drug delivery systems are also considered surgical supplies and are not eligible for separate reimbursement. These items will be denied to provider liability as bundled in the payment for the definitive surgical procedure code(s).

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
UB	=	Uniform Bill

Procedure codes (CPT & HCPCS):

There are no CPT or HCPCS codes that describe placement of a pain pump catheter.

The following listed CPT codes have been used to report the placement of a pain pump catheter for postoperative pain control. However, none of these procedure codes accurately describe this procedure, and should not be used for this purpose. Regardless of the procedure code used, this service is not eligible for separate reimbursement.

Code	Code Description
11981	Insertion, non-biodegradable drug delivery implant
37202	Transcatheter therapy, infusion other than for thrombolysis

The following unlisted CPT codes may also be used to report the placement of a pain pump catheter for postoperative pain control. This list is not exhaustive. Other unlisted codes may also be used, depending

on the surgical site involved. Regardless of the procedure code used, this service is not eligible for separate reimbursement.

Code	Code Description
19499	Unlisted procedure, breast
20999	Unlisted procedure, musculoskeletal system, general
22899	Unlisted procedure, spine
22999	Unlisted procedure, abdomen, musculoskeletal system
23929	Unlisted procedure, shoulder
27599	Unlisted procedure, femur or knee
49329	Unlisted laparoscopy procedure, abdomen, peritoneum and omentum
49999	Unlisted procedure, abdomen, peritoneum and omentum

The following HCPCS codes may be used to report disposable drug delivery systems. This list is not exhaustive. Regardless of the procedure code used, these items are not eligible for separate reimbursement.

Code	Code Description
A4305	Disposable drug delivery system, flow rate of 50 ml or greater per hour
A4306	Disposable drug delivery system, flow rate of less than 50 ml per hour
A9274	External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

It is not correct coding to use a CPT or HCPCS code that does not accurately describe the procedure being performed. CPT specifically states: "Select the name of the procedure or service that accurately identifies the service performed. **Do not select a CPT code that merely approximates the service provided.** If no such specific code exists, then report the service using the appropriate unlisted procedure or service code." (AMA[7]) (Bold added)

"Some services are integral to large numbers of procedures. Other services are integral to a more limited number of procedures. Examples of services integral to a large number of procedures include:

…
- Local, topical or regional anesthesia administered by the physician performing the procedure
…
- Insertion and removal of drains, suction devices, and pumps into same site
- Surgical closure and dressings
- Application, management, and removal of postoperative dressings and analgesic devices (peri-incisional)
- Application of TENS unit
- Institution of Patient Controlled Anesthesia

…" (CMS[1])

"Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 62320-62327, 64400-64489, and 96360-96377 describe some services that may be used for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) may be reported with an NCCI-associated modifier if performed in a non-facility site of service." (CMS[2])

"With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The provider/supplier shall not report CPT codes 00100-01999, 62320-62327, or 64400-64530 for anesthesia for a procedure." (CMS[3, 4])

"Additionally, the provider/supplier shall not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), drug administration (CPT codes 96360-96377) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) shall not be reported when these procedures are related to the delivery of an anesthetic agent." (CMS[3])

"Injections of local anesthesia for musculoskeletal procedures (surgical or manipulative) are not separately reportable….CPT codes 64450 (Injection, anesthetic agent; other peripheral nerve or branch) and 64455 (Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (e.g., Morton's neuroma)) shall not be reported by a surgeon for anesthesia for a surgical procedure." (CMS[3])

"With few exceptions, the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes." (CMS[10])

Cross References

"Global Surgery Package for Professional Claims", Moda Health Reimbursement Policy Manual, RPM011.

References & Resources

1. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, §B, "Coding Based on Standards of Medical/Surgical Practice", pages I-7 – I-10.

2. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 4 Surgery: Musculoskeletal System, § I.20, "General Policy Statements," p IV-18.

3. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 4 Surgery: Musculoskeletal System, § C, "Anesthesia," pages IV-4 – IV-5.

4. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § C, pages I-10 – I-13.

5. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 3 Integumentary System, § C, pages III-3 – III-4.

6. CMS. *National Correct Coding Initiative Policy Manual*. Chapters 3, 4, 5, 6, 8, 11, 12 and 13, “General Policy Statements”.

7. American Medical Association. “Introduction - Instructions for Use of the CPT Codebook.” *Current Procedural Terminology (CPT)*. Chicago: AMA Press.

8. Noridian Healthcare Solutions, LLC & CGS Administrators, LLC. “External Infusion Pumps.” Medicare DME MAC # 19003, Jurisdiction D & Medicare DME MAC # 17013, Jurisdiction B. LCD # L33794. January 1, 2021; February 24, 2021.

9. Noridian Healthcare Solutions, LLC & CGS Administrators, LLC. “External Infusion Pumps.” Medicare DME MAC # 19003, Jurisdiction D & Medicare DME MAC # 17013, Jurisdiction B. Article # A52507. September 15, 2020; February 24, 2021.

10. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 4 Surgery: Musculoskeletal System, § I.5, “General Policy Statements,” p IV-15.

Background Information

Following any surgical procedure there is some degree of pain experienced by the patient. One method of extended pain control being used is the “pain pump”. One or more catheters are placed at the operative site. The catheter is connected to a pain pump that provides continuous infusion of a local anesthetic. The pain pump catheter is usually left in for several days.

Some of the pain pumps that may be used include, but are not limited to, the Marcaine Pump, ON-Q PainBuster Post-Op Pain Relief System, ON-Q C-bloc, Stryker Pain Pump.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member’s medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS’ National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member’s medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member’s medical benefit plan, the member’s medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider’s agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
2/14/2024	Annual/Formatting/Update: Cross References: Hyperlink added.
10/12/2022	Clarification/Update: Change to new header. 3rd paragraph, item # 3: Added "(peri-incisional)" from the CMS footnoted reference. Coding Guidelines: Added 6 quotes. References & Resources: Verified current numbering & updated CMS NCCI references. Added Texas MAC for # 8 & 9. Added item # 10. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
7/22/2011	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
7/22/2011	Original Effective Date (with or without formal documentation). Policy based on CMS guidelines & citations as indicated.