REIMBURSEMENT POLICY STATEMENT
OHIO MEDICAID

Policy Name		Policy Number	Effective Date
Implantable Pain Pump		PY-1070	11/01/2020
Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policy Statement: Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

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A. Subject

Implantable Pain Pump

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Nearly 84% of adults experience back pain during their lifetime. Long term outcomes are largely favorable for most patients, but a small percentage of patient's symptoms are categorized as chronic. Chronic pain is defined by the International Association for the Study of Pain as: "pain that persists beyond normal tissue healing time, which is assumed to be three months".

Interventional procedures for management of acute and chronic pain are part of a comprehensive pain management care plan that incorporates conservative treatment in a multimodality approach. Multidisciplinary treatments include promoting patient self-management and aim to reduce the impact of pain on a patient's daily life, even if the pain cannot be relieved completely. Interventional procedures for the management of pain unresponsive to conservative treatment should be provided only by physicians qualified to deliver these health services.

C. Definitions

- **Implantable Pain Pump -** Implantable pain pumps are medical devices which are inserted subcutaneously to deliver drugs for infusion through intrathecal catheters. Implantable pain pumps allow drug delivery directly to specific sites and can be programmed for continuous or variable rates of infusion.

D. Policy

I. Prior authorization is required for all implantable pain pumps, including trial administration, permanent placement, single shot intrathecal injections and removal and revision of the implanted device. Prior authorization is not required when the drug is prescribed under one of the following circumstances:
   A. To an individual who is a hospice patient in a hospice care program;
   B. To an individual who has been diagnosed with a terminal condition but is not a hospice patient in a hospice care program; and

C. To an individual who has cancer or another condition associated with the individual's cancer or history of cancer.

II. Prior authorization for implantable pain pump services are not required for the following:
   A. Implantable device is considered part of the procedure and does not require a separate PA.
   B. Analysis post implantation.
   C. Refilling and maintenance of the implanted device.

III. Short term and permanent Implantable Pain Pumps are considered medically necessary according to the criteria found in the Implantable Pain Pump medical policy MM-0077.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

F. Related Policies/Rules

Implantable Pain Pump MM-0077

G. Review/Revision History

	DATE	ACTION
Date Issued	07/26/2016	
Date Revised	07/08/2020 08/26/2020	Annual Update: Addition of PA non-requirement criteria. PA is now required for removal/revision of the implanted device.
Date Effective	11/01/2020	
Date Archived		

H. References

1. Ohio Department of Medicaid Fee Schedules and Rates. Retrieved on April 15, 2020 from www.medicaid.ohio.gov
2. Ohio Revised Code. ORC 1751.691 (2017, April 6) Prior authorization requirments or other utlilzation review measures as conditions of providing coverage of an opioid analgesic. Retrieved on July 1, 2020 from codes.ohio.gov

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.