CareSource

REIMBURSEMENT POLICY STATEMENT
INDIANA MEDICAID

Original Issue Date	Next Annual Review	Effective Date
01/01/2017	01/01/2018	01/01/2017 - 07/14/2018
Policy Name		**Policy Number**
Pain Management		PY-0127
Policy Type		
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

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.

CONTENTS OF POLICY

A. SUBJECT

Pain Management

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 does not imply any right to reimbursement or guarantee claims payment.

Pain management is a branch of medicine employing an interdisciplinary approach for easing the suffering and improving the physical function and quality of life of those living with chronic pain. Treatment approaches to chronic pain include, but are not limited to, pharmacological measures, interventional procedures, physical therapy, physical exercise, application of ice and/or heat, and psychological measures, such as biofeedback and cognitive behavioral therapy. Pain management, regarding this policy, is the utilization of different types of injections, stimulator or infusion pump for the relief of chronic pain.

C. DEFINITIONS

- **Medically necessary** - health services that are necessary for the diagnosis or treatment of disease, illness, or injury and meet accepted standards of medical practice.

D. POLICY

I. Prior Authorization (PA): CareSource requires prior authorization for selected pain management injections as described below, for all places of service.

II. Trigger Point Injections (CPT codes 20552 and 20553)
   A. CareSource will reimburse up to a maximum of no more than eight dates of service per calendar year per patient, regardless of location, duration of symptoms, rendering provider, or interval between injections.
   B. CareSource will not reimburse for localization by any technique for trigger point injections.
   C. No prior authorization is required for par providers.

III. Sacroiliac Procedures
   A. Sacroiliac joint injections (CPT code 27096, G0260, G0259)
      1. CareSource will reimburse injections for diagnosis or treatment that are given no less than 14 calendar days apart, with no more than four injections total, 2 per side, in a rolling 12 months.
      2. Image guidance and/or injection of contrast for sacroiliac joint injections for pain will be denied for coverage as not medically necessary. If neural blockade is applied for different regions, or different sides, injections are performed at least one week apart and timelines are monitored in the PA process.
      3. Monitored anesthesia and conscious sedation will be denied as not medically necessary.
      4. Prior authorization is required for providers.
   B. Sacroiliac neurotomy

1. Thermal or pulsed, cooled neurotomy by Radio-Frequency Ablation (RFA) or other techniques for sacroiliac pain are not covered due to insufficient, limited, or inconclusive published data. Also, sacroiliac neurotomy billed as a facet medial branch nerve block are not allowed coverage. Studies provide limited evidence regarding the efficacy and safety of thermal radiofrequency ablation (TRA), for individuals with SI joint pain, and contain insufficient data that allows for definitive conclusions.
2. Sacral injections, identified on the claim by the ICD-10 codes M43.27, M43.28, M46.1, M53.2X7, M53.2X8, M53.3, M53.87, M53.88, are not covered when submitted with a claim for facet medial branch nerve block.

C. Sacroiliac Joint Fusion, or Arthrodesis (CPT code 27279)
1. Sacroiliac joint fusion procedures are not covered due to limited data, mixed outcomes, and inconclusive evidence.

IV. Facet medial branch nerve procedures.
A. A maximum of five (5) facet injection sessions inclusive of medial branch blocks, intraarticular injections, facet cyst rupture and facet medial branch neurotomies may be performed per rolling 12 months in the cervical/thoracic spine and five (5) in the lumbar spine. **A "session"** is defined as all injections/blocks/RF procedures performed on one day and includes medial branch blocks (MBNB), intraarticular injections (IA), facet cyst ruptures, and radiofrequency (RF) ablations.
B. Facet medial branch nerve blocks (CPT codes 64490, 64491, 64492, 64493, 64494, 64495, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T)
1. CareSource will prior authorize and reimburse Facet medial branch nerve blocks up to the targeted joint itself, one joint above and one joint below on the same side, or bilaterally per treatment session if medical necessity criteria are substantiated in the medical record.
2. Facet joint interventions (diagnostic and/or therapeutic) must be performed under fluoroscopic or computed tomographic (CT) guidance. Facet joint interventions performed under ultrasound guidance will not be reimbursed (CPT code 76942)

C. Facet Neurotomy
1. CareSource will prior authorize and reimburse a maximum of 2 Facet Medial Branch Neurotomies in a rolling 12 months, if medically necessary (CPT 64633, 64634, 64635, 64636)
2. Facet Neurotomy should be performed with imaging guidance (. Coverage for image guidance and any injection of contrast are inclusive components and are not reimbursed separately.
3. For conscious sedation, if required for co-morbidities or patient/physician preference, may be provided without prior authorization but services will be considered part of the procedure and are not eligible for additional reimbursement if administered by a second provider. Coverage for monitored anesthesia care (MAC) is not medically necessary. If anesthesia services are provided they must be delivered by CareSource credentialed providers, including anesthesiologists and/or CRNAs

V. Epidural Steroid Injections
A. Includes: Interlaminar, Transforaminal, or Caudal Epidural Injections (For CPT codes 62310, 62311, 0228T, 0229T, 0230T, 0231T).
1. Only 1 Interlaminar or Caudal Epidural Injection will be authorized per treatment date.
2. Bilateral injections and modifiers will not be reimbursed (For CPT codes 62310, 62311).
3. Greater than 3 interlaminar epidural injections within a rolling 12 months will not be reimbursed. (For CPT codes 62310, 62311).
4. Transforaminal Epidurals (CPT codes 64479,64480,64483,64484) provided to more than 2 vertebral levels per treatment date, whether unilateral or bilateral will not be reimbursed.

5. Greater than 3 transforaminal epidural injections within a rolling 12 months will not be reimbursed. (CPT codes 64479,64480,64483,64484)
6. Repeat injections sooner than 3 weeks will not be reimbursed.
7. The maximum epidurals of all types of epidural injections a member can receive in a rolling 12 months is a total of 6, regardless of the number of levels involved.
8. Prior authorization is required for all epidural steroid injections.

B. For conscious sedation, if required for co-morbidities or patient/physician preference, may be provided without prior authorization but services will be considered part of the procedure and are not eligible for additional reimbursement if administered by a second provider. Coverage for monitored anesthesia care (MAC) will not be provided as not medically necessary. If anesthesia services are provided they must be delivered by CareSource credentialed providers, including anesthesiologists and/or CRNAs.

C. Image guidance and any injection of contrast are inclusive components of epidural injections.

VI. Spinal Cord Stimulator

A. A prior authorization is required both for a trial of SCS and a second prior authorization is required for implantation of a permanent SCS. (CPT codes 63650, 63655, 63865)

B. CPT, HCPCS, and ICD-10 codes for inclusion and exclusion in coverage determinations at the claims level are listed below.

VII. Implantable Pain Pump

A. A prior authorization is required for each proposed preliminary trial injection and for each proposed placement of an Implantable Infusion Pain Pump for pain management. (CPT codes 62350-62351 and 62360-62362)

E. CONDITIONS OF COVERAGE

Reimbursement is dependent on, but not limited to, submitting CMS approved HCPCS and CPT codes along with appropriate modifiers. Please refer to the appropriate Indiana Medicaid fee schedule http://provider.indianamedicaid.com/ihcp/Publications/MaxFee/reports/ref03103.txt.

Injections administered by participating physicians will be reimbursed for the bundled CPT code which includes both the injection administration and the pain medication.
CareSource will not reimburse any claim which shows the separate (unbundled) cost for (a) the administration of the injection and (b) the medication. Additionally, CareSource will not reimburse a non-participating provider or pain management clinic or anesthesia group (or other such non-participating provider) for either the administration of these injections or the pain medications injected, without prior authorization from CareSource.

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

- **The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates. Please refer to the above referenced sources for the most current coding information.**

Interventional Pain Injection-related Codes	
CPT Code	**Description**
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
20553	Injection(s); single or multiple trigger point(s), 3 or more muscles
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
62310	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic

	substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic
62311	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)
64479	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level
64480	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level
64484	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)
0213T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level
0214T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound

	guidance, cervical or thoracic; second level (List separately in addition to code for primary procedure)
0215T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)
0216T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level
0217T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; second level (List separately in addition to code for primary procedure)
0218T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)
0228T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level
0229T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)
0230T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level
0231T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)
G0259	Injection procedure for sacroiliac joint; arthrography
G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography
	CareSource does not provide coverage for the below CPT code:
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining of bone graft when performed, and placement of transfixing device

Spinal Cord Stimulators	
Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by "+":	
CPT codes covered if selection criteria are met:	
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling

63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver
CPT codes not covered for indications listed in the policy:	
95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs [intraoperative]
95926	in lower limbs [intraoperative]
95927	in the trunk or head [intraoperative]
95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs [intraoperative]
95929	lower limbs [intraoperative]
95938	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs [intraoperative]
95939	Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs [intraoperative]
+95940	Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure) [MEP and SSEP]
+95941	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure) [MEP and SSEP]
Other CPT codes related to this policy and are covered with appropriate selection criteria:	
95970	Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (i.e., cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming
95971	simple spinal cord, or peripheral (i.e., peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming
95972	complex spinal cord, or peripheral (i.e., peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming
HCPCS codes not covered for indications listed in this policy:	
G0453	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure) [MEP and SSEP]
ICD-10 codes covered if selection criteria are met:	
A52.11	Tabes dorsalis
B02.21 - B02.29	Zoster [herpes zoster] with other nervous system involvement
F10.182, F10.282, F10.982	Alcohol abuse/dependence/use with alcohol-induced sleep disorder
F51.01 - F51.9	Sleep disorders not due to a substance or known physiological condition
G03.9	Meningitis, unspecified [lumbar arachnoiditis]
G11.0 - G11.9	Hereditary ataxia
G47.00 - G47.9	Sleep disorders
G54.6 - G54.7	Phantom limb syndrome
G90.50 - G90.59	Complex regional pain syndrome I

I20.0 - I20.9	Angina pectoris [intractable angina in members who are not surgical candidates and whose pain is unresponsive to all standard therapies]
I49.01	Ventricular fibrillation
I73.00 - I73.9	Other peripheral vascular diseases [with chronic ischemic limb pain]
M96.1	Postlaminectomy syndrome, not elsewhere classified [failed back surgery syndrome]
R26.0 - R27.9	Abnormalities of gait and mobility and other lack of coordination
S22.000+ - S22.089+ S32.000+ - S32.2xx+	Fracture of thoracic and lumbar vertebra, sacrum and coccyx [must be billed an incompleted spinal cord injury code]
S23.100+ - S23.171+ S33.100+ - S33.39x+	Subluxation and dislocation of thoracic and lumbar vertebra, sacrum and coccyx
S24.151+ - S24.159+ ,S34.121+ - S34.129+ S34.132+,	Incomplete spinal cord lesion
S34.3xx+	Injury of cauda equina
ICD-10 codes not covered for indications listed in this policy:	
C00.0 - C96.9	Malignant neoplasms
D00.0 - D09.9	Carcinoma in situ
D43.0 - D43.2	Neoplasm of uncertain behavior of brain [glioma]
E08.40, E08.42, E09.40, E09.42, E10.40, E10.42, E11.40, E11.42, E13.40, E13.42	Diabetes mellitus with diabetic polyneuropathy
G20	Parkinson's disease
G43.001 - G43.919	Migraine
G44.1	Vascular headache, not elsewhere classified
G50.0	Trigeminal neuralgia
G54.8	Other nerve root and plexus disorders [intercostal neuralgia]
G56.00 - G58.9	Mononeuropathies of upper and lower limbs
G89.21 - G89.4	Chronic pain, not elsewhere classified
I47.0 - I47.9	Paroxysmal tachycardia
I69.093, I69.193, I69.293, I69.393, I69.893, I69.993	Ataxia following cerebrovascular disease
K58.0 - K58.9	Irritable bowel syndrome
K83.8	Other specified diseases of biliary tract [Sphincter of Oddi dysfunction]
L59.9	Other disorders of skin and subcutaneous tissue related to radiation [radiation-induced brain injury or stroke]
M50.00 - M50.93	Cervical disc disorders
M51.04 - M51.07	Thoracic, thoracolumbar, and lumbosacral intervertebral disk disorders with myelopathy
M51.24 - M51.27, M51.9	Other and unspecified thoracic, thoracolumbar and lumbosacral intervertebral disc displacement
M53.82	Other specified dorsopathies, cervical region
M54.2	Cervicalgia
M54.11- M54.13	Radiculopathy [cervical region]
M62.40 - M62.49	Contracture of muscle [spasticity of muscle]

M62.830	Muscle spasm of back
M96.1	Postlaminectomy syndrome, not elsewhere classified [failed cervical spine surgery syndrome]
N94.0 - N94.9	Pain and other conditions associated with female genital organs and menstrual cycle [inguinal pain - female] [chronic pelvic pain]
R10.0 - R10.9	Abdominal and pelvic pain [inguinal pain - male] [chronic visceral] [chronic pelvic pain]
R25.0 - R25.9	Abnormal involuntary movements [spasticity]
R40.0 - R40.4	Somnolence, stupor and coma
R51	Headache
S06.0x0+ - S06.9x9+	Intracranial injury [radiation-induced brain injury]
S10.0xx+ - S10.97x+	Superficial injury of neck
S12.000+ - S12.691+	Fracture of cervical vertebra and other parts of neck
S13.100+ - S13.29x+	Subluxation and dislocation of cervical vertebra
S14.0xx+ - S14.9xx+	Injury of nerves and spinal cord at neck level
S22.000+ - S22.089+ S32.000+ - S32.2xx+	Fracture of thoracic and lumbar, sacrum and coccyx
S24.101+ - S24.109+ S24.151+ - S24.159+ S34.101+ - S34.109+ S34.121+ - S34.129+ S34.132+ - S34.139+	Spinal cord injury, incomplete [thoracic, lumbar, sacrum, coccyx and cauda equine] [can be billed with/without ICD-10 code for fracture]
T66.xxx+	Radiation sickness, unspecified [radiation-induced brain injury or stroke]
ICD-10 codes contraindicated for this policy:	
F45.0- F45.9	Somatoform disorders
I01.0 - I15.9 I21.01 - I72.9 I74.0 - I99.9	Diseases of the circulatory system

Implantable Pain Pump	
Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by "+":	
CPT codes covered if selection criteria are met:	
62350 - 62351	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump
62355	Removal of previously implanted intrathecal or epidural catheter
62360 - 62362	Implantation or replacement of device for intrathecal or epidural drug infusion
62365	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion

62367 - 62370	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status)
95990 - 95991	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular)
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)
ICD-10 codes covered if selection criteria are met (not all inclusive):	
G89.0	Central pain syndrome
G89.21 - G89.29	Chronic pain, not elsewhere classified
G89.3	Neoplasm related pain (acute) (chronic)
G89.4	Chronic pain syndrome
G95.11 - G95.19	Vascular myelopathies
S12.000+ - S12.001+ S12.100+ - S12.101+ S12.200+ - S12.201+ S12.300+ - S12.301+ S12.400+ - S12.401+ S12.500+ - S12.501+ S12.600+ - S12.601+ S14.101+ - S14.107+ S14.111+ - S14.117+ S14.121+ - S14.127+ S14.131+ - S14.137+ S14.151+ - S14.157+	Fracture of vertebral column with spinal cord injury
S14.101+ - S14.139+ S14.151+ - S14.159+	Injury of nerves and spinal cord at neck level
ICD-10 codes not covered for indications listed in this policy:	
K31.84	Gastroparesis
M54.10 - M54.18	Radiculopathy
M79.2	Neuralgia and neuritis, unspecified
ICD-10 codes covered if selection criteria are met (not all-inclusive):	
G89.3	Neoplasm related pain (acute) (chronic)

AUTHORIZATION PERIOD

F. RELATED POLICIES/RULES

- See Medical policy ‘Epidural Steroid Injections’
- See Medical policy ‘Facet medial branch nerve blocks’
- See Medical policy ‘Facet Neurotomy’

- See Medical policy 'Trigger Point Injections'
- See Medical policy 'Sacroiliac Joint Injections'

G. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	01/01/2017	New Policy.
Date Revised		
Date Effective	01/01/2017	

H. REFERENCES

1. Indiana Health Coverage Programs Fee Schedule. (2016, October 23). Retrieved 11/11/2016 from http://provider.indianamedicaid.com/ihcp/Publications/MaxFee/reports/ref03103.txt

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