FLOWONIX

Targeted Drug Delivery

HOSPITAL CODING AND PAYMENT GUIDE 2022

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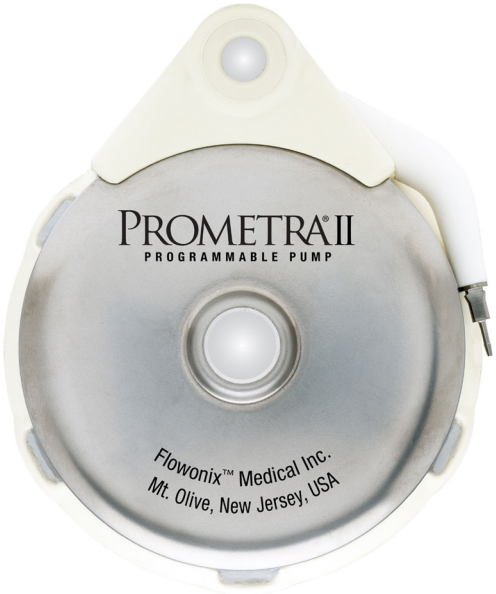
ICD-10-CM Diagnosis Code Options

ICD-10-CM codes are to be used to document the patient's condition. Diagnosis codes are used by both physicians and facilities to document the indication for the procedure. Intrathecal drug delivery is directed at managing chronic, intractable pain. Pain can be coded and sequenced several ways depending on the documentation and the nature of the encounter.

Codes from the G89 category may be used as the principal diagnosis when the encounter is for pain control or pain management, rather than for management of the underlying conditions. Additional codes may then be assigned to give more detail about the nature and location of the pain and the underlying cause. When a specific pain disorder is not documented or the encounter is to manage the cause of the pain, the underlying condition is coded and sequenced as the principal diagnosis. It is the physician's responsibility to code the appropriate diagnosis code(s) based on the patient's condition and presenting symptoms.



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Commonly billed ICD-10-CM diagnosis codes used in all settings.

Category	Code	Code Description
Chronic Pain Disorders	G89.0 G89.2 - G89.29 G89.3 G89.4	Central pain syndrome Chronic pain Neoplasm related pain (acute)(chronic) Chronic pain syndrome
	Note: Pain must be specifically documented as "chronic" to use codes G89.2 - G89.29. Similarly, the diagnostic term "chronic pain syndrome" must be specifically documented to assign code G89.4. If these terms are not documented, then symptom codes for pain may be assigned instead, although they cannot be sequenced as principal diagnosis. Rather, the underlying condition would ordinarily be used as the principal diagnosis in this circumstance.	
Reflex Sympathetic Dystrophy (Complex Regional Pain Syndrome I) and Causalgia (Complex Regional Pain Syndrome II)	G90.521 - G90.529 G57.70 - G57.73	Complex regional pain syndrome I of lower limb(s) Causalgia of unspecified lower limb(s)
	Note: ICD-10-CM does not have a default code for "Complex Regional Pain Syndrome"; type I or II must be specified. Codes from the G89 series in ICD-10-CM should not be assigned with causalgia or reflex sympathetic dystrophy because pain is a known component of these disorders.	
Underlying Causes of Chronic Pain (Non-Cancer)	**Postherpetic Neuropathy**	
	B02.21 B02.22 B02.23 B02.29	Postherpetic geniculate ganglionitis Postherpetic trigeminal neuralgia Postherpetic polyneuropathy Other Postherpetic nervous system indocement
	Arachnoiditis	
	G03.1 G03.9	Chronic meningitis Meningitis, unspecified
	Phantom Limb Pain	
	G54.6	Phantom limb syndrome with pain

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

Category	Code	Code Description
Underlying Causes of Chronic Pain (Non-Cancer)	**Peripheral Neuropathy**	
	G57.90	Unspecified mononeuropathy of unspecified lower limb
	G57.91	Unspecified mononeuropathy of right lower limb
	G57.92	Unspecified mononeuropathy of left lower limb
	G57.93	Unspecified mononeuropathy of bilateral lower limbs
	Radiculopathy	
	M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
	M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
	M54.12	Radiculopathy, cervical region
	M54.13	Radiculopathy, cervicothoracic region
	M54.14	Radiculopathy, thoracic region
	M54.15	Radiculopathy, thoracolumbar region
	M54.16	Radiculopathy, lumbar region
	M54.17	Radiculopathy, lumbosacral region
	Osteoporosis-Related Fracture, Vertebra	
	M80.08XA	Age-related osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture
	M80.88XA	Other osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture
	Postlaminectomy Syndrome	
	M96.1	Postlaminectomy syndrome, not elsewhere classified
Underlying Causes of Chronic Pain (Cancer)	C00-C14	Malignant neoplasms of lip, oral cavity and pharynx
	C15-C26	Malignant neoplasms of digestive organs
	C30-C39	Malignant neoplasms of respiratory and intrathoracic organs
	C40-C41	Malignant neoplasms of bone and articular cartilage
	C43-C44	Melanoma and other malignant neoplasms of skin
	C45-C49	Malignant neoplasms of mesothelial and soft tissue
	C50-C50	Malignant neoplasms of breast
	C51-C58	Malignant neoplasms of female genital organs
	C60-C63	Malignant neoplasms of male genital organs

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

Category	Code	Code Description
Underlying Causes of Chronic Pain (Cancer)	C64-C68	Malignant neoplasms of urinary tract
	C69-C72	Malignant neoplasms of eye, brain and other parts of central nervous system
	C73-C75	Malignant neoplasms of thyroid and other endocrine glands
	C76-C80	Malignant neoplasms of ill-defined, other secondary and unspecified sites
	C7A-C7A	Malignant neuroendocrine tumors
	C7B-C7B	Secondary neuroendocrine tumors
	C81-C96	Malignant neoplasms of lymphoid, hematopoietic and related tissue
Device Complications	T85.610A	Breakdown (mechanical) of cranial or spinal infusion catheter
	T85.615A	Breakdown (mechanical) of other nervous system device, implant or graft
	T85.620A	Displacement of cranial or spinal infusion catheter
	T85.625A	Displacement of other nervous system device, implant or graft
	T85.630A	Leakage of cranial or spinal infusion catheter
	T85.635A	Leakage of other nervous system device, implant or graft
	T85.690A	Other mechanical complication of cranial or spinal infusion catheter
	T85.695A	Other mechanical complication of other nervous system device, implant or graft
	T85.735A	Infection and inflammatory reaction due to cranial or spinal infusion catheter
	T85.738A	Infection and inflammatory reaction due to other nervous system device, implant or graft
	T85.830A	Hemorrhage due to nervous system prosthetic devices, implants and grafts
	T85.840A	Pain due to nervous system prosthetic devices, implants and grafts
	T85.890A	Other specified complication of nervous system prosthetic devices, implants and grafts
Attention to Device	Z45.49	Encounter for adjustment and management of other implanted nervous system device

ICD-10-PCS Procedure Codes

Hospitals use ICD-10-PCS procedure codes for inpatient services.

Trial Procedure	Code	Code Description
Catheter Implantation	00HU33Z	Insertion of infusion device into spinal canal, percutaneous approach
Intrathecal Injection	3E0R3NZ	Introduction of analgesics, hypnotics, sedatives into spinal canal, percutaneous approach
Catheter Procedures	**Code**	**Code Description**
Catheter Implantation	00HU33Z	Insertion of infusion device into spinal canal, percutaneous approach
Catheter Removal	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 the removal of the old device.	
Catheter Revision	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	**Code**	**Code Description**
Pump Implantation	0JH80VZ	Insertion of infusion pump into abdomen subcutaneous tissue and fascia, open approach
Pump Removal	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 the removal of the old device.	
Pump Revision	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

Physician Coding and Payment – CPT® Procedure Codes

The 2022 Medicare national average payment for common pain procedures and intrathecal pain pump management are shown in the table below. The Medicare national average payment is calculated by multiplying the sum of RVUs by the 2022 conversion factor. Specific reimbursement will vary from the national average based on the wage index of the geographical area in which the services are rendered. The complete Medicare Physician Fee Schedule (MPFS) payment rates are available on the CMS website in the downloads section of the CY 2022 Physician Fee Schedule final rule (CMS-1751-F) webpage. The finalized changes are effective January 1, 2022. Specific payments will vary depending on the place of service where the physician rendered the service. Physician payments are generally higher if they are performed in the physician's office. Procedures performed in a facility setting (ASC's or hospitals) generally have a lower payment because the facility is incurring the cost of some of the supplies and materials. Also note, that applicable coinsurance, deductible and other amounts that are the patient obligation are included in the national payments shown below.

			2022 Medicare National Average	
Procedure	Code	Code Description	Physician Office	Facility
Trial	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	$144	$82
	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)	$270	$101
	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	$144	$87
	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)	$276	$106
Implantation or Revision of Catheter	62350	Implantation, revision, or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion/pump; without laminectomy	N/A	$407

CPT® Procedure Codes (continued)

Procedure	Code	Code Description	2022 Medicare National Average	
			Physician Office	Facility
Implantation, or Replacement of Pump	62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming	N/A	$394
Removal of Catheter or Pump	62355	Removal of previously implanted intrathecal or epidural catheter	N/A	$279
	62365	Removal of subcutaneous reservoir or pump previously implanted for intrathecal or epidural infusion	N/A	$303
Revision of Pump Pocket	64999	Unlisted procedure nervous system	N/A	Contractor Pricing
Drug/Refill Kit	J2274	Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg	ASP+6%	—
	A4220	Refill kit for implantable infusion pump		
Analysis/ Reprogramming/ Refill	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	$32	$26
	62368	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming	$45	$36
	62369	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill	$95	$36
	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)	$96	$47
Catheter Dye Study	61070	Puncture of shunt tubing or reservoir for aspiration or injection procedure	N/A	$58
	75809	Shuntogram for investigation of previously placed indwelling non vascular shunt (eg, indwelling infusion pump)	— TC 26	$85

HCPCS II Device and Drug Codes

Commonly billed HCPCS II Device and Drug Codes are used by the entity that purchased and supplied the medical device, which is usually the facility. Physicians may report drug charges when the drug is provided in the office. HCPCS II codes should only be billed for outpatient hospital procedures. They may also be reported with device C-codes when billing Medicare.

Device/Drug	Code	Code Description
Programmable Pump and Catheter	E0783	Infusion pump system, implantable, programmable (includes all components, e.g., pump, catheter, connectors, etc.)
Programmable Pump Only (Replacement)	E0786	Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter)
Intraspinal Implantable Catheter Only	E0785	Implantable intraspinal (epidural/intrathecal) catheter used with implantable infusion pump, replacement
Personal Therapy Controller	A9900	Misc. DME supply, accessory, and/or service component of another HCPCS Code (used for replacement only)
Refill Kit	A4220	Refill Kit for implantable infusion pump
Infumorph™ (preservative-free morphine sulfate sterile solution)	J2274	Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg

Device C-Codes

Hospitals assign C-codes in the outpatient hospital setting only when billing Medicare. Although other payers may also accept C-codes, regular HCPCS-II device codes are generally used for billing non-Medicare carriers.

Device/Drug	Code	Code Description
Infusion Pump	C1772	Infusion pump, programmable, implantable
Intrathecal Catheter	C1755	Catheter, Intraspinal

Device Edits (Medicare)

Medicare's Consolidated Device Edits require that when certain CPT procedure codes for device implantation are billed, associated device category C-codes must also be billed. These are only used in the outpatient hospital setting.

CPT® Procedure Code	CPT Code Description	Associated C-Codes	C-Code Description
62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming	C1772	Infusion pump, programmable, implantable

Hospital Outpatient Coding and Payment

Hospitals use CPT codes for outpatient services. Under Medicare's APC methodology for hospital outpatient payment, each CPT code is assigned to APCs based on similar clinical characteristics and similar costs. Each APC has a relative weight that is then converted into a flat payment amount. Multiple APCs can be assigned for each claim depending on the number of procedures coded and whether any of them map to a Comprehensive APCs (C-APCs). Each CPT procedure code assigned to one of these C-APCs is considered a primary service. All other procedures and services coded on the bill are considered adjunctive to delivery of the primary service. This results in a single APC payment and a single beneficiary copayment for the entire outpatient encounter, based solely on the primary service. Separate payment is not made for the other adjunctive services. Instead, the payment level for the C-APC is calculated to include the costs of the other adjunctive services, which are packaged into the payment for the primary service.

As shown on the following tables, TDD therapy is subject to C-APCs specifically for implantation/replacement of the pump. C-APCs are identified by status indicator J1.

The following table gives information on procedures, codes, APC, status indicator and payment based on the Medicare national average. The complete 2022 CPPS/ASC Payment System final rule is available on the CMS website (CMS-1753-FC) webpage. The finalized changes are effective January 1, 2022.

Procedure	Code	Code Description	APC	APC Descriptor	Status Indicator	Relative Weight	2022 Medicare National Average
Trial	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	5442	Level II Nerve Injections	T	7.7043	$648
	or 62323	With imaging guidance (ie, fluoroscopy or CT)	5442	Level II Nerve Injections	T	7.7043	$648
	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 III Nerve Injections	T	9.9877	$841

Hospital Outpatient Coding and Payment (continued)

Procedure	Code	Code Description	APC	APC Descriptor	Status Indicator	Relative Weight	2022 Medicare National Average
Trial	or 62327	With imaging guidance (ie, fluoroscopy or CT)	5443	Level III Nerve Injections	T	9.9877	$841
Implantation or Revision of Catheter	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	5432	Level III Nerve Procedure	J1	69.1869	$5,824
Implantation or Replacement of Pump	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	206.7704	$17,405
Pump Pocket Revision	64999	Unlisted procedure, nervous system	5441	Level 1 Nerve Procedure	T	3.1699	$267
Removal of Catheter or Pump	62355	Removal of previously implanted intrathecal or epidural catheter	5431	Level I Nerve Procedure	Q2	21.304	$1,793
	62365	Removal of subcutaneous reservoir or pump previously implanted for intrathecal or epidural infusion	5432	Level II Nerve Procedure	Q2	69.1869	$5,824
Drug	J2274	Injection, morphine sulfate, Preservative-free for epidural or intrathecal use, 10 mg	N/A	N/A	N	N/A	N/A

Hospital Outpatient Coding and Payment (continued)

Procedure	Code	Code Description	APC	APC Descriptor	Status Indicator	Relative Weight	2022 Medicare National Average
Refill/Analysis/ Reprogramming	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 III Electronic Analysis of Devices	S	3.3128	$279
	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 III Electronic Analysis of Devices	S	3.3128	$279
	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 III Electronic Analysis of Devices	S	3.3128	$279
	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 III Electronic Analysis of Devices	S	3.3128	$279

Hospital Outpatient Coding and Payment (continued)

Procedure	Code	Code Description	APC	APC Descriptor	Status Indicator	Relative Weight	2022 Medicare National Average
Catheter Dye Study	61070	Puncture of shunt tubing or reservoir for aspiration or injection procedure	5442	Level II Nerve Injections	T	7.7043	$648
	75809	Shuntogram for investigation of previously placed indwelling non vascular shunt (eg, indwelling infusion pump)	5522	Level II Imaging Without Contrast	Q2	1.3209	$111

Hospital Inpatient Coding and Payment
MS-DRG Assignments Non-Cancer Pain

Under Medicare's DRG methodology for hospital inpatient payment, each inpatient stay is assigned to a diagnosis related group (DRG), based on the ICD-10-CM codes assigned to the diagnoses and procedure. Only one DRG is assigned by inpatient stay, regardless of the number of procedures performed.

The following table shows MS-DRG assignments to specific procedure and diagnosis along with national Medicare average payments for non-cancer pain for the inpatient hospital setting.

Procedure	Scenario		MS-DRG	MS-DRG Title	Relative Weight	2022 Medicare National Average
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 DRG is assigned according to the principal diagnosis.					
Implantation	Whole system implant (pump plus catheter)	Nervous system disorders	040	Peripheral/Cranial Nerve and Other Nervous System Procedures with MCC	3.8648	$23,346
			041	Peripheral/Cranial Nerve and Other Nervous System Procedures with CC	2.3497	$14,194
	Pump only implant		042	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	1.9012	$11,484

Hospital Inpatient Coding and Payment (Non-Cancer Pain), (continued)

Procedure	Scenario		MS-DRG	MS-DRG Title	Relative Weight	2022 Medicare National Average
Implantation	Whole system implant (pump plus catheter) Pump only implant	Musculo-skeletal disorders	515	Other Musculoskeletal System and Connective Tissue OR Procedure with MCC	3.1406	$18,971
			516	Other Musculoskeletal System and Connective Tissue OR Procedure with CC	1.9628	$11,857
			517	Other Musculoskeletal System and Connective Tissue OR Procedure W/O CC/MCC	1.3982	$8,446
	Catheter only implant	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. The DRGs displayed for the screening trial are common.				
Replacement	Whole system replacement (pump plus catheter) or catheter replacement	Nervous system disorders	028	Spinal Procedures with MCC	5.8231	$35,175
			029	Spinal Procedures with CC	3.2968	$19,915
			030	Spinal Procedures W/O CC/MCC	2.3568	$14,237
	Pump only replacement	Nervous system disorders	040	Peripheral/Cranial Nerve and Other Nervous System Procedures with MCC	3.8648	$23,346
			041	Peripheral/Cranial Nerve and Other Nervous System Procedures with CC	2.3497	$14,194
			042	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	1.9012	$11,484
Removal (without replacement)	Whole system removal (pump plus catheter) or catheter only removal		028	Spinal Procedures with MCC	5.8231	$35,175
			029	Spinal Procedures with CC	3.2968	$19,915
			030	Spinal Procedures W/O CC/MCC	2.3568	$14,237
	Pump only removal	These codes are 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 (Non-Cancer Pain), (continued)

Procedure	Scenario	MS-DRG	MS-DRG Title	Relative Weight	2022 Medicare National Average
Revision	Catheter revision (intrathecal portion)	028	Spinal Procedures with MCC	5.8231	$35,175
		029	Spinal Procedures with CC	3.2968	$19,915
		030	Spinal Procedures W/O CC/MCC	2.3568	$14,237
	Catheter revision (subcutaneous portion)	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.			
	Pump revision	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 (Cancer-Pain)

Procedure	Scenario		MS-DRG	MS-DRG Title	Relative Weight	2022 Medicare National Average
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 DRG is assigned according to the principal diagnosis.					
Implantation	Whole system implant (pump plus catheter)	Neoplasm-related pain	939	OR Procedure W Diagnoses of Other Contact W Health Services with MCC	3.3746	$20,385
			940	OR Procedure W Diagnoses of Other Contact W Health Services with CC	2.2209	$13,416
			941	OR Procedure W Diagnoses of Other Contact W Health Services W/O CC/MCC	1.9231	$11,617

Hospital Inpatient Coding and Payment (Cancer-Pain), (continued)

Procedure	Scenario		MS-DRG	MS-DRG Title	Relative Weight	2022 Medicare National Average
Implantation	Whole system implant (pump plus catheter)	Bone cancer and pathologic al fracture due to bone cancer	515	Other Musculoskeletal System and Connective Tissue OR Procedure with MCC	3.1406	$18,971
			516	Other Musculoskeletal System and Connective Tissue OR Procedure with CC	1.9628	$11,857
			517	Other Musculoskeletal System and Connective Tissue OR Procedure W/O CC/MCC	1.3982	$8,446
		Esophageal, stomach, colon, rectal and anal cancer	356	Other Digestive System OR Procedures with MCC	4.3078	$26,022
			357	Other Digestive System OR Procedures with CC	2.2685	$13,703
			358	Other Digestive System OR Procedures W/O CC/MCC	1.3491	$8,149
		Liver and pancreatic cancer	423	Other Hepatobiliary or Pancreas OR Procedures with MCC	4.1859	$25,286
			424	Other Hepatobiliary or Pancreas OR Procedures with CC	2.2841	$13,797
			425	Other Hepatobiliary or Pancreas OR Procedures W/O CC/MCC	1.5427	$9,319
		Lung, bronchus and trachea cancer	166	Other Respiratory System OR Procedures with MCC	3.7235	$22,492
			167	Other Respiratory System OR Procedures with CC	1.8187	$10,986
			168	Other Respiratory System OR Procedures W/O CC/MCC	1.3544	$8,181
		Breast cancer	579	Other Skin, Subcutaneous Tissue and Breast Procedures with MCC	3.1449	$18,997
			580	Other Skin, Subcutaneous Tissue and Breast Procedures with CC	1.7288	$10,443
			581	Other Skin, Subcutaneous Tissue and Breast Procedures W/O CC/MCC	1.3768	$8,317

Hospital Inpatient Coding and Payment (Cancer-Pain), (continued)

Procedure	Scenario		MS-DRG	MS-DRG Title	Relative Weight	2022 Medicare National Average
Implantation	Whole system implant (pump plus catheter)	Uterine, cervical, and ovarian cancer	749	Other Female Reproductive System OR Procedures with CC/MCC	2.7138	$16,393
			750	Other Female Reproductive System OR Procedures W/O CC/MCC	1.4638	$8,842
		Prostate and testicular cancer	715	Other Male Reproductive System OR Procedures for Malignancy with CC/MCC	2.0216	$12,212
			716	Other Male Reproductive System OR Procedures for Malignancy W/O CC/MCC	1.2758	$7,707
		Kidney and bladder cancer	673	Other Kidney and Urinary Tract Procedures with MCC	3.4683	$20,951
			674	Other Kidney and Urinary Tract Procedures with CC	2.3832	$14,396
			675	Other Kidney and Urinary Tract Procedures W/O CC/MCC	1.7547	$10,599
		Brain and spinal cord cancer	040	Peripheral/Cranial Nerve and Other Nervous System Procedures with MCC	3.8648	$23,346
			041	Peripheral/Cranial Nerve and Other Nervous System Procedures with CC	2.3497	$14,194
			042	Peripheral/Cranial Nerve and Other Nervous System Procedures W/O CC/MCC	1.9012	$11,484
	Pump only	The same DRGs are assigned for pump only implantation as for whole system implantation (see above).				
	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.				

MS-DRG assignments for cancer pain for system replacement, removal (without replacement) and revision are the same as those listed for non-cancer pain on pages 13-14.

Sources: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index