ICD-9-CM Diagnosis Code options

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. **Regardless of the site of service, ICD-9-CM diagnosis codes do not change.**

Codes from the "338" series can 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.

The table below gives a breakdown of commonly billed ICD-9-CM diagnosis codes used in all settings.

Category	Code	Code Description
Chronic Pain Disorders	338.0	Central Pain Syndrome
	338.29[1]	Other Chronic Pain
	338.3	Neoplasm-related pain
	338.4	Chronic Pain Syndrome
Reflex Sympathetic Dystrophy and Causalgia[2]	337.22	Reflex sympathetic dystrophy of the lower limb (CRPS Type I)
	355.71	Causalgia of the lower limb (CRPS Type II)
Underlying Causes of Chronic Non-Cancer Pain	053.12-053.13	Postherpetic neuralgia
	322.2	Arachnoiditis, chronic
	322.9	Arachnoiditis, other and unspecified
	353.6	Phantom limb syndrome
	355.8	Peripheral neuropathy of lower limb
	722.10	Radiculitis due to herniated disc, lumbar
	722.52	Radiculitis due to degenerative disc disease, lumbar
	722.83	Postlaminectomy syndrome, lumbar region (failed back syndrome)
	724.4	Radicular syndrome of lower limbs
	733.13 and 733.0X	Collapsed vertebra due to osteoporosis
Underlying Causes of Cancer Pain	150.0-150.9	Esophageal Cancer
	151.0-151.9	Stomach Cancer
	153.0-154.8, 197.5	Colon and rectal Cancer
	155.0, 197.7	Liver Cancer
	157.0-157.9	Pancreatic Cancer
	162.0-162.9, 197.0	Lung Cancer
	170.0-170.9, 198.5	Bone Cancer
	174.0-174.9	Breast Cancer
	180.0-180.9	Cervical Cancer
	182.0-182.8	Uterine Cancer
	183.0, 198.6	Ovarian Cancer
	185.0	Prostate Cancer
	186.0-186.9	Testicular Cancer
	188.0-189.1, 198.0	Bladder Cancer
	189.0-189.1, 198.0	Kidney Cancer
	191.0-192.9, 198.3	Brain and Spinal Cord Cancer
	733.13 plus 170.0 or 198.5	Pathological fracture due to bone cancer
Attention to Device	V53.09[3]	Fitting and adjustment of devices related to nervous system

1. Pain must be specifically documented as “chronic” to use code 338.29. Similarly the diagnostic term “chronic pain syndrome” must be specifically documented to use code 338.4. If these terms are not documented, then other symptom codes for pain may be assigned instead. However, they cannot be sequenced as a principal diagnosis. Rather, the underlying condition would ordinarily be used as the principal diagnosis in this circumstance.

2. CRPS not specified by type defaults to type 1. Codes from the 338 series should not be assigned with CRPS as pain is a known component of these disorders.

3. V53.09 is used as the principal diagnosis when patients are seen for routine device replacement and maintenance. A secondary diagnosis code is then used for the underlying condition.

HCPCS II Device and Drug Codes

Commonly billed HCPCS II Device and Drug Codes used in all settings. However, in the outpatient hospital setting these codes are used in conjunction 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)
Programmable Pump Only (Replacement)	E0786	Implantable programmable infusion pump, replacement, does not include implantable catheter.
Intraspinal Implantable Catheter Only	E0785	Implantable intraspinal catheter used with implantable infusion pump, replacement
Preservative-Free Morphine Sulfate	J2275	Injection, morphine sulfate, 10 mg
Anesthetic drug administered through IV	J7799	NOC drugs, other than inhalation drugs, administered through DME
Refill Kit	A4220	Refill Kit for implantable infusion pump

Device C-Codes (Medicare)

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	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 specific CPT procedure codes for device implantation are billed associated C-codes for the devices must also be billed. Because Device Edits go with C-codes, 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

CPT® Procedure Codes and APC Codes

Hospitals use CPT codes for outpatient services. Under Medicare's APC methodology for hospital outpatient payment, each CPT code is assigned to one of about 820 ambulatory payment classes. 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.

Ambulatory Payment Classes (APC) are used in addition to CPT codes for inpatient and outpatient procedures. Multiple APCs can be assigned for each claim depending on the number of procedures coded.

The status indicator shows how a code is handled for payment purposes.

The table below gives information on procedures, codes, APC, status indicator, and payment based on the Medicare national average.

Procedure	Code	Code Description	APC	APC Descriptor	Status Indicator	2009 Medicare National Average
Trial	62310	Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrasts (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opiod, steroid, other solution), epidural or subarachnoid; cervical or thoracic	0207	Level III Nerve Injections	T	$474
	62311	Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrasts (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opiod, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal) Injection, including catheter	0207	Level III Nerve Injections	T	$474

	62318	placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opiod, steroid, other solution), epidural or subarachnoid; cervical or thoracic	0207	Level III Nerve Injections	T	$474
	62319	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opiod, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)	0207	Level III Nerve Injections	T	$474
	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	0224	Implantation of Catheter/reservoir/ shunt	T	$2,777
Implantation, Revision, or Replacement 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	0224	Implantation of catheter/reservoir/ shunt	T	$2,777
	62351	Implantation, revision, or	0208	Laminotomies and	T	$3,211

		repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion/pump; without laminectomy		Laminectomies		
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	0227	Implantation of drug infusion device	T	$12,282
Removal of Catheter or pump	62355	Removal of previously implanted intrathecal or epidural catheter	0203	Level IV nerve injection	T	$949
	62365	Removal of Subcutaneous reservoir or pump previously implanted for intrathecal or epidural infusion	0221	Level II nerve procedures	T	$2,375
Fluoroscopy for catheter placement and injection	77003	Fluoroscopic guidance and localization of needle or catheter tip for diagnostic or therapeutic injection procedures (epidural, subarachnoid)			N	
Drug	J2275	Injection, morphine sulfate (preservative-free sterile solution), 10 mg			N	
Analysis/ Programming	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	0692	Level III Electronic Analysis of Devices	S	$109
	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	0691	Level IV Electronic Analysis of Devices	S	$163

Refill and Maintenance Note: the code for the refill kit can be found within the HCPCS codes	95990	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular)	0440	Level V Drug Administration	S	$188
	95991	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), administered by a physician	0440	Level V Drug Administration	S	$188
Catheter Dye Study	61070	Puncture of Reservoir for injection procedure	0121	Level I Tube or catheter changes and repositioning	T	$304
Evaluation and Management	99201	Office or other outpatient visit, new patient, problem focused	0604	Level 1 Hospital Clinic Visit	V	$55
	99202	Office or other outpatient visit, new patient, straightforward	0605	Level 2 Hospital Clinic Visit	V	$69
	99203	Office or other outpatient visit, new patient, low complexity	0606	Level 3 Hospital Clinic Visit	V	$90
	99204	Office or other outpatient visit, new patient, moderate complexity	0607	Level 4 Hospital Clinic Visit	V	$114
	99205	Office or other outpatient visit, new patient, high complexity	0608	Level 5 Hospital Clinic Visit	V	$162
	99211	Office or other outpatient visit, established patient, problem focused	0604	Level 1 Hospital Clinic Visit	V	$55
	99212	Office or other outpatient visit, new patient, straightforward	0605	Level 2 Hospital Clinic Visit	V	$69
	99213	Office or other outpatient visit, established patient, low complexity	0606	Level 3 Hospital Clinic Visit	V	$69
	99214	Office or other outpatient visit, established patient, moderate complexity	0607	Level 4 Hospital Clinic Visit	V	$90
	99215	Office or other outpatient visit, established patient, high	0608	Level 5 Hospital Clinic Visit	V	$114

		complexity				

Inpatient Hospital Coding and Payment (non-cancer)

ICD-9-CM procedure Codes

ICD-9 Procedure codes are used by hospitals (both inpatient and outpatient) to identify and define procedures performed during an inpatient stay. Hospitals use these codes to identify patient stays by diagnosis related group (DRG) payment codes. DRGs define the amount of reimbursement the hospital receives for facility services or procedures performed in the inpatient hospital setting.

Procedure	Code	Code Description
Catheter Insertion	3.90	Insertion of catheter into spinal canal for infusion of therapeutic or palliative substances
Intrathecal Injection	3.92	Injection of other agent into spinal cord
Pump Implantation	86.06	Insertion of totally implantable infusion pump
Catheter Removal	3.99	Other operation on spinal cord and spinal canal procedures
Pump Removal	86.05	Incision with removal of foreign body or device from skin or subcutaneous tissue

MS-DRG Codes

Under Medicare's DRG methodology for hospital inpatient payment, each inpatient stay is assigned to **one** of about 745 diagnosis related groups, based on the ICD-9-CM codes assigned to the diagnoses and procedure. Only one DRG is assigned by inpatient stay, regardless of the number of procedures performed. As you will see below, reimbursement is cited as a range – and the ranges can be considerable. (For example, catheter only removal DRG ranges from $8,543 - $28,828.) This range is based on whether or not major complications or comorbidities exist. Additionally, the range is affected by whether or not the complications or comorbidities were identified prior to hospital admittance or after.

Please note that the DRG codes change considerably when the pain is designated as "cancer pain" although as a general rule, reimbursement rates do not change significantly.

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

Hospital Inpatient Coding and Payment (Non Cancer-Pain)

Procedure	Scenario	MS-DRG	MS-DRG Title	Relative Weight	2009 Medicare National Average
Screening Test	Pain Disorder	091	Other disorders of the nervous system W MCC	1.5747	$
		092	Other disorders of the nervous system W CC	0.9218	$
		093	Other disorders of the nervous system W/O CC/MCC	0.6777	$
	Caualgia, reflex sympathetic dystrophy, postherpetic neuralgia, phantom limb syndrome, and peripheral neuropathy	073	Cranial and Peripheral Nerve Disorders W MCC	1.3082	$7,264
		074	Cranial and Peripheral Nerve Disorder W/O MCC	0.8423	$4,677
	Arachnoiditis	097	Non-Bacterial Infections of the nervous system except viral meningitis W MCC	3.2073	$17,809
		098	Non-Bacterial Infections of the nervous system except viral meningitis W CC	1.8504	$10,274
		099	Non-Bacterial Infections of the nervous system except viral meningitis W/O CC/MCC	1.2593	$6,992
	Collapsed Vertebrae	542	Pathological Fractures and Musculoskeletal Malignancy W MCC	1.9045	$10,575
		543	Pathological Fractures and Musculoskeletal Malignancy W CC	1.1302	$6,275
		544	Pathological Fractures and Musculoskeletal Malignancy W/O CC/MCC	0.7698	$4,275
	Failed back syndrome, radicular syndrome, and radiculitis due to disc disease	551	Medical Back Problems W MCC	1.5323	$8,508
		552	Medical Back Problems W/O MCC	0.7657	$4,252
Implantation or Replacement of pump and catheter		040	Peripheral/cranial nerve and other nervous system procedures W MCC	3.9645	$22,013
		041	Peripheral/cranial nerve and other nervous system	2.1518	$11,948

	Entire system implant or replacement, pump and catheter	Pain Disorder, Causalgia, RSD, arachnoiditis, and other nervous system disorders		procedures W CC Peripheral/cranial nerve and		
			042	other nervous system procedures W/O CC/MCC	1.6759	$9,305
			515	Other musculoskeletal system OR procedure W MCC	3.0669	$17,029
			516	Other musculoskeletal system OR procedure W CC	1.8083	$10,041
		Pain due to Collapsed vertebrae and other musculoskeletal disorders	517	Other musculoskeletal system OR procedure W/O CC/MCC	1.3293	$7,381
Implantation or Replacement of Pump only	Pump only implant or replacement	Pain Disorder, Causalgia, RSD, arachnoiditis, and other nervous system disorders	040	Peripheral/cranial nerve and other nervous system procedures W MCC	3.9645	$22,013
			041	Peripheral/cranial nerve and other nervous system procedures W CC	2.1518	$11,948
			042	Peripheral/cranial nerve and other nervous system procedures W/O CC/MCC	1.6759	$9,305
			515	Other musculoskeletal system OR procedure W MCC	3.0669	$17,029
			516	Other musculoskeletal system OR procedure W CC	1.8083	$10,041
		Pain due to Collapsed vertebrae and other musculoskeletal disorders	517	Other musculoskeletal system OR procedure W/O CC/MCC	1.3293	$7,381
Implantation or Replacement of Catheter only	Catheter only implant or replacement (3.90)		This code is not considered a significant procedure for the purpose of DRG assignment. A non-surgical (i.e. medical) DRG is assigned to the stay according to the principal diagnosis			
Removal without replacement	Entire system removal, pump and catheter		028	Spinal Procedures W MCC	5.1919	$28,828
			029	Spinal Procedures W CC or	2.7943	$15,516

			spinal neurostimulator		
		030	Spinal Procedures W/O CC/MCC	1.5385	$8,543
	Pump only removal	This code is not considered a significant procedure for the purpose of DRG assignment. A non-surgical (i.e. medical) DRG is assigned to the stay according to the principal diagnosis			
	Catheter only removal	028	Spinal Procedures W MCC	5.1919	$28,828
		029	Spinal Procedures W CC or spinal neurostimulator	2.7943	$15,516
		030	Spinal Procedures W/O CC/MCC	1.5385	$8,543

Hospital Inpatient Coding and Payment (Cancer-Pain)

Procedure	Scenario	MS-DRG	MS-DRG Title	Relative Weight	2009 Medicare National Average
Screening Test	Neoplasm-related pain (338.3)	947	Signs and Symptoms W MCC	1.0575	$5,872
		948	Signs and Symptoms W/O MCC	.6500	$3,609
	Bone cancer and pathological fracture due to bone cancer	542	Pathological fracture and Musculoskeletal Malignancy W MCC	1.9045	$10,575
		543	Pathological fracture and Musculoskeletal Malignancy W CC	1.1302	$6,275
		544	Pathological fracture and Musculoskeletal Malignancy W/O CC/MCC	.7698	$4,275
	Esophageal, stomach, colon, and rectal cancer	374	Digestive Malignancy W MCC	1.9075	$10,592
		375	Digestive Malignancy W CC	1.2543	$6,965
		376	Digestive Malignancy W/O CC/MCC	.8820	$4897
	Liver and Pancreatic cancer	435	Malignancy o Hepatobiliary system or pancreas W MCC	1.7205	$9,553
		436	Malignancy o Hepatobiliary system or pancreas W CC	1.1921	$6,619
		437	Malignancy o Hepatobiliary system or pancreas W/O CC/MCC	.9531	$5,292
	Lung Cancer	180	Respiratory Neoplasms W MCC	1.6950	$9,411
		181	Respiratory Neoplasms W CC	1.2316	$6,839
		182	Respiratory Neoplasms W/O CC/MCC	.8736	$4,851
	Breast Cancer	597	Malignant Breast Disorders W MCC	1.6061	$8,918
		598	Malignant Breast Disorders W CC	1.0808	$6,001

		599	Malignant Breast Disorders W/O CC/MCC	.7310	$4,059
	Uterin, cervical, and ovarian cancer	754	Malignancy, female reproductive system W MCC	1.7546	$9,743
		755	Malignancy, female reproductive system W CC	1.0780	$5,986
		756	Malignancy, female reproductive system W/O CC/MCC	.6337	$3,518
	Bladder and Kidney Cancer	686	Kidney and Urinary Tract Neoplasms W MCC	1.6234	$9,014
		687	Kidney and Urinary Tract Neoplasms W CC	1.0748	$5,968
		688	Kidney and Urinary Tract Neoplasms W/O CC/MCC	.6822	$3,788
	Prostate and Testicular Cancer	722	Malignancy, Male Reproductive System W MCC	1.5686	$8,710
		723	Malignancy, Male Reproductive System W CC	.9922	$5,509
		724	Malignancy, Male Reproductive System W/O CC/MCC	.5971	$3,315
	Brain and Spinal Cord Cancer	054	Nervous System Neoplasms W MCC	1.5860	$8,806
		055	Nervous System Neoplasms W/O MCC	1.0828	$6,012
Implant or Replacement	Neoplasm Related Pain (338.8)	939	OR procedure W Diagnosis of other Contact W Health Services W MCC	2.6570	$14,753
		940	OR procedure W Diagnosis of other Contact W Health Services W CC	1.6352	$9,080
		941	OR procedure W Diagnosis of other Contact W Health Services W/O CC/MCC	1.0731	$5,959
Entire system implant or replacement, pump and catheter	Bone cancer and pathological fracture due to bone cancer	515	Other Musculoskeletal System OR procedure W MCC	3.0669	$17,029
		516	Other Musculoskeletal System OR procedure W CC	1.8083	$10,041
		517	Other Musculoskeletal System OR procedure W/O CC/MCC	1.3293	$7,381
or	Esophageal, stomach, colon, and rectal cancer	356	Other Digestive System OR procedure W MCC	3.8569	$21,416
Pump only implant or replacement		357	Other Digestive System OR procedure W CC	2.1709	$12,054
		358	Other Digestive System OR procedure W/O CC/MCC	1.3474	$7,481
	Liver and Pancreatic Cancer	423	Other Hepatobiliary or Pancreas OR procedures W MCC	4.5812	$25,437
		424	Other Hepatobiliary or Pancreas OR	2.5188	$13,986

			procedures W CC		
		425	Other Hepatobiliary or Pancreas OR procedures W/O CC/MCC	1.3752	$7,636
	Lung Cancer	166	Other respiratory system OR procedure W MCC	3.6912	$20,496
		167	Other respiratory system OR procedure W CC	2.0264	$11,252
		168	Other respiratory system OR procedure W/O CC/MCC	1.3433	$7,459
	Breast Cancer	579	Other skin, subq and breast OR procedure W MCC	2.7946	$15,517
		580	Other skin, subq and breast OR procedure W CC	1.4110	$7,835
		581	Other skin, subq and breast OR procedure W/O CC/MCC	0.8595	$4,773
	Uterine, cervical and ovarian cancer	749	Other female reproductive system OR procedures W CC/MCC	2.4834	$13,789
		750	Other female reproductive system OR procedures W/O CC/MCC	0.9614	$5,338
	Bladder and Kidney Cancer	673	Other kidney and urinary tract procedures W MCC	2.7704	$15,383
		674	Other kidney and urinary tract procedures W CC	2.1587	$11,987
		675	Other kidney and urinary tract procedures W/O CC/MCC	1.3091	$7,269
	Prostate and Testicular Cancer	715	Other male reproductive system OR procedures for malignancy W CC/MCC	1.7072	$9,479
		716	Other male reproductive system OR procedures for malignancy W/O CC/MCC	0.9636	$5,350
	Brain and Spinal Cord Cancer	040	Peripheral/cranial nerve and other nervous system procedures W MCC	3.9645	$22,013
		041	Peripheral/cranial nerve and other nervous system procedures W CC or peripheral neurostimulator	2.1518	$11,948
		042	Peripheral/cranial nerve and other nervous system procedures W/O CC/MCC	1.6759	$9,305
Implantation or Replacement	Catheter only implant or replacement (3.90)	This code is not considered a significant procedure for the purpose of DRG assignment. A non-surgical (i.e. medical) DRG is assigned to the stay according to the principal diagnosis			
Removal without replacement	Entire system removal, pump (86.05) and catheter (3.99)	028	Spinal procedures W MCC	5.1919	$28,828
		029	Spinal procedures W CC or spinal	2.7943	$15,516

			neurostimulator		
		030	Spinal procedures W/O CC/MCC	1.5385	$8,543
	Catheter only removal	028	Spinal procedures W MCC	5.1919	$28,828
		029	Spinal procedures W CC or spinal neurostimulator	2.7943	$15,516
		030	Spinal procedures W/O CC/MCC	1.5385	$8,543
	Pump only removal	This code is not considered a significant procedure for the purpose of DRG assignment. A non-surgical (i.e. medical) DRG is assigned to the stay according to the principal diagnosis			