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Eli's Rehab Report

No Need to Hesitate With Spinal Infusion Pumps

Balance opioid therapy between patients and DEA

When your physician provides long-term opioid therapy through spinal infusion pumps to patients with chronic intractable pain, you may not have to fear intense scrutiny from law enforcement.

Efforts to prevent abuse of opioid analgesics, sometimes delivered to the patient by intrathecal or epidural pumps, should not interfere with medical practice and patient care, according to the Drug Enforcement Agency (DEA).

How to Code Opioids via Infusion Pumps

One of the methods of administering opioid therapy is through intrathecal or epidural infusion pumps.

"Usually, in order for a patient to qualify for an implantable infusion pump, they must be treated through a multi-modal approach (non-narcotic therapy such as TENS unit, muscle relaxants, physical therapy, epidural injections, etc.)," says **Myriam Portillo, CPC,** director of coding and reimbursement at Axis Management and Billing Services in Hollywood, Fla.

In particular, patients undergoing chemotherapy or radiation may not tolerate oral, transdermal, or rectal medication due to the side effects of chemotherapy: nausea, vomiting, constipation or drowsiness. In this circumstance, intrathecal pain therapy may be an effective means to manage the patient's pain.

Murthy Cherala, president-CEO of MC Business Solutions Inc. in Elgin, Ill., provides the following example for common codes to choose:

1. Pump implant - **CPT 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). You would not use this code for intrathecal or epidural catheters inserted percutaneously for intermittent injections or infusions through a portable pump.

2. Programmable pump - 62362 (Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming).

3. Electronic analysis of programmable pump - 62367 (Electric analysis of programmable, implanted pump for intrathecal or epidural drug infusion [includes evaluation of reservoir status, alarm status, drug prescription status]; without reprogramming).

4. Electronic analysis with reprogramming - 62368 (... with programming)

5. Pump refill by nonphysician - 95990 (Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal [intrathecal, epidural] or brain [intraventricular]).

6. Pump refill by physician - 95991 (... administered by physician).

7. If the physician uses fluoroscopy, you should use 76005 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures [epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint], including neurolytic agent destruction).

8. Refill kit - A4220 (Refill kit for implantable infusion pump).

9. Medicines - J2275 (Injection, morphine sulfate [preservative-free sterile solution], per 10 mg) for morphine sulfate, or J3490 (Unclassified drugs) for all compounded or combination drugs.

Don't Forget Modifier -KD

You should take into account that one unit of J2275 is equal to 10 mg of morphine sulfate, meaning that you will have to determine the number of units to bill.

Here is an easy formula to follow, according to Cherala:

(fill volume) X (concentration of drug)
---------- = # of units
10 mg

For instance, if the physician refills the pump with 18 mL of pf morphine sulfate at a concentration of 25 mg/mL, you should incorporate these numbers into the formula like this:

18 mL X 25 mg/mL
--------- = 45 units
10 mg

So you would report on your CMS-1500 form that you used 45 units, Cherala says.

Also, be sure to attach modifier -KD (Infusion drugs furnished through implantable durable medical equipment [DME]) to the J code "to clarify that the medication was infused through DME and therefore reimbursable at 95 percent of the average wholesale price (AWP) instead of 85 percent by Medicare and some third-party payers," Portillo says.

For example, J2275's reimbursement increases from $6.99 to $11.07 when you add modifier -KD.

2 Ways to Take Protective Measures

To prevent trouble with law enforcement or medical and nursing licensure boards, you can help your practice by developing policies and procedures for addressing these concerns, such as fulfilling all requirements for documentation and alerting members of the practice that you're filing more serious pain prescriptions than usual.

1. Make sure the physician clearly documents the rationale for the medication in the patient's chart. The medical record should include:

10. evidence that the treatment takes place within the standard of medical practice (history and physical examination, a pain assessment, and treatment plan for initial evaluation) (99201-99205 or 99241-99245), and appropriate interim history and focused exam when indicated, pain reassessment, and re-evaluation of treatment plan for follow-up visits (99211-99215)

11. evidence that the physician evaluated the pain complaint, earlier treatments, impact of the pain, important comorbidities, and alcohol and drug history

12. a range of outcomes the physiatrist repeatedly assessed during the course of opioid therapy, including pain intensity, physical and psychosocial functioning, side effects, and drug use behaviors.

Note: Check with your state medical board for specific state requirements.

2. If you notice more claims involving intractable or chronic pain, alert the physician or nurse and ask them to contact the local DEA agent to say, "We're treating more patients with serious pain and wonder if you have any recommendations." Also suggest that the prescribing clinicians contact their medical and/or nursing board for guidelines on treating patients with opioids.