blue of california

Payment Policy

Pain Medication-Administration Through Pain Pumps	
Original effect date:	Revision date:
05/16/2008	08/03/2018

IMPORTANT INFORMATION

Blue Shield of California payment policy may follow industry standard recommendations from various sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT) and/or other professional organizations and societies for individual provider scope of practice or other coding guidelines. The above referenced payment policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms or their electronic equivalent. This information is intended to serve only as a general reference regarding Blue Shield's payment policy and is not intended to address every facet of a reimbursement situation. Blue Shield of California may use sound discretion in interpreting and applying this policy to health care services provided in a particular case. Furthermore, the policy does not address all payment attributes related to reimbursement for health care services provided to a member. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy such as coding methodology, industry-standard reimbursement logic, regulatory/legislative requirements, benefit design, medical and drug policies. Coverage is subject to the terms, conditions and limitation of an individual member's programs benefits.

Application

The purpose of this policy is to describe the process for payment review of claims for compounding, refill, and administration of pain medications provided via pain pumps. This policy also provides instruction for claims submission for the referenced services.

Policy

Payment for injectable drug services (including pain pump refills) is based on a percentage above Average Sales Price (ASP) data provided by Centers for Medicare and Medicaid (CMS) on a quarterly basis. Average Sales Price data is compiled by the CMS at the National Drug Code (NDC) level. Therefore, ASP pricing is based on sales data by a defined list of NDCs and cross-walked to the HCPCS code, to establish a payment value; such drugs are approved by the United States Food and Drug Administration (FDA) and are premanufactured by a drug company and its laboratories and facilities holding a license to manufacture these products.

Any medications compounded by a compounding pharmacy from bulk powder (or other formulations) for use in an implanted pain or infusion pump not on the defined list of NDCs approved by the FDA for which the HCPCS ASP value is determined are subject to review for payment. This is because the product being used in the compounded pain medication

is not premanufactured by the licensed drug manufacturer and therefore its value is not utilized to determine its ASP-based HCPCS price.

If such products for use in a pain pump (or other such device) are compounded by a pharmacy, payment to the provider rendering services shall be based on the invoice from the compounding pharmacy. The payment should cover the cost of the actual medication used and administrative time of the pharmacy staff for compounding the product. For a copy of the NDC-HCPC crosswalk, please see the ASP NDC-HCPCS crosswalk files at http://www.cms.hhs.gov .

If the medication is purchased or obtained from a compounding pharmacy, use the unlisted HCPCS code for Unclassified drugs (J3490). This will be paid at the compounding pharmacy invoice rate. A copy of the invoice must be attached to the drug refill claim when submitted for payment. ONLY pre-manufactured, United States Food and Drug Administration (FDA)-approved drugs are billable by specific HCPCS codes. Standard codes should NOT be used when the drug is compounded.

When purchasing powdered drugs, to compound in the office, the claim must reflect current and accurate National Coverage Determination (NDC) codes, and amounts, for the products used. Documentation for drugs mixed in the office must clearly state strength (milligram (mg)) and amounts (milliliter (ml)) used for the pain pump. Documenting mg/kg/ml is insufficient information for determining reimbursement.

HCPCS codes A4220 and A4221 (refill kits and supplies) are included in CPT code 95990 or 95991. Thus, the refill kit and supplies are included in the refilling and maintenance fee. The refill kit for implantable infusion pump is considered bundled/excluded from Medicare coverage by the Centers for Medicare and Medicaid (CMS).

The procedure to refill and maintain the implantable pump or reservoir for drug delivery should reflect intrathecal, epidural, or intraventricular administration or CPT code 95990 or 95991. Do NOT use the intravenous or intra-arterial administration code.

Claims for the following drugs must be submitted according to the Billing Parameters listed below:

- Baclofen (Lioresal Intrathecal Screening or Refill Kit)
- Bupivacaine (Marcaine, Sensorcaine)
- Clonidine (Duraclon)
- Fentanyl (Sublimaze) and sufentanil (Sufenta)
- Hydromorphone (Dilaudid)
- Morphine (Astramorph, Duramorph, Infumorph)
- Ziconotide (Prialt) Note: See Pharmacy Services; Injectable Information; Medication Policy

An Independent Member of the Blue Shield Association

Billing Parameters:

- Use HCPCS code J3490 (Unclassified drugs), with one unit of service, for compounded drug refills
- Drug specific HCPCS "J" should not be used for these drug mixtures (for epidural/subarachnoid pain pump refills) as these codes do not specifically describe the actual formulations of the drugs used in this reconstituting/compounding process
- A copy of the "compounding" pharmacy invoice is required for each claim
- The correct code for an implantable epidural, intrathecal or intraventricular pain pump refill and maintenance is CPT code 95990 when performed "incident to" a physician's services, or CPT code 95991 when administered by a physician
- The correct code for pump analysis is CPT code 62367 and CPT code 62368 for analysis with or without re-programming. CPT codes 62369 and 62370 are the correct codes for pump analysis including re-programming and refills.
- An Evaluation and Management (E & M) service is allowed, if performed at the time of pump refill for a significant, separately identifiable reason. The applicable appropriate E & M code should be billed with the CPT -25 modifier
- The dollar amounts on these invoices should be identical to those that would have been on an invoice sent to a physician's office if the identical drug mixture had been supplied by that pharmacy and had been used for that patient in that physician's office

Documentation Required for Clinical Review
Post Service
If drugs are compounded by a pharmacy, the following documentation is required: • Copy of computer analysis report • Copy of pharmacy invoice • Copy of the pharmacy tag compounded by the provider; the following If drugs are received from a Vendor, to be documentation is required: • Copy of invoice for drugs (from Vendor) • Current, accurate NDC codes for the products used, if applicable
• Name and final strength of drug(s) used, amounts in milliliters, of each drug placed in pump If electronic analysis performed: • Copy of computer analysis report required

An Independent Member of the Blue Shield Association

Rationale

Any medications compounded by a compounding pharmacy from bulk powder (or other formulations) for use in an implanted pain or infusion pump not on the defined list of NDCs approved by the FDA for which the HCPCS ASP value is determined are subject to review for payment. This is because the product being used in the compounded pain medication is not premanufactured by the licensed drug manufacturer and therefore its value is not utilized to determine its ASP-based HCPCS price.

Reimbursement Guideline

Blue Shield of California will reference national or regional industry standards, such as Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and MUE (Medically Unlikely Edits) rules, and American Medical Association's (AMA) CPT guidelines, as coding standards for adjudication of professional claims and as guidance for payment policy. In claims payment scenarios where CMS and/or CPT reference is lacking or insufficient, the Payment Policy Committee (PPC) may develop customized payment policies that are based on other accepted or analogous industry payment standards and or expert input.

Code (s) impacted	
	Defined codes within policy
Resources	
• **American Medical Association** http://www.ama-assn.org/ama • **Centers for Medicare & Medicaid Services** http://www.cms.gov/	

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Payment Policy.

Effective Date	Action	Reason
5/16/2008	New Medical Policy	Medical Policy Committee
03/13/2012	Policy revision with position change	Administrative Review

An Independent Member of the Blue Shield Associationssociation

11/01/2015	Revision	Payment Policy Committee
01/01/2016	Maintenance	Payment Policy Committee
07/08/2017	Maintenance	Payment Policy Committee
08/03/2018	Maintenance	Payment Policy Committee

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available.

An Independent Member of the Blue Shield Association