Instructions for use
The following coverage policy applies to health benefit plans administered by Cigna. Coverage policies are intended to provide guidance in interpreting certain standard Cigna benefit plans and are used by medical directors and other health care professionals in making medical necessity and other coverage determinations. Please note the terms of a customer’s particular benefit plan document may differ significantly from the standard benefit plans upon which these coverage policies are based. For example, a customer’s benefit plan document may contain a specific exclusion related to a topic addressed in a coverage policy.

In the event of a conflict, a customer’s benefit plan document always supersedes the information in the coverage policy. In the absence of federal or state coverage mandates, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of:
1. The terms of the applicable benefit plan document in effect on the date of service
2. Any applicable laws and regulations
3. Any relevant collateral source materials including coverage policies
4. The specific facts of the particular situation

Coverage policies relate exclusively to the administration of health benefit plans. Coverage policies are not recommendations for treatment and should never be used as treatment guidelines.

This evidence-based medical coverage policy has been developed by eviCore, Inc. Some information in this coverage policy may not apply to all benefit plans administered by Cigna.

CPT® (Current Procedural Terminology) is a registered trademark of the American Medical Association (AMA). CPT® five digit codes, nomenclature and other data are copyright 2015 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in the CPT® book. AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for the data contained herein or not contained herein.

©Copyright 2015 eviCore healthcare
# CMM-210~Implantable Intrathecal Drug Delivery Systems

<table>
<thead>
<tr>
<th>CMM-210</th>
<th>Implantable Intrathecal Drug Delivery Systems</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>210.1</td>
<td>Definitions</td>
<td>3</td>
</tr>
<tr>
<td>210.2</td>
<td>General Guidelines</td>
<td>3</td>
</tr>
<tr>
<td>210.3</td>
<td>Indications and Non-Indications</td>
<td>3</td>
</tr>
<tr>
<td>210.4</td>
<td>Procedure (CPT®) Codes</td>
<td>5</td>
</tr>
<tr>
<td>210.5</td>
<td>References</td>
<td>6</td>
</tr>
</tbody>
</table>
CMM-210~Implantable Intrathecal Drug Delivery Systems

CMM-210.1 Definitions

An implantable intrathecal drug delivery system (Pain pump or Baclofen pump) is a device used for the continuous infusion of a drug directly into the cerebrospinal fluid via a catheter placed in the intrathecal or epidural space. A pump is placed in the subcutaneous tissue of the abdomen and connected to the catheter. The pump reservoir holds the medication(s), and the pump is programmed to give a set dose of medication over time. For most individuals, it should be used as part of a program to facilitate restoration of function and return to activity, and not just for pain reduction.

CMM-210.2 General Guideline

Please note, this guideline does not apply to epidural injections administered for obstetrical or surgical epidural anesthesia.

CMM-210.3 Indications and Non-Indications

✓ The use of an implantable intrathecal or epidural drug delivery system is considered medically necessary for ANY of the following indications when the associated criteria are met:
  • Nonmalignant, chronic intractable pain (e.g., failed back surgery syndrome with low back pain and/or radicular pain, complex regional pain syndrome [i.e., reflex sympathetic dystrophy], post-herpetic neuralgia)
  • Severe, refractory spasticity or chronic intractable dystonia in individuals who are unresponsive to or cannot tolerate oral anti-spasticity agents (i.e., baclofen [Lioresal®]) (i.e., intrathecal injection of Baclofen)
  • Cancer-related pain

✓ A trial with a percutaneous intrathecal or epidural drug delivery system for nonmalignant chronic intractable pain is considered medically necessary when ALL of the following criteria have been met:
  • There is a documented pathology (i.e., an objective basis for the pain complaint)
  • Failure of a sufficient trial of at least six (6) months of all reasonable treatment options for pain management which could potentially provide benefit with a reasonable expectation that the treatment could possibly render the need for the intrathecal pain pump medically unnecessary
- Participation in a reasonable trial of aggressive active rehabilitative exercises
- Failure of a sufficient trial of strong opioids or other analgesics in adequate doses, with a fixed schedule (not on an as-needed basis) dosing
- Further surgical intervention or other treatment is not indicated or likely to be effective
- Statement from a primary care physician, neurologist, physiatrist, psychiatrist, psychologist, or other licensed behavioral and/or medical health care provider attesting to the absence of untreated, underlying mental health conditions/issues (e.g., depression, drug, alcohol abuse) as a major contributor to chronic pain.

✓ A trial with a percutaneous intrathecal drug delivery system for severe, refractory spasticity or chronic intractable dystonia is considered medically necessary when there is failure, contraindication or intolerance to at least a six-week trial of oral antispasmodic drugs and physical therapy.

✓ A trial with a percutaneous intrathecal or epidural drug delivery system for cancer-related pain is considered medically necessary when there is failure, intolerance, or contraindication to noninvasive methods of pain control, including systemic opioids.

✓ A permanent implantable intrathecal or epidural drug delivery system for the above listed pain conditions is considered medically necessary if the individual has met the above criteria for a preliminary trial and has experienced at least a 50% reduction in pain during an appropriate trial.

✓ An intrathecal or epidural drug delivery system is experimental, investigational or unproven for ANY other indication, including the following:
  - Cancer-related pain, spastic/dystonic, or other pain conditions that do not meet the above criteria
  - Administration of insulin for diabetes
  - Administration of antibiotics for osteomyelitis
  - Administration of heparin for thromboembolic disease
CMM-210.4 Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code’s inclusion on this list does not necessarily indicate prior authorization is required.

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Code Description/Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>62310</td>
<td>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</td>
</tr>
<tr>
<td>62311</td>
<td>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)</td>
</tr>
<tr>
<td>62318</td>
<td>Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic</td>
</tr>
<tr>
<td>62319</td>
<td>Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)</td>
</tr>
<tr>
<td>62350</td>
<td>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</td>
</tr>
<tr>
<td>62351</td>
<td>Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy</td>
</tr>
<tr>
<td>62355</td>
<td>Removal of previously implanted intrathecal or epidural catheter</td>
</tr>
<tr>
<td>62360</td>
<td>Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir</td>
</tr>
<tr>
<td>62361</td>
<td>Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump</td>
</tr>
<tr>
<td>62362</td>
<td>Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump with or without programming</td>
</tr>
<tr>
<td>62365</td>
<td>Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion</td>
</tr>
</tbody>
</table>

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual’s policy or benefit entitlement structure as well as claims processing rules.


