Name of Policy:
Implantable Infusion Pump

Policy #: 442
Category: Surgery
Latest Review Date: July 2013
Policy Grade: B

Background/Definitions:
As a general rule, benefits are payable under Blue Cross and Blue Shield of Alabama health plans only in cases of medical necessity and only if services or supplies are not investigational, provided the customer group contracts have such coverage.

The following Association Technology Evaluation Criteria must be met for a service/supply to be considered for coverage:

1. The technology must have final approval from the appropriate government regulatory bodies;
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
3. The technology must improve the net health outcome;
4. The technology must be as beneficial as any established alternatives;
5. The improvement must be attainable outside the investigational setting.

Medical Necessity means that health care services (e.g., procedures, treatments, supplies, devices, equipment, facilities or drugs) that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice; and
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease; and
3. Not primarily for the convenience of the patient, physician or other health care provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.
**Description of Procedure or Service:**
Implantable infusion pumps can provide long-term drug infusion at constant or variable rates. Primary uses are delivery of chemotherapy agents and analgesics; several devices are commercially available.

An implantable infusion pump (IIP) is intended to provide long-term continuous or intermittent drug infusion. Possible routes of administration include intravenous, intra-arterial, subcutaneous, intraperitoneal, intrathecal and epidural. The IIP is surgically placed in a subcutaneous pocket under the infraclavicular fossa or in the abdominal wall, and a catheter is threaded into the desired position. Intrathecal and epidural catheter positions are both intraspinal; however, the intrathecal position is located in the subarachnoid space, which is past the epidural space and dura mater and through the theca of the spinal cord.

A drug is infused over an extended period of time and may be delivered at a constant or variable rate by calibrating the IIP per physician specifications. The drug reservoir may be refilled as needed by an external needle injection through a self-sealing septum in the IIP. Bacteriostatic water or physiological saline is often used to dilute drugs. A heparinized saline solution may also be used during an interruption of drug therapy to maintain catheter patency.

The driving mechanisms may include peristalsis, fluorocarbon propellant, osmotic pressure, piezoelectric disk benders, or the combination of osmotic pressure with an oscillating piston.

**Policy:**
Implantable infusion pumps meet Blue Cross and Blue Shield of Alabama’s medical criteria for coverage when used to deliver drugs having FDA approval for this route of access and for the related indication for the treatment of:

- Primary liver cancer (intrahepatic artery injection of chemotherapeutic agents);
- Metastatic colorectal cancer where metastases are limited to the liver (intrahepatic artery injection of chemotherapeutic agents);
- Head/neck cancers (intra-arterial injection of chemotherapeutic agents);
- Primary epithelial ovarian cancer (intraperitoneal infusion as component of chemotherapy) *(Effective 01/01/2013)*
- Severe, chronic, intractable pain (intravenous, intrathecal, and epidural injection of opioids) following a successful temporary trial of opioid or non-opioid analgesics by the same route of administration as the planned treatment. A successful trial is defined as greater than 50% reduction in pain following implementation of treatment; *(excludes headache or head pain. Refer to policy #314)*
- Severe spasticity of cerebral or spinal cord origin in patients who are unresponsive to or who cannot tolerate oral baclofen therapy (intrathecal injection of baclofen).

Implantable infusion pumps do not meet Blue Cross and Blue Shield of Alabama’s medical criteria for coverage and are considered investigational for all other uses (e.g., heparin for thromboembolic disease, insulin for diabetes, antibiotics for osteomyelitis).
Blue Cross and Blue Shield of Alabama does not approve or deny procedures, services, testing, or equipment for our members. Our decisions concern coverage only. The decision of whether or not to have a certain test, treatment or procedure is one made between the physician and his/her patient. Blue Cross and Blue Shield of Alabama administers benefits based on the members' contract and corporate medical policies. Physicians should always exercise their best medical judgment in providing the care they feel is most appropriate for their patients. Needed care should not be delayed or refused because of a coverage determination.

**Key Points:**

**Chemotherapy for Cancer Patients**

**Primary liver cancer**

No randomized controlled trials (RCTs) have evaluated whether hepatic arterial infusion of chemotherapy in patients with primary liver cancer improves health outcomes. Several case series were identified. Most recently, Jarnagin and colleagues reported on 34 patients with unresectable primary liver cancer who received hepatic arterial infusion of floxuridine and dexamethasone. Sixteen of 34 (47%) patients had a partial response to treatment. Median survival was 29.5 months; the two-year survival rate was 67%. In addition, Smith and colleagues studied 11 patients and found a complete response to chemotherapy in one patient and partial responses in six patients. Atiq and colleagues found a partial response in four of ten (40%) of patients with unresectable liver cancer treated with intrahepatic chemotherapy delivered through an implantable pump. The evidence is limited but suggests that some patients, with limited other treatment options, may benefit from arterial infusion of chemotherapy.

**Liver metastases from colorectal cancer**

In 2009, a Cochrane review was published comparing hepatic arterial infusion versus systemic chemotherapy for patients with unresectable liver metastases from colorectal cancer. Ten RCTs that evaluated a total of 1,277 patients were included. Nine of these provided data on tumor response. The response rate was significantly higher in the hepatic arterial infusion group (198 of 461, 43%) than the systemic chemotherapy group (81 of 440, 18%). The pooled risk ratio (RR) was 2.26 (95% confidence interval [CI]: 1.80-2.84). However, there was not a significantly higher survival rate associated with hepatic arterial infusion chemotherapy. The mean weighted median overall survival times were 15.9 months with hepatic arterial infusion chemotherapy and 12.4 months for systemic chemotherapy (pooled hazard ratio: 0.90; 95% CI: 0.76-1.07). Adverse effects and quality-of-life outcomes were not reported.

This evidence suggests that arterial infusion of chemotherapy improves response rates for patients with colorectal cancer metastatic to the liver compared to systemic chemotherapy. The impact on survival is uncertain.

**Head and neck cancers**

Several studies have evaluated interventions that combine radiotherapy and concomitant intra-arterial cisplatin (known as RADPLAT) on patients with head and neck cancer. These studies used intra-arterial delivery of cisplatin via an intra-arterial catheter rather than an implantable pump. Although an implantable infusion pump was not used, the principle of treatment is similar, so that these studies have some relevance to the evaluation of infusion pumps.
In 2006, Hoebers and colleagues in The Netherlands randomized patients with stage III or IV head and neck squamous cell carcinoma to radiotherapy with standard intravenous (IV) cisplatin (n=21) or high-dose intra-arterial cisplatin (n=14). Rates of acute mucositis and hematological toxicity did not differ significantly between groups; however, there was a higher rate of acute renal toxicity in the IV group (30%) compared to the intra-arterial group (0%). Over two years, there were no significant differences between treatment groups in locoregional control of disease, disease-free survival, or overall survival.

A study by Ackerstaff and colleagues examined 17 quality-of-life scales at several time points after treatment with radiotherapy with intravenous or intra-arterial cisplatin. The study included 207 patients with inoperable advanced head and neck cancer. The only statistically significant difference between groups was in the nausea/vomiting scale at seven weeks, at which time the rate of symptoms were higher in the intravenous compared to the intra-arterial group. Otherwise, quality-of-life symptoms were similar in the two groups.

**Primary epithelial ovarian cancer**

A 2011 Cochrane review examined literature on whether an intraperitoneal (IP) component of chemotherapy improves ovarian cancer outcomes compared to intravenous chemotherapy-only. Nine RCTs with a total of 2,119 patients were identified; six trials were considered to be of high-quality. In a pooled analysis of data from eight studies, there was a significantly lower rate of mortality with an IP component of chemotherapy compared to no IP component (hazard ratio [HR]: 0.81; 95% CI: 0.72 to 0.90). Moreover, a pooled analysis of data from five studies found that an IP component of chemotherapy is associated with a significantly longer disease-free interval (HR: 0.78; 95% CI: 0.70 to 0.86). However, an IP component of chemotherapy was associated with significantly more adverse effects (e.g., infection, fever, pain, and gastrointestinal symptoms). For example, a pooled analysis of three studies found a significantly higher infection rate when there was an IP component of chemotherapy compared to IV-only chemotherapy (RR: 3.34, 95% CI: 2.06 to 5.43).

An example of one of the individual RCTs is a high-quality RCT with a relatively large number of patients published by Markman and colleagues in 2001. This was a multicenter study conducted in the United States and included women diagnosed with Stage III epithelial ovarian cancer who entered the study within six weeks of surgery. Patients were randomized to receive either standard dose IV cisplatin/paclitaxel for six courses or two cycles of moderately high-dose carboplatin, followed by six courses of IV paclitaxel and intraperitoneal cisplatin. A total of 523 patients entered the trial, and 61 (12%) were subsequently found to be ineligible for reasons including the wrong stage of cancer or inadequate surgery. Of the remaining 462 eligible patients, 227 were in the IV chemotherapy-only group and 235 were in the intraperitoneal component chemotherapy group. At the time of data analysis, 103 of 227 (45.4%) patients in the IV-only group and 126 of 235 (53.6%) in the IP-component chemotherapy group were still alive. There was an improvement in survival with IP chemotherapy that was of borderline statistical significance (RR: 0.81; 95% CI: 0.65 to 1.00). The length of progression-free survival was significantly longer in the IP chemotherapy component group compared to the IV chemotherapy-only group (median time to recurrence: 27.9 months vs. 22.2 months, respectively, p=0.01). Rates of several adverse events were higher in the IP chemotherapy component group compared
to the IV-only chemotherapy group. These included Grade 3 and 4 gastrointestinal events (37% vs. 17%, respectively) and platelet toxicity (3% vs. 49%, respectively). Two patients in each group died of causes considered to be related to chemotherapy.

The evidence from multiple RCTs, including some of high-quality, and systematic reviews, indicates that intraperitoneal chemotherapy for patients with primary epithelial ovarian cancer has a significant impact on progression-free survival and likely also improves overall survival. This benefit is accompanied by an increased risk of adverse effects with intraperitoneal infusions, including infections, pain, and gastrointestinal symptoms.

**Gastric cancer**

A 2011 systematic review examined RCTs and observational studies on intraperitoneal chemotherapy used to treat gastric cancer. The authors identified 14 studies, two RCTs, two case-control studies and 10 observational studies. One of the RCTs compared groups of patients who did and did not receive intraperitoneal taurolidine following tumor resection and did not find statistically significant differences in outcomes. The other RCT (n=118) found a significantly higher rate of survival in patients who received either IP chemotherapy plus intraoperative peritoneal lavage or IP chemotherapy-only in addition to surgery versus surgery only. (Additionally, all patients in the second study received adjuvant oral 5-fluorouracil derivatives for two years.) The authors of the systematic review recommended that future studies evaluate preoperative or intraoperative IP chemotherapy in association with systemic chemotherapy. There is insufficient evidence on intraperitoneal chemotherapy for treating gastric cancer, and therefore, no change was made to the policy statement.

**Pain**

**Cancer pain**

One systematic review of the literature was identified; it was published in 2010 by Myers and colleagues. They identified 12 RCTs on intraspinal techniques for managing pain in cancer patients; studies are required to report pain as an outcome measure using a validated scale. The investigators did not identify the type or types of cancer addressed in individual studies and did not pool study findings. Two RCTs specifically addressed implantable infusion pumps. One compared intrathecal morphine delivered via an implantable infusion pump plus medical management (n=101) to medical management alone (n=99) in patients with refractory cancer pain. The difference between groups in clinical success (defined as at least 20% reduction in pain score and at least 20% reduction in drug toxicity at four weeks) reached borderline statistical significance, favoring the implantable pump group over the control group (85% vs. 71%, respectively, p=0.05). The proportion of patients who experienced pain score reduction was 52% in the implantable pain pump group and 39% in the control group; this was not a statistically significant difference (p=0.55). The other RCT on implantable pumps compared epidural morphine delivered as a continuous infusion by the Infusaid pump to intermittent delivery by a Port-a-Cath® (Deltec, Saint Paul, MN). The two groups did not differ significantly in their pain scores; scores were low in both groups and the study, which had only 29 participants, was likely underpowered. The authors of the systematic review concluded that intraspinal techniques may be appropriate for selected cancer patients with intractable cancer pain but note the shortage of RCTs.
Noncancer pain
A systematic review by Patel and colleagues on intrathecal infusion pumps used to treat chronic non-cancer pain was published in 2009. To be included in the review, studies needed to evaluate an intrathecal device (programmable or fixed infusion rate), state a specific indication and the drug that was injected, follow patients for at least 12 months, and include at least 25 patients. In addition, the investigators rated study quality and, to be included, studies needed to score at least 50 out of 100 on a methodologic quality scale. The primary outcome of interest to the systematic review was pain relief. A total of 15 studies on intrathecal infusion for non-cancer pain were identified; however, six did not have sufficient follow-up, four included fewer than 25 patients, and one had unacceptably low quality, leaving four eligible studies. All of the studies were observational and involved intrathecal opioid administration; sample sizes ranged from 69 to 120. Most patients experienced lumbospinal pain. Two of the four studies showed positive results for pain relief, one study had negative results, and results were not available for the fourth study. The authors of the systematic review acknowledged the paucity of literature and lack of RCTs. Using the grading system developed by Guyatt and colleagues, the authors concluded that a 1C recommendation is appropriate; that is, a strong recommendation based on low-quality or very low-quality evidence in which the benefits outweigh the risks and the recommendation may change when higher quality evidence becomes available.

Several additional case series were identified in recent literature searches. One study conducted in the United States was published in 2010 by Atli and colleagues. This was a retrospective review of outcomes in 57 patients referred for pain management at a single center who received an implanted intrathecal infusion pump. Twenty-eight of the 57 (49%) patients had failed back surgery syndrome, 16 (28%) had neuropathic pain, and the remaining 13 (23%) had a variety of different diagnoses. A preservative-free opioid (usually morphine) was infused, and the patients could also receive oral medication; adjustments in dosage could be made at any time. Forty-nine of 57 patients (86%) completed the three-year follow-up. At the time of the first pump refill (three to six months), 23 of 49 (47%) study completers reported having at least a 50% reduction in pain from baseline, as measured on a 10-point visual analogue scale. The proportion of responders decreased over time and, at the three-year follow-up, nine of 49 (18%) had at least a 50% reduction in pain from baseline. The 9 patients represented 39% of those who met the at least 50% criterion at the first refill. The use of oral opioids was significantly lower at the one- and three-year follow-ups than at baseline (p values not reported). The mean baseline oral opioid dose in morphine or its equivalent was 184 mg/24 hours. At one and three years, mean doses were 44 mg/24 hours and 58 mg/24 hours, respectively. At three years, 12 of 49 (25%) patients had ceased all oral opioid use. In contrast, the mean dose of intrathecal opioids significantly increased during follow-up, compared to the dose at discharge after pump implantation. The mean dose at discharge was 6.5 mg/24 hours, at one year was 9.3 mg/24 hours, and at three years was 12.2 mg/24 hours. Complications occurred in 10 of 57 (17.5%) patients; these included five infections, three catheter revisions, two seromas at the pump site, and two intrathecal granulomas. Another retrospective case series conducted in the United States and published in 2011 included 126 non-cancer intractable pain patients. Patients received intrathecal opioids-only (n=72) or opioids and bupivacaine (n=54). Outcomes were evaluated 12 months after pump implantation. Pain intensity was assessed using an 11-point numeric rating scale (NRS) where 0=no pain and 10=the worst imaginable pain. In the group that began with opioids-only, mean pain intensity score decreased significantly from 7.42 (standard deviation [SD]: 2.1) at baseline...
to 5.85 (SD: 2.8) at 12 months, p<0.001. In the opioid plus bupivacaine group, the mean pain intensity score decreased from 7.35 (SD: 2.1) at baseline to 5.03 (SD: 2.4) at 12 months, p<0.001.

In 2012, Duarte and colleagues in the U.K. published a case series with long-term follow-up on 20 patients with chronic nonmalignant pain who received intrathecal delivery of opioid analgesics. Patients were followed for a mean of 13.5 years (range: 10.4 to 17.9 years). At four-year and thirteen-year assessments, outcomes were significantly improved compared to baseline. However, outcomes did not significantly improve between four and thirteen years. For example, mean pain intensity (measured on an 11-point scale where 0 represents no pain and 10 represents the worst pain) was 8.65 (SD: 0.29) at baseline, 4.95 (SD: 0.53) at four years post-treatment, and 5.30 (SD: 0.35) at thirteen years post-treatment. Similarly, the mean quality-of-life score (0 represents no interference with quality of life and 10 represents maximum interference) was 8.45 (SD: 0.49) at baseline, 4.95 (SD: 0.69) at four years, and 4.45 (SD: 0.48) at thirteen years.

The evidence on the use of infusion pumps for chronic, non-cancer pain consists of numerous uncontrolled observational studies. These studies, which are limited methodologically, report that pain and quality of life is improved with the use of infusion pumps.

### Severe spasticity

The evidence base consists of case series and a systematic review of case series. The systematic review, published in 2011 by Pin and colleagues, focused on intrathecal baclofen therapy for spasticity and/or dystonia of cerebral origin. The authors identified 16 uncontrolled studies with a total of 227 participants. All of the studies were judged to be of low quality. Most of the outcomes were intermediate measures such as range of motion and muscle strength; several of the studies used objective outcomes. The authors’ interpretation of the studies was that they showed a higher rate of benefit with intrathecal baclofen therapy in patients who were already ambulatory. Adverse events were not consistently defined and reported but appeared to be common. An example of a study that used objective outcomes was published in 2011 by Motta and colleagues in Italy. This study found a statistically significant increase in the Gross Motor Function Measure (GMFM) score after one year. The median GMFM score (as a percentage of maximum score) in 30 cerebral palsy patients with spasticity who received intrathecal baclofen increased from 65.0 to 69.4, p=0004.

In 2011 (after the Pin et al literature search), Morton and colleagues in the U.K. published findings of a non-randomized controlled study of intrathecal baclofen therapy in non-ambulant children with severe spastic cerebral palsy. Patients who responded to a one-time test dose of 50ug intrathecal baclofen were fitted for a pump and placed on a waiting list for surgery. The investigators compared patients who had been on the waiting list between six and twelve months (Group 1, n=18) to patients who had undergone surgery (group 2, n=20). The mean time between baseline and outcome assessment was 8.5 months in group 1 and 9.5 months in Group 2. There was not a statistically significant difference between the two groups in the primary outcome measure, the Pediatric Evaluation of Disability Inventory (PEDI). The authors noted, however, that given the small number of patients recruited, the study was underpowered to detect clinically significant differences between groups on this outcome. Several secondary outcomes favored Group 2, including scores on the Modified Ashworth Scale (difference between groups 1.7,
p=0.008), scores on the Penn Spasm Scale (difference between groups -1.3, p=0.0010) and the range-of-motion score (difference between groups 8.3, p=0.005).

**Implanted infusion pumps for other indications**

No systematic reviews, meta-analyses, or large RCTs were identified on use of implanted infusion pumps for any additional indication.

**Summary**

There is a large body of evidence on the use of infusion pumps, but the quality of the literature varies by condition. For patients with colorectal cancer metastatic to the liver, a 2009 meta-analysis of randomized controlled trials found that hepatic arterial infusion of chemotherapy with implanted infusion pumps improves tumor control. For women with primary epithelial ovarian cancer, evidence from randomized controlled trials (RCTs) and a systematic review of RCTs indicates that an intraperitoneal infusion of chemotherapy can lead to improved survival and progression-free survival compared to intravenous chemotherapy only. The benefits of an intraperitoneal chemotherapy must be weighed against the risk of adverse events, which have been found to be higher with an intraperitoneal component of chemotherapy. For patients with chronic cancer pain, a systematic review of RCTs concluded that pain symptoms were less for patients who used an infusion pump. For these three indications, the evidence is sufficient to conclude that the use of an implantable infusion pump improves outcomes and therefore may be considered medically necessary.

There is insufficient evidence suggesting that chemotherapy delivered through implantable infusion pumps improves health outcomes for patients with gastric cancer. Clinical input did not support use of this technology for this type of cancer. Thus, this indication is considered investigational.

For patients with intractable, non-cancer pain, the evidence consists of uncontrolled studies that report improvements in pain and quality of life following use of an implantable infusion pump. In addition, guidelines from specialty societies support use of infusion pumps for this indication. For patients with severe spasticity, evidence from case series and non-randomized controlled studies reports improvements in symptoms, and there is support from specialty society guidelines for use in spasticity. Because of the strong rationale for use, the suggestive evidence, and the support from clinical guidelines, infusion pumps may be considered medically necessary for chronic, intractable non-cancer pain and for severe spasticity.

**Practice Guidelines and Position Statements**

The 2012 guidelines from the National Comprehensive Cancer Network include the following statements:

- “Placement of a hepatic arterial port or implantable pump during surgical intervention for liver resection with subsequent infusion of chemotherapy directed to the liver metastases through the hepatic artery (e.g., HAI) remains an option.”
- “The panel recommends that systemic cytotoxic chemotherapy (single agent or combination), intra-arterial chemotherapy, as well as the combination of cytotoxic chemotherapy and radiation therapy be given to patients with unresectable HCC only in the context of a clinical trial.”
The 2012 information summaries from the National Cancer Institute (NCI) state the following:

- For patients with Stage IV and recurrent colon cancer with liver metastases, hepatic intra-arterial chemotherapy with floxuridine has had higher overall response rates but not a consistent improvement in survival when compared to systemic chemotherapy.
- For patients with localized and locally advanced unresectable adult primary liver cancer, infusion of chemotherapeutic agents with a subcutaneous portal or implantable pump via a catheter placed in the hepatic artery is described as a standard treatment option.

In 2010, the European Working group for Spasticity in Children published a consensus statement on use of intrathecal baclofen therapy in children with spasticity. For children with spasticity that interferes with function or quality of life, they recommend that conservative treatment and a trial of oral medication be tried prior to use of a pump to deliver intrathecal baclofen. They also recommend individuation of treatment and involvement of parents and caregivers. The group received an unrestricted educational grant from Medtronic (Minneapolis, MN).

In 2003 (updated 2009), the American Society of Interventional Pain Physicians published evidence-based guidelines on interventions for managing chronic spinal pain. The guidelines state that there is strong evidence to support the use of implantable intrathecal drug administration systems with proper patient selection criteria.

**Key Words:**
Implantable Infusion Pumps, Infusion Pumps, Implantable Pump, Implantable Infusion

**Approved by Governing Bodies:**
Several implantable infusion pumps have been approved by the U.S. Food and Drug Administration (FDA) through the premarket approval process, including, but not limited to, the SynchroMed (Fridley, MN) family of pumps, Codman® 3000 (Raynham, MA), Arrow International Constant Flow, and Shiley Infusaid pumps (Norwood, MA). In August 2012, the FDA approved the MEDSTREAM Programmable Infusion System (Codman and Shurtleff), which includes an implantable pump, for intrathecal delivery of baclofen in patients with spasticity.

**Benefit Application:**
Coverage is subject to member’s specific benefits. Group specific policy will supersede this policy when applicable.

ITS: Home Policy provisions apply
FEP: Special benefit consideration may apply. Refer to member’s benefit plan. FEP does not consider investigational if FDA approved. Will be reviewed for medical necessity.
Pre-certification requirements: Not applicable
Current Coding:

CPT Codes:

36260 Insertion of implantable intra-arterial infusion pump (e.g., for chemotherapy of liver)
36261 Revision of implanted intra-arterial infusion pump
36262 Removal of implanted intra-arterial infusion pump
36563 Insertion of tunneled centrally inserted central venous access device with subcutaneous pump
36576 Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site
36583 Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access
36590 Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion
61215 Insertion of subcutaneous reservoir, pump, or continuous infusion system for connection to ventricular 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
62351 ; with laminectomy
62360 Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
62361 ; non-programmable pump
62362 ; programmable pump, including preparation of pump, with or without programming
62365 Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion
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*
62368 ; with reprogramming*
62369 ; with reprogramming and refill* (Effective 01/01/2012)
62370 ; with reprogramming and refill (requiring skill of a physician or other qualified health care professional)* (Effective 01/01/2012)

Effective for dates of service on or after January 1, 2012:
*Do not report 62367-62370 in conjunction with 95990, 95991. For refilling and maintenance of a reservoir or an implantable infusion pump for spinal or brain drug delivery without reprogramming, see 95990, 95991)
References:


Available for comment August 6-September 18, 2010
Medical Policy Group, October 2011; Updated Policy (clarification only), Key Points, & References
Medical Policy Group, November 2011 (1); Added 2012 CPT Codes effective 1/1/2012
Medical Policy Group, December 2012 (3): 2013 Coding Update: Verbiage change to code 62370
Medical Policy Panel November, 2012
Medical Policy Group, July 2013 (1) Primary epithelial ovarian cancer (intraperitoneal infusion as component of chemotherapy) added as medically necessary; clarification statement added to severe intractable pain bullet “excludes headache or head pain, refer to policy #314”; coverage for head/neck cancers (intra-arterial injection of chemotherapeutic agents) remains unchanged, as do all remaining coverage statements; Update to Key Points and References.
Medical Policy Administration Committee, August 2013
Available for comment July 23 through October 1, 2013

This medical policy is not an authorization, certification, explanation of benefits, or a contract. Eligibility and benefits are determined on a case-by-case basis according to the terms of the member’s plan in effect as of the date services are rendered. All medical policies are based on (i) research of current medical literature and (ii) review of common medical practices in the treatment and diagnosis of disease as of the date hereof. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment.

This policy is intended to be used for adjudication of claims (including pre-admission certification, pre-determinations, and pre-procedure review) in Blue Cross and Blue Shield’s administration of plan contracts.