AVANOS | ON-Q* PAIN RELIEF SYSTEM

2024 Comprehensive Reimbursement Resource Guide

Contents

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ON-Q* Pain Relief System

Indications for Use[1]:

ON-Q* Pump (510(k) K181360) is intended to provide continuous delivery of medication (such as local anesthetics) to or around surgical wound sites and/or close proximity to nerves for preoperative, perioperative, and postoperative regional anesthesia and/or pain management. Routes of administration include intraoperative site, peripheral nerve block, percutaneous and epidural.

ON-Q* Pump is indicated to ***significantly decrease pain and narcotic use*** when used to deliver local anesthetics to or around surgical wound sites, or close proximity to nerves, when compared to only pain management.

ON-Q* Pump with Bolus device is intended for users 18 years of age and older.

[1]U.S. Food& Drug Administration. 510(k) Premarket Notification. https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpmn/pmn.cfm?ID=K181360. Accessed 01/02/2024.

Coding Pathway Options

This guide provides physician, hospital outpatient and ambulatory surgery center coding with key considerations for addressing the status of the code options provided. 2024 Medicare national average reimbursement rates have also been included. Coding pathway information is intended for provider guidance and allows the physician to consider his or her reporting pathways on a case-by-case basis. Final decision-making regarding third-party payers remains with the individual payer.

CPT modifiers provide additional information about the reported procedure. Many times, the specific modifier may reflect actual reimbursement of services. CPT modifiers may describe whether multiple procedures were performed, why that procedure was necessary, where the procedure was performed on the body, how many surgeons worked on the patient, and other information that may be critical to a claim's status.

Please check specific guidelines for reporting individual cases. Additional documentation may be required to support procedures reported with modifier -52 -59 or XS. A complete list of all modifiers is available in the 2024 AMA CPT book and online on the Medicare website. See also sample below.

SAMPLE CPT/HCPCS MODIFIERS

MODIFIER	DESCRIPTION
-52	**Reduced Services.** When the work required to provide a service is significantly decreased beyond the typical work required a modifier -52 may be appended. The documentation must support the decreased services or the reasoning.
-26	**Professional Component.** Some procedures have both a professional and technical component. When the modifier -26 is appended to the professional service the components may be paid separately per payer guidelines.
-50	**Bilateral Procedure.** When CPT codes are not identified as bilateral in the code description or parenthetical a modifier -50 may be appended when the procedure is performed bilaterally.
-51	**Multiple Procedures.** When more than one procedure is performed at the same session a modifier -51 is appended to additional procedures. It is not appended to codes listed as "add-on" codes.
-59	**Distinct Procedural Service.** Modifier -59 is used to report separate services that are distinct or independent and not normally reported together. Documentation must support the distinct service (Example; separate area of injury in extensive injuries)
-XE	**Separate Encounter.** A service That is Distinct Because It Occurred During A Separate Encounter
-XS	**Separate Structure.** A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
-XP	**Separate Practitioner.** A Service That Is Distinct Because It Was Performed By A Different Practitioner
-XU	**Unusual Separate Service.** The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

Effective January 1, 2015 CMS has established four new modalities to define specific subsets of the -59 modifier. Modifier -59 is still recognized but should not be used when a more descriptive modifier is available. MLN Matters®Number MM8863.
HTTPS://WWW.HHS.GOV/GUIDANCE/SITES/DEFAULT/FILES/HHS-GUIDANCE-DOCUMENTS/MM8863.PDF. Accessed 01/02/2024.

DEVICE CODES:

Level II HCPCS codes are used by facilities to report supplies used in conjunction with procedures performed. Level II HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT-4 codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside the physician's office.

It is important to follow individual payer guidelines for reporting and coding supplies used in conjunction with procedures performed in order for proper tracking of utilization, cost reporting, and for billing and payment when appropriate. Use of HCPCS Level II codes for private payers is subject to payer guidelines for coding, coverage, and payment.

HCPCS CODING PATHWAY OPTIONS

HCPCS CODE [1]	HCPCS CODE DESCRIPTION
A4306	**Disposable drug delivery system, flow rate of less than 50ml per hour**

[1]2024 HCPCS Quarterly Update, https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update. Accessed 01/02/2024.

MEDICARE considers disposable drug delivery systems as surgical supplies for the definitive systems as surgical supplies for the definitive and/or primary surgical procedure code(s) and reimbursement is included in a packaged Medicare payment. Drugs and supplies used with disposable drug delivery systems are also considered surgical supplies included in the Medicare packaged payment.

COMMERCIAL coding and coverage policies differ and widely vary. When billing Commercial Payers please check directly with your payer(s) for coding and coverage considerations as well as any applicable contract(s) provisions for guidance.

CPT[2] CODES:

The following tables illustrate potential CPT codes that may be used to denote procedures associated with placement of the ON-Q* System.

Separate payment may be available for an anesthesiologist placing the infusion catheter just prior or following the operative session. Payer guidelines differ and should be followed for appropriate billing of the catheter placement for post-operative pain relief. The global surgical package, also called global surgery, includes all the necessary services normally furnished by a surgeon before, during and after a procedure. Medicare payment for a surgical procedure includes the preoperative, intra-operative, and post-operative services routinely performed by the surgeon or members of the same group with the same specialty. (MLN Article ICN 907166 September 2018)

CPT CODE & DESCRIPTION[2]		2024 MEDICARE NATIONAL AVG.[3] (IN-FACILITY) Physician Payment	Medicare RVUs
Continuous Peripheral Nerve Blocks			
64416	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement), including imaging guidance when performed	$74	2.28
64446	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed	$73	2.23
64449	Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)	$61	1.89
64448	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed	$69	2.13
Continuous Infusion TAP Blocks			
64487	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by continuous infusion(s) (includes imaging guidance, when performed)	$61	1.87
64489	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by continuous infusions (includes imaging guidance, when performed)	$74	2.28
Continuous Infusion Paravertebral Blocks			
64463	Paravertebral block (PVB) (paraspinous block), thoracic; continuous infusion by catheter (includes imaging guidance, when performed)	$78	2.41
TAP Blocks: Injections			
64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	$53	1.63
64488	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injection(s) (includes imaging guidance, when performed)	$66	2.03
Paravertebral Blocks: Injections			
64461	Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed)	$75	2.31

CPT CODE & DESCRIPTION[2]			2024 MEDICARE NATIONAL AVG.[3] (IN-FACILITY) Physician Payment	Medicare RVUs
64462	Paravertebral block (PVB) (paraspinous block), thoracic; second and any additional injection site(s) (includes imaging guidance, when performed) (List separately in addition to code for primary procedure)		$46	1.43
Other Nerve Injections				
64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level		$56	1.73
64421	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level (List separately in addition to code for primary procedure)		$24	0.74
64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves		$53	1.62
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch		$40	1.25
64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)		$83	2.54
64999	Unlisted procedure, nervous system		RVU and payment amounts priced by carrier	
Ultrasound Guidance				
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Professional	$29	0.89

MULTIPLE PROCEDURES:

The following CPT codes are subject to multiple procedure reduction rules in both outpatient hospital and the ambulatory surgery center (ASC) setting. The multiple procedure reduction applies when two or more services with the multiple procedure indicator are billed on the same day. An example of the calculation is as follows:

- Primary procedure 100%
- Second procedure 50%
- Third procedure 25%
- Forth procedure 25%

[2]2024 AMA Current Procedural Terminology (CPT)®. All Rights Reserved
[3]2024 Medicare Physician Fee Schedule. https://www.cms.gov/medicare/payment/fee-schedules/physician. Accessed 01/02/2024.

CPT CODE & DESCRIPTION		2024 MEDICARE NATIONAL AVG.[4] APC	HOPD	ASC
Continuous Peripheral Nerve Blocks				
64416	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed	5443	$869	$472
64446	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed			
64449	Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)			
64448	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed			
Continuous Infusion TAP Blocks				
64487	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral, by continuous infusion(s) (includes imaging guidance, when performed)		Packaged Payment	
64489	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral, by continuous infusions (includes imaging guidance, when performed)			
Continuous Infusion Paravertebral Blocks				
64463	Paravertebral block (PVB) (paraspinous block), thoracic; continuous infusion by catheter (includes imaging guidance, when performed)	5442	$659	$358
TAP Blocks: Injections				
64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)		Packaged Payment	
64488	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral, by injections (includes imaging guidance, when performed)			
Paravertebral Blocks: Injections				
64461	Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed)	5442	$659	$358
64462	Paravertebral block (PVB) (paraspinous block), thoracic, second and any additional injection site(s) (includes imaging guidance, when performed) (List separately in addition to code for primary procedure)		Packaged Payment	
Other Nerve Injections				
64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level	5442	$659	$358

CPT CODE & DESCRIPTION		2024 MEDICARE NATIONAL AVG.[4]		
		APC	HOPD	ASC
64421	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level (List separately in addition to code for primary procedure)	5443	$869	$472
64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves	5442	$659	$358
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	5442	$659	$358
64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)	5443	$869	$472
64999	Unlisted procedure, nervous system	RVUs and payment amounts priced by carrier		
Ultrasound Guidance				
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	NA	Packaged Payment	
ON-Q*	**Product Code**			
A4306	Disposable drug delivery system, flow rate of less than 50 ml per hour	NA	Packaged Payment	

[4]2024 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc. Accessed 01/02/2024.

MEDICARE considers disposable drug delivery systems as surgical supplies for the definitive and/or primary surgical procedure code(s) and reimbursement is included in a packaged Medicare payment. Drugs and supplies used with disposable drug delivery systems are also considered surgical supplies included in the Medicare packaged payment.

COMMERCIAL coding and coverage policies differ and widely vary. When billing Commercial Payers please check directly with your payer(s) for coding and coverage considerations as well as any applicable contract(s) provisions for guidance.

[†]Information provided is derived from a variety of public sources as of January 2024 and is intended for general purposes only. It does not constitute reimbursement or legal advice. It is not intended to increase or maximize reimbursement by a payer. Avanos encourages providers to submit accurate and appropriate claims for payment. It is always the provider's responsibility to determine medical necessity, the proper delivery of any services and to submit appropriate codes, charges and modifies for services rendered. Avanos recommends that you consult with your payers, reimbursement specialists, and/or legal counsel regarding coding, coverage, and reimbursement matters. Payer policies vary and should be verified prior to treatment for limitations on diagnosis, coding, or site of service requirements.