Medical Coverage Policy

Effective Date..... 4/2/2021
Next Review Date..... 3/15/2022
Coverage Policy Number 0553

Site of Care: Outpatient Hospital for Select Musculoskeletal Procedures

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Related Coverage Resources

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar 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 Policies. In the absence of a controlling federal or state coverage mandate, 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/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgement and have discretion in making individual coverage determinations. 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. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

It is Cigna's intention to give advanced notification of our site of care policies in order to allow providers and other impacted parties ample time to prepare. This coverage policy will be used to support medical necessity determinations for outpatient facility site of care for selected musculoskeletal procedures in select rollout markets for 2021. In 2022 Cigna expects this policy will apply to all markets. Additional information outlining the 2021 market roll out and schedule will be available in 2021.

This Coverage Policy addresses medical necessity for outpatient facility sites of care for selected musculoskeletal procedures that are elective and/or non-emergent. For the intent of this coverage policy these procedures include shoulder, hip and knee arthroscopic procedures, epidural injections, implantation of spinal cord stimulators, facet injections, sacroiliac injections, regional sympathetic blocks, and radiofrequency ablation / denervation procedures.

The interventional pain management procedures noted above and selected shoulder, hip and knee procedures must meet applicable medical necessity criteria for coverage. When applicable coverage criteria is met for the procedure, this coverage policy is used to help determine medical necessity of the site of care for the procedure.

Coverage Policy

For the intent of this medical coverage policy the following procedures are subject to site of care medical necessity review:

- Knee arthroscopy
- Hip arthroscopy
- Shoulder arthroscopy
- Epidural Steroid Injections
- Facet Injections
- Radiofrequency Joint Ablation/Denervation
- Regional Sympathetic Blocks
- Sacroiliac Joint Injections
- Spinal Cord Stimulation

An outpatient hospital site of care for any of the above interventional pain management and/or shoulder, hip and knee procedures is considered medically necessary when ANY of the following criteria is met:

- there is no ambulatory surgery center (ASC) available where the procedure can be performed
- absence of an available ASC where the physician performing the procedure has surgical privileges
- the available ASC guidelines restrict performance of the procedure due to potential for compromised safety (e.g., limitations due to body mass index [BMI], severity of obstructive sleep apnea [OSA], age)
- the individual's medical condition(s) or the surgical procedure(s) being performed requires pre, intra, or post-procedural care/monitoring that cannot be provided at an ASC
- prolonged anesthesia is anticipated (e.g., > 3 hours)
- the presence of ANY of the following conditions/comorbidities considered high risk for adverse outcomes (e.g., American Society of Anesthesiologists [ASA] Physical Status Classification System III or greater):

    - History of any of the following pulmonary conditions that would increase risk:
        - abnormal airway
        - history of difficult intubation
        - poorly or uncontrolled asthma
        - severe chronic obstructive pulmonary disease (COPD)
    - History of any of the following gastrointestinal conditions that would increase risk for aspiration:
        - achalasia
        - delayed gastric emptying
        - gastroparesis
    - History of any of the following cardiovascular conditions that would increase risk:
        - aortic stenosis
        - cardiomyopathy
        - implanted cardioverter-defibrillator
        - implanted pacemaker
        - myocardial infarction (MI) with three (3) months
        - recent coronary intervention (i.e., plain angioplasty within 90 days, bare metal stents placed within 90 days, drug eluting stents placed within one year)
        - severe/significant valvular disease
        - stage 3 hypertension (HTN) (e.g., BP > 180/110)
        - symptomatic/unstable cardiac arrhythmia
        - unstable coronary syndromes (i.e., unstable or severe angina [Canadian Class III or IV], uncompensated chronic heart failure [CHF] [NYHA class III or IV])
    - History of any of the following neurological diagnoses that would increase risk:
        - active multiple sclerosis
        - cerebrovascular accident (CVA) or transient ischemic attack (TIA) within the last three (3) months

        - myasthenia gravis
        - preexisting cognitive dysfunction (e.g., Alzheimer's disease, dementia, disorientation)
    - History of a significant endocrinology diagnosis that would increase risk (e.g., uncontrolled/difficult to control diabetes mellitus [DM])
    - Any of the following other conditions/comorbidities:
        - advanced liver disease (e.g., MELD [model for end stage liver disease] score > 8, waiting for liver transplant, active hepatitis)
        - age < 18 years
        - current or recent history of substance use disorder (i.e., alcohol and/or drug abuse)
        - end stage renal disease (ESRD)
        - history of a significant hemodynamic instability during a prior surgical procedure and is considered a risk for future procedures
        - history of or at risk for malignant hyperthermia
        - individual is awaiting major organ transplant (e.g., heart, liver, lung)
        - moderate to severe OSA
        - morbid obesity (BMI ≥40)
        - pregnancy
        - sickle cell disease
        - uncontrolled coagulopathy (e.g., anticipated need for transfusion)

An outpatient hospital site of care setting for non-emergent, elective procedures is considered not medically necessary for any other indication.

General Background

"Site of care" refers to the location where a procedure is performed. Site of care for medical-surgical procedures generally includes inpatient hospital facility, outpatient hospital facility/department, or an ambulatory surgery center (ASC) (i.e., freestanding surgery center). In contrast to inpatient surgical procedures, outpatient surgery eliminates the need for inpatient hospital admission for many procedures while maintaining safety.

The Centers for Medicare and Medicaid (CMS) define the ambulatory surgery center as "...a distinct entity that operates exclusively to furnish surgical services to patients who do not require hospitalization", the ASC can be independent or a hospital-operated ASC (CMS, 2019). Whether the ASC is independently owned or owned/operated by a hospital, ASCs provide a high quality, cost-effective alternative to procedures that are performed in outpatient hospital departments (i.e., owned by the hospital). As a result, performance of surgical procedures in a freestanding ambulatory surgery center (ASC) may offer Cigna members a lower cost yet equally safe alternative to an outpatient setting for medically necessary elective, non-emergent surgical procedures.

Evidence in the medical literature demonstrates that the number of surgical procedures that can safely be performed in hospital and non-hospital based ASCs has continued to increase. Moreover, many types of surgical procedures may be performed safely at ASCs, hospital based or other. For individuals whose health status does not necessitate a higher level of supportive care for the reduction of risk and adverse health outcomes, surgery in an ASC is an established safe alternative to procedures performed in the outpatient setting.

For some individuals however the presence of comorbid health conditions can lead to risk for adverse events following surgical procedures. For these individuals, performance of the surgical procedure is best performed in the outpatient setting. For example, medications administered during surgical procedures and post-operatively can place some individuals at risk for complications, such as those with obstructive sleep apnea (OSA). While a diagnosis of sleep apnea does not exclude an individual from having surgery in an ASC, factors to be considered in determining the site of care include the severity of obstructive sleep apnea, type of anesthetic, length of procedure, amount of pain medications required after the procedure, and the individuals compliance with the use of positive pressure airway machines. Other risk factors include obesity, chronic obstructive pulmonary disease (COPD), history of transient ischemic attack (TIA)/stroke, severe hypertension, previous cardiac surgical intervention (which may include implanted defibrillators, drug eluting or metal stents and pacemakers), and

prolonged operative time (Mathis, et. a., 2013; Whippey, et al., 2013). In addition, surgery in an ASC is not warranted when preoperative planning determines the individual requires overnight recovery and care following a surgical procedure.

There is no general consensus regarding an age limit for when individuals should have surgery at an outpatient facility versus ambulatory surgery center, however some studies support an elderly individual or child may be at higher risk of adverse events during an ambulatory procedure. Premature infants are at risk for postoperative apnea. Postconceptual age (PCA) is an important concept for consideration of ambulatory surgery and is defined by the weeks of gestation plus weeks in age (Butz, 2019), an alternate concept is the postgestational age (PGA) or postmenstrual age (PMA) in which delivery is calculated in weeks from the date of the first day of the mothers last menstrual cycle before becoming pregnant. PGA and PMA are both 2 weeks longer than the PCA (Butz, 2019). Using 60 weeks PCA is an acceptable recommendation (Butz, 2019). Other limits related to age, such as age limits defined by the facility, if applicable, and a recommendation by the surgeon and/or anesthesiologist for the most appropriate site of care based on age should be considered.

Related Medical Necessity Information

Stage of Hypertension: The American College of Cardiology and American Heart Association published guidelines for the prevention, detection, evaluation and management of high blood pressure (Whelton, et al., 2017). Within these guidelines the task force developed four levels of blood pressure categories in adults. The levels are as follows:

- Normal: systolic less than 120 mm Hg and diastolic less than 80 mm Hg
- Elevated: systolic between 120-129 mm Hg and diastolic less than 80 mm Hg
- Stage 1: systolic between 130-139 mm Hg or diastolic between 80-89 mm Hg
- Stage 2: systolic at least 140 mm Hg or diastolic at least 90 mm Hg

Obstructive Sleep Apnea (OSA): Individuals with a diagnosis of OSA are traditionally classified as having mild, moderate, or severe disease on the basis of the apnea-hypopnea index (AHI), respiratory disturbance index (RDI), respiratory event index (REI) and symptoms. Types of OSA include the following (American Academy of Sleep Medicine, 2008):

- Mild: Mild OSA has been defined as AHI/RDI/REI between 5 and 14 respiratory events per hour of sleep. Involuntary sleepiness during activities that require little attention, such as watching TV or reading.
- Moderate: Moderate OSA has been defined as AHI/RDI/REI between 15 and 30 respiratory events per hour of sleep. Involuntary sleepiness during activities that require some attention, such as meetings or presentations.
- Severe: Severe OSA has been defined as AHI/RDI/REI greater than 30 respiratory events per hour of sleep. Involuntary sleepiness during activities that require more active attention, such as talking or driving.

MELD Score: The Model for Endstage Liver Disease (MELD) score is a prognostic model used for estimating the severity of liver disease and mortality risk. MELD was initially adopted by the United Network for Organ Sharing (UNOS) in 2002 for prioritization of patients awaiting liver transplantation in the United States. Obtaining a MELD score requires a patient's laboratory values for serum bilirubin, serum creatinine, and the international normalized ratio (INR) to predict three-month survival.

New York Heart Association (NYHA) Functional Classification: The New York Heart Association Functional Classification classifies individuals in one of four categories based on their limitations during physical activity; the limitations/symptoms are in regards to normal breathing and varying degrees in shortness of breath and/or angina pain. The New York Heart Association (NYHA) Functional Classification is defined as follows:

- Class I - No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea (shortness of breath).
- Class II - Slight limitation of physical activity. Comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea (shortness of breath).

- Class III - Marked limitation of physical activity. Comfortable at rest. Less than ordinary activity causes fatigue, palpitation, or dyspnea.
- Class IV - Unable to carry on any physical activity. Symptoms of heart failure at rest. If any physical activity is undertaken, discomfort increases.

Canadian Cardiovascular Society (CCS): The CCS grading scale is used for classification of angina severity as follows:

- Grade I – Angina only with strenuous activity. Presence of angina during strenuous, rapid, or prolonged ordinary activity (walking or climbing the stairs).
- Grade II - Angina with moderate exertion. Slight limitation of ordinary activities when they are performed rapidly, after meals, in cold, in wind, under emotional stress, during the first few hours after waking up, but also walking uphill, climbing more than one flight of ordinary stairs at a normal pace and in normal conditions.
- Grade III - Angina with mild exertion. Having difficulties walking one or two blocks or climbing one flight of stairs at normal pace and conditions.
- Grade IV- Angina at rest. No exertion needed to trigger angina.

Professional Societies/Organizations

American Academy of Pediatrics (AAP): The AAP published an update in 2016 to "Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures" (AAP, 2016). Within this guideline the AAP does not identify an age limit related to site of care for surgical procedures. However, the AAP reports that sedation and anesthesia in a nonhospital environment (e.g., private physician's or dental office, freestanding imaging facility) has been associated with an increased incidence of "failure to rescue" from adverse events because these settings may lack immediately available backup. Immediate activation of emergency medical services (EMS) may be required in such settings, and the practitioner is responsible for life support measures while awaiting EMS arrival." (AAP, 2016).

The American College Obstetricians of Gynecologists (ACOG): Within a Committee Opinion document ACOG makes the following recommendations for "Nonobstetric Surgery During Pregnancy" (ACOG, 2019):

- Elective surgery should be postponed until after delivery.
- When nonobstetric surgery is planned, the primary obstetric care provider should be notified. If that health care provider is not at the institution where surgery is to be performed, another obstetric care provider with privileges at that institution should be involved. If fetal monitoring is to be used, consider the following recommendations:
  - Surgery should be done at an institution with neonatal and pediatric services.
  - An obstetric care provider with cesarean delivery privileges should be readily available.
  - A qualified individual should be readily available to interpret fetal heart rate patterns.

American Society of Anesthesiologists (ASA): The ASA developed the ASA Physical Status Classification System, last amended October 2019, to assess and communicate an individual's pre-anesthesia co-morbidities. The ASA acknowledges the classification system alone does not predict perioperative risk, however when used with other factors (e.g., type of surgery, frailty, level of deconditioning), it can be helpful in predicting perioperative risks. ASA Classification is defined as follows:

- ASA I - normal, healthy patient (healthy, non-smoking, no or minimal alcohol use)
- ASA II - patient with mild systemic disease (Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled diabetes mellitus (DM)/HTN, mild lung disease)
- ASA III - patient with severe systemic disease (substantive functional limitations; one or more moderate to severe diseases; examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or coronary artery disease (CAD)/stents)

- ASA IV - patient with severe systemic disease that is a constant threat to life (examples include (but not limited to): recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, disseminated intravascular coagulation (DIC), acute respiratory distress (ARD) or ESRD not undergoing regularly scheduled dialysis)
- ASA V – a moribund patient who is not expected to survive without the operation (examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction)
- ASA VI – a declared brain-dead patient whose organs are being removed for donor purposes

The ASA Physical Status Classification System is one means to determine risk and whether or not a patient should have surgery. Other factors to consider include age, obesity, nature and severity of the procedure, type of anesthetic, and duration of anesthesia or surgery.

The American College of Surgeons (ACS): The ACS Revised statement on "Patient Safety Principles for Office-based Surgery Utilizing Moderate Sedation /Analgesia" supports the use of the ASA Physical Status Classification System for selection criteria in the office-based/ambulatory surgical setting. The ACS supports that ASA III and above patients should undergo surgical procedures in an accredited surgical center (ACS, 2019).

Society of Ambulatory Anesthesia: The Society for Ambulatory Anesthesia Consensus issued a guideline statement "Perioperative Blood Glucose Management in Diabetic Patients Undergoing Ambulatory Surgery" (Joshi, et al., 2010). Within this guideline the authors report the following:

- The American Diabetes Association (ADA) recommends that outpatient management of diabetes should ideally include a combination of a target hemoglobin HgA1c 7% (normal 4%–7%), a preprandial blood glucose level of 90 to 130 mg/dL and a peak postprandial blood glucose level of 180 g/dL (The authors note however this has not been verified in the ambulatory surgical population).
- In chronically poorly controlled diabetic patients, the decision to proceed with ambulatory surgery should be made in conjunction with the surgeon while taking into consideration the presence of other comorbidities and the potential risks of surgical complications (e.g., delayed wound healing and wound infection)
- There is no evidence in the literature that any particular blood glucose level is either beneficial or harmful for patients undergoing ambulatory surgical procedures.

In a guideline titled "Preoperative Selection of Adult Patients with Obstructive Sleep Apnea Scheduled for Ambulatory Surgery" (Joshi, et al., 2012) the authors note:

- Individuals with a known diagnosis of OSA and optimized comorbid medical conditions can be considered for ambulatory surgery, if they are able to use a continuous positive airway pressure device in the postoperative period.
- Individuals with a presumed diagnosis of OSA, based on screening tools such as the STOP–Bang questionnaire, and with optimized comorbid conditions, can be considered for ambulatory surgery, if postoperative pain can be managed predominantly with nonopioid analgesic techniques.
- Individuals diagnosed with OSA with nonoptimized comorbid medical conditions are not considered good candidates for ambulatory surgery.

Use Outside of the US
No relevant information.

Medicare Coverage Determinations

	Contractor	Policy Name/Number	Revision Effective Date
NCD	National	No NCD	
LCD		No LCD	

Note: Please review the current Medicare Policy for the most up-to-date information.

Coding/Billing Information

Note: 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary for outpatient hospital care when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic
23430	Tenodesis of long tendon of biceps
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
29805	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
29807	Arthroscopy, shoulder, surgical; repair of SLAP lesion
29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
29820	Arthroscopy, shoulder, surgical; synovectomy, partial
29821	Arthroscopy, shoulder, surgical; synovectomy, complete
29822	Arthroscopy, shoulder, surgical; debridement, limited
29823	Arthroscopy, shoulder, surgical; debridement, extensive
29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)
29825	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29828	Arthroscopy, shoulder, surgical; biceps tenodesis
29860	Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)
29861	Arthroscopy, hip, surgical; with removal of loose body or foreign body
29862	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum
29863	Arthroscopy, hip, surgical; with synovectomy
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])
29867	Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)
29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral
29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
29873	Arthroscopy, knee, surgical; with lateral release
29874	Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)
29875	Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure)
29876	Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (eg, medial or lateral)
29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)

CPT®* Codes	Description
29879	Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
29882	Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)
29883	Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)
29884	Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure)
29885	Arthroscopy, knee, surgical; drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)
29886	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion
29887	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixation
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)
29916	Arthroscopy, hip, surgical; with labral repair
62320	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
62321	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)
62322	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)
62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)
62326	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other

CPT®* Codes	Description
	solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)
64479	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level
64480	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level
64484	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerve innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)
64510	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)
64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)
G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography

Place of Service	Description

19	Off Campus-Outpatient Hospital
22	On Campus-Outpatient Hospital

***Current Procedural Terminology (CPT®) ©2020 American Medical Association: Chicago, IL.**

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