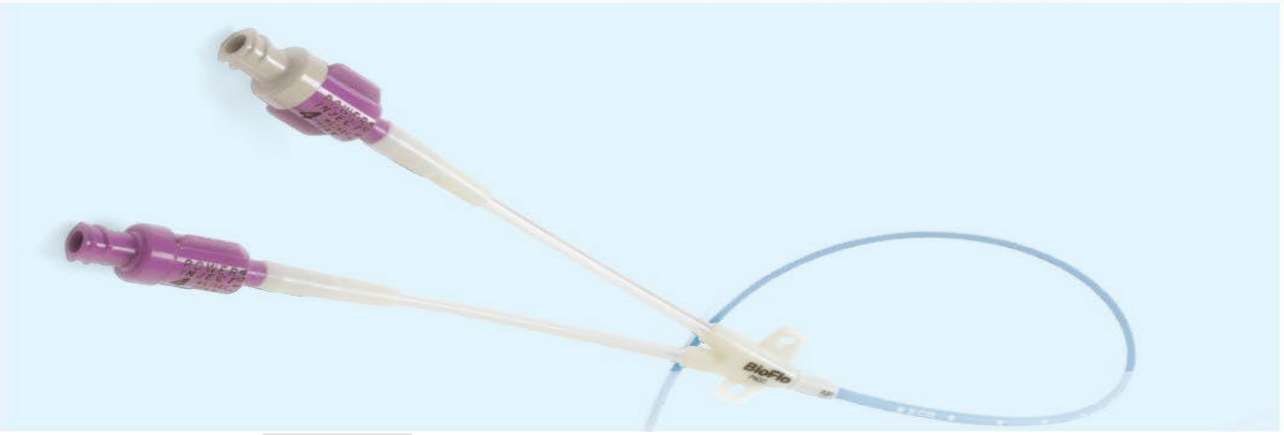
Reimbursement Guidelines

2024 Coding and Reimbursement Guidelines for
Vascular Access Procedures
EFFECTIVE JANUARY 2024



This is general reimbursement information only and is intended to assist in the compliance of complex and changing reimbursement policies. It is not legal advice, nor is it advice about how to code, complete, or submit any particular claim for payment, nor is it intended to increase or maximize reimbursement by any third-party payor. This information has been gathered from third-party sources and was correct at the time of publication and is subject to change without notice. It is the provider's responsibility to exercise independent clinical judgment to determine appropriate coding and charges that accurately reflect all the patient's conditions and services provided. These should be recorded in the patient's medical record. The information provided here is for informational purposes only and represents no statement, promise or guarantee by AngioDynamics concerning levels of reimbursement, payment, or charges.
Payors may have their own coding and reimbursement requirements and policies. If reimbursement questions arise for a particular patient, providers should contact the payor to confirm current requirements and billing policies. All decisions related to reimbursement, including amounts to bill, are exclusively that of the provider.
Providers should check and confirm coding from complete and authoritative coding sources to ensure accuracy. This document is not intended to promote the off-label use of medical devices and physicians should use medical devices fully consistent with all government requirements. The content is not intended to instruct hospitals and/or physicians on how to use medical devices or bill for healthcare procedures.
 US/VA/MS/75 Rev 11 03/2024

angiodynamics

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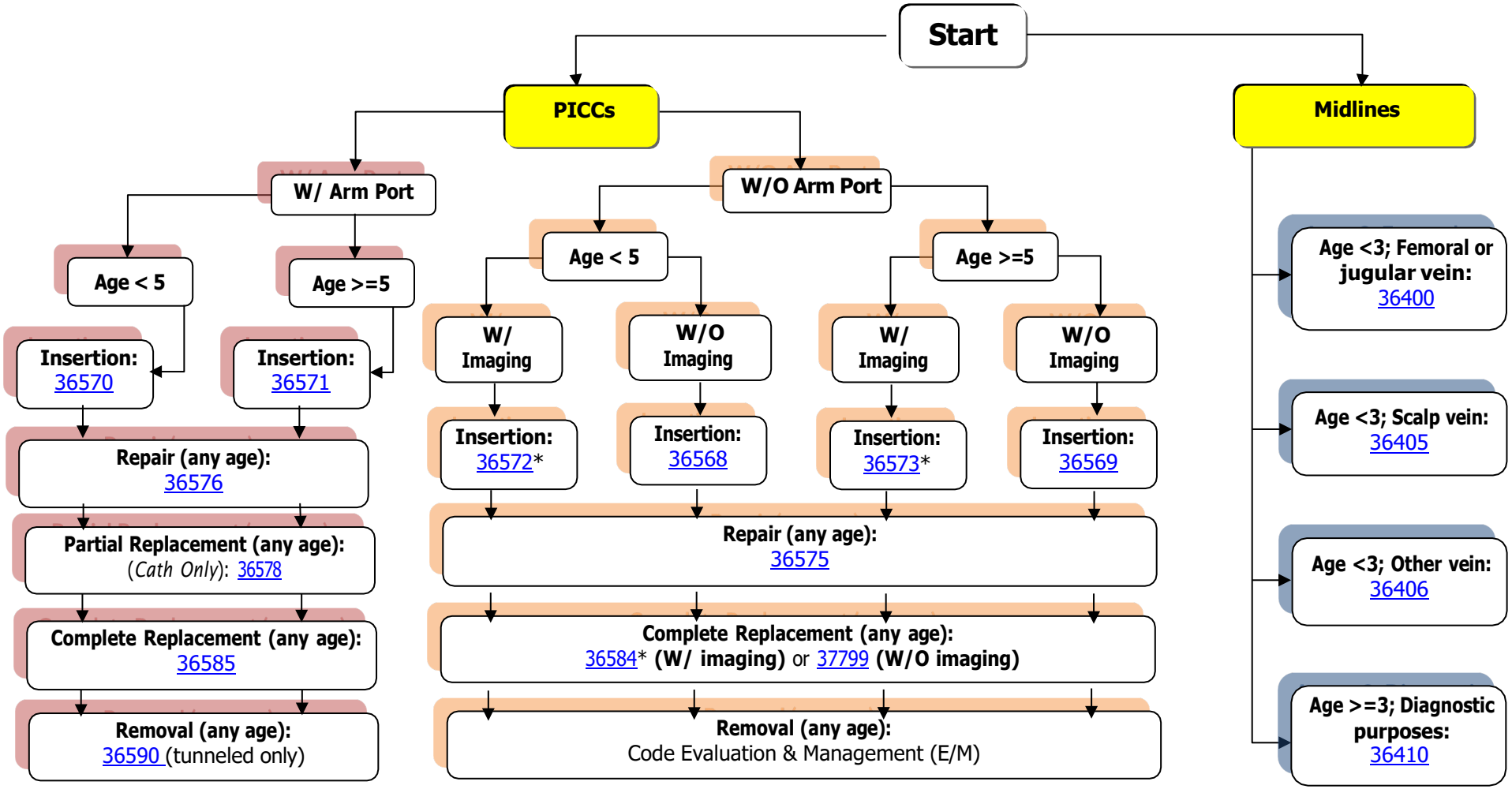
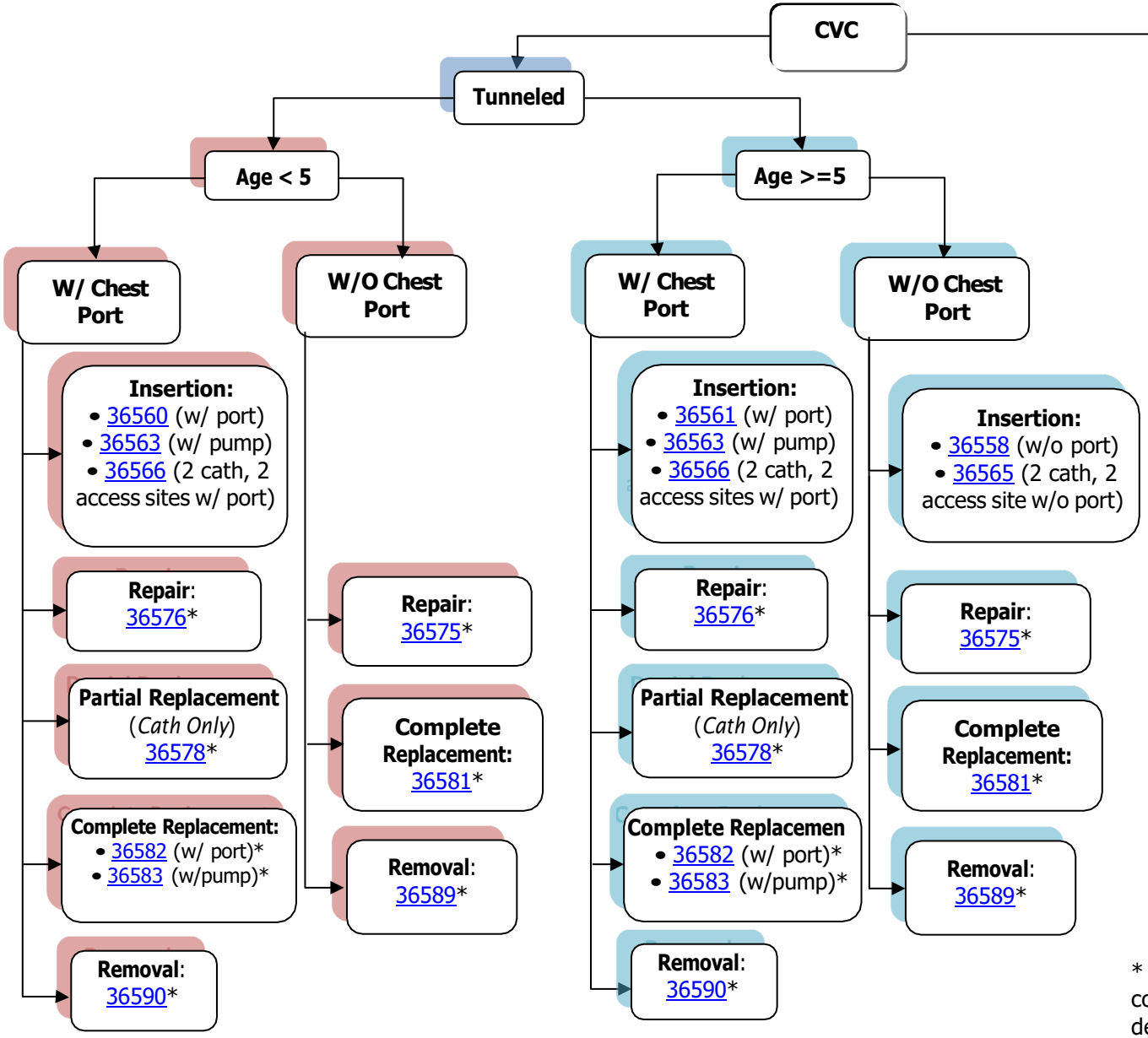


The procedures involving central venous catheter devices fall into five categories:

1. **Insertion** – placement of catheter through a newly established venous access.
2. **Repair** – fixing device without replacement of either catheter or port/pump, other than pharmacologic or mechanical correction of intra-catheter or per-catheter occlusion (see 36595 or 36596).
3. **Partial replacement** – of only the catheter component associated with a port/pump device, but not the entire device.
4. **Complete replacement** – of entire device via same venous access site (complete exchange).
5. **Removal** – of entire device.

* Do not report 36572, 36573 in conjunction with 76937, 77001[1]

Centrally Inserted CVC Overview – Example of CPT Coding Flow[1]



* For the repair, partial (catheter only) replacement, complete replacement, or removal of multi-catheter device, use the appropriate code describing the service with a frequency of two.

Peripherally Inserted Central Catheter (PICC) Payment

PHYSICIAN, HOSPITAL OPPS, ASC CODING & PAYMENT (JANUARY 1, 2024 to DECEMBER 31, 2024)

Medicare 2024 National Average Payment (Not Geographically Adjusted)									
Service Provided		Physician Fee Schedule[2]				Hospital OPPS Reimbursement[3]		ASC Payment[4] *(Payment Indicator)*
CPT® Code[1]	CPT® Description[1]	Non-Facility		Facility		APC *(Status Indicator)*	Payment	
		RVUs	Payment	RVUs	Payment			
36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; younger than 5 years of age	NA	NA	2.70	$89.88	5182 (J1)	$1,525.93	$777.05 (A2)
36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; age 5 years or older	NA	NA	2.79	$92.87	5182 (J1)	$1,525.93	$619.18 (A2)
36570	Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age	42.84	$1,426.04	9.96	$331.54	5183 (J1)	$3,037.01	$1,949.55 (A2)
36571	Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older	36.92	$1,228.97	9.29	$309.24	5183 (J1)	$3,037.01	$1,548.00 (A2)
36572	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; younger than 5 years of age	11.02	$366.83	2.38	$79.22	5181 (T)	$598.55	$325.87 (G2)
36573	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; age 5 years or older	11.26	$374.82	2.44	$81.22	5182 (J1)	$1,525.93	$619.18 (G2)
36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the replacement	9.57	$318.56	1.71	$56.92	5182 (J1)	$1,525.93	$619.18 (A2)
36585	Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access	33.54	$1,116.46	8.25	$274.62	5183 (J1)	$3,037.01	$1,548.00 (A2)

Click on blue arrow to return to PICC & Midlines Flow-Chart

PICC notes:

In 2019, the CPT Professional Edition issued new guidance for PICCs[5]:

Peripherally inserted central venous catheters (PICCs) may be placed or replaced with or without imaging guidance. When performed without imaging guidance, report using 36568 or 36569. When imaging guidance (e.g., ultrasound, fluoroscopy) is used for PICC placement or repositioning, bundled service codes 36572, 36573, 36584 include all imaging necessary to complete the procedure, image documentation (representative images from all modalities used are stored to patient's permanent record), associated radiological supervision and interpretation, venography performed through the same venous puncture, and documentation of final central position of the catheter with imaging. Ultrasound guidance for PICC placement should include documentation of evaluation of the potential puncture sites, patency of the entry vein, and real-time ultrasound visualization of needle entry into the vein.[5]

Codes 71045, 71046, 71047, 71048 should not be reported for the purpose of documenting the final catheter position on the same day of service as 36572, 36573, 36584. Codes 36572, 36573, 36584 include confirmation of catheter tip location. The physician or other qualified health care professional reporting image-guided PICC insertion cannot report confirmation of catheter tip location separately (e.g., via x-ray, ultrasound).
Report 36572, 36573, 36584 with modifier 52 when performed without confirmation of catheter tip location.[5]

"Midline" catheters by definition terminate in the peripheral venous system. They are not central venous access devices and may not be reported as a PICC service. Midline catheter placement may be reported with 36400, 36405, 36406, or 36410. PICCs placed using magnetic guidance or any other guidance modality that does not include imaging or image documentation are reported with 36568, 36569.[5]

In 2019:

The 2019 CPT® code set added two new codes (36572 and 36573) to report peripherally inserted central venous catheter (PICC) insertion that include all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion. Report 36572 for patients younger than 5 years of age and 36573 for patients 5 years of age or older. Do not report 36572, 36573 in conjunction with 76937, 77001.

Of note, to report a PICC line insertion without imaging guidance, you would report one of two codes that were revised for 2019: 36568 for patients younger than 5 years of age and 36569 for patients 5 years of age or older.

Inpatient hospital Use – This document does not address hospital coding or reimbursement for hospital inpatient procedures.

Midline Catheter Payment

PHYSICIAN, HOSPITAL OPPS, ASC CODING & PAYMENT (JANUARY 1, 2024 to DECEMBER 31, 2024)

Medicare 2024 National Average Payment (Not Geographically Adjusted)								
Service Provided		Physician Fee Schedule[2]				Hospital OPPS Payment[3]		ASC Payment[4]
CPT® Code[1]	CPT® Description[1]	Non-Facility		Facility		APC	Payment	
		RVU	Payment	RVU	Payment			
36400	Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; femoral or jugular vein	0.82	$27.30	0.55	$18.31	Venipuncture performed in the Hospital OPPS or ASC setting is packaged into the procedure payment.		
36405	Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; scalp vein	0.72	$23.97	0.44	$14.65			
36406	Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; other vein	0.53	$17.64	0.26	$8.65			
36410	Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)	0.53	$17.64	0.27	$8.99			

Click on blue arrow to return to PICC & Midlines Flow-Chart

Tunneled and Non-Tunneled Venous Access

PHYSICIAN, HOSPITAL OPPS, ASC CODING & PAYMENT (JANUARY 1, 2024 to DECEMBER 31, 2024)

Medicare 2024 National Average Payment (Not Geographically Adjusted)								
Service Provided		Physician Reimbursement[2]				Hospital OPPS Payment[3]		ASC Payment[4] *(Payment Indicator)*
		Non-Facility		Facility				
CPT® Code[1]	CPT® Description[1]	RVUs	Payment	RVUs	Payment	APC	Payment	
Tunneled								
36560	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; younger than 5 years of age	36.43	$1,212.66	11.47	$381.81	5183 (J1)	$3,037.01	$1,548.00 (G2)
36561	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older	28.74	$956.68	9.81	$326.55	5183 (J1)	$3,037.01	$1,548.00 (A2)
36566	Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; with subcutaneous port(s)	123.98	$4,126.98	10.55	$351.18	5184 (J1)	$5,235.92	$2,903.10 (A2)
36582	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous port, through same venous access	25.73	$856.49	8.48	$282.28	5183 (J1)	$3,037.01	$1,548.00 (A2)
Non-Tunneled								
36555	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age	5.60	$186.41	2.48	$82.55	5183 (J1)	$3,037.01	$1,548.00 (A2)
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	6.35	$211.38	2.49	$82.89	5183 (J1)	$3,037.01	$1,548.00 (A2)
36580	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	5.58	$185.74	1.91	$63.58	5182 (J1)	$1,525.93	$619.18 (J8)

Click on orange arrow to return to CVC Flow-Chart

Repair, Removal, Partial Replacement Procedures

PHYSICIAN, HOSPITAL OPPS, ASC CODING & PAYMENT (JANUARY 1, 2024 to DECEMBER 31, 2024)

Medicare 2024 National Average Payment (Not Geographically Adjusted)								
Service Provided		Physician Fee Schedule[2]				Hospital OPPS Payment[3]		ASC Payment[4] *(Payment Indicator)*
		Non-Facility		Facility		APC	Payment	
CPT® Code[1]	CPT® Description[1]	RVUs	Payment	RVUs	Payment			
36575	Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site	4.28	$142.47	0.98	$32.62	5181 (T)	$598.55	$325.87 (A2)
36576	Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	10.22	$340.20	5.43	$180.75	5182 (J1)	$1,525.93	$619.18 (A2)
36578	Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	12.74	$424.08	6.04	$201.06	5183 (J1)	$3,037.01	$1,984.13 (A2)
36589	Removal of tunneled central venous catheter, without subcutaneous port or pump	4.91	$163.44	4.03	$134.15	5181 (Q2)	$598.55	$325.87 (A2)
36590	Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion	6.64	$221.03	5.62	$187.08	5182 (Q2)	$1,525.93	$619.18 (A2)

Click on blue arrow to return to PICC & Midlines Flow-Chart

Click on orange arrow to return to CVC Flow-Chart

Additional Procedures

PHYSICIAN, HOSPITAL OPPS, ASC CODING & PAYMENT (JANUARY 1, 2024 to DECEMBER 31, 2024)

Medicare 2024 National Average Payment (Not Geographically Adjusted)								
Service Provided		Physician Fee Schedule[2]				Hospital OPPS Payment[3]		ASC Payment[4] *(Payment Indicator)*
		Non-Facility		Facility		APC [2] *(Status Indicator)*		
CPT® Code[1]	CPT® Description[1]	RVUs	Payment	RVUs	Payment			
76000	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time	0.44	$14.65	0.44	$14.65	5523 (S)	$233.47	N/A
75860	Venography, venous sinus (e.g., petrosal and inferior sagittal) or jugular, catheter, radiological supervision and interpretation	1.57	$52.26	1.57	$52.26	5183 (Q2)	$3,037.01	N/A Packaged (N1)
75820	Venography, extremity, unilateral, radiological supervision and interpretation	1.45	$48.27	1.45	$48.27	5182 (Q2)	$1,525.93	N/A Packaged (N1)
37799	Unlisted procedure, vascular surgery	Medicare does not set a national physician payment for unlisted CPT codes. Check with local Medicare contractor				5181 (T)	$598.55	Not Covered

Guidance Procedures

PHYSICIAN, HOSPITAL OPPS, ASC CODING & PAYMENT (JANUARY 1, 2024 to DECEMBER 31, 2024)

Medicare 2024 National Average Payment (Not Geographically Adjusted)								
Service Provided		Physician Fee Schedule[2]				Hospital OPPS Payment[3]		ASC Payment[4] *(Payment Indicator)*
		Non-Facility		Facility		APC	Payment	
CPT® Code[1]	CPT® Description[1]	RVUs	Payment	RVUs	Payment			
76937*	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real-time ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)	0.41	$13.65	0.41**	$13.65	Imaging performed in the Hospital OPPS or ASC setting is packaged into the procedure payment.		
77001*	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to primary procedure)	0.53	$17.64	0.53**	$17.64			

*A permanent record or report of the ultrasound guidance must be documented, and multiple sites must be evaluated. ** (26) Physician component only, no technical component allowed.

Reimbursement Terminology

Term[2,3]	Description[2,3]
APC	Ambulatory Payment Classification
APC (N)	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.
APC (Q2)	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "T". (2) In other circumstances, payment is made through a separate APC payment.
APC (J1)	Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS status indicator of "F","G", "H", "L" and "U"; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.
APC (T)	Procedure or Service, Multiple Procedure Reduction Applies. Paid under OPPS; separate APC payment.
ASC	Ambulatory Surgery Center
APC (S)	Procedure or Service, Not Discounted When Multiple. Paid under OPPS; separate APC payment.
ASC (A2)	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.
ASC (G2)	Non-office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight
ASC (J8)	Device-intensive procedure; paid at adjusted rate.
ASC (N1)	Packaged service/item; no separate payment made.
ASC (Z3)	Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS non-facility PE RVUs.
CPT	Current Procedural Terminology
C-Code	Device category codes reported by hospitals in conjunction with outpatient hospital procedures
E/M	Evaluation and Management
Facility	Physician payment level for professional services provided in a facility setting such as a hospital or ambulatory surgery center
Non-Facility	Physician payment level for professional services provided in a non-facility setting such as a physician's office
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
ICD-10-PCS	International Classification of Diseases, 10th Revision, Procedure Coding System
IPPS	Inpatient Prospective Payment System
OPPS	Outpatient Prospective Payment System
W MCC	Major Complications and Comorbidities
W CC	With Complications and Comorbidities
W/O CC/MCC	Without complications or comorbidities, and without major complications and comorbidities.

References

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2. CMS, CMS 1784-F: Revisions to Payment Policies under the Medicare Physician Fee Schedule Quality Payment Program and Other Revisions to Part B for CY 2023. Conversion factor $32.7375. https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1784-f. Published November 16, 2023. Effective January 1, 2024. Accessed November 29, 2023.
3. CMS, CMS-1786-FC: Hospital Outpatient Prospective Payment Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1786-fc. Published November 16, 2023. Effective January 1, 2024.
   Accessed November 29, 2023.
4. CMS, CMS-1786-FC: Ambulatory Surgical Center Payment- Notice of Final Rulemaking with Comment Period (NFRM)
   https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and/cms-1786-fc. Published November 16, 2023. Effective
   January 1, 2024. Accessed November 29, 2023.
5. CPT® 2019 Professional Edition, "Cardiovascular 33010-39599" Page 267-268, American Medical Association, 2019.

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