Reimbursement Guide

2023 Coding and Reimbursement Guide for

Hemodialysis Catheter Procedures

EFFECTIVE JANUARY 2023

angiodynamics

Table of Contents

Table of Contents

Catheter Insertion Procedures....3
Catheter Removal, Replacement, and Repair....4
Additional Procedures....5
HCPCS Codes....5
Guidance Procedures....6
Miscellaneous....6
Reimbursement Terminology....7
Other Resources....8
Reimbursement Support....8

Catheter Insertion Procedures

PHYSICIAN, HOSPITAL OPPS, ASC CODING & PAYMENT (JANUARY 1, 2023 to DECEMBER 31, 2023)

Medicare 2023 National Average Payments (Not Geographically Adjusted)								
Service Provided		Physician Fee Schedule[2]				Hospital OPPS Payment [3]		ASC Payment[4] (Payment Indicator)
CPT® Code[1]	CPT® Description[1]	Non- Facility		Facility		APC (Status Indicator)	Payment	
		RVUs	Payment	RVUs	Payment			
36555	Insertion of non-tunneled centrally inserted central venous catheter, younger than 5 years of age	5.68	$192.48	2.49	$84.38	5183, Level 3 Vascular Procedures (J1)	$2,979.00	$1,444.00 (A2)
36556	Insertion of non-tunneled centrally inserted central venous catheter, age 5 years or older	6.41	$217.22	2.48	$84.04	5183, Level 3 Vascular Procedures (J1)	$2,979.00	$1,444.00 (A2)
36557	Insertion of tunneled centrally inserted central venous catheter, younger than 5 years of age	35.02	$1,186.73	9.52	$322.61	5184, Level 4 Vascular Procedures (J1)	$5,140.00	$2,641.00 (J8)
36558	Insertion of tunneled centrally inserted central venous catheter, age 5 years or older	25.06	$849.21	7.65	$259.24	5183, Level 3 Vascular Procedures (J1)	$2,979.00	$1,444.00 (A2)
36565	Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate access sites, without subcutaneous port or pump (e.g., Tesio type catheter)	24.78	$839.72	9.91	$335.82	5183, Level 3 Vascular Procedures (J1)	$2,979.00	$1,444.00 (A2)

Catheter Removal, Replacement, and Repair

PHYSICIAN, HOSPITAL OPPS, ASC CODING & PAYMENT (JANUARY 1, 2023 to DECEMBER 31, 2023)

Medicare 2023 National Average Payments (Not Geographically Adjusted)								
Service Provided		Physician Reimbursement[2]				Hospital OPPS Payment[3]		ASC Payment[4] (Payment Indicator)
CPT® Code[1]	CPT® Description[1]	Non- Facility		Facility		APC (Status Indicator)	Payment	
		RVUs	Payment	RVUs	Payment			
36580	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	5.72	$193.83	1.93	$65.40	5182, Level 2 Vascular Procedures (J1)	$1,488.00	$749.00 (J8)
36581	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	23.46	$794.99	5.38	$182.31	5183, Level 3 Vascular Procedures (J1)	$2,979.00	$1,873.00 (A2)
36589	Removal of tunneled central venous catheter, without subcutaneous port or pump	4.93	$167.06	4.04	$136.90	5181, Level 1 Vascular Procedures (Q2)	$579.00	$301.00 (A2)
36575	Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site	4.35	$147.41	0.98	$33.21	5181, Level 1 Vascular Procedures (T)	$579.00	$301.00 (A2)
36596	Mechanical removal of tunneled central venous catheter	3.42	$115.89	1.30	$44.05	5182, Level 2 Vascular Procedures (J1)	$1,488.00	$583.00 (G2)
36597	Reposition venous catheter under fluoroscopy	3.35	$113.52	1.79	$60.66	5182, Level 2 Vascular Procedures (J1)	$1,488.00	$583.00 (G2)

Additional Procedures

PHYSICIAN, HOSPITAL OPPS, ASC CODING & PAYMENT (JANUARY 1, 2023 to DECEMBER 31, 2023)

Medicare 2023 National Average Payment (Not Geographically Adjusted)								
Service Provided		Physician Reimbursement[2]				Hospital OPPS Payment[3]		ASC Payment[4] (Payment Indicator)
CPT® Code[1]	CPT® Description[1]	Non-Facility		Facility		APC 2 (Status Indicator)	Payment	
		RVUs	Payment	RVUs	Payment			
76000	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time	1.30	$44.05	0.46	$14.57	5523, Level 3 Imaging W/O Contrast (S)	$234.00	N/A (Z3)
75860	Venography, venous sinus (e.g., petrosal and inferior sagittal) or jugular, catheter, radiological supervision and interpretation	3.78	$128.09	1.59	$53.88	5183, Level 3 Vascular Procedures (Q2)	$2,979.00	N/A Packaged (N1)
75820	Venography, extremity, unilateral, radiological supervision and interpretation	3.27	$110.81	1.46	$49.48	5182, Level 2 Vascular Procedures (Q2)	$1,488.00	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, Level 1 Vascular Procedures (T)	$578.50	Not Covered

HCPCS Codes

Healthcare Common Procedure Coding System (HCPCS) Level II codes were developed to help categorize, document, and track the use of products, supplies, and services. While HCPCS codes do not generally result in additional payment, it is important for hospitals to use HCPCS codes as a means of cost reporting which CMS uses to help determine future payment rates.

HCPCS[5]	Description[5]	Use[5]
C1750	Catheter, hemodialysis/peritoneal, long-term	Chronic
C1752	Catheter, hemodialysis/peritoneal, short-term	Acute
C1769	Guidewire	N/A
C1892	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away	N/A
C1894	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, non-laser	N/A

Guidance Procedures

PHYSICIAN, HOSPITAL OPPS, ASC CODING & PAYMENT (JANUARY 1, 2023 to DECEMBER 31, 2023)

Medicare 2023 National Average Payment (Not Geographically Adjusted)						
Service Provided		Physician Reimbursement[2]				Hospital OPPS Payment and ASC Payment[3,4]
CPT® Code[1]	CPT® Description[1]	Non-Facility		Facility**		
		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)	1.18	$39.99	0.42	$14.23	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)	3.02	$102.34	0.53	$17.96	

*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

Miscellaneous

ICD-10-CM Code [6]	Description
N18.6	End Stage Renal Disease
ICD-10-PCS Code [7]	**Description**
02H633Z	Insertion of infusion device right atrium, percutaneous

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 (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 HCPCS codes reported by hospitals in conjunction with outpatient hospital procedures
HCPCS	Healthcare Common Procedure Coding System
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	With major complications and comorbidities
W CC	With complications and comorbidities
W/O CC/MCC	Without complications or comorbidities, and/or without major complications and comorbidities.

References

1. CPT© 2023 Professional. American Medical Association (AMA). All rights reserved. CPT® is a registered trademark of the AMA. No fee schedules, basic units, relative values, or related listings are included in CPT® including for Category 3 codes. Inclusion of a CPT® code does not represent AMA endorsement or imply any coverage or reimbursement policy. Reimbursement information here is from the Centers for Medicare and Medicaid Services (CMS), see sources below. Applicable FARS/DFARS restrictions apply to Government Use.
2. CMS, CMS 1770-F: Revisions to Payment Policies under the Medicare Physician Fee Schedule Quality Payment Program and Other Revisions to Part B for CY 2022. Conversion Factor 33.8872. https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1770-f. Published November 18, 2022. Effective January 1, 2023. Accessed January 26, 2023.
3. CMS, CMS-1772-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/medicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1772-fc Published October 31, 2022. Effective January 1, 2023. Accessed December 13, 2022.
4. CMS, CMS-1772-FC: Ambulatory Surgical Center Payment- Notice of Final Rulemaking with Comment Period (NFRM) Published October 31, 2022. Effective January 1, 2023. Accessed December 13, 2022. https://www.cms.gov/medicaremedicare-fee-service-paymentascpaymentasc-regulations-and-notices/cms-1772-fc.
5. AAPC. 2022 HCPCS Level II Expert: Service Supply Codes for Caregivers and Suppliers. American Academy of Professional Coders; 2021.
6. Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS). 2022 release of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) . Updated October 17, 2022. Accessed December 13, 2022. https://www.cdc.gov/nchs/icd/icd-10-cm.htm.
7. CMS, 2023 ICD-10 Procedure Coding System (ICD-10-PCS). https://www.cms.gov/medicare/icd-10/2023-icd-10-pcs. Accessed December 13, 2022.

Other Resources

For other reimbursement educational materials, guides, and resources, please visit the AngioDynamics Reimbursement Resources website.

Reimbursement Support

For questions regarding coding, payment, coverage, and other reimbursement information, please contact us at:

reimbursement@angiodynamics.com

USA > 14 Plaza Drive, Latham, NY 12110 > tel: 800-772-6446 or 518-798-1215 > fax: 518-798-1360
International > Haaksbergweg 75 (Margriettoren), 1101 BR, Amsterdam Z-O > The Netherlands >
tel: +31 (0)20 753 2949 > fax: +31 (0)20 753 2939

www.angiodynamics