

Venous Access Procedures

Reimbursement Information



2009 CODING & PAYMENT QUICK REFERENCE

BACKGROUND

- Navilyst Medical, Inc. has compiled this Reimbursement Guide for coding, billing and reimbursement personnel at medical facilities. As always, the provider is responsible for determining coverage and submitting appropriate codes, modifiers and charges for the services that were rendered. All rates shown are 2009 Medicare national averages; actual rates will vary.

MEDICARE HOSPITAL OUTPATIENT (APC), ASC and PHYSICIAN PAYMENTS

CPT® Code	Code Description	Physician ¹		Facility	
		MD In-Office Payment	MD In-Facility Payment	Hospital Outpatient Payment ²	ASC Payment ³
PICC Procedures					
36568	Insertion of peripherally inserted CVC, w/o port, under 5 years	\$298.27	\$96.30	\$730.96	\$385.67
36569	Insertion of peripherally inserted CVC, w/o port, 5 years or older	\$260.40	\$97.38	\$730.96	\$385.67
36584	Replacement , complete, of a peripherally inserted CVC, w/o subcutaneous port or pump, through same venous access	\$220.73	\$72.86	\$730.86	\$385.67
Chest Port Procedures					
36560	Insertion of tunneled centrally inserted central venous access device (CVAD), with subcutaneous port, under 5 years	\$1,109.42	\$350.21	\$1,965.10	\$848.99
36561	Insertion of tunneled centrally inserted CVAD, with subcutaneous port, 5 years or older	\$1,097.88	\$339.03	\$1,965.10	\$848.99
36582	Replacement , complete, of a tunneled centrally inserted CVAD, w/sub. port, through same venous access site	\$1,011.32	\$289.98	\$1,965.10	\$848.99
Tunneled Venous Access					
36557	Insertion of tunneled centrally inserted CVC, without reservoir, under 5 years	\$809.70	\$297.19	\$1,645.88	\$720.27
36558	Insertion of tunneled centrally inserted CVC, without reservoir, 5 years or older	\$783.74	\$284.57	\$1,645.88	\$720.27
36581	Replacement , complete, of a tunneled centrally inserted CVC, w/o subcutaneous port or pump, through same venous access site	\$725.67	\$198.37	\$1,645.88	\$720.27
Non-Tunneled Venous Access					
36555	Insertion of non-tunneled centrally inserted central venous catheter (CVC), under 5 years	\$262.57	\$124.79	\$730.96	\$385.67
36556	Insertion of non-tunneled centrally inserted CVC, 5 years or older	\$225.06	\$119.38	\$730.96	\$385.67
36580	Replacement , complete, of a non-tunneled centrally inserted CVC, w/o subcutaneous port or pump, through same venous access site	\$223.98	\$70.69	\$730.96	\$385.67
Arm Port Procedures					
36570	Insertion of peripherally inserted CVAD, w/port, under 5 years	\$1,128.18	\$313.78	\$1,645.88	\$751.47
36571	Insertion of peripherally inserted CVAD, w/port, 5 years or older	\$1,170.01	\$305.13	\$1,645.88	\$751.47
36585	Replacement , complete, of a peripherally inserted CVAD, w/subcutaneous port, through same venous access	\$1,038.73	\$272.67	\$1,645.88	\$751.47

Important - Please Note: Reimbursement information provided by Navilyst Medical, Inc. is gathered from third-party sources and is presented for illustrative purposes only. This information does not constitute reimbursement or legal advice. Navilyst Medical, Inc. makes no representation or warranty regarding this information or its completeness, accuracy, timeliness, or applicability with a particular patient. Navilyst Medical, Inc. specifically disclaims liability or responsibility for the results or consequences of any actions taken in reliance on information in this document. Navilyst Medical, Inc. encourages providers to submit accurate and appropriate claims for services. Laws, regulations and payer policies concerning reimbursement are complex and change frequently. Providers are responsible for making appropriate decisions relating to coding and reimbursement submissions. Accordingly, Navilyst Medical, Inc. recommends that you consult with your payers, reimbursement specialist and/or legal counsel regarding coding, coverage and reimbursement matters.

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REPAIR, REMOVAL and PARTIAL REPLACEMENT PROCEDURES

CPT® Code	Code Description	Physician		Facility	
		MD In-Office Payment ¹	MD In-Facility Payment ¹	Hospital Outpatient Payment ²	ASC Payment ³
36575	Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site	\$156.17	\$40.40	\$303.59	\$310.19
36576	Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	\$344.44	\$183.22	\$730.96	\$440.76
36578	Replacement , catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	\$481.13	\$209.55	\$1,645.88	\$720.27
36589	Removal of tunneled central venous catheter, without subcutaneous port or pump	\$162.30	\$137.78	\$303.59	\$255.10
36590	Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion	\$264.73	\$196.20	\$730.96	\$385.67

ULTRASOUND GUIDANCE

- In 2004, the American Medical Association created a new CPT Code specific to ultrasound guidance of vascular access procedures. The ultrasound component should be billed using the following CPT Code:

CPT Code	Code Description	Physician		Facility	
		MD In-Office Payment ¹	MD In-Facility Payment ¹	Hospital Outpatient Payment ²	ASC Payment ³
76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)	\$36.79	\$15.87	bundled	bundled

- As stated in the procedural descriptor, a permanent record or report of the ultrasound guidance must be documented and multiple sites must be evaluated.

MEDICARE HOSPITAL INPATIENT

- Because the principal ICD-9 diagnosis codes for patients receiving these procedures can vary widely, the number of potential DRG groupings is quite large and listing them all would be of little practical value.

¹ Medicare national average MD payments calculated using the 2009 Conversion Factor of \$36.067, which contains a mandated neutrality adjustor of 6.41%. Moving the budget neutrality adjustor from only the work RVUs to the conversion factor and thus all RVUs was enacted as part of the Medicare Improvements for Patient and Providers Act of 2008-H.R. 6331. MD rates are effective from January 1 - December 31, 2009 and will vary geographically. Source: 2009 Final Medicare Physician Fee Schedule, November 19, 2008 Federal Register.

² Hospital Outpatient payments are 2008 Medicare national averages. Source: November 19, 2008 Federal Register. Actual rates will vary geographically.

³ ASC rates are from the 2009 Medicare ASC Final Rule. Source: November 19, 2008 Federal Register.

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