



# 2011 Procedural Reimbursement Guide

Effective January 1 - December 31, 2011

## Background

Navilyst Medical has compiled this Reimbursement Guide for coding, billing and reimbursement personnel at medical facilities using resources published by the Centers for Medicare and Medicaid Services. 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 2011 Medicare national averages; actual rates will vary based on geographic adjustment.

### VENOUS ACCESS PROCEDURE

#### (Medicare Hospital Outpatient (APC), Ambulatory Surgical Center (ASC) and Physician Payments)

CPT® Code	Code Description	Physician <sup>1</sup>		Facility	
		MD In-Office Payment	MD In-Facility Payment	Hospital Outpatient Payment <sup>2</sup>	ASC Payment <sup>3</sup>
<b>PICC Procedures</b>					
36568	Insertion of peripherally inserted CVC, w/o port, under 5 years	\$300.01	\$97.17	\$783.08	\$440.49
36569	Insertion of peripherally inserted CVC, w/o port, 5 years or older	\$259.92	\$94.79	\$783.08	\$440.49
36584	<b>Replacement</b> , complete, of a peripherally inserted CVC, w/o subcutaneous port or pump, through same venous access	\$216.09	\$68.63	\$783.08	\$440.49
<b>Chest Port Procedures</b>					
36560	Insertion of tunneled centrally inserted central venous access device (CVAD), with subcutaneous port, under 5 years	\$1,273.44	\$363.55	\$2,119.74	\$1,192.37
36561	Insertion of tunneled centrally inserted CVAD, w/subcutaneous port, 5 years or older	\$1,192.23	\$362.19	\$2,119.74	\$1,192.37
36582	<b>Replacement</b> , complete, of a tunneled centrally inserted CVAD, w/subcutaneous port, through same venous access site	\$1,110.69	\$315.64	\$2,119.74	\$1,192.37
<b>Tunneled Venous Access</b>					
36557	Insertion of tunneled centrally inserted CVC, without reservoir, under 5 years	\$945.22	\$325.83	\$1,768.17	\$994.61
36558	Insertion of tunneled centrally inserted CVC, without reservoir, 5 years or older	\$813.73	\$288.80	\$1,768.17	\$994.61
36581	<b>Replacement</b> , complete, of a tunneled centrally inserted CVC, w/o subcutaneous port or pump, through same venous access site	\$772.62	\$205.22	\$1,768.17	\$994.61
<b>Arm Port Procedures</b>					
36570	Insertion of peripherally inserted CVAD, w/port, under 5 years	\$1,135.15	\$307.49	\$1,768.17	\$994.61
36571	Insertion of peripherally inserted CVAD, w/port, 5 years or older	\$1,282.27	\$326.51	\$1,768.17	\$994.61
36585	<b>Replacement</b> , complete, of a peripherally inserted CVAD, w/subcutaneous port, through same venous access site	\$1,116.12	\$289.14	\$1,768.17	\$994.61

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**REPAIR, REMOVAL and PARTIAL REPLACEMENT PROCEDURES**

CPT® Code	Code Description	Physician <sup>1</sup>		Facility	
		MD In-Office Payment	MD In-Facility Payment	Hospital Outpatient Payment <sup>2</sup>	ASC Payment <sup>3</sup>
36575	Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site	\$163.43	\$36.35	\$435.97	\$245.24
36576	Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	\$377.82	\$199.10	\$783.08	\$440.49
36578	<b>Replacement</b> , catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	\$516.44	\$222.21	\$1,768.17	\$994.61
36589	Removal of tunneled central venous catheter, without subcutaneous port or pump	\$169.88	\$143.38	\$435.97	\$245.24
36590	Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion	\$288.80	\$207.94	\$783.08	\$440.49

**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 <sup>1</sup>		Facility	
		MD In-Office Payment	MD In-Facility Payment	Hospital Outpatient Payment <sup>2</sup>	ASC Payment <sup>3</sup>
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)	\$35.00	\$15.29	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.

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**EMBOLIZATION PROCEDURES (Hypervascular Tumors)**

**Medicare Hospital Outpatient (APC), Ambulatory Surgical Center (ASC) and Physician Payments**

CPT® Code	Code Description	Physician <sup>1</sup>		Facility	
		MD In-Office Payment	MD In-Facility Payment	Hospital Outpatient Payment <sup>2</sup>	ASC Payment <sup>3</sup>
<b>Non-head or Neck (including UAE)</b>					
37204	Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	NA	\$939.45	\$6,386.54	\$3,592.47
36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	\$1,963.50	\$342.48	Bundled	Bundled
<b>Head or Neck</b>					
61626	Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; non-central nervous system, head or neck (extracranial, brachiocephalic branch)	NA	\$876.93	\$6,386.54	Not on ASC List
<b>Supervision &amp; Interpretation</b>					
75736	Angiography, pelvic, selective or supraseductive, radiological supervision and interpretation	\$231.38	\$56.74	\$2,026.59	Bundled
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	NA	\$68.29	Bundled	Bundled

**DRAINAGE PROCEDURES**

**Medicare Hospital Outpatient (APC), Ambulatory Surgical Center (ASC) and Physician Payments**

CPT® Code	Code Description	Physician <sup>1</sup>		Facility	
		MD In-Office Payment	MD In-Facility Payment	Hospital Outpatient Payment <sup>2</sup>	ASC Payment <sup>3</sup>
<b>Biliary</b>					
47510	Introduction of percutaneous transhepatic catheter for biliary drainage	NA	\$484.84	\$2,185.82	\$1,229.54
47511	Introduction of percutaneous transhepatic stent for internal and external biliary drainage	NA	\$599.68	\$2,185.82	\$1,229.54
47525	Change of percutaneous biliary drainage catheter	\$514.40	\$98.53	\$1,123.86	\$632.18
47530	Revision and/or reinsertion of transhepatic tube	\$1,448.07	\$364.91	\$1,123.86	\$632.18
<b>Urinary</b>					
50392	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous	NA	\$184.83	\$1,210.41	\$680.87
<b>Abscess</b>					
49423	Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)	\$570.46	\$75.77	\$1,123.86	\$632.18

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## MEDICARE HOSPITAL INPATIENT REIMBURSEMENT

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.

## MEDICARE HOSPITAL OUTPATIENT REIMBURSEMENT

C codes are used ONLY as a part of Hospital Outpatient Prospective Payment System (HOPPS) and are not to be used to report other services

C1729 - Catheter, drainage

C1750 - Catheter, hemodialysis/peritoneal, long-term

C1751 - Catheter, infusion, inserted peripherally, centrally, or midline (other than hemodialysis)

C1758 - Catheter, ureteral

C1769 - Guidewire

C1788 - Port, Indwelling (implantable)

C2628 - Catheter, occlusion

- <sup>1</sup> Medicare national average MD payments calculated using the 2011 Conversion Factor of \$33.98. MD rates are effective from January 1-December 31, 2011 and will vary based on geography. Source: 2011 Final Medicare Physician Fee Schedule, November 29, 2010 Federal Register.
- <sup>2</sup> Hospital Outpatient payments are 2011 Medicare national averages. Source: November 24, 2010 Federal Register. Actual rates will vary geographically.
- <sup>3</sup> ASC rates are from the 2011 Medicare ASC Final Rule. Source: November 24, 2010 Federal Register.

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