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2025 Billing and Coding Guide

Renal care and dialysis access

This guide is intended to aid providers in appropriate CPT®[1] code selection for procedures associated with hemodialysis, peritoneal, and dialysis access maintenance. The document reflects applicable and commonly billed procedure codes as well as the unadjusted national Medicare average rates assigned to the code. This document is not all-inclusive, nor does it replace advice from your coding and compliance departments and/or CPT®[1] coding manuals. CPT®[1] code descriptions in this document have been shortened to the consumer-friendly version per the American Medical Association (AMA) guidelines.[2] Note, CPT®[1] consumer-friendly descriptors should not be used for clinical coding or documentation.[3]

TABLE OF CONTENTS

Dialysis Access Maintenance Procedures

		Physician[5]			Hospital outpatient[6]		Ambulatory surgery[6]
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	Rate	Rate
36901	Angiogram of dialysis access	3.36	$654	$160	5182	$1,572[†]	$528
36902	Angioplasty of dialysis access	4.83	$1,113	$227	5192	$5,771[†]	$2,630
36903	Stent placement within dialysis access including angioplasty	6.39	$3,845	$298	5193	$11,478	$7,351
36904	Thrombectomy of dialysis access	7.50	$1,667	$348	5192	$5,771	$3,516
36905	Thrombectomy of dialysis access with angioplasty	9.00	$2,088	$419	5193	$11,478	$6,491
36906	Thrombectomy of dialysis access with angioplasty and stent	10.42	$4,905	$482	5194	$18,174	$11,783
36907	Angioplasty of dialysis access, central veins	3.00	$545	$139	NA	NA[§]	NA[§]
36908	Angioplasty and stent of dialysis access, central veins	4.25	$1,298	$196	NA	NA[§]	NA[§]
36909	Embolization or occlusion, dialysis access circuit	4.12	$1,871	$190	NA	NA[§]	NA[§]

Hemodialysis Catheter Procedures

		Physician[5]			Hospital outpatient[6]		Ambulatory surgery[6]
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	Rate	Rate
Removal of obstruction from catheter							
36593	Declotting of central venous catheter	0.00	$34	NA	5694	$336	$33
36595	Mechanical removal of obstructive material from central venous catheter	3.59	$551	$172	5183	$3,186†	$421
36596	Mechanical removal of tissue or obstructive material from central venous catheter	0.75	$111	$44	5182	$1,572†	$632
Repositioning/Repair of catheter							
36575	Repair of central venous catheter for infusion	0.98	$135	$32	5181	$626	$332
Insertion of catheter							
36555	Insertion of non-tunneled central venous catheter for infusion (younger than 5 years)	2.48	$178	$81	5183	$3,186†	$1,589
36556	Insertion of non-tunneled central venous catheter for infusion (5 years or older)	2.49	$201	$83	5183	$3,186†	$1,589
36557	Insertion of tunneled central venous catheter for infusion (younger than 5 years)	4.89	$1,071	$313	5184	$5,471†	$3,010
36558	Insertion of tunneled central venous catheter for infusion (5 years or older)	4.59	$763	$248	5183	$3,186†	$1,589
Replacement of catheter							
36580	Replacement of non-tunneled central venous catheter	1.31	$177	$62	5182	$1,572†	$632¶
36581	Replacement of tunneled central venous catheter	3.23	$712	$175	5183	$3,186†	$2,020¶
Removal of catheter							
36589	Removal of tunneled central venous catheter	4.03	$159	$131	5181	$626§	$332

Hemodialysis Catheter Procedures

		Physician[5]			Hospital outpatient[6]		Ambulatory surgery[6]
CPT®[1] code	**Description**	**Work RVU**	**Office rate**	**Facility rate**	**APC**	**Rate**	**Rate**
Imaging guidance for insertion, replacement, and removal							
+76937	Ultrasonic guidance for blood vessel access	0.41	$37	$13	NA	NA[§]	NA
+77001	Fluoroscopic guidance for insertion or removal of central vein access device	0.53	$94	$17	NA	NA[§]	NA

Peritoneal Dialysis Catheter Procedures

		Physician[5]			Hospital outpatient[6]		Ambulatory surgery[6]
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	Rate	Rate
Insertion procedure							
49324	Insertion of abdominal cavity tube using an endoscope	6.32	NA	$377	5361	$5,905†	$2,860
49418	Insertion of abdominal tube using imaging guidance with review by radiologist	3.96	$961	$191	5341	$3,572†	$1,685
49421	Insertion of abdominal cavity tube for drainage or dialysis	4.21	NA	$219	5341	$3,572†	$1,685
+49326	Suture of internal abdominal lining using an endoscope	3.50	NA	$181	NA	NA§	NA§
Placement of subcutaneous extension							
+49435	Of abdominal cavity tube extension	2.25	NA	$115	NA	NA§	NA§
Creation of exit site (externalization, exteriorization)							
49436	Creation of exit site for tube in abdominal cavity	2.72	$507	$182	5302	$1,920†	$864
Removal of catheter							
49422	Removal of abdominal cavity tube	4.00	NA	$213	5183	$3,186§	$1,589
Revision or repositioning of catheter: laparoscopic							
49325	Revision of abdominal cavity tube using an endoscope	6.82	NA	$403	5361	$5,903†	$2,860
+49326	Suture of internal abdominal lining using an endoscope	3.50	NA	$181	NA	NA§	NA§

Peritoneal Dialysis Catheter Procedures

		Physician[5]			Hospital outpatient[6]		Ambulatory surgery[6]
CPT®[1] code	**Description**	**Work RVU**	**Office rate**	**Facility rate**	**APC**	**Rate**	**Rate**
Unlisted procedure							
49999	Other procedure on abdomen	Carrier priced			5301	$949	NA
Catheter evaluation							
49400	Injection of air or X-ray contrast into abdominal cavity	1.88	$148	$88	NA	NA§	NA§
74190	Review by radiologist of abdominal cavity lining image	0.00	$22	NA	5524	$555§	NA

Hospital Inpatient Coding – ICD 10 – PCS

ICD-10-PCS[7] procedure codes are used by hospitals to report surgeries and procedures performed in the inpatient setting. Below are commonly used ICD-10-PCS procedure codes, however codes listed below are not exhaustive as other codes may apply.

ICD-10-PCS[7]	Description
Catheter Insertion	
02H633Z	Insertion of Infusion Device into Right Atrium, Percutaneous Approach
02HV33Z	Insertion of Infusion Device into Superior Vena Cava, Percutaneous Approach
0JH63XZ	Insertion of Tunneled Vascular Access Device into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0WHG03Z	Insertion of Infusion Device into Peritoneal Cavity, Open Approach
0WHG33Z	Insertion of Infusion Device into Peritoneal Cavity, Percutaneous Approach
0JHT33Z	Insertion of Infusion Device into Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
Catheter removal and revision	
0JWT33Z	Revision of Infusion Device in Trunk Subcutaneous Tissue and Fascia, Percutaneous Approach
0WPG03Z	Removal of Infusion Device from Peritoneal Cavity, Open Approach
0WPG33Z	Removal of Infusion Device from Peritoneal Cavity, Percutaneous Approach
0WPG43Z	Removal of Infusion Device from Peritoneal Cavity, Percutaneous Endoscopic Approach
0WPGX3Z	Removal of Infusion Device from Peritoneal Cavity, External Approach
0WWG03	Revision of Infusion Device in Peritoneal Cavity, Open Approach
0WWG33Z	Revision of Infusion Device in Peritoneal Cavity, Percutaneous Approach
0WWG43Z	Revision of Infusion Device in Peritoneal Cavity, Percutaneous Endoscopic Approach

ICD-10-PCS[7]	Description
Placement of central venous access catheter (Non-tunneled and Tunneled)	
02H633Z	Insertion of Infusion Device into Right Atrium, Percutaneous Approach
02HV33Z	Insertion of Infusion Device Into Superior Vena Cava, Percutaneous Approach
0JH63XZ	Insertion of Tunneled Vascular Access Device into Chest Subcutaneous Tissue and Fascia, Percutaneous
Continuous renal replacement therapy (CRRT)	
5A1D70Z	Performance of Urinary Filtration, Intermittent, Less than 6 hours Per Day
5A1D80Z	Performance of Urinary Filtration, Prolonged Intermittent, 6-18 hours Per Day
5A1D90Z	Performance of Urinary Filtration, Continuous, Greater than 18 hours Per Day
Dialysis Access Endovascular Interventions	
02CV3ZZ	Extirpation of Matter, Superior Vena Cava, Perc Approach
05CY3ZZ	Extirpation of Matter, Upper Vein, Perc Approach
06CY3ZZ	Extirpation of Matter, Lower Vein, Perc Approach
3E03317	Introduction, Peripheral Vein, Other Thrombolytic, Perc Approach
3E04317	Introduction, Central Vein, Other Thrombolytic, Perc Approach

Hospital Inpatient Coding - DRG

Hospital Diagnosis Related Groups (DRG)[8]

Under Medicare's MS-DRG[8] methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 750 diagnosis-related groups, based on the ICD-10 codes assigned to the diagnoses and procedures. Each MS-DRG has a relative weight that is then converted to a flat payment amount. Only one MS- DRG is assigned for each inpatient stay, regardless of the number of procedures performed.

The DRGs below are typically assigned for the common scenario in which the patient is diagnosed with renal failure and undergoes CRRT following placement of non-tunneled central venous access catheter. Other MS- DRGs are available in different scenarios, e.g., when CRRT is provided during the birth episode of care, when a non-tunneled catheter is placed, or when the patient is admitted for fluid overload.

MS-DRG[8]	Description	Rate
252	Other Vascular procedures W MCC	$24,481
253	Other Vascular procedures W CC	$18,220
254	Other Vascular procedures W/O CC/MCC	$12,481
291	Heart Failure and Shock W MCC	$9,312
292	Heart Failure and Shock W CC	$6,146
293	Heart Failure and Shock W/O CC/MCC	$3,916
314	Other Circulatory System Diagnoses W MCC	$15,369
315	Other Circulatory System Diagnoses W CC	$6,867
316	Other Circulatory System Diagnoses W/O CC/MCC	$4,872
652	Kidney Transplant	$21,919
673	Other Kidney and Urinary Tract procedures W MCC	$29,899

MS-DRG[8]	Description	Rate
674	Other Kidney and Urinary Tract procedures W CC	$16,474
675	Other Kidney and Urinary Tract procedures W/O CC/MCC	$11,171
682	Renal Failure W MCC	$10,718
683	Renal Failure W CC	$6,344
684	Renal Failure W/O CC/MCC	$4,335
698	Other Kidney and Urinary Tract Diagnoses W MCC	$11,996
699	Other Kidney and Urinary Tract Diagnoses W CC	$7,279
700	Other Kidney and Urinary Tract Diagnoses W/O CC/MCC	$4,954

MCC: Major Complications and/or Comorbidities
CC: Complications and/or Comorbidities

HCPCS II[4] Codes

Level II HCPCS[4] codes are primarily used to report supplies, drugs and implants that are not reported by a CPT®[1] code. HCPCS codes are reported by the physician, hospital or DME provider that purchased the item, device, or supply. Different payers have different payment methods for these items.

C-codes are a series of HCPCS codes that facilities reimbursed under the Medicare Outpatient Prospective Payment System (OPPS) are required to report for eligible items and services. Medicare assigns C codes to specific devices eligible for pass-through payment. Every year, in the OPPS rule, Medicare publishes a list of CPT®[1] and HCPCS codes that are designated as device-intensive procedures. When reporting procedures on this list, facilities should capture both the CPT®[1] code representing the procedure performed and the C-code representing the device used. Although C-codes only affect Medicare outpatient reimbursement, facilities may also want to report C-codes on inpatient claims if the device is not used exclusively for inpatient procedures. Medicare tracks this information and uses it in its rate-setting process. Non-OPPS facilities may report C- codes at their discretion.

HCPCS[4] Code	Description
A4300	Implantable access catheter (eg, venous, arterial, epidural subarachnoid, or peritoneal, etc), external access
C1750	Catheter, hemodialysis/peritoneal, long-term
C1769	Guidewire
C1894	Introducer sheath

Footnotes

NA	Indicates that there is no established Medicare allowable in this site of care
+	Add-on codes are always listed in addition to the primary procedure code
†	Comprehensive APCs (C-APCs)
¶	Device intensive
§	Packaged Payment
RVU	Indicates Relative Value Unit

References

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