2023 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].

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, hemodiaylsis/peritoneal, long-term
C1769	Guidewire
C1894	Introducer sheath

Hemodialysis catheter procedure reimbursement

		Physician[5]			Hospital outpatient[6]			Ambulatory surgery[6]	
CPT®[1] code	Description	Work RVU	Office Rate	Facility Rate	APC	SI	Rate	PI	Rate
Insertion of catheter									
36555	Insertion of non-tunneled central venous tube for infusion (younger than 5 years)	1.93	$192	$84	5183	J1	$2,979†	A2	$1,444
36556	Insertion of non-tunneled central venous tube for infusion (5 years or older)	1.75	$217	$84	5183	J1	$2,979†	A2	$1,444
36557	Insertion of tunneled central venous tube for infusion (younger than 5 years)	4.89	$1,187	$323	5184	J1	$5,140†	A2	$2,641
36558	Insertion of tunneled central venous tube for infusion (5 years or older)	4.59	$849	$259	5183	J1	$2,979†	A2	$1,444
Replacement of catheter									
36580	Replacement of non-tunneled central venous tube	1.31	$194	$65	5182	J1	$1,488†	J8	$749¶
36581	Replacement of tunneled central venous tube	3.23	$795	$182	5183	J1	$2,979†	J8	$1,873¶
Removal of catheter									
36589	Removal of tunneled central venous tube	2.28	$167	$137	5181	Q2	$579§	A2	$301
Imaging guidance for insertion, replacement, and removal									
+76937	Ultrasonic guidance for blood vessel access	0.30	$40	$14	NA	N	NA§	NA	NA
+77001	Fluoroscopic guidance for insertion or removal of central vein access device	0.38	$102	$18	NA	N	NA§	NA	NA
Repair of catheter									
36575	Repair of central venous tube for infusion	0.67	$147	$33	5181	T	$579	A2	$301

Please refer to page 7 for footnotes

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Hemodialysis catheter procedure reimbursement

		Physician[5]			Hospital outpatient[6]			Ambulatory surgery[6]	
CPT®[1] code	**Description**	**Work RVU**	**Office rate**	**Facility rate**	**APC**	**SI**	**Rate**	**PI**	**Rate**
Removal of obstruction from catheter									
36593	Declotting of central venous tube	0.00	$34	NA	5694	T	$333	P3	$33
36595	Mechanical removal of obstructive material from central venous tube	3.59	$604	$179	5183	J1	$2,979†	P3	$468
36010	Insertion of tube into vena cava	2.18	$552	$107	NA	N	NA§	N1	NA§
36011	Insertion of tube into vein, first order branch	3.14	$822	$155	NA	N	NA§	N1	NA§
36012	Insertion of tube into vein, second order branch	3.51	$851	$171	NA	N	NA§	N1	NA§
36596	Mechanical removal of tissue or obstructive material from central venous tube	0.75	$116	$44	5182	J1	$1,488†	G2	$583
Repositioning catheter									
36575	Repair of central venous tube for infusion	0.67	$147	$33	5181	T	$579	A2	$301
76000	Imaging guidance for procedure, 60 minutes or less	0.30	$44	$16	5523	S	$234	Z3	$28
Catheter evaluation									
36598	Contrast injection for imaging to evaluate central venous access device	0.74	$123	$36	5693	T	$207	P3	$96

Please refer to page 7 for footnotes

Peritoneal dialysis catheter procedure reimbursement

		Physician[5]			Hospital outpatient[6]			Ambulatory surgery[6]	
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	SI	Rate	PI	Rate
Insertion procedure									
49324	Insertion of abdominal cavity tube using an endoscope	6.32	NA	$392	5361	J1	$5,212[†]	G2	$2,498
49418	Insertion of abdominal tube using imaging guidance with review by radiologist	3.96	$1,009	$200	5341	J1	$3,542[†]	G2	$1,666
49421	Insertion of abdominal cavity tube for drainage or dialysis	4.21	NA	$227	5341	J1	$3,542[†]	G2	$1,666
+49326	Suture of internal abdominal lining using an endoscope	3.50	NA	$189	NA	N	NA[§]	N1	NA[§]
Placement of subcutaneous extension									
+49435	Of abdominal cavity tube extension	2.25	NA	$119	NA	N	NA[§]	N1	NA[§]
Creation of exit site (externalization, exteriorization)									
49436	Creation of exit site for tube in abdominal cavity	2.72	$556	$188	5302	J1	$1,742[†]	G2	$752
Removal of catheter									
49422	Removal of abdominal cavity tube	4.00	NA	$222	5183	Q2	$2,979[§]	A2	$1,444
Revision or repositioning of catheter: laparoscopic									
49325	Revision of abdominal cavity tube using an endoscope	6.82	NA	$419	5361	J1	$5,212[†]	G2	$2,498
+49326	Suture of internal abdominal lining using an endoscope	3.50	NA	$189	NA	N	NA[§]	N1	NA[§]

Please refer to page 7 for footnotes

Peritoneal dialysis catheter procedure reimbursement

		Physician[5]			Hospital outpatient[6]			Ambulatory surgery[6]	
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	SI	Rate	PI	Rate
Unlisted procedure									
49999	Other procedure on abdomen	Carrier priced			5301	T	$826	NA	NA
Catheter evaluation									
49400	Injection of air or X-ray contrast into abdominal cavity	1.88	$152	$90	NA	N	NA[§]	N1	NA[§]
74190	Review by radiologist of abdominal cavity lining image	0.00	$22	NA	5524	Q2	$503[§]	NA	NA

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Dialysis access maintenance procedure reimbursement

		Physician[5]			Hospital outpatient[6]			Ambulatory surgery[6]	
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	SI	Rate	PI	Rate
Angiography & Angioplasty									
36901	Insertion of needle and/or tube into hemodialysis circuit with review by radiologist	3.36	$719	$166	5182	J1	$1,488†	P2	$583
36902	Insertion of needle and/or tube into hemodialysis circuit and balloon dilation of dialysis segment with review by radiologist	4.83	$1,231	$237	5192	J1	$5,215†	G2	$2,327
+36907	Balloon dilation of dialysis segment with review by radiologist	3.00	$602	$144	NA	N	NA§	N1	NA§
37248	Balloon dilation of vein with review by radiologist, initial vein	6.00	$1,385	$292	5192	J1	$5,215†	G2	$2,327
36010	Insertion of tube into vena cava	2.18	$552	$107	NA	N	NA§	N1	NA§
36011	Insertion of tube into vein, first order branch	3.14	$822	$155	NA	N	NA§	N1	NA§
36012	Insertion of tube into vein, second order branch	3.51	$851	$171	NA	N	NA§	N1	NA§

Please refer to page 7 for footnotes

Dialysis access maintenance procedure reimbursement

		Physician[5]			Hospital outpatient[6]			Ambulatory surgery[6]	
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	SI	Rate	PI	Rate
Disruption of fibrin sheath from tunneled central venous catheter									
36581	Replacement of tunneled central venous tube	3.23	$795	$182	5183	J1	$2,979†	J8	$1,873¶
37248	Balloon dilation of vein with review by radiologist, initial vein	6.00	$1,385	$292	5192	J1	$5,215†	G2	$2,327
37799	Other procedure on blood vessel	Carrier priced			5181	T	$579	NA	NA
+77001	Fluoroscopic guidance for insertion or removal of central vein access device	0.38	$102	$18	NA	N	NA§	N1	NA
Thrombectomy of dialysis circuit									
36904	Removal and/or dissolving of blood clot in hemodialysis circuit and balloon dilation of dialysis segment with review by radiologist	7.50	$1,847	$364	5192	J1	$5,215†	J8	$3,070¶
Thrombectomy of dialysis circuit with angioplasty of underlying stenosis									
36905	Removal and/or dissolving of blood clot in hemodialysis circuit and balloon dilation of dialysis segment with imaging review by radiologist, with balloon tube	9.00	$2,326	$437	5193	J1	$10,615†	J8	$5,907¶

Footnotes

NA	Indicates that there is no establish Medicare allowable in this site of care
SI	Indicates Status Indicator
PI	Indicates Payment Indicator
+	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

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Hospital inpatient coding

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

Hospital inpatient coding

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

Hospital inpatient coding

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
682	Renal Failure W MCC	$10,197
683	Renal Failure W CC	$6,139
684	Renal Failure W/O CC/MCC	$4,149
291	Heart Failure and Shock W MCC	$8,779
292	Heart Failure and Shock W CC	$5,918
293	Heart Failure and Shock W/O CC/MCC	$3,843
314	Other Circulatory System Diagnoses W MCC	$14,286
315	Other Circulatory System Diagnoses W CC	$6,643
316	Other Circulatory System Diagnoses W/O CC/MCC	$4,678
673	Other Kidney and Urinary Tract procedures W MCC	$23,967
674	Other Kidney and Urinary Tract procedures W CC	$16,260
675	Other Kidney and Urinary Tract procedures W/O CC/MCC	$11,568
698	Other Kidney and Urinary Tract Diagnoses W MCC	$10,992
699	Other Kidney and Urinary Tract Diagnoses W CC	$6,943
700	Other Kidney and Urinary Tract Diagnoses W/O CC/MCC	$5,082

MCC: Major Complications and/or Comorbidities

CC: Complications and/or Comorbidities

References

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