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2023 Billing and Coding Guide

CARPEDIEM™ cardio-renal pediatric dialysis emergency machine

This guide is intended to aid providers in appropriate CPT®[1] code selection for procedures associated with the CARPEDIEM™ cardio-renal pediatric dialysis emergency machine. The document reflects applicable and commonly billed procedure codes as well as the unadjusted national Medicare average rates assigned to the CPT®[1] 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[4] II 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[4] 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.

There are no designated Level II HCPCS[4] codes associated with CARPEDIEM™ cardio-renal pediatric dialysis emergency machine. The CARPEDIEM™ system is used on an inpatient basis and HCPCS[4] device codes cannot be reported on an inpatient bill.

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
Placement of central venous access 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
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
Imaging guidance for central venous access catheter placement									
+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
Continuous renal replacement therapy									
90945	Dialysis procedure including 1 evaluation	1.56	NA	$85	5024	V	$382	NA	NA
90947	Dialysis procedure requiring repeat evaluation	2.52	NA	$122	NA	B	NA	NA	NA

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Footnotes

NA	Indicates that there is no established 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

Hospital Inpatient procedure 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[7] procedure codes, however codes listed below are not exhaustive as other codes may apply.

ICD-10-PCS[7]	Description
Non-tunneled catheters & tunneled catheters	
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
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[7] codes assigned to the diagnoses and procedures. Each MS-DRG[8] has a relative weight that is then converted to a flat payment amount. Only one MS-DRG[8] is assigned for each inpatient stay, regardless of the number of procedures performed.

The DRGs below are typically assigned for procedures related to CARPEDIEM™ system, however other MS-DRG[8] are available in different scenarios.

MS-DRG[8]	Description	Rate
Cystectomy		
653	Major Bladder Procedures with MCC	$38,116
654	Major Bladder Procedures without CC	$19,498
655	Major Bladder Procedures without CC/MCC	$14,808

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

All Patient Refined Diagnosis Related Groups (APR-DRG)[9]

Alternately, APR-DRGs[9] (All Patient Refined Diagnosis Related Groups)[9] may be used for hospital inpatient payment. APR-DRG[9] are similar in concept to MS-DRGs[8], but provide more granularity for non-Medicare patients, particularly newborns and children. APR-DRGs[9] expand on the basic DRG concept by adding a subclass for severity of illness (SOI) at four different levels.

The DRGs below are typically assigned for the common scenario in which the patient is admitted for renal failure associated with a congenital renal anomaly and undergoes continual renal replacement therapy (CRRT) following placement of a non-tunneled central venous access catheter. For the CARPEDIEM™ system, either Neonatal APR-DRGs[9] or Non-Neonatal APR-DRGs[9] can be assigned depending on the pate of the patient at admission.

Neonatal APR-DRG[9]	SOI Level	APR-DRG Description
633	3	Neonate Birth Weight >2499 Grams With Major Anomaly
633	4	Neonate Birth Weight >2499 Grams With Major Anomaly

Non-neonatal APR DRG[9]	SOI Level	APR-DRG Description
469	3	Acute Kidney Injury
469	4	Acute Kidney Injury

References

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Resources

Medtronic Reimbursement Support is available to assist you with your coding and reimbursement questions. If your coding or reimbursement questions were not answered in this guide, please check out these additional resources:

Visit our website: https://www.medtronic.com/covidien/en-us/support/reimbursement.html

Email us: rs.MedtronicMedicalSurgicalReimbursement@medtronic.com

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