

Venous Access Procedures

Reimbursement Information

2008 CODING & PAYMENT QUICK REFERENCE

BACKGROUND

- Boston Scientific Corporation 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 2008 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	\$324	\$91	\$695	\$363
36569	Insertion of peripherally inserted CVC, w/o port, 5 years or older	\$293	\$92	\$695	\$363
36584	Replacement , complete, of a peripherally inserted CVC, w/o subcutaneous port or pump, through same venous access	\$256	\$70	\$695	\$363
Chest Port Procedures					
36560	Insertion of tunneled centrally inserted central venous access device (CVAD), with subcutaneous port, under 5 years	\$1,203	\$341	\$1,839	\$681
36561	Insertion of tunneled centrally inserted CVAD, with subcutaneous port, 5 years or older	\$1,211	\$330	\$1,839	\$681
36582	Replacement , complete, of a tunneled centrally inserted CVAD, w/sub. port, through same venous access site	\$1,088	\$283	\$1,839	\$681
Tunneled Venous Access					
36557	Insertion of tunneled centrally inserted CVC, without reservoir, under 5 years	\$884	\$287	\$1,535	\$584
36558	Insertion of tunneled centrally inserted CVC, without reservoir, 5 years or older	\$867	\$277	\$1,535	\$584
36581	Replacement , complete, of a tunneled centrally inserted CVC, w/o subcutaneous port or pump, through same venous access site	\$790	\$193	\$1,535	\$584
Non-Tunneled Venous Access					
36555	Insertion of non-tunneled centrally inserted central venous catheter (CVC), under 5 years	\$276	\$120	\$695	\$363
36556	Insertion of non-tunneled centrally inserted CVC, 5 years or older	\$253	\$116	\$695	\$363
36580	Replacement , complete, of a non-tunneled centrally inserted CVC, w/o subcutaneous port or pump, through same venous access site	\$259	\$67	\$695	\$363
Arm Port Procedures					
36570	Insertion of peripherally inserted CVAD, w/port, under 5 years	\$1,237	\$292	\$1,535	\$632
36571	Insertion of peripherally inserted CVAD, w/port, 5 years or older	\$1,301	\$298	\$1,535	\$632
36585	Replacement , complete, of a peripherally inserted CVAD, w/subcutaneous port, through same venous access	\$1,128	\$267	\$1,535	\$632

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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	\$170	\$40	\$361	\$393
36576	Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	\$360	\$180	\$695	\$447
36578	Replacement , catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	\$512	\$207	\$1,535	\$584
36589	Removal of tunneled central venous catheter, without subcutaneous port or pump	\$163	\$135	\$361	\$308
36590	Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion	\$261	\$191	\$695	\$363

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)	\$15	\$15	\$0	\$0

- 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 MD payments calculated using the 2008 conversion factor of \$38.0869 and mandated budget neutrality work adjuster of 0.8806. MD rates are effective through June 30, 2008. Source: Medicare, Medicaid and SCHIP Extension Act of 2007 and 2008 Medicare Physician Fee Schedule Addendum B revised December 4, 2007.

² Hospital Outpatient payments are 2008 Medicare national averages. Source: November 27, 2007 Federal Register. Actual rates will vary geographically.

³ ASC rates are from the 2008 Update to the Ambulatory Surgical Center Covered Procedures List. Source: November 27, 2007 Federal Register.

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