Coding for Central Venous Catheter Procedures

April 2023

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Introduction

Central venous catheters (CVCs) are a means of venous access. They are used to deliver substances into *or* remove substances from a patient's large central veins.

Examples: Groshong®, Hickman™, Broviac™, Port-A-Cath®, Quinton

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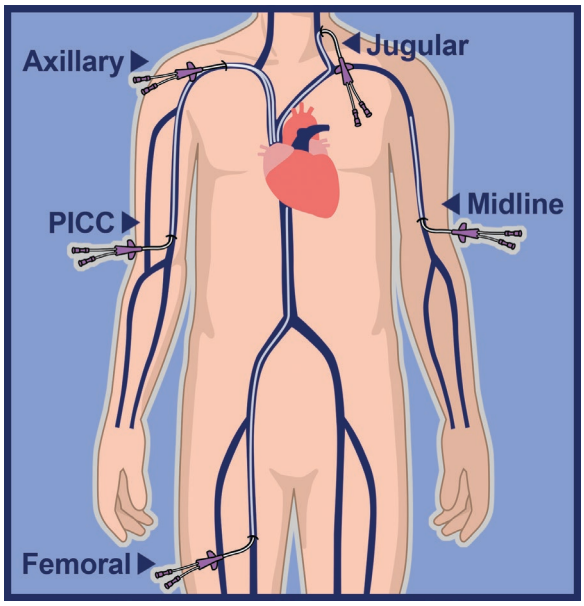
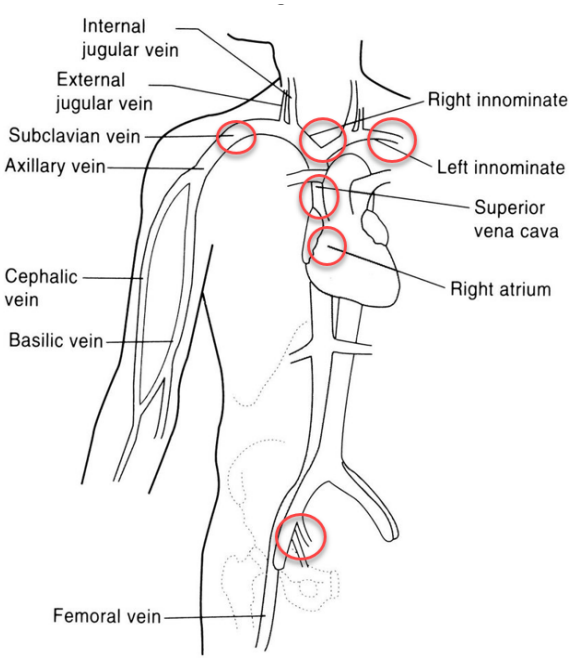


According to CPT®, "to qualify as a central venous catheter or device, the tip of the catheter/device must terminate in the subclavian, brachiocephalic (innominate) or iliac veins, the superior or inferior vena cava, or the right atrium."

Midline catheters are <u>not</u> central venous access devices and do not terminate in the peripheral system – do not use PICC placement codes for these devices.



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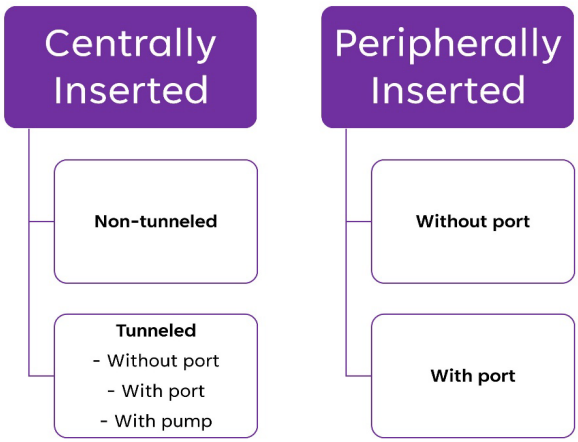
Categories of Central Venous Catheter

Centrally inserted CVCs are inserted into the jugular vein, subclavian vein, femoral vein, or inferior vena cava. They may be tunneled or non-tunneled. Some tunneled CVCs are connected to a port (a reservoir under the patient's skin) or pump (to dispense medication at specific times/dosages).

Peripherally inserted CVCs (PICCs) are inserted into a peripheral vein (e.g., basilic or cephalic vein) and terminate in the central veins. PICCs are non-tunneled. They may be connected to a port (a reservoir under the patient's skin).



Coding for CVC Procedures

Code selection for CVC procedures is based on the following:

- Type of procedure (insertion, replacement, repair, etc.)
- Type of device (centrally inserted vs. peripherally inserted, tunneled vs. non-tunneled)
- Patient's age
- Use of imaging guidance (for PICCs)

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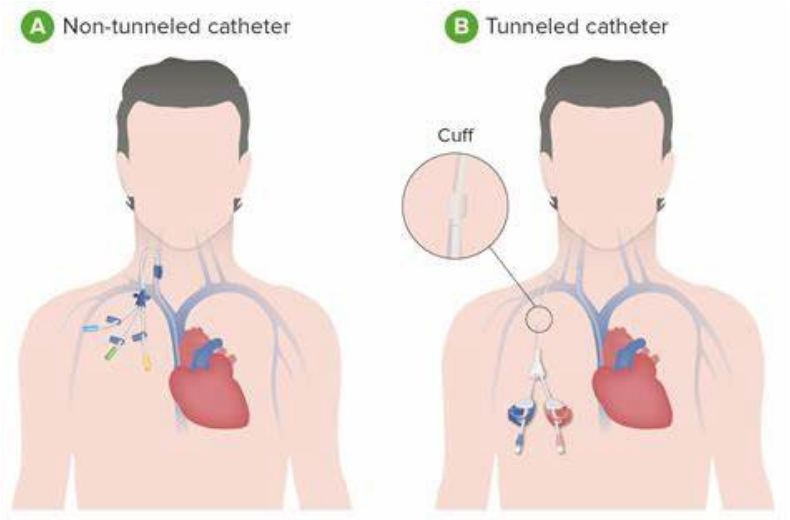
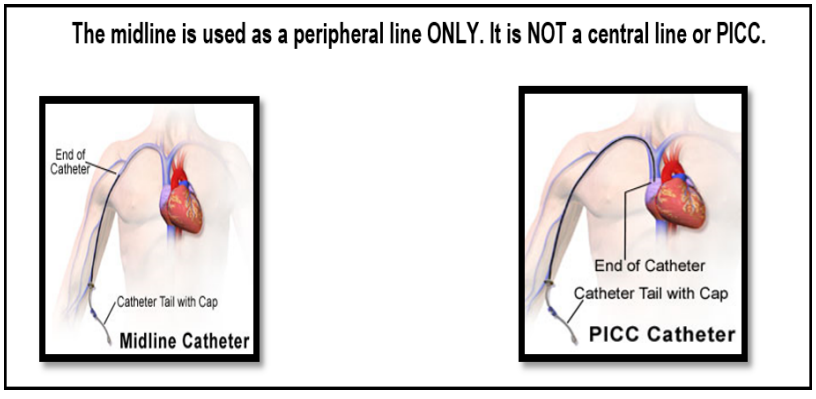


Central Venous Catheters							
Centrally Inserted					Peripherally Inserted		
Non-Tunneled		Tunneled w/o port or pump	Tunneled w/port	Tunneled w/pump	(PICC) W/o Port or Pump, w/o imaging	(PICC) w/o port or pump with imaging	(PICC) with port
Insertion (< 5 years)	36555	36557	36560	36563	36568	36572	36570
Insertion (? 5 years)	36556	36558 (1 access) 36565 (2 access)	36561 (1 access) 36566 (2 access)	36563	36569	36573	36571
Repair	36575	36575	36576		36575	36575	36576
Replacement (cath only)			36578	36578			36578
Replacement, complete (through same venous access)	36580	36581	36582	36583	37799	36584	36585
Removal	36589	36590	36590				36590
Guidance*		Fluoroscopic guidance: 77001 Ultrasound guidance: 76937					

*Where assignment is allowed by code definition

Midline catheters are a type of IV catheter. They are not central venous access devices and do not terminate in the peripheral system. Do not use PICC codes for these devices. Midline catheters may be coded with 36400, 36406, or 36410.



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For additional information regarding coding and billing for midline catheters, please see the following Q&A available on the Advisor tab of the PARA Data Editor:

https://apps.para-hcfs.com/pde/documents/QA_2019%20Midline_Catheter_Placement%20Change.pdf

Central Venous Catheter Insertion

Central insertion is reported with codes **36555-36566** (these do not include imaging guidance). Peripheral (PICC) insertion is reported with codes **36568-36573**. Two PICC codes **include imaging guidance** (36572, 36573) and two PICC codes describe when imaging is **not** used (36568, 36569).

36555 - INSERTION OF NON-TUNNELED CENTRALLY INSERTED CENTRAL VENOUS CATHETER; YOUNGER THAN 5 YEARS OF AGE
36566 - INSERTION OF TUNNELED CENTRALLY INSERTED CENTRAL VENOUS ACCESS DEVICE, REQUIRING 2 CATHETERS VIA 2 SEPARATE VENOUS ACCESS SITES; WITH SUBCUTANEOUS PORT(S)
36568 - INSERTION OF PERIPHERALLY INSERTED CENTRAL VENOUS CATHETER (PICC), WITHOUT SUBCUTANEOUS PORT OR PUMP, WITHOUT IMAGING GUIDANCE; YOUNGER THAN 5 YEARS OF AGE
36569 - INSERTION OF PERIPHERALLY INSERTED CENTRAL VENOUS CATHETER (PICC), WITHOUT SUBCUTANEOUS PORT OR PUMP, WITHOUT IMAGING GUIDANCE; AGE 5 YEARS OR OLDER
36570 - INSERTION OF PERIPHERALLY INSERTED CENTRAL VENOUS ACCESS DEVICE, WITH SUBCUTANEOUS PORT; YOUNGER THAN 5 YEARS OF AGE
36571 - INSERTION OF PERIPHERALLY INSERTED CENTRAL VENOUS ACCESS DEVICE, WITH SUBCUTANEOUS PORT; AGE 5 YEARS OR OLDER
36572 - INSERTION OF PERIPHERALLY INSERTED CENTRAL VENOUS CATHETER (PICC), WITHOUT SUBCUTANEOUS PORT OR PUMP, INCLUDING ALL IMAGING GUIDANCE, IMAGE DOCUMENTATION, AND ALL ASSOCIATED RADIOLOGICAL SUPERVISION AND INTERPRETATION REQUIRED TO PERFORM THE INSERTION; YOUNGER THAN 5 YEARS OF AGE
36573 - INSERTION OF PERIPHERALLY INSERTED CENTRAL VENOUS CATHETER (PICC), WITHOUT SUBCUTANEOUS PORT OR PUMP, INCLUDING ALL IMAGING GUIDANCE, IMAGE DOCUMENTATION, AND ALL ASSOCIATED RADIOLOGICAL SUPERVISION AND INTERPRETATION REQUIRED TO PERFORM THE INSERTION; AGE 5 YEARS OR OLDER

For **PICC placements**, if confirmation of the location of the catheter tip is not documented, modifier -52 must be applied to the appropriate PICC code. If the PICC is placed using MR or other guidance that does not provide image documentation, this should be reported with the non-imaging codes 36568, 36569.

For **centrally inserted** CVCs, ultrasound and/or fluoroscopic guidance is reported separately when used, and the documentation requirements outlined in the code description must be met.

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Multiple Insertion Attempts – Unsuccessful

If multiple attempts are made at inserting a central venous access catheter and none are successful, one instance of the attempted insertion may be billed with modifier -52 appended to the appropriate CPT® code for the procedure.

The following Medicare transmittal discusses appropriate use of modifier -52 for discontinued procedures in the facility setting:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r442cp.pdf

CMS Manual System
Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 442 | **Date: JANUARY 21, 2005**

CHANGE REQUEST 3507

SUBJECT: Hospital Outpatient Prospective Payment System (OPPS): Use of Modifiers -52, -73 and -74 for Reduced or Discontinued Services

I. SUMMARY OF CHANGES: This manual revision clarifies use of modifiers -52, -73, and -74. These modifiers are used to report procedures that are discontinued by the physician due to unforeseen circumstances. Modifier -52 is used to indicate partial reduction or discontinuation of radiology procedures and other services that do not require anesthesia. For surgeries and certain diagnostic procedures requiring anesthesia

Multiple Insertion Attempts – Successful

According to the National Correct Coding Initiative Policy Manual (Chapter 1):

> "If 2 procedures only differ in that 1 is described as an 'incomplete' procedure and the other as a 'complete' procedure, the 'incomplete' procedure is included in the 'complete' procedure and is not separately reportable unless the 2 procedures are performed at separate patient encounters or at separate anatomic sites."

Because unsuccessful attempts are considered part of the successful procedure, only the successful completed catheter insertion would be reported. If all attempts at a central or peripheral venous catheter placement are unsuccessful and only a midline catheter is placed, then only the midline catheter placement (36400-36410) should be coded.

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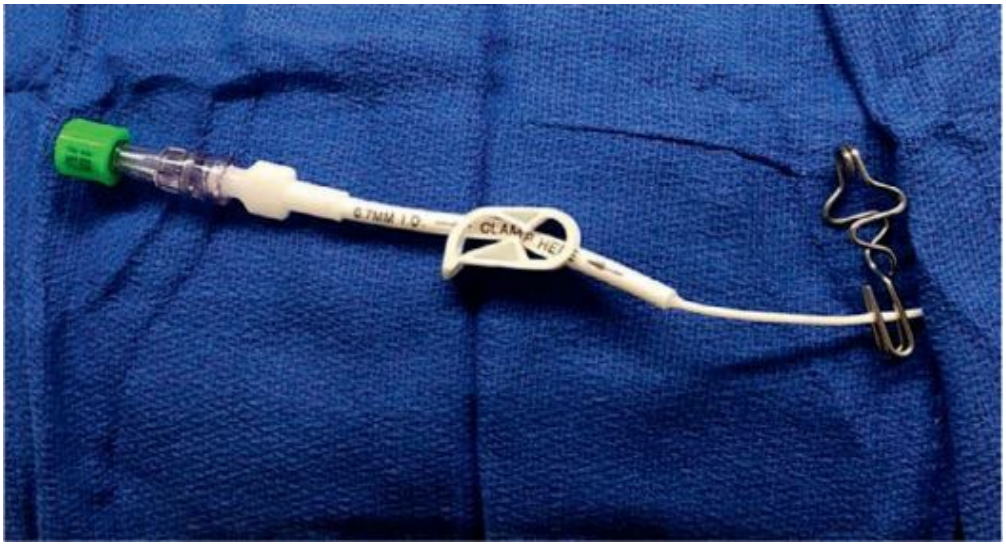
CVC Repair

CPT® defines CVC repair **(36575/36576)** as "fixing [a] device *without* replacement of either catheter or port or pump, other than pharmacologic or mechanical correction of intracatheter or pericatheter occlusion." Code selection is based on whether the CVC has a subcutaneous port or pump.

36575 - REPAIR OF TUNNELED OR NON-TUNNELED CENTRAL VENOUS ACCESS CATHETER, WITHOUT SUBCUTANEOUS PORT OR PUMP, CENTRAL OR PERIPHERAL INSERTION SITE

36576 - REPAIR OF CENTRAL VENOUS ACCESS DEVICE, WITH SUBCUTANEOUS PORT OR PUMP, CENTRAL OR PERIPHERAL INSERTION SITE



Partial Replacement (Catheter Only)

For replacement of a catheter connected to a port or pump (without replacing the port or pump), use code **36578** (regardless of whether central or peripheral).

36578 - REPLACEMENT, CATHETER ONLY, OF CENTRAL VENOUS ACCESS DEVICE, WITH SUBCUTANEOUS PORT OR PUMP, CENTRAL OR PERIPHERAL INSERTION SITE

Complete Replacement

Complete CVC replacement **(36580-36585)** requires removal of the entire device and replacement with a new device via **the same venous access**. These codes include all necessary imaging guidance, supervision, and interpretation (S&I). These codes also include replacement of implanted port or pump as well as the catheter, if performed.

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Complete replacement of a PICC line without a port or pump/without imaging guidance is coded as 37799.

36580 - REPLACEMENT, COMPLETE, OF A NON-TUNNELED CENTRALLY INSERTED CENTRAL VENOUS CATHETER, WITHOUT SUBCUTANEOUS PORT OR PUMP, THROUGH SAME VENOUS ACCESS
36581 - REPLACEMENT, COMPLETE, OF A TUNNELED CENTRALLY INSERTED CENTRAL VENOUS CATHETER, WITHOUT SUBCUTANEOUS PORT OR PUMP, THROUGH SAME VENOUS ACCESS
36582 - REPLACEMENT, COMPLETE, OF A TUNNELED CENTRALLY INSERTED CENTRAL VENOUS ACCESS DEVICE, WITH SUBCUTANEOUS PORT, THROUGH SAME VENOUS ACCESS
36583 - REPLACEMENT, COMPLETE, OF A TUNNELED CENTRALLY INSERTED CENTRAL VENOUS ACCESS DEVICE, WITH SUBCUTANEOUS PUMP, THROUGH SAME VENOUS ACCESS
36584 - REPLACEMENT, COMPLETE, OF A PERIPHERALLY INSERTED CENTRAL VENOUS CATHETER (PICC), WITHOUT SUBCUTANEOUS PORT OR PUMP, THROUGH SAME VENOUS ACCESS, INCLUDING ALL IMAGING GUIDANCE, IMAGE DOCUMENTATION, AND ALL ASSOCIATED RADIOLOGICAL SUPERVISION AND INTERPRETATION REQUIRED TO PERFORM THE REPLACEMENT
36585 - REPLACEMENT, COMPLETE, OF A PERIPHERALLY INSERTED CENTRAL VENOUS ACCESS DEVICE, WITH SUBCUTANEOUS PORT, THROUGH SAME VENOUS ACCESS
37799 - UNLISTED PROCEDURE, VASCULAR SURGERY

CVC Removal

Codes 36589 and 36590 describe removal of a tunneled CVC without & with a subcutaneous port or pump, respectively. Do not report these codes for removal of non-tunneled central venous catheters. If the physician removes a CVC from one site and inserts a new one at a different site/different access, it is appropriate to code both the removal and the insertion.

36589 - REMOVAL OF TUNNELED CENTRAL VENOUS CATHETER, WITHOUT SUBCUTANEOUS PORT OR PUMP
36590 - REMOVAL OF TUNNELED CENTRAL VENOUS ACCESS DEVICE, WITH SUBCUTANEOUS PORT OR PUMP, CENTRAL OR PERIPHERAL INSERTION

Declotting of a CVC

If a CVC is obstructed by blood clot, the physician may perform injection of a thrombolytic drug like tPA into the catheter or port to dissolve the clot. This is reported with code 36593. 36593 is a technical-only code; there is no professional component for this procedure. This code includes injection of a thrombolytic and is reported only once per session. Do not report 36593 for routine flushing (e.g., heparin). Injections of tPA or other thrombolytics to declot a CVC should not be reported as thrombolytic infusion (37211-37214), according to *Clinical Examples in Radiology,* Summer 2012.

36593 - DECLOTTING BY THROMBOLYTIC AGENT OF IMPLANTED VASCULAR ACCESS DEVICE OR CATHETER

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The appropriate HCPCS code should also be reported for the declotting agent injected. tPA (also called Activase, alteplase, or CathFlo) is reported using HCPCS code J2997:

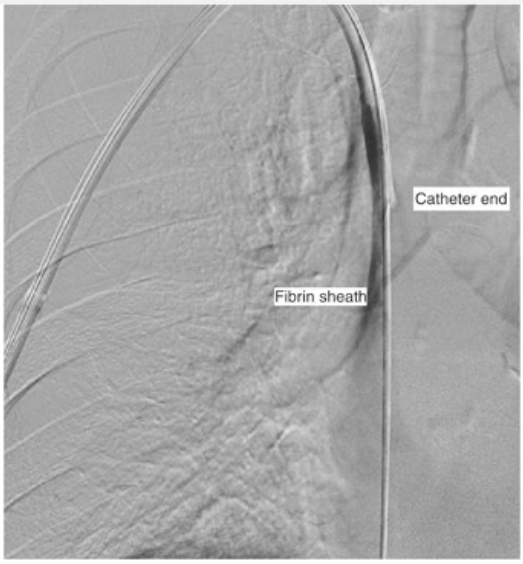
HCPCS/CPT®	Status	APC	Weight Payment Nat. Copay Min. Copay
J2997 - INJECTION, ALTEPLASE RECOMBINANT, 1 MG Berenson-Eggers Type of Service: O1E - OTHER DRUGS	K	7048	- 88.03 0.00 17.61

Typically, at least 2 units of J2997 are reported when code 36593 is reported.

Mechanical Removal of Obstructive Material

Codes 36595 + 75901 describe removal of pericatheter material. This is sometimes called "catheter stripping." These codes describe removal of a *fibrin sheath* (scar tissue/blood cell buildup) around a CVC using internal snare maneuver with radiologic supervision and interpretation.

36595 - MECHANICAL REMOVAL OF PERICATHETER OBSTRUCTIVE MATERIAL (EG, FIBRIN SHEATH) FROM CENTRAL VENOUS DEVICE VIA SEPARATE VENOUS ACCESS
75901 - MECHANICAL REMOVAL OF PERICATHETER OBSTRUCTIVE MATERIAL (EG, FIBRIN SHEATH) FROM CENTRAL VENOUS DEVICE VIA SEPARATE VENOUS ACCESS, RADIOLOGIC SUPERVISION AND INTERPRETATION



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Intraluminal removal of obstructive material is reported with 36596 + 75902. In this procedure, the physician inserts a small brush into the catheter to remove the fibrin sheath from the catheter tip, typically under imaging guidance.

36596 - MECHANICAL REMOVAL OF INTRALUMINAL (INTRACATHETER) OBSTRUCTIVE MATERIAL FROM CENTRAL VENOUS DEVICE THROUGH DEVICE LUMEN
75902 - MECHANICAL REMOVAL OF INTRALUMINAL (INTRACATHETER) OBSTRUCTIVE MATERIAL FROM CENTRAL VENOUS DEVICE THROUGH DEVICE LUMEN, RADIOLOGIC SUPERVISION AND INTERPRETATION

If selective venous catheterizations are performed (as described by 36010-36012), these should be reported separately (CPT® *Assistant*, December 2004). Catheter declotting (39593) is included and not reported separately. Do not assign venous angioplasty codes if a balloon catheter is used to remove a fibrin sheath – instead code 37799.

36010 - INTRODUCTION OF CATHETER, SUPERIOR OR INFERIOR VENA CAVA
36011 - SELECTIVE CATHETER PLACEMENT, VENOUS SYSTEM; FIRST ORDER BRANCH (EG, RENAL VEIN, JUGULAR VEIN)
36012 - SELECTIVE CATHETER PLACEMENT, VENOUS SYSTEM; SECOND ORDER, OR MORE SELECTIVE, BRANCH (EG, LEFT ADRENAL VEIN, PETROSAL SINUS)

37799 - UNLISTED PROCEDURE, VASCULAR SURGERY

Repositioning a Central Venous Catheter

Repositioning a CVC is reported with 36597. The code description for 36597 mentions fluoroscopy but does not include fluoroscopic guidance if used. This should be reported separately using 76000 (not +77001, as there is no vascular access).

36597 - REPOSITIONING OF PREVIOUSLY PLACED CENTRAL VENOUS CATHETER UNDER FLUOROSCOPIC GUIDANCE
76000 - FLUOROSCOPY (SEPARATE PROCEDURE), UP TO 1 HOUR PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL TIME

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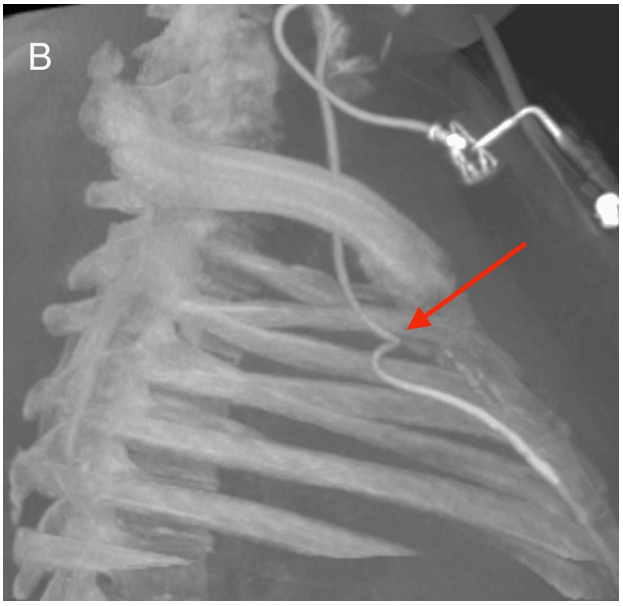

Contrast Injection of a CVC

Contrast injection of a CVC under fluoroscopy to evaluate patency/position is reported with code 36598. This code includes the use of fluoroscopy so it should not be reported separately. Additionally, this code cannot be reported with codes 36595-36596 for mechanical removal of obstructive material. 39598 does not include complete diagnostic studies of the central veins, so a complete diagnostic extremity study performed from a separate injection site should be coded separately (75820).

36598 - CONTRAST INJECTION(S) FOR RADIOLOGIC EVALUATION OF EXISTING CENTRAL VENOUS ACCESS DEVICE, INCLUDING FLUOROSCOPY, IMAGE DOCUMENTATION AND REPORT
75820 - VENOGRAPHY, EXTREMITY, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION

Chest X-Ray After CVC

Per the National Correct Coding Initiative Policy Manual (Chapter 9), chest x-ray to confirm catheter placement should not be separately reported. The CPT® manual also contains this guidance. If another chest x-ray is taken later the same day (e.g., for a complication), it may be reported.

> "9. When a central venous catheter is inserted, a chest radiologic examination is usually performed to confirm the position of the catheter and absence of pneumothorax.

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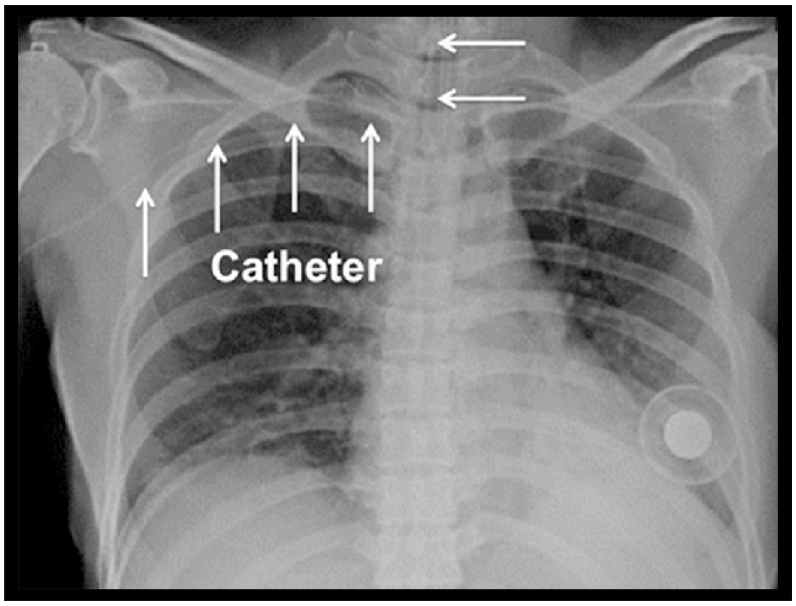
Similarly, when an emergency endotracheal intubation procedure (CPT code 31500), chest tube insertion procedure (e.g., CPT codes 32550, 32551, 32554, 32555), or insertion of a central flow directed catheter procedure (e.g., Swan-Ganz) (CPT code 93503) is performed, a chest radiologic examination is usually performed to confirm the location and proper positioning of the tube or catheter. The chest radiologic examination is integral to the procedures, and the chest radiologic examination (e.g., CPT codes 71045, 71046) shall not be reported separately."



Fluoroscopic Guidance

Fluoroscopic guidance for central venous access device placement (when not included in the procedure code) is reported with +77001. This is an add-on code, so it must be reported in addition to a primary procedure code. +77001 includes the use of fluoroscopy for guidance, contrast injections through the access site, and spot films/x-ray to confirm final catheter position. Formal extremity venograms via a separate access site may be reported separately when documented.

77001 - FLUOROSCOPIC GUIDANCE FOR CENTRAL VENOUS ACCESS DEVICE PLACEMENT, REPLACEMENT (CATHETER ONLY OR COMPLETE), OR REMOVAL (INCLUDES FLUOROSCOPIC GUIDANCE FOR VASCULAR ACCESS AND CATHETER MANIPULATION, ANY NECESSARY CONTRAST INJECTIONS THROUGH ACCESS SITE OR CATHETER WITH RELATED VENOGRAPHY RADIOLOGIC SUPERVISION AND INTERPRETATION, AND RADIOGRAPHIC DOCUMENTATION OF FINAL CATHETER POSITION) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

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For additional information regarding coding and billing for fluoroscopic guidance with central venous access procedures, please see the following PARA Paper available under the Advisor tab in the PARA Data Editor:

https://apps.para-hcfs.com/pde/documents/Fluoroscopy%20in%20the%20Hospital%20Setting.pdf

Fluoroscopy In the Hospital Setting

Central Venous Access

According to the NCCI Policy Manual, Chapter 1, insertion of central venous access devices frequently requires the use of fluoroscopic guidance: "Since CPT® code 77001 describes fluoroscopic guidance for central venous access device procedures, CPT® codes for more general fluoroscopy (e.g., 76000, 77002) shall not be reported separately. (CPT® code 76001 was deleted January 1, 2019.)"

Ultrasound Guidance

Ultrasound guidance for vascular access is reported with +76937. This is an add-on code, so it must be reported in addition to a primary procedure code. Do not report +76937 for skin marking/non-guided punctures. This code may be used with other vascular interventional procedures (it is not limited to central venous access). Code +76937 requires:

- Evaluation of potential vessel access sites
- Documentation of selected vessel patency (narrowed, thrombosed, patent)
- Concurrent real-time ultrasound visualization of vascular needle entry
- Permanently recorded images of the site to be localized & documented description of the localization process

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)

https://apps.para-hcfs.com/pde/documents/Ultrasound%20Guidance%20in%20the%20Hospital%20Setting.pdf

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Ultrasound Guidance in the Hospital Setting

Central Venous Access

Ultrasound guidance for vascular access, including (but not limited to) central venous access device procedures, is reported with add-on code +76937. This code is reported in addition to the primary code for the intervention or central venous access device procedure performed, when applicable. Under Medicare (42 CFR 410.32(b)(3)(iii)), this service requires personal physician supervision:

> (iii) *Personal supervision* means a physician must be in attendance in the room during the performance of the procedure.

Many central venous access device procedure codes already include all necessary imaging guidance to complete the procedure, so it is important to review the specific code description to determine if +76937 should be reported separately when documentation requirements are met.

The description for code +76937 states this code requires documentation of evaluation of potential access sites, selected vessel patency, and concurrent real-time ultrasound visualization of needle entry. *Clinical Examples in Radiology* (Summer 2014) indicates that describing the vessel as "patent, narrowed, aneurysmal, or even thrombosed" supports the documentation of selected vessel patency. Like all other US guidance codes, this code requires acquisition and storage of a film or digital permanent image documenting the guidance procedure. This code should not be reported when a hand-held ultrasound device is used but the above documentation requirements are not met (e.g., no documentation of vessel patency, no permanent image).

Central Venous Catheter Supply Codes

There are several potential device HCPCS codes for central and peripheral venous catheters and access devices, as well as associated supplies. Code selection will depend on the type of device used. Below are some examples of possible supply codes utilized for central and peripheral venous catheter procedures. This list is not exhaustive.

HCPCS/CPT®	Status
A4300 - IMPLANTABLE ACCESS CATHETER, (E.G., VENOUS, ARTERIAL, EPIDURAL SUBARACHNOID, OR PERITONEAL, ETC.) EXTERNAL ACCESS Berenson-Eggers Type of Service: Y1 - OTHER - MEDICARE FEE SCHEDULE	N
A4649 - SURGICAL SUPPLY; MISCELLANEOUS Berenson-Eggers Type of Service: D1A - MEDICAL/SURGICAL SUPPLIES	N
C1750 - CATHETER, HEMODIALYSIS/PERITONEAL, LONG-TERM Berenson-Eggers Type of Service: D1A - MEDICAL/SURGICAL SUPPLIES	N
C1751 - CATHETER, INFUSION, INSERTED PERIPHERALLY, CENTRALLY OR MIDLINE (OTHER THAN HEMODIALYSIS) Berenson-Eggers Type of Service: D1A - MEDICAL/SURGICAL SUPPLIES	N

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C1752 - CATHETER, HEMODIALYSIS/PERITONEAL, SHORT-TERM Berenson-Eggers Type of Service: D1A - MEDICAL/SURGICAL SUPPLIES	N
C1769 - GUIDE WIRE Berenson-Eggers Type of Service: D1A - MEDICAL/SURGICAL SUPPLIES	N
C1788 - PORT, INDWELLING (IMPLANTABLE) Berenson-Eggers Type of Service: D1A - MEDICAL/SURGICAL SUPPLIES	N
C1889 - IMPLANTABLE/INSERTABLE DEVICE, NOT OTHERWISE CLASSIFIED Berenson-Eggers Type of Service: D1A - MEDICAL/SURGICAL SUPPLIES	N
C1894 - INTRODUCER/SHEATH, OTHER THAN GUIDING, OTHER THAN INTRACARDIAC ELECTROPHYSIOLOGICAL, NON-LASER Berenson-Eggers Type of Service: D1A - MEDICAL/SURGICAL SUPPLIES	N

Surfacer Inside-Out Access Catheter System

The Surfacer System (Bluegrass Vascular) is a unique medical device that uses an innovative inside-out technique and is the first of its kind to be cleared by the FDA. Its purpose is to assist with central venous access in patients with venous obstructions or other conditions that prevent traditional access methods from being used. For Medicare beneficiaries, hospitals and ambulatory surgery centers (ASCs) should report HCPCS code C9780 for the "Inside-Out" procedure when performed with the Surfacer System. This code includes any imaging guidance utilized for the procedure.

HCPCS/CPT®	Status	APC	Weight Payment Nat. Copay Min. Copay
C9780 - INSERTION OF CENTRAL VENOUS CATHETER THROUGH CENTRAL VENOUS OCCLUSION VIA INFERIOR AND SUPERIOR APPROACHES (E.G., INSIDE-OUT TECHNIQUE), INCLUDING IMAGING GUIDANCE	S	1534	- 8250.50 0.00 1650.10

There are several potential corresponding device and supply HCPCS codes for the Surfacer "Inside-Out" procedure:

HCPCS/CPT®	Status
C1750 - CATHETER, HEMODIALYSIS/PERITONEAL, LONG-TERM Berenson-Eggers Type of Service: D1A - MEDICAL/SURGICAL SUPPLIES	N
C1752 - CATHETER, HEMODIALYSIS/PERITONEAL, SHORT-TERM Berenson-Eggers Type of Service: D1A - MEDICAL/SURGICAL SUPPLIES	N
C1769 - GUIDE WIRE Berenson-Eggers Type of Service: D1A - MEDICAL/SURGICAL SUPPLIES	N

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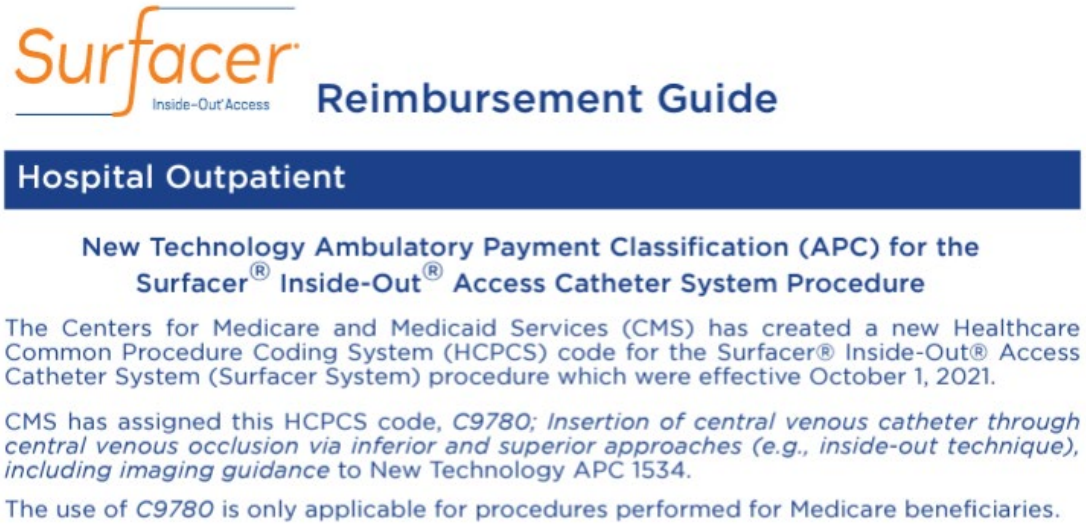
C1788 - PORT, INDWELLING (IMPLANTABLE) **Berenson-Eggers Type of Service: D1A** - MEDICAL/SURGICAL SUPPLIES	N
C1889 - IMPLANTABLE/INSERTABLE DEVICE, NOT OTHERWISE CLASSIFIED **Berenson-Eggers Type of Service: D1A** - MEDICAL/SURGICAL SUPPLIES	N
C1894 - INTRODUCER/SHEATH, OTHER THAN GUIDING, OTHER THAN INTRACARDIAC ELECTROPHYSIOLOGICAL, NON-LASER **Berenson-Eggers Type of Service: D1A** - MEDICAL/SURGICAL SUPPLIES	N

For additional information about the Surfacer Inside-Out procedure, please visit:

http://bluegrassvascular.com/wp-content/uploads/2023/03/Surfacer-System-Reimbursement-Guide-700236-02.pdf


Surfacer Inside-Out Access

Reimbursement Guide

Hospital Outpatient

New Technology Ambulatory Payment Classification (APC) for the Surfacer® Inside-Out® Access Catheter System Procedure

The Centers for Medicare and Medicaid Services (CMS) has created a new Healthcare Common Procedure Coding System (HCPCS) code for the Surfacer® Inside-Out® Access Catheter System (Surfacer System) procedure which were effective October 1, 2021.

CMS has assigned this HCPCS code, *C9780; Insertion of central venous catheter through central venous occlusion via inferior and superior approaches (e.g., inside-out technique), including imaging guidance* to New Technology APC 1534.

The use of *C9780* is only applicable for procedures performed for Medicare beneficiaries.

Conclusion

Code selection for central venous access devices and their corresponding supply charges is based on a variety of very specific factors and requirements. Clear documentation is extremely important to ensure proper coding and reimbursement. Code descriptions and documentation should be reviewed carefully, and when unclear, the provider should be queried.

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