Medtronic

2022 Billing and Coding Guidelines
Chameleon™ PTA Balloon Catheter

The Chameleon™ PTA balloon catheter uniquely combines the functionality of a high-pressure balloon catheter and a diagnostic catheter to enable proximal injection of diagnostic and therapeutic fluids. The Chameleon™ PTA balloon catheter serves multiple purposes allowing both angioplasty and injection of diagnostic or therapeutic fluids in multiple procedures. Included in this guide are coding scenarios for the use of the Chameleon™ PTA balloon catheter.

Rates listed in this guide are based on their respective site of care - physician office, ambulatory surgical center, or hospital outpatient department. Office-based laboratories (OBL) are not considered a unique site of care under Medicare payment and are reimbursed based on the Medicare Physician Non-Facility rate. All rates provided are for the Medicare national unadjusted average for the calendar year rounded to the nearest whole number and do not represent adjustment specific to the provider's location or facility. Commercial rates are based on individual contracts. Providers are encouraged to review contracts to verify their specific contracted allowables. The product addressed within this guide does not have a dedicated HCPCS[1] Level ll code. Payment is included in the associated procedure.

Angiography of dialysis circuit without any associated interventions

CPT©[2] Code	Description	Physician[3]	Ambulatory Surgery Center[4]	Hospital Outpatient[4]
36901	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report	Facility:$170 Non-Facility: $753	$558	$1,436
As defined, code 36901 is complete and includes all antegrade and retrograde punctures, catheterizations, contrast injection, all imaging of the entire dialysis circuit, and fluoroscopy. It also includes advancing the catheter into the vena cava, any accessory veins communicating with the dialysis segment, and through the arterial anastomosis to sufficiently visualize the anastomosis and the peri-anastomotic portion of the arterial inflow. In general, code 36901 is assigned when diagnostic angiographic is the only service performed. Otherwise, a fistulogram is included in the code for all primary dialysis circuit interventions. However, code 36901 can be used as the primary code for certain add-on codes.				

Angioplasty

Angioplasty of stenosed dialysis circuit

CPT© Code	Description	Physician[3]	Ambulatory Surgery Center[4]	Hospital Outpatient[4]
36902	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report, with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	Facility:$1,295 Non-Facility: $242	$2,208	$5,062
As defined, 36902 is complete and includes fistulogram, punctures, catheterizations, all imaging and fluoroscopy, guidance, and completion angiography. Code 36902 is used for angioplasty of the peripheral dialysis segment. The peripheral dialysis segment begins at the arterial anastomosis, including the nearby portions of the inflow artery and dialysis vein, and runs the length of the venous outflow tract up to and including the axillary vein or the cephalic vein depending on the specific venous outflow tract. Code 36902 is assigned just once, regardless of the number of lesions ballooned within the entire peripheral segment.				

Angioplasty of stenosis of central veins with angioplasty of stenosed peripheral dialysis circuit

CPT© Code	Description	Physician[3]	Ambulatory Surgery Center[4]	Hospital Outpatient[4]
36902	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report, with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	Facility: $1,257 Non-Facility: $235	$2,208	$5,062

CPT© Code	Description	Physician[3]	Ambulatory Surgery Center[4]	Hospital Outpatient[4]
+36907	Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)	Facility: $147 Non-Facility: $632	NA	NA
Code 36902 is used for angioplasty of the peripheral dialysis segment and code +36907 is for angioplasty of the central dialysis segment. The central dialysis segment begins with the subclavian vein and runs through the brachiocephalic vein up to an including the superior vena cava. Code +36907 is an add-on code and must also be assigned with a primary code, including 36901, 36902, 36904 and 36905. The code is assigned just once, regardless of the number of lesions ballooned within the entire central segment.				

Angioplasty of stenosis of central veins only, performed through the dialysis circuit, following fistulogram

CPT© Code	Description	Physician[3]	Ambulatory Surgery Center[4]	Hospital Outpatient[4]
36901	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report	Facility: $170 Non-Facility: $753	$558	$1,436
+36907	Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)	Facility: $147 Non-Facility: $632	NA	NA
By definition, code 36901 must be performed through the dialysis circuit via direct percutaneous access puncture to the dialysis circuit. Because code +36907 is an add-on and can never be assigned alone, code 36901 for the accompanying diagnostic fistula serves as the primary code. Code +36907 is assigned just once, regardless of the number of lesions ballooned within the entire central segment.				

Angioplasty of stenosis of central veins only, not performed through the dialysis circuit, following fistulogram

CPT© Code	Description	Physician[3]	Ambulatory Surgery Center[4]	Hospital Outpatient[4]
37248	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein, initial vein	Facility:$299 Non-Facility: $1,465	$2,208	$5,062
36010	Introduction of catheter, superior or inferior vena cava	Facility:$110 Non-Facility: $584	NA	NA
36011	Selective catheter placement, venous system; first order branch	Facility:$158 Non-Facility: $874	NA	NA
36012	Selective catheter placement, venous system; second order, or more selective, branch	Facility:$175 Non-Facility: $894	NA	NA
36901	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report	Facility:$170 Non-Facility: $753	$558	$1,436

Non-dialysis circuit angioplasty code 37248 is assigned when the central veins are accessed outside the dialysis circuit, e.g., accessing a stenotic region in the superior vena cava by puncture of the right internal jugular vein. Code 37248 does not include catheterization, so a catheterization code is assigned separately. Either 36010, 36011, or 36012 may be assigned, depending on the puncture site and location of the central vein stenosis.

Angioplasty of all lesions within the same central vessel are reported with a single code. If a stenotic lesion extends into another central vein but is treated with the same intervention, only one code is assigned.

Fibrin sheath disruption

Disruption of fibrin sheath from tunneled central venous catheter with exchange of the tunneled central venous catheter under fluoroscopy, when performed via the same access as original tunneled central venous catheter

CPT© Code	Description	Physician[3]	Ambulatory Surgery Center[4]	Hospital Outpatient[4]
36581	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	Facility:$185 Non-Facility: $840	$1,848	$2,924
+77001	Fluoroscopic guidance for central venous access device placement, replacement, or removal	Facility: $19 Non-Facility: $107	NA	NA
37799	Unlisted procedure, vascular surgery	Facility: NA Non-Facility: NA	NA	$552
Code 37799 is assigned to represent the fibrin sheath disruption. Unlisted codes do not have set valuation under Medicare. Instead, all are designated as contractor priced. Submission of an unlisted code generally requires the physician to provide a copy of the procedure report as well as a suggested comparable reference code. The payer must then manually review the submission to determine the payment amount on a case-by-case basis. Unlisted codes are not paid in the ASC setting.				

Disruption of fibrin sheath from tunneled central venous catheter with angioplasty of underlying stenosis within the vein and exchange of tunneled central venous catheter under fluoroscopy

CPT© Code	Description	Physician[3]	Ambulatory Surgery Center[4]	Hospital Outpatient[4]
37248	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein, initial vein	Facility:$299 Non-Facility: $1,465	$2,208	$5,062
36581	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	Facility:$185 Non-Facility: $840	$1,848	$2,924
Disruption of the fibrin sheath is considered integral to the angioplasty and is not coded separately. Fluoroscopy used during the catheter replacement is not coded separately because it is considered to be integral to the angioplasty.				

Thrombectomy

Thrombectomy of dialysis circuit

CPT© Code	Description	Physician[3]	Ambulatory Surgery Center[4]	Hospital Outpatient[4]
36904	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s)	Facility:$370 Non-Facility: $1,933	$2,954	$5,062
As defined, code 36904 is complete and includes fistulogram, punctures, catheterizations, all imaging and fluoroscopy, guidance, and completion angiography. Code 36904 is used for thrombectomy of the entire dialysis circuit, including both peripheral and central segments. It is assigned just once, regardless of the amount and distribution of thrombus treated. Code 36904 includes treatment of thrombus by mechanical thrombectomy, suction, and thrombolysis, or any combination. Removal of the plug at the arterial anastomosis is considered part of the thrombectomy even when performed with a balloon and is not coded separately.				

Thrombectomy of dialysis circuit with angioplasty of underlying stenosis

CPT© Code	Description	Physician[3]	Ambulatory Surgery Center[4]	Hospital Outpatient[4]
36905	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	Facility:$447 Non-Facility: $2,451	$5,671	$10,258
As defined, code 36905 is complete and includes fistulogram, punctures, catheterizations, all imaging and fluoroscopy, guidance, and completion angiography. The code is used for thrombectomy of the peripheral and central segments plus angioplasty in the peripheral segment only. Code 36905 is assigned just once, regardless of the amount and distribution of thrombus treated, and regardless of the number of lesions ballooned within the peripheral segment. Removal of the plug at the arterial anastomosis is considered part of the thrombectomy even when performed with a balloon and should not be coded as angioplasty.				

For more information, please contact the Medtronic MITG Reimbursement Hotline: 877-278-7482 or Rs.MedtronicMITGReimbursement@medtronic.com

[1] Centers for Medicare & Medicaid Services. Alpha-numeric HCPCS. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

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[3]Centers for Medicare and Medicaid Services. Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Federal Register (86 Fed. Reg. No. 221 64996-66031) https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf Published November 19, 2021. Physician Fee Schedule – January 2022 Release. https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-value-files/rvu22a

[4]Centers for Medicare and Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Final Rule, Federal Register (86 Fed. Reg. No.218 63458-63477), https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf Published November 16, 2021. ASC Payment Rates – Addenda January 2022 ASC Approved HCPCS Code and Payment Rates-Updated January 4, 2022. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates

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