Ambulatory Surgery Center Payment System, Hospital Outpatient Prospective Payment System and Physician Fee Schedule

Medicare has made some significant changes to its Ambulatory Surgery Center payment system (ASC) [Table 1], Outpatient Prospective Payment System (OPPS) [Table 2], and Physician Fee Schedule (PFS) [Tables 3 and 4] for 2017. In the charts below, we have identified some of the most significant changes. We have chosen to focus on changes greater than or equal to $100 for ASC, OPPS and PFS from 2016 to 2017. If you have questions about specific information in this document, or perhaps something you do not see in this document, please do not hesitate to contact our reimbursement team at 800.468.1379 or reimbursement@cookmedical.com.

Table 1: Changes in Ambulatory Surgery Center Reimbursement for Procedures of Interest

CPT Code	Procedural Description	2017 Ambulatory Surgery Center Fee Schedule	2016 Ambulatory Surgery Center Fee Schedule	Payment Difference
35475	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel	Deleted 2017	$1,314.98	($1,314.98)
35476	Transluminal balloon angioplasty, percutaneous; venous	Deleted 2017	$1,244.41	($1,244.41)
36147	Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)	Deleted 2017	$482.30	($482.30)
36555	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age	$369.36	$482.30	($112.94)
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	$369.36	$482.30	($112.94)
36557	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; younger than 5 years of age	$2,118.71	$1,256.68	$862.03
36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; younger than 5 years of age	$369.36	$482.30	($112.94)
36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older	$369.36	$482.30	($112.94)
36576	Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	$369.36	$482.30	($112.94)
36580	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	$369.36	$482.30	($112.94)
36583	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access	$3,599.73	$2,122.27	$1,477.46
36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access	$369.36	$482.30	($112.94)
36590	Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion	$369.36	$482.30	($112.94)
36596	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen	$369.36	$482.30	($112.94)
36597	Repositioning of previously placed central venous catheter under fluoroscopic guidance	$369.36	$482.30	($112.94)
36870	Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)	Deleted 2017	$2,287.57	($2,287.57)

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Table 1: Changes in Ambulatory Surgery Center Reimbursement for Procedures of Interest (Continued)				
CPT Code	Procedural Description	2017 Ambulatory Surgery Center Fee Schedule	2016 Ambulatory Surgery Center Fee Schedule	Payment Difference
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	$369.36	New code for 2017	$369.36
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	$3,119.32	New code for 2017	$3,119.32
36903	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 transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment	$6,025.55	New code for 2017	$6,025.55
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)	$3,119.32	New code for 2017	$3,119.32
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	$6,025.55	New code for 2017	$6,025.55
36906	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 transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit	$9,341.79	New code for 2017	$9,341.79
37184	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel	$2,964.43	$2,122.27	$842.16
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	$3,472.83	$2,287.57	$1,185.26
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	$7,449.17	$5,984.06	$1,465.11
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$6,569.16	$5,984.06	$585.10

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Table 1: Changes in Ambulatory Surgery Center Reimbursement for Procedures of Interest (Continued)				
CPT Code	Procedural Description	2017 Ambulatory Surgery Center Fee Schedule	2016 Ambulatory Surgery Center Fee Schedule	Payment Difference
37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when	$10,869.39	$9,819.12	$1,050.27
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	$4,186.62	$5,984.06	($1,797.44)
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	$10,065.14	$9,819.12	$246.02
37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$10,088.26	$9,819.12	$269.14
37231	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	$9,934.61	$9,819.12	$115.49
37236	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery	$4,186.62	$5,984.06	($1,797.44)
37238	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein	$6,334.14	$5,984.06	$350.08
37241	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous mal-formations, venous and capillary hemangiomas, varices, varicoceles)	$4,186.62	$5,984.06	($1,797.44)
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)	$4,186.62	$5,984.06	($1,797.44)
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	$4,186.62	$5,984.06	($1,797.44)
NOTE: This is not an all-inclusive list of procedural code changes.				

Table 2: Changes in Hospital Outpatient Reimbursement for Procedures of Interest				
CPT Code	Procedural Description	2017 Hospital Outpatient Payment	2016 Hospital Outpatient Payment	Payment Difference
35475	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel	Deleted 2017	$4,592.15	($4,592.15)
35476	Transluminal balloon angioplasty, percutaneous; venous	Deleted 2017	$4,592.15	($4,592.15)
36147	Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/ fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)	Deleted 2017	$862.51	($862.51)

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Table 2: Changes in Hospital Outpatient Reimbursement for Procedures of Interest (Continued)				
CPT Code	Procedural Description	2017 Hospital Outpatient Payment	2016 Hospital Outpatient Payment	Payment Difference
36555	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age	$683.84	$862.51	($178.67)
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	$683.84	$862.51	($178.67)
36557	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; younger than 5 years of age	$3,922.62	$2,247.33	$1,675.29
36558	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older	$2,359.60	$2,247.33	$112.27
36560	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; younger than 5 years of age	$2,359.60	$2,247.33	$112.27
36561	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older	$2,359.60	$2,247.33	$112.27
36563	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump	$3,922.62	$3,795.28	$127.34
36565	Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; without subcutaneous port or pump (eg, Tesio type catheter)	$2,359.60	$2,247.33	$112.27
36566	Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; with subcutaneous port(s)	$3,922.62	$3,795.28	$127.34
36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; younger than 5 years of age	$683.84	$862.51	($178.67)
36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older	$683.84	$862.51	($178.67)
36570	Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age	$2,359.60	$2,247.33	$112.27
36571	Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older	$2,359.60	$2,247.33	$112.27
36575	Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site	$683.84	$482.83	$201.01
36576	Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	$683.84	$862.51	($178.67)
36578	Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	$2,359.60	$2,247.33	$112.27
36580	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	$683.84	$862.51	($178.67)
36581	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	$2,359.60	$2,247.33	$112.27
36582	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous port, through same venous access	$2,359.60	$2,247.33	$112.27
36583	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access	$3,922.62	$3,795.28	$127.34
36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access	$683.84	$862.51	($178.67)
36585	Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access	$2,359.60	$2,247.33	$112.27
36589	Removal of tunneled central venous catheter, without subcutaneous port or pump	$683.84	$482.83	$201.01
36590	Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion	$683.84	$862.51	($178.67)

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Table 2: Changes in Hospital Outpatient Reimbursement for Procedures of Interest (Continued)				
CPT Code	Procedural Description	2017 Hospital Outpatient Payment	2016 Hospital Outpatient Payment	Payment Difference
36595	Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access	$2,359.60	$2,247.33	$112.27
36596	Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen	$683.84	$862.51	($178.67)
36597	Repositioning of previously placed central venous catheter under fluoroscopic guidance	$683.84	$862.51	($178.67)
36870	Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)	Deleted 2017	$4,592.15	($4,592.15)
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	$683.84	New code for 2017	$683.84
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	$4,823.16	New code for 2017	$4,823.16
36903	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 transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment	$9,748.31	New code for 2017	$9,748.31
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)	$4,823.16	New code for 2017	$4,823.16
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	$9,748.31	New code for 2017	$9,748.31
36906	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 transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit	$14,775.90	New code for 2017	$14,775.90

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Table 2: Changes in Hospital Outpatient Reimbursement for Procedures of Interest (Continued)

CPT Code	Procedural Description	2017 Hospital Outpatient Payment	2016 Hospital Outpatient Payment	Payment Difference
37184	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel	$3,922.62	$3,795.28	$127.34
37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	$3,922.62	$3,795.28	$127.34
37188	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy	$2,359.60	$2,247.33	$112.27
37191	Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	$3,922.62	$3,795.28	$127.34
37192	Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	$2,359.60	$2,247.33	$112.27
37193	Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	$2,359.60	$2,247.33	$112.27
37200	Transcatheter biopsy	$3,922.62	$3,795.28	$127.34
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	$4,823.16	$4,592.15	$231.01
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$9,748.31	$9,542.35	$205.96
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	$4,823.16	$4,592.15	$231.01
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	$9,748.31	$9,542.35	$205.96
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$9,748.31	$9,542.35	$205.96
37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	$14,775.90	$14,612.17	$163.73
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	$9,748.31	$9,542.35	$205.96
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	$14,775.90	$14,612.17	$163.73
37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$14,775.90	$14,612.17	$163.73
37231	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	$14,775.90	$14,612.17	$163.73
37236	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery	$9,748.31	$9,542.35	$205.96

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Table 2: Changes in Hospital Outpatient Reimbursement for Procedures of Interest (Continued)

CPT Code	Procedural Description	2017 Hospital Outpatient Payment	2016 Hospital Outpatient Payment	Payment Difference
37238	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein	$9,748.31	$9,542.35	$205.96
37241	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous mal-formations, venous and capillary hemangiomas, varices, varicoceles)	$9,748.31	$9,542.35	$205.96
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)	$9,748.31	$9,542.35	$205.96
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	$9,748.31	$9,542.35	$205.96
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	$9,748.31	$9,542.35	$205.96
75791	Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and interpretation	Deleted 2017	$667.93	($667.93)
75825	Venography, caval, inferior, with serialography,, radiological supervision and interpretation	$2,359.60	$2,718.83	($359.23)
75978	Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation	Deleted 2017	$2,247.33	($2,247.33)

NOTE: This is not an all-inclusive list of procedural code changes.

Table 3: Changes in Non-Facility Physician Fee Schedule Reimbursement for Procedures of Interest

NOTE: This applies to procedures performed in a physician's office.

CPT Code	Procedural Description	2017 Medicare Non-Facility Physician Fee Schedule	2016 Medicare Non-Facility Physician Fee Schedule	Payment Difference
35475	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel	Deleted 2017	$1,585.74	($1,585.74)
35476	Transluminal balloon angioplasty, percutaneous; venous	Deleted 2017	$1,453.54	($1,453.54)
36147	Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/ fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)	Deleted 2017	$852.70	($852.70)
36148	Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/ fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure)	Deleted 2017	$266.56	($266.56)
36560	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; younger than 5 years of age	$1,024.98	$1,373.45	($348.47)
36563	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump	$1,254.31	$1,357.34	($103.03)

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Table 3: Changes in Non-Facility Physician Fee Schedule Reimbursement for Procedures of Interest (Continued)				
CPT Code	Procedural Description	2017 Medicare Non-Facility Physician Fee Schedule	2016 Medicare Non-Facility Physician Fee Schedule	Payment Difference
36583	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access	$1,272.25	$1,395.29	($123.04)
36870	Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)	Deleted 2017	$1,866.99	($1,866.99)
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	$580.68	New code for 2017	$580.68
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	$1,234.93	New code for 2017	$1,234.93
36903	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 transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment	$5,663.24	New code for 2017	$5,663.24
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)	$1,800.54	New code for 2017	$1,800.54
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	$2,304.05	New code for 2017	$2,304.05
36906	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 transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit	$6,867.30	New code for 2017	$6,867.30
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)	$738.95	New code for 2017	$738.95

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Table 3: Changes in Non-Facility Physician Fee Schedule Reimbursement for Procedures of Interest (Continued)

CPT Code	Procedural Description	2017 Medicare Non-Facility Physician Fee Schedule	2016 Medicare Non-Facility Physician Fee Schedule	Payment Difference
36908	Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)	$2,721.80	New code for 2017	$2,721.80
36909	Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)	$1,985.36	New code for 2017	$1,985.36
37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	$2,004.03	$2,107.80	($103.77)
37188	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy	$1,710.46	$1,815.28	($104.82)
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	$3,113.70	$3,225.97	($112.26)
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$4,617.08	$4,755.89	($138.80)
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	$3,776.57	$3,914.13	($137.56)
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	$11,063.05	$11,244.34	($181.29)
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$9,065.13	$9,247.53	($182.41)
37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	$14,986.76	$15,186.39	($199.63)
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	$5,408.79	$5,561.48	($152.70)
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	$10,905.86	$11,084.65	($178.80)
37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$8,332.64	$8,473.45	($140.81)
37231	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	$13,492.72	$13,638.57	($145.86)
37236	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery	$4,017.38	$4,202.35	($184.97)

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Table 3: Changes in Non-Facility Physician Fee Schedule Reimbursement for Procedures of Interest (Continued)

CPT Code	Procedural Description	2017 Medicare Non-Facility Physician Fee Schedule	2016 Medicare Non-Facility Physician Fee Schedule	Payment Difference
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)	$7,554.21	$7,829.33	($275.11)
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	$9,816.64	$9,943.21	($126.58)
75791	Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and interpretation	Deleted 2017	$328.68	($328.68)
75962	Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation	Deleted 2017	$141.52	($141.52)
75978	Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation	Deleted 2017	$139.73	($139.73)

NOTE: This is not an all-inclusive list of procedural code changes.

Table 4: **Changes in Facility Physician Fee Schedule Reimbursement for Procedures of Interest**

NOTE: This applies to procedures performed in a hospital or ambulatory surgery center (ASC).

CPT Code	Procedural Description	2017 Medicare Facility Physician Fee Schedule	2016 Medicare Facility Physician Fee Schedule	Payment Difference
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	$151.09	New code for 2017	$151.09
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	$225.02	New code for 2017	$225.02

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Table 4: Changes in Facility Physician Fee Schedule Reimbursement for Procedures of Interest (Continued)

CPT Code	Procedural Description	2017 Medicare Non-Facility Physician Fee Schedule	2016 Medicare Non-Facility Physician Fee Schedule	Payment Difference
36903	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 transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment	$307.93	New code for 2017	$307.93
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)	$354.58	New code for 2017	$354.58
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	$445.02	New code for 2017	$445.02
36906	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 transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit	$519.31	New code for 2017	$519.31
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)	$129.56	New code for 2017	$129.56
36908	Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)	$194.16	New code for 2017	$194.16
36909	Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)	$184.47	New code for 2017	$184.47
35475	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel	Deleted 2017	$348.96	($348.96)

Table 4 continues on next page

Table 4: **Changes in Facility Physician Fee Schedule Reimbursement for Procedures of Interest (Continued)**

CPT Code	Procedural Description	2017 Medicare Facility Physician Fee Schedule	2016 Medicare Facility Physician Fee Schedule	Payment Difference
35476	Transluminal balloon angioplasty, percutaneous; venous	Deleted 2017	$281.97	($281.97)
36147	Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/ fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)	Deleted 2017	$194.19	($194.19)
36870	Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)	Deleted 2017	$312.06	($312.06)

NOTE: This is not an all-inclusive list of procedural code changes.

Disclaimer: The information provided herein reflects Cook's understanding of the procedure(s) and/or device(s) from sources that may include, but are not limited to, the CPT coding system; Medicare payment systems; commercially available coding guides; professional societies; and research conducted by independent coding and reimbursement consultants. This information should not be construed as authoritative. The entity billing Medicare and/or third party payers is solely responsible for the accuracy of the codes assigned to the services and items in the medical record. Cook does not, and should not, have access to medical records, and therefore cannot recommend codes for specific cases. When you are making coding decisions, we encourage you to seek input from the AMA, relevant medical societies, CMS, your local Medicare Administrative Contractor and other health plans to which you submit claims. Cook does not promote the off-label use of its devices.