

Transjugular Liver and Kidney Biopsy

2018 CODING AND REIMBURSEMENT GUIDE

Coverage, coding and payment for medical procedures and devices can be confusing. This guide was developed to assist you in correctly reporting and identifying Medicare reimbursement for transjugular liver and kidney biopsy. If you have any questions, please contact our reimbursement team at 800.468.1379 or by e-mail at Reimbursement@cookmedical.com.

Coverage

Medicare carriers may issue local coverage decisions (LCDs) listing criteria that must be met prior to coverage. Physicians are urged to review these policies (www.cms.hhs.gov/mcd/search.asp?) and encouraged to contact their local carrier medical directors (www.cms.hhs.gov/apps/contacts) or commercial insurers to determine if a procedure is covered.

Coding

Transcatheter Biopsy

37200	Transcatheter biopsy
75970	Transcatheter biopsy, radiological supervision and interpretation

Catheter Placement

36011	Selective catheter placement, venous system; first order branch (eg, renal vein, jugular vein)
-------	--

Venography

75831	Venography, renal, unilateral, selective, radiological supervision and interpretation
75889	Hepatic venography, wedged or free, with hemodynamic evaluation, radiological supervision and interpretation
75891	Hepatic venography, wedged or free, without hemodynamic evaluation, radiological supervision and interpretation

NOTE: Diagnostic venography performed at a separate setting from an interventional procedure is separately reported.¹

NOTE: Diagnostic venography performed at the time of an interventional procedure is NOT separately reportable if it is specifically included in the interventional code descriptor.¹

¹ American Medical Association. Veins and Lymphatics. In: CPT 2018 Professional Edition. Chicago, IL: American Medical Association; 2017: 463.



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.

Payment

2018 MEDICARE REIMBURSEMENT FOR TRANSJUGULAR LIVER AND KIDNEY BIOPSY

CPT* Code	Procedure Description	Ambulatory Surgery Center	Outpatient Facility	Physician Services		
		Facility Payment (National Medicare Avg) ²	APC	Facility Payment (National Medicare Avg) ³	Fee When Procedure Is Performed in Hospital or ASC (National Medicare Avg) ⁴	Fee When Procedure Is Performed in Office (National Medicare Avg) ⁴
Transcatheter Biopsy						
37200	Transcatheter biopsy	\$2,222.03	5184	\$4,264.67	\$227.16	N/A*
75970	Transcatheter biopsy, radiological supervision and interpretation	Imaging is included in the payment allowance for the biopsy		Items and services are packaged into the payment rate for the biopsy procedure	\$40.68	Carrier-Priced Procedure
Catheter Placement						
36011	Selective catheter placement, venous system; first order branch (eg, renal vein, jugular vein)	Catheter placement is included in the payment allowance for the biopsy		Items and services are packaged into the payment rate for the biopsy procedure	\$164.16	\$846.71
Venography						
75831	Venography, renal, unilateral, selective, radiological supervision and interpretation	Imaging is included in the payment allowance for the biopsy		Items and services are packaged into the payment rate for the biopsy procedure	\$56.52	\$142.92
75889	Hepatic venography, wedged or free, with hemodynamic evaluation, radiological supervision and interpretation	Imaging is included in the payment allowance for the biopsy		Items and services are packaged into the payment rate for the biopsy procedure	\$55.80	\$146.16
75891	Hepatic venography, wedged or free, without hemodynamic evaluation, radiological supervision and interpretation	Imaging is included in the payment allowance for the biopsy		Items and services are packaged into the payment rate for the biopsy procedure	\$56.52	\$147.24

² 2018 Medicare Ambulatory Surgery Center Fee Schedule

³ 2018 Medicare Hospital Outpatient Prospective Payment System Fee Schedule

⁴ 2018 Medicare Physician Fee Schedule

*Medicare has not developed a rate for the in-office setting because these procedures are typically performed in a hospital setting. Physicians should contact the Medicare contractor to determine if the service can be performed in office. If the contractor determines the service or procedure may be performed in office, the physician will receive Medicare's physician fee schedule amount for procedures performed in the hospital/ASC.

CPT © 2017 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

2018 physician fees for your local area can be found at the following CMS links:

<https://www.cms.gov/apps/physician-fee-schedule/overview.aspx>

or

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html>



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.