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.

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Payment

2018 MEDICARE REIMBURSEMENT FOR TRANSJUGULAR LIVER AND KIDNEY BIOPSY

		Ambulatory Surgery Center		*Outpatient Facility*	*Physician Services*	
CPT® Code	Procedure Description	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.

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

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