Transjugular Liver and Kidney Biopsy

2012 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.

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 (e.g., renal vein, jugular vein)

Venography *May be coded separately (if performed for diagnostic indications)*[1]

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

Inpatient Hospital

Hospitals use ICD-9-PCS codes to describe procedures performed during hospital admissions. The following are examples of procedure codes that may be pertinent for a given hospital admission.

Facilities coding for transjugular liver biopsy should consider:

50.13 Transjugular liver biopsy

Transvenous liver biopsy

Excludes: closed (percutaneous) [needle] biopsy of the liver

laparoscopic liver biopsy

Facilities coding for transjugular biopsy of kidney should consider:

55.23 Closed [percutaneous] [needle] biopsy of kidney

Endoscopic biopsy via existing nephrostomy, nephrotomy, pyelostomy, or pyelotomy

1. Zielske D, Broek R, Dunn D. *Dr. Z's Medical Coding Series: Interventional Radiology Coding Reference.* 9th ed. Nashville, TN: ZHealth Publishing; 2012.

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Payment

2012 MEDICARE REIMBURSEMENT FOR TRANSJUGULAR LIVER AND KIDNEY BIOPSY

		Ambulatory Surgery Center	*Outpatient Facility*		*Physician Services*	
CPT® Code	Procedure Description	ASC Facility Fee (National Medicare Avg)[2]	APC	Facility Fee Schedule (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	$1,225.19	0623	$2,123.47	$226.35	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	$41.19	Carrier-Priced Procedure
Catheter Placement						
36011	Selective catheter placement, venous system; first order branch (e.g., 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	$161.00	$921.06
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	$60.93	$190.27
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	$55.48	$184.82
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	$55.48	$185.16

2. 2012 Medicare Ambulatory Surgery Center Fee Schedule
3. 2012 Medicare Hospital Outpatient Prospective Payment System Fee Schedule
4. 2012 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.

2012 physician fees for your local area can be found at the following CMS links:

www.cms.hhs.gov/PFSlookup/

or

www.cms.hhs.gov/PhysicianFeeSched/PFSNPAF/

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