2020 Coding and Reimbursement Guide
Office Based Lab (OBL)
Effective July 1, 2020

This coding and reimbursement guide contains the CPT® and HCPCS codes to describe percutaneous creation of arteriovenous fistula (endoAVF) using the Ellipsys® Vascular Access System in the Hospital Outpatient setting. Information contained in this coding and reimbursement guide reflects Medicare payments, payment status indicators and billing guidelines at the time it was prepared. Non-Medicare payers may have different rules and guidelines for coding and reimbursement for the procedures discussed in this document. Non-Medicare payers may not update their systems to recognize new codes mid-year. For appropriate code selection, it is recommended that you contact your local payer prior to claims submittal. It is the responsibility of the provider to submit claims using appropriate codes with accurate information.

The following information describes the codes available to report percutaneous creation of an arteriovenous fistula for dialysis (endoAVF) using the Ellipsys Vascular Access System and associated procedures.

I. Commonly Used Pre-procedure Codes and Payment

The table below provides the CPT codes and 2020 Medicare national average payment amounts.

CPT® Code[1]	Description	Physician Non-Facility Payment[2]
93985	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study	Global $271.75 Professional Component $39.70 Technical Component $232.06
93986	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete unilateral study	Global $137.86**† Professional Component $25.62 Technical Component $112.24**†

II. Ellipsys Procedure Coding and Payment

OBLs may use HCPCS code G2170 to report the endoAVF procedure performed with the Ellipsys Vascular Access System. Some non-Medicare insurers may not recognize HCPCS G2170 and in those circumstances the unlisted procedure code 37799 may be reported.

The table below provides the procedure code and 2020 Medicare national average payment amounts.

HCPCS Code[3]	Description	Physician Non-Facility Payment[2]
Procedure Code(s)		
G2170	Percutaneous arteriovenous fistula creation (avf), direct, any site, by tissue approximation using thermal resistance energy, and secondary procedures to redirect blood flow (e.g., transluminal balloon angioplasty, coil embolization) when performed, and includes all imaging and radiologic guidance, supervision and interpretation, when performed	Carrier Priced*
37799	Unlisted procedure, vascular surgery	Carrier Priced*

III. Commonly Used Maintenance Codes and Payment

The table below provides the CPT codes and 2020 Medicare national average payment amounts.

CPT® Code[1]	Description	Physician Non-Facility Payment[2]
93990	Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)	Global $137.86**† Professional Component $25.62 Technical Component $112.24**†
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	$1,334.59
+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)	$2,050.61**
37607	Ligation or banding of angioaccess arteriovenous fistula	$391.93**

For questions regarding coding, coverage and payment, please contact the Ellipsys® Reimbursement Hotline at 888-ENDOAVF (363-6283) or by email at ellipsys@emersonconsultants.com

References:

[1] 2020 Current Procedural Terminology (CPT®) Professional Edition. CPT® is a registered trademark of the American Medical Association. 2019. All rights reserved.

[2] CMS-1715-F; Physician Fee Schedule final rule CY2020. Effective through December 31, 2020. Conversion Factor: $36.0896

[3] Healthcare Common Procedure Coding System (HCPCS) Level II Expert, 2020. Centers for Medicare and Medicaid Service

** Status Indicators –*

C: Carrier Priced.

† OPPS capped payment amount - Section 5102(b) of the Deficit Reduction Act of 2005 requires a payment cap on the technical component (TC) of certain diagnostic imaging procedures and the TC portions of the global diagnostic imaging services. This cap is based on the Outpatient Prospective Payment System (OPPS) payment. To implement this provision, the physician fee schedule amount is compared to the OPPS payment amount and the lower amount is used in the formula to calculate payment.

***This procedure is rarely or never performed in a non-facility setting.*

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Avenu Medical, Inc.
27123 Calle Arroyo, Suite 2101
San Juan Capistrano, CA 92675

Phone: 949-276-2483
info@avenumedical.com
www.avenumedical.com

The Ellipsys Vascular Access System is covered by Patents 8,951,276B2; 9,138,230B1; 9,439,710; 9,439,728; 9,445,868; 9,452,015; 9,474,562; 9,522,016; 9,649,157; 9,801,653. Additional Patents Pending. Ellipsys and EndoAVF are registered trademarks of Avenu Medical, Inc. ©Copyright 2020 Avenu Medical, Inc. All rights reserved.

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