Reimbursement and Coding
Hospital Facility-Based Continuous Renal Replacement Therapy (CRRT) Procedures

2022 National Average Medicare Payments

Inpatient Prospective Payment System Coding: Inpatient Hospital (Illustrative)

Background: The Medicare-Severity Diagnosis-Related Group (MS-DRG) is a diagnostic classification system used by the Centers for Medicare and Medicaid Services to pay for inpatient hospital services. Specific cases are classified into MS-DRGs based on the principal diagnosis, up to 24 additional diagnoses, and up to 25 procedures performed during the stay. In certain circumstances, additional factors may be associated with classification.

MS-DRG	Description	Relative Weight	Geometric Mean Length of Stay	*2022 Medicare Facility Payment
682	RENAL FAILURE WITH MCC	1.4727	4.3	$9,711.34
683	RENAL FAILURE WITH CC	0.8793	3.1	$5,798.32
684	RENAL FAILURE WITHOUT CC/MCC	0.6079	2.2	$4,008.64

Note: These payment amounts are not wage index adjusted, and do not include the indirect medical education adjustment, disproportionate share hospital adjustment, uncompensated care, adjustments for readmission, and other hospital value-based program consideration. These payment amounts are specific to prospective payment for cases and assumes no reduction for the post-acute transfer policy and no additional payments for high-cost outliers.

ICD-10 Diagnosis Coding: General (Illustrative)

Description	ICD-10-CM
Acute kidney failure with tubular necrosis (*MCC)	N17.0
Acute kidney failure with acute cortical necrosis (*MCC)	N17.1
Acute kidney failure with medullary necrosis (*MCC)	N17.2
Other acute kidney failure (*CC)	N17.8
Acute kidney failure, unspecified (*CC)	N17.9
Chronic obstructive pyelonephritis (*CC)	N11.1
Hydronephrosis with ureteral stricture, not elsewhere classified (*CC)	N13.1
Crossing vessel and stricture of ureter without hydronephrosis	N13.5

*Note: MCCs and CCs apply when listed as a secondary diagnosis.

ICD-10 Procedure Coding: General (Illustrative)

Description	ICD-10-PCS
Performance of Urinary Filtration, Intermittent, Less than 6 Hours Per Day	5A1D70Z
Performance of Urinary Filtration, Prolonged Intermittent, 6-18 hours Per Day	5A1D80Z
Performance of Urinary Filtration, Continuous, Greater than 18 hours Per Day	5A1D90Z

Physician Fee Schedule Coding: Physician Services (Illustrative)

Background: The CPT code set is a system used to classify physician procedures and services. RVUs are the mechanism that assigns payment valuations to CPT codes based on consumption of time, effort, and financial cost involved in providing a service to patients. RVUs are converted to dollar amounts using a nationally established 'Conversion Factor'. Many procedure codes, such as those used to report diagnostic tests, may be billed as either a professional or technical component to reflect different aspects of the service. The professional component relates to the physician work (e.g., physician time, intensity, supervision, interpretation, and documentation by the physician or other health care professional) and some associated overhead costs. The technical component reflects the direct costs incurred by the billing provider to perform the service (e.g., acquisition and provisioning of equipment, supplies, and clinical personnel) The professional component is reported with a modifier "26" and the technical component is billed with a "TC" modifier.

When the same provider performs both aspects of the service, no modifier is necessary and total payment for both aspects of the service is made.

CPT Code – Vascular Access	Modifier	Description	Facility RVUs	Payment to the MD/DO in the Facility Setting
36556	--	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	2.47	$85.48
36800	--	Insertion of cannula for hemodialysis, other purpose (separate procedure); vein to vein	3.57	$123.54
*37799	--	Unlisted procedure, vascular surgery	Carrier Valuated	Carrier Priced

*Note: As an unlisted code, 37799 would go through manual review and payment would be determined by Medicare Administrative Contractors

CPT Code – Guidance Imaging for Vascular Access	Modifier	Description	Facility RVUs	Payment to the MD/DO in the Facility Setting
76937	26	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real time ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)	0.40	$13.84
77001	26	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)	0.54	$18.69

Note: 76937 and 77001 are add-on codes and must be billed with primary procedure code 36800

CPT Code - CRRT	Modifier	Description	Facility RVUs	Payment to the MD/DO in the Facility Setting
90945	--	Dialysis procedure other than hemodialysis (e.g., peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single physician evaluation or other qualified health care professional	2.51	$86.86
90947	--	Dialysis procedure other than hemodialysis (e.g., peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated physician or other qualified health care professional, with or without substantial revision of dialysis prescription	3.63	$125.62
*90999	--	Unlisted dialysis procedure, inpatient or outpatient	Carrier Valuated	Carrier Priced

*Note: As an unlisted code, 90999 would go through manual review and payment would be determined by Medicare Administrative Contractors

Product Codes

Product Codes	Description
24571-102-06	PRISMASOL BGK2/0 SOLUTION
24571-103-06	PRISMASOL BGK2/3.5 SOLUTION
24571-105-06	PRISMASOL BGK4/2.5 SOLUTION
24571-104-05	PRISMASOL BGK4/3.5 SOLUTION
24571-108-06	PRISMASOL BGK0/2.5 SOLUTION
24571-111-06	PRISMASOL B22GK4/0 SOLUTION
24571-113-06	PRISMASOL BK0/0/1.2 SOLUTION
24571-114-06	PRISMASOL BK4/0/1.2 SOLUTION

24571-116-05	PHOXILLUM BK4/2.5 SOLUTION
24571-117-05	PHOXILLUM B22K4/0 SOLUTION

Disclaimer: This is a selection of codes that may describe diagnoses related to continuous renal replacement therapy procedures. This has been prepared and is intended for informational purposes only. Coding constantly changes so please reference the American Medical Association, the American Hospital Association, the Centers for Medicare and Medicaid Services and your local contractors for additional information. This is not a comprehensive list of codes and is not intended to increase or maximize reimbursement. It does not represent a guarantee, promise or statement that the use of the codes will ensure coverage, reimbursement, payment or charges at any particular level. The decision as to how to complete a claim form, including the amounts to bill, is exclusively the responsibility of the provider. Healthcare professionals and hospitals should confirm with a particular payor or coding authority, such as the American Medical Association or medical specialty society, which codes or combinations of codes are appropriate for a particular procedure or combination procedures.

Notes: Physician payment amounts reflect national Medicare fee-for-service rates in Calendar Year (CY) 2022 as per the CMS published RVU file version A. Medicare reimburses 80% of the listed payment rates for physician services. The remaining 20% is covered by supplemental insurance or paid out-of-pocket by patients. ICD-10 procedure codes are only used for inpatient services and impact inpatient (hospital) reimbursement. Payment information represents Medicare national payment rates. Providers can determine the Medicare payment of their geographical area here https://apps.ama-assn.org/CptSearch/user/search/cptSearch.do.

Definitions: MCC = Major Complications or Comorbidities; CC = Complications or Comorbidities; ICD-10 = International Classification of Diseases, Tenth Revision; CPT = Current Procedural Terminology; RVU = Relative Value Unit

Sources: American Medical Association. 2022 Current Procedural Terminology (CPT) Professional Edition; American Medical Association. ICD-10-CM 2022: The Complete Official Code Book.; CMS. Calendar Year (CY) 2022 Inpatient Prospective Payment Systems (IPPS) Final Rule; CMS. CY 2022 Medicare Physician Fee Schedule (PFS) Final Rule