2020 PERITONEAL DIALYSIS CATHETERS
CODING AND REIMBURSEMENT GUIDE

Contents

Medtronic

Overview of Peritoneal Dialysis

Since 1983, Medicare has paid dialysis facilities a predetermined, bundled rate intended to cover a specific bundle of services provided to patients in a given dialysis treatment. However, procedures involving peritoneal dialysis catheters are separately payable outside the outpatient dialysis services bundle.

Medtronic Argyle™* catheters are used for peritoneal dialysis in patients with renal failure[1]. In a surgical procedure performed in a hospital or ambulatory surgery center, the inner tip of the catheter is inserted within the patient's peritoneal cavity. A portion of the catheter is then tunneled subcutaneously along the patient's abdominal wall and the other end of the catheter exits through the skin. The catheter can then be connected externally to dialysate fluid which is introduced into the abdomen and later flushed out. The peritoneum itself acts as a filtration membrane, removing waste products that the kidneys can no longer filter out.

Once the peritoneal dialysis catheter is placed, an extension may be needed to supplement the subcutaneously tunneled portion of the catheter. Typically, the external exit site is created during the same procedure as the catheter insertion. Alternately, the peritoneal catheter may be "buried" within the abdominal wall when initially implanted to avoid potential peritoneal infection. After healing, the external exit site is then created during a separate procedure, referred to as externalization or exteriorization.

Physician Reimbursement for Peritoneal Dialysis Catheters

CPT® codes are used by physicians for all sites of service. Under Medicare's Resource-Based Relative Value Scale (RBRVS) methodology for physician payment, each code is assigned a point value, the relative value unit (RVU), which is then converted to a flat payment amount.

These amounts will vary based on the physician's specific Medicare locality. Reimbursement is also subject to the following payment rules:

Global Days

During a global period, services related to the initial dialysis catheter procedure are not separately payable, as follows:

- 0 day global: related services same day as the procedure are not separately paid; services on following days are paid separately
- 10 day global: related services on the same day and for 10 days after are not separately paid

Multiple Procedure Discounting

When two or more procedures are performed during the same encounter, the highest-valued code pays at 100% and other codes pay at 50% of the rate. Discounting applies to codes marked "Y". Codes marked "N" always pay at 100%.

Non-Facility and Facility Payment

Codes have different payments depending on the setting in which the procedure was performed.

- Non-facility refers to physician payment when procedures are performed in the office setting. For a code marked "NA", no payment has been developed because the procedure is rarely or never performed in the office.
- Facility refers to physician payment when procedures are performed in a hospital or an ambulatory surgical center (ASC). Generally, Non-facility payments are higher since the physician incurs all costs in the office whereas the hospital or ASC incurs costs in the Facility.

Generally, non-facility payments are higher since the physician incurs all costs in the office, whereas the hospital or ASC incurs costs in the facility setting.

Medicare National Average Payments for Physicians[2]

Catheter Insertion Procedure

Different CPT codes are assigned depending on the approach used: laparoscopic, percutaneous, or open.

				NON-FACILITY	FACILITY
PROCEDURE	CODE AND DESCRIPTION	GLOBAL DAYS	MULT PROC DISCOUNTING	CY2020 PAYMENT	CY2020 PAYMENT
Catheter Insertion	**49324,** Laparoscopy, surgical, with insertion of tunneled intraperitoneal catheter	10	Y	NA	$409
	49418, Insertion of tunneled intraperitoneal catheter (e.g., dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous	0	Y	$1,231	$212
	49421, Insertion of tunneled intraperitoneal catheter for dialysis, open	0	Y	NA	$240

Placement of Subcutaneous Extension

A separate CPT code is assigned if an extension is also placed to supplement the subcutaneously tunneled portion of the catheter. As an add-on code (+), this code cannot be assigned by itself but must always be assigned with either 49324 or 49421.

				NON-FACILITY	FACILITY
PROCEDURE	CODE AND DESCRIPTION	GLOBAL DAYS	MULT PROC DISCOUNTING	CY2020 PAYMENT	CY2020 PAYMENT
Insertion of Subcutaneous Extension	**+ 49435,** Insertion of subcutaneous extension to intraperitoneal cannula or catheter with remote chest exit site	NA	N	NA	$126

Omentopexy

A separate CPT code is assigned when omentopexy is performed with laparoscopic peritoneal catheter insertion to prevent omental entrapment of the peritoneal catheter. As an add-on code (+), this code cannot be assigned by itself but must always be assigned with 49324.

				NON-FACILITY	FACILITY
PROCEDURE	CODE AND DESCRIPTION	GLOBAL DAYS	MULT PROC DISCOUNTING	CY2020 PAYMENT	CY2020 PAYMENT
Omentopexy	**+49326,** Laparoscopy, surgical, with omentopexy (omental tacking procedure)	NA	N	NA	$199

Creation of Exit Site (Externalization, Exteriorization)

When the external exit site for the catheter is created during the same procedure as the catheter insertion, no separate code is assigned. However, when the external exit site for the catheter is created during a separate encounter, the code below is assigned. [3]

				NON-FACILITY	FACILITY
PROCEDURE	CODE AND DESCRIPTION	GLOBAL DAYS	MULT PROC DISCOUNTING	CY2020 PAYMENT	CY2020 PAYMENT
Creation of Exit Site	**49436**, Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter	10	Y	NA	$195

Replacement of Catheter

Replacement of a peritoneal catheter uses the same code as insertion of a peritoneal catheter, to capture placement of the new catheter.

In accordance with National Correct Coding Initiative (NCCI) edits, removal of the old peritoneal catheter is not coded separately when the catheter is replaced at the same anatomic site. When the old catheter is surgically removed at the original site and a new catheter is placed at a different site, removal can be coded separately using modifier -59 as needed to indicate a different anatomic site.

Removal of Catheter

The peritoneal dialysis catheter may be removed during a replacement or when the patient no longer requires peritoneal dialysis, for example if the patient switches to hemodialysis or undergoes a kidney transplant. There is no procedure code for removal of a non-tunneled central venous catheter, eg, removal by pull after the sutures are removed. An E/M office visit code can be billed as appropriate for the visit during which the removal took place. Removal of tunneled catheters, however, requires surgical dissection to release the catheter.

				NON-FACILITY	FACILITY
PROCEDURE	CODE AND DESCRIPTION	GLOBAL DAYS	MULT PROC DISCOUNTING	CY2020 PAYMENT	CY2020 PAYMENT
Catheter Removal	No code for removal of non-tunneled catheter	payable under E/M code for visit, as applicable			
	49422, Removal of tunneled intraperitoneal catheter	0	Y	NA	$233

Revision or Repositioning of Catheter

Laparoscopic

If the peritoneal catheter is not functioning properly because it has migrated out of position or is obstructed, this can be corrected by laparoscopy. A separate CPT code is assigned when omentopexy is also necessary to relieve omental entrapment of the peritoneal catheter. As an add-on code (+), this code cannot be assigned by itself but must always be assigned with 49325.

				NON-FACILITY	FACILITY
PROCEDURE	CODE AND DESCRIPTION	GLOBAL DAYS	MULT PROC DISCOUNTING	CY2020 PAYMENT	CY2020 PAYMENT
Catheter Revision, Laparoscopic	**49325,** Laparoscopy, surgical, with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed	10	Y	NA	$437
	+49326, Laparoscopy, surgical, with omentopexy (omental tacking procedure)	NA	N	NA	$199

Open or Percutaneous

There is no specific CPT code for open or percutaneous manipulation of a peritoneal catheter into a new position. An unlisted, i.e., miscellaneous, code must be reported.

				NON-FACILITY	FACILITY
PROCEDURE	CODE AND DESCRIPTION	GLOBAL DAYS	MULT PROC DISCOUNTING	CY2020 PAYMENT	CY2020 PAYMENT
Catheter Revision, Other	**49999,** Unlisted procedure, abdomen, peritoneum and omentum	NA	Y	contractor-priced	contractor-priced

Unlisted codes do not have set valuation under Medicare. Instead, all are designated as "contractor-priced". Submission of an unlisted code generally requires the physician to provide a copy of the procedure report as well as suggest a comparable reference code. The payer must then manually review the submission to determine the payment amount on a case-by-case basis.

Catheter Evaluation

When a catheter is not functioning properly, it may be injected with contrast and imaged to identify any obstruction or malposition. Codes 49400 and 74190 are used together for injection of contrast material into the peritoneal cavity through the dialysis catheter with evaluation of the images obtained.

				NON-FACILITY	FACILITY
PROCEDURE	**CODE AND DESCRIPTION**	**GLOBAL DAYS**	**MULT PROC DISCOUNTING**	**CY2020 PAYMENT**	**CY2020 PAYMENT**
Catheter Evaluation	**49400,** Injection of air or contrast into peritoneal cavity	0	Y	$97	$150
	74190, Peritoneogram (e.g., after injection of air or contrast), radiological supervision and interpretation	NA	N	contractor-priced	-
	74190-26, Peritoneogram (e.g., after injection of air or contrast), radiological supervision and interpretation, professional component	NA	N	-	$24
Note: In the office, if the physician owns the equipment, radiology codes are billed without modifiers and the physician receives payment for both technical and professional components. However, for code 74190, this is contractor priced. In the facility, the hospital or ASC owns the equipment and the physician bills with modifier -26 to receive payment for the professional component only. Code 74190-26 has a set valuation in the facility setting.					

HCPCS Device Codes

For procedures performed in the office where the physician incurs the cost of the catheter, the physician can bill the HCPCS code for the catheter in addition to the CPT code for the procedure of placing it. However, many payers include payment for the device in the payment for the CPT procedure code and do not pay separately for the catheter itself.

PROCEDURE	CODE AND DESCRIPTION	ADDITIONAL INFORMATION
A4300	Implantable access catheter (e.g., venous, arterial, epidural subarachnoid, or peritoneal, etc.), external access	Can be used for all dialysis catheters.

Hospital Outpatient Reimbursement for Peritoneal Dialysis Catheters

CPT codes are used by hospitals for outpatient procedures. Under Medicare's methodology for hospital outpatient payment, each procedural CPT code is assigned to a specific Ambulatory Payment Classification (APC) with a flat payment rate. Depending on the procedures performed, multiple APCs can be assigned for each case.

Multiple APCs can sometimes be assigned for each encounter, unless at least one of the CPT procedure codes billed maps to a Comprehensive APC (C-APC). C-APCs are identified by status indicator J1. As shown on the tables below, most CPT codes for peritoneal dialysis catheters map to C-APCs.

Each CPT procedure code assigned to a C-APC is considered a primary service, and all other procedures coded on the bill are considered adjunctive. This results in a single APC payment for the entire outpatient encounter, based solely on the primary service. Separate payment is not made for any of the other adjunctive procedures. Instead, the payment level for the C-APC is calculated to include the costs of the other adjunctive procedures.

Medicare Average Payments for Hospital Outpatient[3]

PROCEDURE	CODE AND DESCRIPTION	STATUS INDICATOR[4]	APC	CY2020 PAYMENT
Catheter Insertion	**49324,** Laparoscopy, surgical, with insertion of tunneled intraperitoneal catheter	J1	5361	$4,833
	49418, Insertion of tunneled intraperitoneal catheter (e.g., dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous	J1	5341	$3,109
	49421, Insertion of tunneled intraperitoneal catheter for dialysis, open	J1	5341	$3,109
Insertion of Subcutaneous Extension	**+ 49435,** Insertion of subcutaneous extension to intraperitoneal cannula or catheter with remote chest exit site (use with 49324 or 43421)	N	-	-
Creation of Exit Site, (Externalization, Exteriorization)	**49436,** Delayed creation of exist site from embedded subcutaneous segment of intraperitoneal cannula or catheter	J1	5302	$1,557
Replacement of Catheter	Replacement of a peritoneal catheter uses the same code as insertion of a peritoneal catheter, to capture placement of the new catheter. In accordance with NCCI edits, removal of the old peritoneal catheter is not coded separately when the catheter is replaced at the same anatomic site. When the old catheter is surgically removed at the original site and a new catheter is placed at a different site, removal can be coded separately using modifier -59 as needed to indicate a different anatomic site. However, because all insertion codes are status J1, payment is made for catheter insertion only without separate payment for catheter removal.			
Catheter Removal	No code for removal of non-tunneled catheter	Payable under E/M code for clinic visit, as applicable		
	49422, Removal of tunneled intraperitoneal catheter	Q2	5183	$2,771
Catheter Revision, Laparoscopic	**49325,** Laparoscopy, surgical, with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed	J1	5361	$4,833
Omentopexy	**+49326,** Laparoscopy, surgical, with omentopexy (omental tacking procedure) (use with 49324 or 49325)	N	-	-
Catheter Revision, Other[5]	**49999,** Unlisted procedure, abdomen, peritoneum and omentum	T	5301	$786
Catheter Evaluation[5]	**49400,** Injection of air or contrast into peritoneal cavity	N	-	-
	74190, Peritoneogram (e.g., after injection of air or contrast), radiologic supervision and interpretation	Q2	5524	$482

HCPCS Device Codes

In addition to the CPT code for the procedure, hospitals may report the Healthcare Common Procedure Coding System (HCPCS) code for the catheter, as well as guidewires and introducer sheaths.

Medicare Billing

For Medicare, C-codes should be used. The payment for the catheter and other items, are included in the payment for the procedure code, therefore the C-codes are not paid separately.

HCPCS	CODE DESCRIPTION
C1750	Catheter, hemodialysis/peritoneal, long-term
C1769	Guidewire
C1894	Introducer sheath

Non-Medicare Billing

Some non-Medicare payers accept C-codes but more commonly, hospitals submit the regular HCPCS code. Although many payers include payment for the device in the payment for the CPT procedure code and do not pay separately for the catheter itself, some payers may do so.

HCPCS	CODE DESCRIPTION
A4300	Implantable access catheter (e.g., venous, arterial, epidural subarachnoid, or peritoneal, etc.), external access

Ambulatory Surgery Center Reimbursement for Peritoneal Dialysis Catheters

CPT codes are used by ASCs for outpatient procedures. Medicare payment for procedures performed in an ambulatory surgery center is adapted from hospital outpatient APCs and physician office payments. Medicare only pays for surgical procedures performed in the ASC. Some ancillary services, such as imaging, are also covered when they are integral to covered surgical procedures, but they are usually not separately paid. Generally, there is no separate payment for devices because their payment is included in the payment for the procedure.

PROCEDURE	CODE AND DESCRIPTION	PAYMENT INDICATOR[4]	MULT PROC DISCOUNTING	CY2020 PAYMENT
Catheter Insertion	**49324,** Laparoscopy, surgical, with insertion of tunneled intraperitoneal catheter	G2	Y	$2,194
	49418, Insertion of tunneled intraperitoneal catheter (e.g., dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous	G2	Y	$1,377
	49421, Insertion of tunneled intraperitoneal catheter for dialysis, open	G2	Y	$1,377
Insertion of Subcutaneous Extension	**+ 49435,** Insertion of subcutaneous extension to intraperitoneal cannula or catheter with remote chest exit site (use with 49324 or 43421)	N1	-	-
Creation of Exit Site (Externalization, Exteriorization)	**49436,** Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter	G2	Y	$663
Replacement of Catheter	Replacement of a peritoneal catheter uses the same code as insertion of a peritoneal catheter, to capture placement of the new catheter. In accordance with NCCI edits, removal of the old peritoneal catheter is not coded separately when the catheter is replaced at the same anatomic site. However, when the old catheter is surgically removed at the original site and a new catheter is placed at a different site, removal can be coded separately using modifier -59 as needed to indicate a different anatomic site. In the ASC, payment is made for catheter insertion plus, as appropriate, catheter removal.			
Catheter Removal	No code for removal of non-tunneled catheters	Not payable in the ASC		
	49436, Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter	G2	Y	$663
	Note: Because ASCs do not have clinics for non-surgical services, removal of non-tunneled catheters is not recognized in ASCs.			
Catheter Revision, Laparoscopic	**49325**, Laparoscopy, surgical, with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed	G2	Y	$2,194
	Note: Open and percutaneous approaches to catheter revision must use unlisted code 49999. Medicare policy does not permit procedures using unlisted codes to be performed in ASCs.			
Omentopexy	**+49326,** Laparoscopy, surgical, with omentopexy (omental tacking procedure), (use with 49324 or 49325)	N1	-	-

Medicare Average Payments for ASC[3]

ASCs may only perform radiologic services when they are associated with a primary procedure performed at the same time. As a stand-alone procedure, catheter evaluation is considered a primary radiology service and is not payable to ASCs by Medicare.

HCPCS Codes

Medicare specifically instructs ASCs not to bill HCPCS codes for devices that are packaged into the payment for the CPT code, as is the case for peritoneal dialysis catheters.

Hospital Inpatient Reimbursement for Peritoneal Catheters

Under Medicare's Diagnosis-Related Groups (DRG) system for hospital inpatient payment, each inpatient stay is assigned to one of about 750 surgical or medical DRGs. The DRG assignment for any given case is based on the ICD-10-CM codes assigned to the diagnoses and ICD-10-PCS codes assigned to the procedures.

ICD-10-PCS Procedure Codes

Hospitals use ICD-10-PCS procedure codes for inpatient procedures. Procedures with peritoneal dialysis catheters are typically performed in the outpatient setting. However, some patients may require an inpatient stay in which procedures are performed involving peritoneal dialysis catheters.

PROCEDURE	ICD-10-PCS PROCEDURE CODE	CODE DESCRIPTION
Catheter Insertion	0WHG03Z	Insertion of infusion device into peritoneal cavity, open approach
	0WHG33Z	Insertion of infusion device into peritoneal cavity, percutaneous approach
	0WHG43Z	Insertion of infusion device into peritoneal cavity, percutaneous endoscopic approach
Insertion of Subcutaneous Extension	0JHT33Z	Insertion of infusion device into trunk subcutaneous tissue and fascia, percutaneous approach
Creation of Exit Site (Externalization, Exteriorization)	0JWT33Z	Revision of infusion device in trunk subcutaneous tissue and fascia, percutaneous approach
Replacement of Catheter	Replacing the catheter, e.g., removing the existing left-sided catheter and placing a new right-sided catheter, requires two codes: one for catheter insertion (as shown above) and one for catheter removal (as shown below).	
Catheter Removal	0WPG03Z	Removal of infusion device from peritoneal cavity, open approach
	0WPG33Z	Removal of infusion device from peritoneal cavity, percutaneous approach
	0WPG43Z	Removal of infusion device from peritoneal cavity, percutaneous endoscopic approach
	0WPGX3Z	Removal of infusion device from peritoneal cavity, external approach
	Note: Code 0WPGX3Z, defined for external approach, is assigned for removal of the peritoneal dialysis catheter by pull.	
Catheter Revision or Repositioning	0WWG03Z	Revision of infusion device in peritoneal cavity, open approach
	0WWG33Z	Revision of infusion device in peritoneal cavity, percutaneous approach
	0WWG43Z	Revision of infusion device in peritoneal cavity, percutaneous endoscopic approach
	Note: These codes refer to procedures involving the portion of the peritoneal dialysis catheter that is within the peritoneal cavity, not any subcutaneous components.	

Medicare Average Payments for Hospital Inpatient[6]

The DRGs shown are those typically assigned to the following scenarios. Many DRGs below are tiered as W MCC, W CC, WO CC/MCC. MCCs are major complications/comorbidities. CCs are other complications/comorbidites. Assignment to a DRG W MCC or W CC occurs if any of the secondary diagnoses assigned to the patient are designated as MCCs or CCs, according to fixed DRG logic. If non of the secondary diagnosis codes for the case are designated as an MCC or a CC, a DRG WO CC/MCC is assigned.

Common ICD-10-CM diagnosis codes are listed at the end of this Guide.

	DRG	DRG TITLE	FY 2020 PAYMENT
	CATHETER INSERTION OR REPLACEMENT		
Catheter Insertion, Open or Laparoscopic Catheter Insertion, Percutaneous	Principal diagnosis: N18.6, E10.22, E11.2, I12.0, I13.11		
	673	Other Kidney and Urinary Tract Procedures W MCC	$22,373
	674	Other Kidney and Urinary Tract Procedures W CC	$15,298
	675	Other Kidney and Urinary Tract Procedures WO CC/MCC	$10,215
	Principal diagnosis: I13.2		
	981	Extensive OR Procedure Unrelated to Principal Diagnosis W MCC	$28,107
	982	Extensive OR Procedure Unrelated to Principal Diagnosis W CC	$15,260
	983	Extensive OR Procedure Unrelated to Principal Diagnosis WO CC/MCC	$10,247
	DRG logic currently designates principal diagnosis code I13.2 in a different body system from the catheter insertion procedure codes. This results in the assignment of the mismatch DRGs 981, 982, and 983. The DRGs are valid and payable.		
Catheter Insertion, Percutaneous	The percutaneous insertion code is not considered a "significant procedure" for the purpose of DRG assignment. A non-surgical (i.e., medical) DRG is assigned to the stay according to the principal diagnosis.		
Insertion of Subcutaneous Extension	The code for insertion of a subcutaneous extension is not considered a "significant procedure" for the purpose of DRG assignment. A non-surgical (i.e., medical) DRG is assigned to the stay according to the principal diagnosis.		
Creation of Exit Site (Externalization, Exteriorization)	The code for creation of exit site (externalization, exteriorization) is not considered a "significant procedure" for the purpose of DRG assignment. A non-surgical (i.e., medical) DRG is assigned to the stay according to the principal diagnosis.		
Catheter Removal, Open or Laparoscopic	Principal diagnosis: T85.6-1A, T85.71XA, T85.8-XA		
	907	Other OR Procedures for Injuries W MCC	$24,971
	908	Other OR Procedures for Injuries W CC	$12,913
	909	Other OR Procedures for Injuries WO CC/MCC	$8, 254
	Note: Removal of the peritoneal dialysis catheter by pull is not considered a "significant procedure" for the purpose of DRG assignment. A non-surgical (i.e., medical) DRG is assigned to the stay according to the principal diagnosis when removal by pull is the only procedure performed.		
Catheter Replacement (Insertion plus Removal), Open or Laparoscopic	Principal Diagnosis: T85.6-1A, T85.71XA, T85.8-XA		
	907	Other OR Procedures for Injuries W MCC	$24,971
	908	Other OR Procedures for Injuries W CC	$12,913
	909	Other OR Procedures for Injuries WO CC/MCC	$8,254
Catheter Revision and Replacement	Principal Diagnosis: T85.6-1A, T85.71XA, T85.8-XA		
	907	Other OR Procedures for Injuries W MCC	$24,971
	908	Other OR Procedures for Injuries W CC	$12,913
	909	Other OR Procedures for Injuries WO CC/MCC	$8,254

Common Diagnosis Codes for Peritoneal Dialysis Catheters

Peritoneal dialysis catheters are used to treat chronic renal failure, also referred to as chronic kidney disease (CKD) with end stage renal disease (ESRD). ESRD is frequently due to hypertension or diabetes, and the diagnosis code assignments reflect this.

ICD-9-CM DX CODE	CODE DESCRIPTION	COMMENT
END STAGE RENAL DISEASE		
N18.6	End stage renal disease	Includes Stage V chronic kidney disease that requires dialysis.
NOTE: This diagnosis is designated as an MCC but there are exceptions: ▪ N18.6 does not count as an MCC when sequenced as the principal diagnosis ▪ N18.6 does not count as an MCC when assigned as a secondary diagnosis with the principal diagnosis codes below for diabetes. Otherwise, code N18.6 for ESRD does count as an MCC and a DRG W MCC will be assigned when code N18.6 is used as a secondary diagnosis.		
END STAGE RENAL DISEASE DUE TO OR WITH DIABETES		
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease	The diabetes code is sequenced first, followed by N18.6
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease	
END STAGE RENAL DISEASE DUE TO OR WITH HYPERTENSION		
I12.0	Hypertensive CKD with stage 5 chronic kidney disease or ESRD	The hypertension code is sequenced first, followed by N18.6.
END STAGE RENAL DISEASE DUE TO OR WITH HYPERTENSION WITH HEART DISEASE		
I13.11	Hypertensive heart and CKD without heart failure, with stage 5 chronic kidney disease, or ESRD	The hypertension code is sequenced first, followed by N18.6.
I13.2	Hypertensive heart and CKD with heart failure and with stage 5 chronic kidney disease, or ESRD	
COMPLICATIONS OF PERITONEAL DIALYSIS CATHETERS		
When complications arise, peritoneal dialysis catheters may be replaced, removed, or revised. There are specific codes for catheter complications. The underlying ESRD is coded as well.		
T85.611A	Breakdown (mechanical) of intraperitoneal dialysis catheter	
T85.621A	Displacement of intraperitoneal dialysis catheter	
T85.631A	Leakage of intraperitoneal dialysis catheter	
T85.691A	Other mechanical complication of intraperitoneal dialysis catheter	
T85.71XA	Infection and inflammatory reaction due to peritoneal dialysis catheter[17]	
T85.818A	Embolism due to internal prosthetic devices, implants and grafts, not elsewhere classified	
T85.828A	Fibrosis due to internal prosthetic devices, implants and grafts, not elsewhere classified	
T85.838A	Hemorrhage due to internal prosthetic devices, implants and grafts, not elsewhere classified	
T85.848A	Pain due to internal prosthetic devices, implants and grafts, not elsewhere classified	
T85.858A	Stenosis due to internal prosthetic devices, implants and grafts, not elsewhere classified	
T85.868A	Thrombosis due to internal prosthetic devices, implants and grafts, not elsewhere classified	
T85.898A	Other specified complication of internal prosthetic devices, implants and grafts, not elsewhere classified	

1. Renal failure can also be treated with hemodialysis, which is addressed in a separate guide.

2. Centers for Medicare & Medicaid Services. Medicare Program; Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2020; Federal Register (84 Fed. Reg. No. 221 (62568-63563) https://www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other Published November 15, 2019. Final payment to the physician is adjusted by the Geographic Practice Cost Indices (GPCI). Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the payment amount shown

3. Centers for Medicare & Medicaid Services. Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs. Final Rule, Federal Register (83 Fed. Reg. No. 225 58818-59179) https://www.govinfo.gov/content/pkg/FR-2019-11-12/pdf/2019-24138.pdf. Published November 12, 2019. Correction Notice 85 Fed Reg 224-230. https://www.govinfo.gov/content/pkg/FR-2020-01-03/pdf/2019-28364.pdf . Published January 3, 2020.

4. Status Indicator (SI) shows how a code is handled for payment purposes. J1 = paid under a comprehensive APC, single payment based on primary service without separate payment for other adjunctive services; T - paid at 50% of the rate when submitted with a higher-valued T procedure; N - no separate payment made because procedure is packaged with another primary procedure; Q2 - not separately payable when submitted with a status T procedure.

5. The Payment Indicator shows how a code is handled for payment purposes. A2 = surgical procedure, payment based on hospital outpatient rate adjusted for ASC; G2 = non office-based surgical procedure, payment based on hospital outpatient rate adjusted for ASC; N1 = packaged service, no separate payment

6. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Policy Changes and FY2020 Rates Final Rule 84 Fed. Reg. 42044-42701. https://www.govinfo.gov/content/pkg/FR-2019-08-16/pdf/2019-16762.pdf . Published August 16, 2019. Correction Notice 84 Fed. Reg. 53603-53630 https://www.govinfo.gov/content/pkg/FR-2019-10-08/pdf/2019-21865.pdf . Published October 8, 2019.

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