Vascular Access Procedures

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When a blood sample is obtained and sent for laboratory testing, the procedure is essentially the same, regardless of the technique used to obtain the specimen. However, code assignment and reimbursement vary depending on the access technique, bundling guidelines, and/or packaging rules for the blood draw service.

Venipuncture

During venipuncture, a nurse, phlebotomist, technician, medical assistant, or other healthcare specialist punctures the patient's vein and obtains a blood sample for analysis. In general, a 5 ml to 25 ml sample of blood is adequate, depending on what blood tests have been requested. This procedure is reported with code **36415:** collection of venous blood by venipuncture.

Procedure code 36415 is located in the surgical section of the *CPT® Manual*, and documentation should include the date blood was drawn, the site accessed, the condition of the access site, name and discipline of the individual who obtained the sample, and any patient complaints or concerns (e.g., pain, erythema, inflammation). Note, procedure code 36415 is *not* bundled or packaged into drug administration on the same service date.

Port or PICC Access

In some cases, a separate venous access is not required to obtain the blood sample. For patients with an existing implanted port or peripherally inserted central catheter (PICC), these specimens can be obtained directly from the vascular access device. Depending on the type of port or catheter, this service may be reported using one of two codes:

- **36591:** Collection of blood specimen from a completely implantable venous access device.
- **36592:** Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified.

The type of existing catheter differentiates these specimen collection codes. Code 36591 is collection from an implanted port, and code 36592 is collection from a peripherally-inserted line. Guidelines published by the American Medical Association (AMA) in the *CPT® Manual* state that these codes are *not* separately reported when any other service is performed on the same date. As a result, the only time these port/PICC draw codes will be paid is when they are the sole procedure performed for the patient on a particular service date.

ILLUSTRATION/FOTOLIA

Hospitals billing under the Outpatient Prospective Payment System (OPPS) will continue to report "packaged" services, including both of these specimen collection codes. While code 36592 will never be separately paid in the hospital outpatient department, code 36591 is a "special packaged" code and will be reimbursed when it is the only service performed for the patient that day.

Port Flush

Patients who receive drug administration through an implanted port may require maintenance procedures, such as 'flushing' of the port, between drug administration cycles. The capture of this charge and reporting of this code may be an area of confusion for hospitals and physician practices. The code for the port flush service is **96523:** irrigation of implanted venous access device for drug delivery systems.

This code was established for reporting irrigation required for implanted venous access devices for drug delivery systems when these services are provided on a separate day from the injection or infusion services. A notation in the *CPT® Manual* states that code 96523 is *not* charged if any other services are provided to the patient on the same service date.

While this service will never be separately paid in the hospital outpatient department, code 96523 is another "special packaged" code that will be reimbursed when it is the sole service performed for the patient that day. For all sites of service, flushing of a

vascular access port prior to or after drug administration is considered to be part of the administration service and not separately charged.

HCPCS code **J1642:** injection, heparin sodium, (heparin lock flush), per 10 units, may also be assigned for the heparin used to perform the port flush. Individual payer guidelines will determine whether there is separate reimbursement for the heparin; it is often considered to be a supply charge rather than a drug charge.

Port Declot

When a patient has a port in place for an extended period of time, the port or catheter may become obstructed. Catheter obstruction is typically defined as the inability to infuse fluid, sluggish flow, and/or the inability to withdraw blood samples. In this situation, providers may need to declot the implanted vascular device using a thrombolytic agent (e.g., Alteplase).

This procedure necessitates the use of a thrombolytic agent that is introduced through a syringe and then slowly instilled into the device or catheter. This service may consist of a single bolus of thrombolytic agent, or repeat instillation of a thrombolytic agent until the clot has been resolved. The correct code to charge for this declotting procedure is **36593:** declotting by thrombolytic agent of implanted vascular access device or catheter.

In addition to the procedure code, the HCPCS Level II code for the thrombolytic agent should also be reported. Existing codes for these agents include:

- **J2997:** Injection, alteplase recombinant, 1 mg
- **J3364:** Injection, urokinase, 5000 IU vial
- **J3365:** Injection, IV, urokinase, 250,000 IU vial
- **J2995:** Injection, streptokinase, per 250,000 IU.

In general, this service must be linked to appropriate diagnosis codes, such as 996.74 (complications due to vascular device) and E878.8 (surgical operation and other surgical procedures as the cause of abnormal reaction of patient, or of later complication, without mention of misadventure at the time of operation).

If the declotting service is performed with saline or a non-thrombolytic substance, however, code 36593 is *not* reported. The infusion of saline or a bolus of non-thrombolytic substance is included in other services performed on the same day and not separately charged.

As you can see, a variety of port maintenance procedures are performed for individual patients. Cancer programs must ensure that these services are reported to payers based on the nature of the service ordered, performed, and documented in the medical record. Authoritative guidelines for the charging of these services are included in the *CPT® Manual* and apply to Medicare and all other third-party insurers.

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References

CPT® Manual, 2008. Available online at: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3756.pdf http://www.cms.hhs.gov/OutpatientCodeEdit/Downloads/AttachmentBReleaseFinal.pdf.* Last accessed June 2, 2008.