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Engineering the extraordinary

Health Economics Policy & Reimbursement

Percutaneous AV Fistula Creation

Reimbursement Guide

2025

About this document

For more information, contact the Cardiovascular Health Economics, Policy & Reimbursement Team.

The purpose of this interactive PDF is to provide reimbursement information related to Medtronic's Percutaneous AV Fistula Creation products.

For further information please see the links to the Inpatient, Outpatient and ASC rules as well as the Physician Fee Schedule in the references section on slide 11.

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Navigating the document:
The buttons found in the top righthand corner can be used to help navigate the document.

Inpatient reimbursement:

Outpatient reimbursement:

ASC reimbursement:

Physician* reimbursement:

Coding† information:

Previous slide:

*Physician reimbursement includes OBL data
†Coding information general coding information and includes examples of:
- diagnosis codes (ICD-10-CM)
- inpatient procedure codes (ICD-10-PCS)
- place of service codes (POS)
- HCPCS C-Codes

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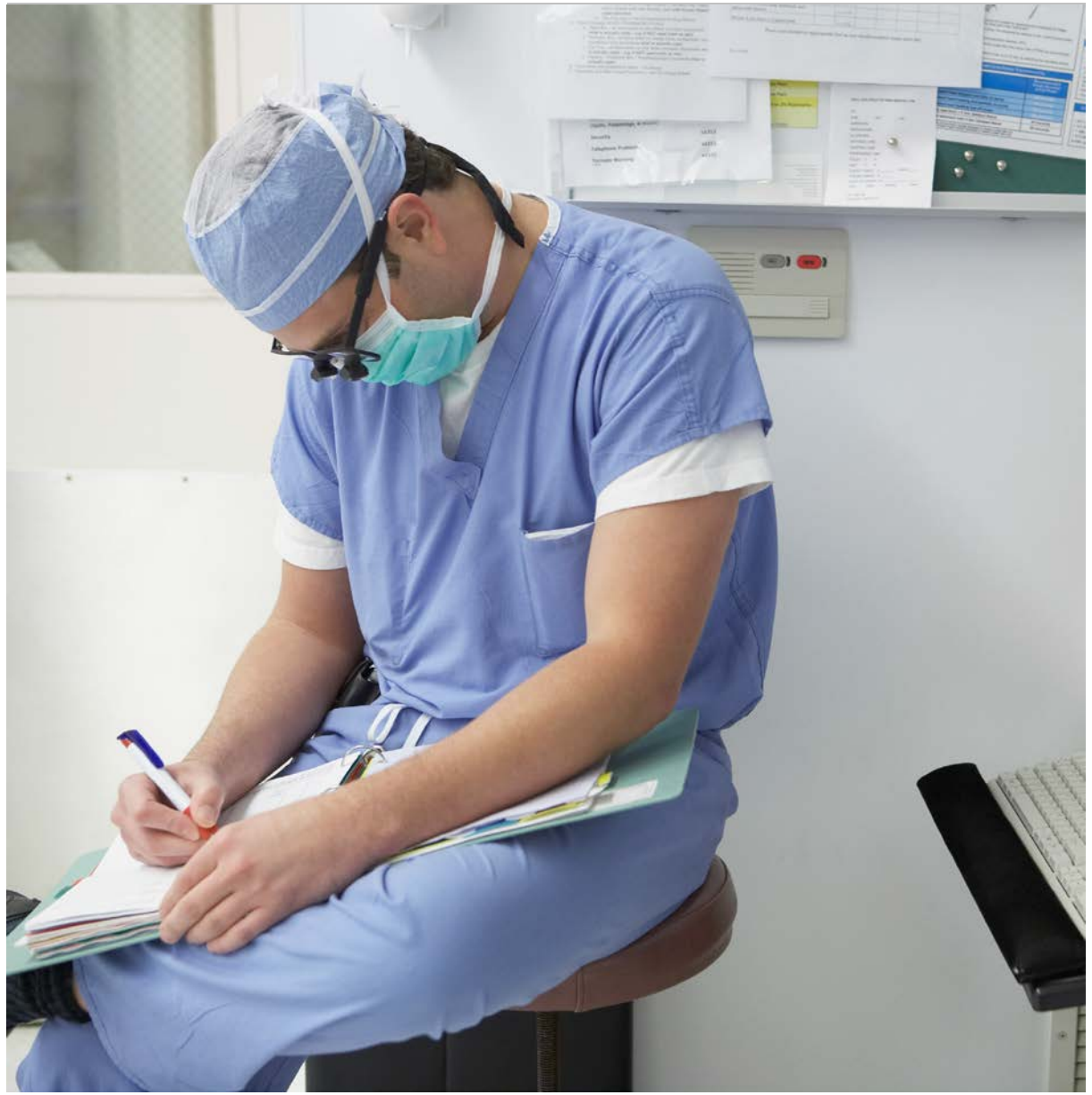
About this document

- National Unadjusted Reimbursement Rates:
  - Please note that all Medicare rates displayed in this table reflect the “national unadjusted” amounts inclusive of beneficiary cost-sharing and do not reflect any additional payment adjustments.
- “+” represents an add-on code
- MS-DRG average payment is a weighted average based upon historical volumes for the MS-DRG group highlighted
- In the ASC section, “MPD” represents the “Multi-Procedure Discount”
- Under physician reimbursement:
  - Facility (“Fac”) reimbursement represents reimbursement to the physician in settings such as a hospital or Ambulatory Surgical Center (ASC)
  - Non-Facility (“NF”) includes office-based-labs (OBLs)
  - -TC represents the Technical Component modifier; -26 represents the Professional Component modifier
- Medtronic doesn’t offer products with approved indications for all procedures listed.



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CMS FY 2025 Inpatient National Unadjusted Reimbursement Rates (effective October 1st, 2024, to September 30th, 2025)

Diagnosis*	MS-DRG	MS-DRG Description	Payment
Primary diagnosis of hypertensive heart and chronic kidney disease with *heart* failure (I13.2) and N18.6 as secondary	264	Other Circulatory System O.R. Procedures	$22,867
Primary diagnosis of end stage renal disease (N18.6):	673	Other Kidney and Urinary Tract Procedures w/ MCC	$25,892
OR	674	Other Kidney and Urinary Tract Procedures w/ CC	$16,679
Primary diagnosis of (with N18.6 as secondary): - diabetes with chronic kidney disease (E08.22, E09.22, E10.22, E11.22, E13.22) - hypertensive chronic kidney disease (I12.0) - hypertensive heart and chronic kidney disease without heart failure (I13.11)	675	Other Kidney and Urinary Tract Procedures w/o CC/ MCC	$11,108
	Average Payment		$23,061

*See slide 10 for information on diagnosis codes

NOTE: Average payment is a weighted average across the MS-DRGs listed for the groups above and is based upon historical volumes.

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CMS CY 2025 Outpatient National Unadjusted Reimbursement Rates (effective January 1st, 2025, to December 31st, 2025)

Therapy	CPT®	CPT® Description	Status Indicator	APC	Payment
Fistula Creation	36836	Percutaneous AVF creation, single access of both peripheral artery & vein	J1	5194	$17,957
	36837	Percutaneous AVF creation, separate access of both peripheral artery & vein	J1	5194	$17,957
Vessel Mapping, Preoperative	93985	Duplex scan of arterial inflow, venous outflow, bilateral study	S	5523	$242
	93986	Duplex scan of arterial inflow, venous outflow, unilateral study	S	5522	$106
Follow-up	93990	Duplex scan of hemodialysis access (inc. arterial inflow, body of access and venous outflow)	Q1	5522	$106
Maturation Procedures, During Separate Encounter from Fistula Creation*	36902	Dialysis circuit PTA, peripheral segment	J1	5192	$5,702
	+36907	Central segment PTA, through dialysis circuit	N		$0
	+36909	Dialysis circuit embolization or occlusion	N		$0
	36818	Arteriovenous anastomosis, open; by upper arm cephalic vein transposition	J1	5184	$5,406
	36819	Arteriovenous anastomosis, open; by upper arm basilic vein transposition	J1	5184	$5,406
	36832	Revision, open, arteriovenous fistula; without thrombectomy, autogenous or non-autogenous dialysis graft (separate procedure)	J1	5184	$5,406
	37246	PTA (outside dialysis circuit), initial artery	J1	5192	$5,702
	37607	Ligation or banding of angioaccess arteriovenous fistula	J1	5183	$3,148
	37799	Unlisted procedure, vascular surgery	T	5181	$618

*The codes listed here are shown in numerical order and not necessarily the order in which a patient may receive care. A patient may not receive all of these procedures. It may also not be appropriate for a provider to bill for all of the codes.

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CMS CY 2025 ASC National Unadjusted Reimbursement Rates (effective January 1st, 2025, to December 31st, 2025)

Therapy	CPT®	CPT® Description	Payment Indicator	MPD	Payment
Fistula Creation	36836	Percutaneous AVF creation, single access of both peripheral artery & vein	J8	Y	$11,571
	36837	Percutaneous AVF creation, separate access of both peripheral artery & vein	J8	Y	$11,328
Vessel Mapping, Preoperative	93985	Duplex scan of arterial inflow, venous outflow, bilateral study	P2	N	$130
	93986	Duplex scan of arterial inflow, venous outflow, unilateral study	P2	N	$57
Follow-up	93990	Duplex scan of hemodialysis access (inc. arterial inflow, body of access and venous outflow)	N/A	N/A	N/A
Maturation Procedures, During Separate Encounter from Fistula Creation*	36902	Dialysis circuit PTA, peripheral segment	G2	Y	$2,630
	+36907	Central segment PTA, through dialysis circuit	N1	N	$0
	+36909	Dialysis circuit embolization or occlusion	N1	N	$0
	36818	Arteriovenous anastomosis, open; by upper arm cephalic vein transposition	A2	Y	$3,010
	36819	Arteriovenous anastomosis, open; by upper arm basilic vein transposition	A2	Y	$3,010
	36832	Revision, open, arteriovenous fistula; without thrombectomy, autogenous or non-autogenous dialysis graft (separate procedure)	A2	Y	$3,010
	37246	PTA (outside dialysis circuit), initial artery	J8	Y	$3,422
	37607	Ligation or banding of angioaccess arteriovenous fistula	A2	Y	$1,589
	37799	Unlisted procedure, vascular surgery	N/A	N/A	N/A

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CMS CY 2025 Physician National Unadjusted Reimbursement Rates (effective January 1st, 2025, to December 31st, 2025)

Therapy	CPT®	CPT® Description	Work RVUs	NF Payment	Fac Payment
Fistula Creation	36836	Percutaneous AVF creation, single access of both peripheral artery & vein	7.20	$7,382	$338
	36837	Percutaneous AVF creation, separate access of both peripheral artery & vein	9.30	$8,767	$436
Vessel Mapping	93985	Duplex scan of arterial inflow, venous outflow, bilateral study	0.80	$239	N/A
	93985-TC		0.00	$202	N/A
	93985-26		0.80	$37	$37
	93986	Duplex scan of arterial inflow, venous outflow, unilateral study	0.50	$140	N/A
	93986-TC		0.00	$118	N/A
	93986-26		0.50	$22	$22
Follow-up	93990	Duplex scan of hemodialysis access (inc. arterial inflow, body of access and venous outflow)	0.50	$140	N/A
	93990-TC		0.00	$118	N/A
	93990-26		0.50	$22	$22

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CMS CY 2025 Physician National Unadjusted Reimbursement Rates (effective January 1st, 2025, to December 31st, 2025)

Therapy	CPT®	CPT® Description	Work RVUs	NF Payment	Fac Payment
Maturation Procedures*	36902	Dialysis circuit PTA, peripheral segment	4.83	$1,113	$227
	+36907	Central segment PTA, through dialysis circuit	3.00	$545	$139
	+36909	Dialysis circuit embolization or occlusion	4.12	$1,719	$190
	36818	Arteriovenous anastomosis, open; by upper arm cephalic vein transposition	12.39	N/A	$656
	36819	Arteriovenous anastomosis, open; by upper arm basilic vein transposition	13.29	N/A	$693
	36832	Revision, open, arteriovenous fistula; without thrombectomy, autogenous or non-autogenous dialysis graft (separate procedure)	13.50	N/A	$720
	37246	PTA (outside dialysis circuit), initial artery	7.00	$1,657	$330
	37607	Ligation or banding of angioaccess arteriovenous fistula	6.25	N/A	$359
	37799	Unlisted procedure, vascular surgery	0.00	$0	$0

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Coding Information

Example Inpatient Procedure Codes

ICD-10-PCS	ICD-10-PCS Description
X2KB317	Bypass Right Radial Artery using Thermal Resistance Energy, Percutaneous Approach, New Technology Group 7
X2KC317	Bypass Left Radial Artery using Thermal Resistance Energy, Percutaneous Approach, New Technology Group 7

Example Diagnosis Code

ICD-10-CM	ICD-10-CM Description
N18.6	End stage renal disease

Example Diagnosis Codes - additional diagnosis codes are also assigned for the underlying condition causing end stage renal disease, if known.

ICD-10-CM	ICD-10-CM Description	ICD-10-CM	ICD-10-CM Description
E08.22	Diabetes mellitus due to underlying condition with diabetic chronic kidney disease	E13.22	Other specified diabetes mellitus with diabetic chronic kidney disease
E09.22	Drug or chemical induced diabetes mellitus with diabetic chronic kidney disease	I12.0	Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease	I13.11	Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease	I13.2	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease

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Coding Information

Example HCPCS C-Codes

HCPCS Code	HCPCS Description
C1889	Implantable/insertable device, not otherwise classified
C1725	Catheter, transluminal angioplasty, non-laser (may include infusion/perfusion capability)

Example Place of Service Codes

POS Code	POS Description	POS Code	POS Description
11	Physician Office	22	On-Campus Outpatient Hospital
19	Off-Campus Outpatient Hospital	24	Ambulatory Surgical Center
21	Hospital Inpatient		

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References

For more information, contact the Cardiovascular Health Economics, Policy & Reimbursement Team.

- The Inpatient rules can be found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html
- Outpatient rules can be found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html
- ASC rules (including an explanation of Payment Indicators) can be found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html
- Physician Fee Schedules can be found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/

Code descriptions have been abbreviated in this document. For specific AMA descriptions of current CPT® coding, please refer to the most recent version of the CPT® Coding Book.

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