Inserting a central line? Tips to go beyond E/M services codes

There are 27 new codes to bill for inserting a central line. Here are some tips to make the most of them

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Coding and patient care

Do you know how to properly code for procedures like inserting a central venous line?

I know what many of you are probably thinking: As a hospitalist, you don't perform these types of procedures every day. Central venous lines are common in the inpatient setting, but they are often handled by the ICU and not performed on the wards.

At smaller hospitals and rural facilities that don't always have enough intensivists on hand, however, hospitalists often find themselves performing procedures like inserting central lines. And from what I hear, many hospitalists could use a little help properly billing for these procedures.

In previous columns, I've discussed coding and documentation guidelines for general critical care services. In many instances in which you're seeing a critically ill or critically injured patient in the ICU, critical care services codes naturally apply once you've spent more than 30 minutes on the patient's care.

If these codes don't apply, you can consider an appropriate subsequent hospital visit code. (For more on these codes, see previous columns, which are online at www.todayshospitalist.com.)

But services that fall outside of E/M guidelines—and inserting central lines is a good example—call for an entirely different set of codes. Just this year, in fact, CPT released a new set of codes specifically for inserting central lines.

In this month's column, I'll explain how to document this procedure, and how that documentation affects your use of critical care codes. In future columns, I'll focus on documentation for other common procedures performed by hospitalists.

Central lines

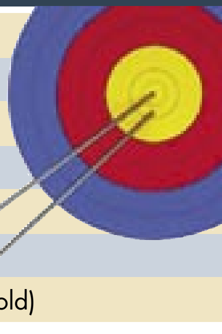
The CPT guidelines tell us that in order to qualify as a central venous access catheter or device, "the tip of the catheter/device must terminate in the subclavian, brachiocephalic (innominate), or iliac veins, the superior or inferior vena cava, or the right atrium." The catheter can be inserted centrally (in the jugular, subclavian, femoral vein or inferior vena cava catheter site) or peripherally (via the basilic or cephalic vein).

In previous years, there were only a handful of codes to choose from when inserting a central line. In 2004, however, the AMA released 27 new codes (CPT codes 36555-36597) in the CPT-4 manual.

This new list of codes identifies several factors that should guide the codes you use when you insert central venous catheters. Here are a few of the determining factors you need to consider to choose the right code:

- insertion (CPT 36555-36571);
- repair (CPT 36575 & 36576);
- partial replacement (CPT 36578);
- complete replacement (CPT 36580-36585);
- removal (CPT 36589-36596);
- tunneled vs. non-tunneled; and
- age of patient: greater or less than 5 years old.

Factors to consider when coding the insertion of a central line
Insertion (CPT 36555-36571)
Repair (CPT 36575 & 36576)
Partial replacement (CPT 36578)
Complete replacement (CPT 36580-36585)
Removal (CPT 36589-36596)
Tunneled vs. non-tunneled
Age of patient (greater or less than 5 years old)



Make sure you deduct the time you spend on a procedure from the time you count in critical care services codes.

Other coding considerations

Here are some other considerations when it comes to coding the insertion of a central line:

- **Imaging services.** If you need imaging guidance, whether it's to gain entry to the venous site or to manipulate its final position, CPT refers to the radiology section. When you need fluoroscopic guidance, use CPT 75998 in addition to the primary procedure code. And if you use ultrasound guidance, use CPT 76937 in addition to the primary procedure code.
- **Existing devices.** If a patient has an existing vascular access device that you will remove and replace with a new device, code the removal first and then the insertion of the new device.
- **Multiple conditions.** In most cases, patients will have multiple conditions that are all related to the evaluation and management service. If one or two of those services could be construed as related to the procedure you perform, modify your E/M service with a -25 modifier. This shows that the procedure was separate and distinct from the visit.

While central venous access lines—all 27 of them—are listed as separately billable procedures from critical care, you need to be careful when using them in combination with critical care services codes. When you document the total time you spend on critical care services, you must deduct any time you spent performing a procedure like inserting a central line.

The problem? Auditors may frown upon an episode of 30 minutes of critical care that includes time spent on a procedure like inserting a central line. Technically, you should not count any time spent on procedures in the time that you count toward critical care services codes.

If you deduct the time you have spent on a procedure from critical care services and you're left with less than 30 minutes—the minimum block for critical care services—you should consider using an E/M service code.

Finally, remember that the key to reporting these services is always documentation. Be careful to capture all services rendered and avoid leaving money on the table. TH

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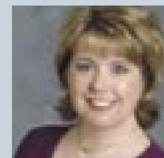

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