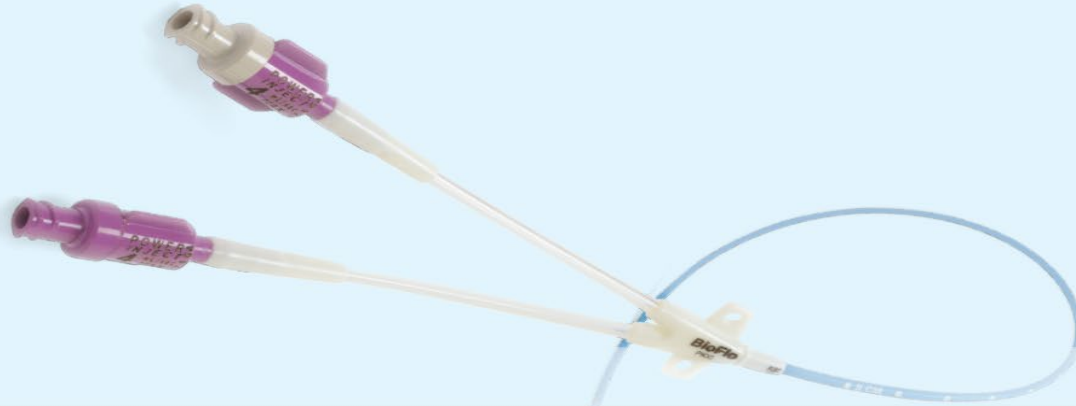


# Reimbursement Guidelines

2021 Coding and Reimbursement Guidelines for  
Vascular Access Procedures  
EFFECTIVE JANUARY 2021



This is general reimbursement information only and is intended to assist you to comply with complex and changing reimbursement policies. It is not legal advice, nor is it advice about how to code, complete, or submit any particular claim for payment, nor is it intended to increase or maximize reimbursement by any third-party payor. This information has been gathered from third-party sources and was correct at the time of publication and is subject to change without notice. It is the provider's responsibility to exercise independent clinical judgment to determine appropriate coding and charges that accurately reflect all the patient's conditions and services provided. These should be recorded in the patient's medical record. The information provided here is for informational purposes only and represents no statement, promise or guarantee by AngioDynamics concerning levels of reimbursement, payment, or charges.

Payors may have their own coding and reimbursement requirements and policies. If reimbursement questions arise for a particular patient, providers should contact the payor to confirm current requirements and billing policies. All decisions related to reimbursement, including amounts to bill, are exclusively that of the provider.

Providers should check and confirm coding from complete and authoritative coding sources to ensure accuracy. This document is not intended to promote the off-label use of medical devices and physicians should use medical devices fully consistent with all government requirements. The content is not intended to instruct hospitals and/or physicians on how to use medical devices or bill for healthcare procedures.

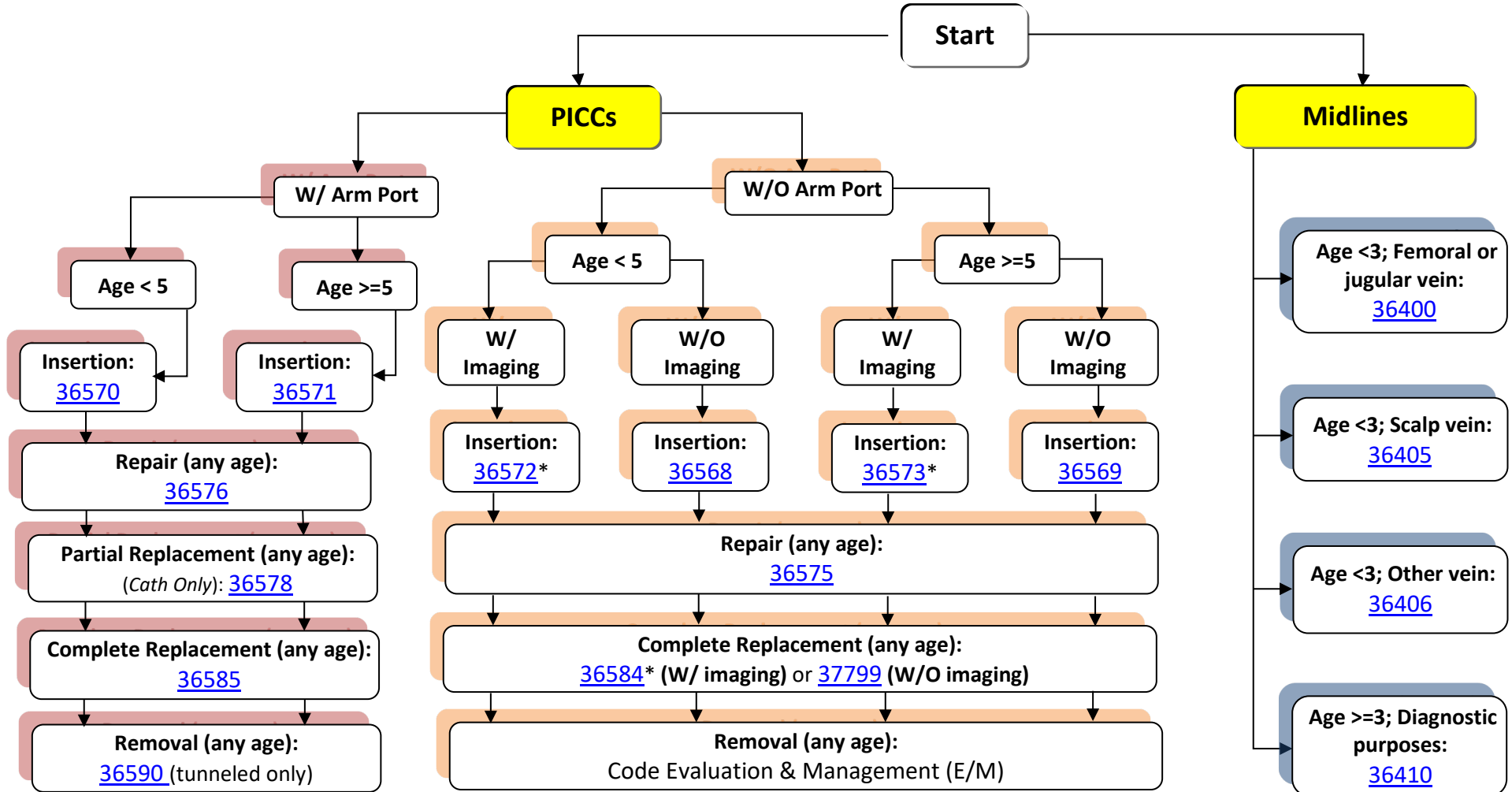
CPT codes © 2021 American Medical Association. All Rights Reserved. CPT® is a trademark of the AMA. Applicable FARS/DFARS restrictions apply to Government Use. US/VA/MS/75 Rev 03 03/2021

# Table of Contents

## Table of Contents

PICCs & Midlines Overview – Example of CPT Coding Flow .....	3
Centrally Inserted CVC Overview – Example of CPT Coding Flow .....	4
Peripherally Inserted Central Catheter (PICC) Payment .....	5
Midline Catheters Payment .....	7
Tunneled Venous Access .....	8
Non-Tunneled Venous Access .....	9
Repair, Removal, Partial Replacement Procedures .....	10
Additional Procedures .....	11
Guidance Procedures .....	11
References.....	13

## PICCs & Midlines Overview – Example of CPT Coding Flow

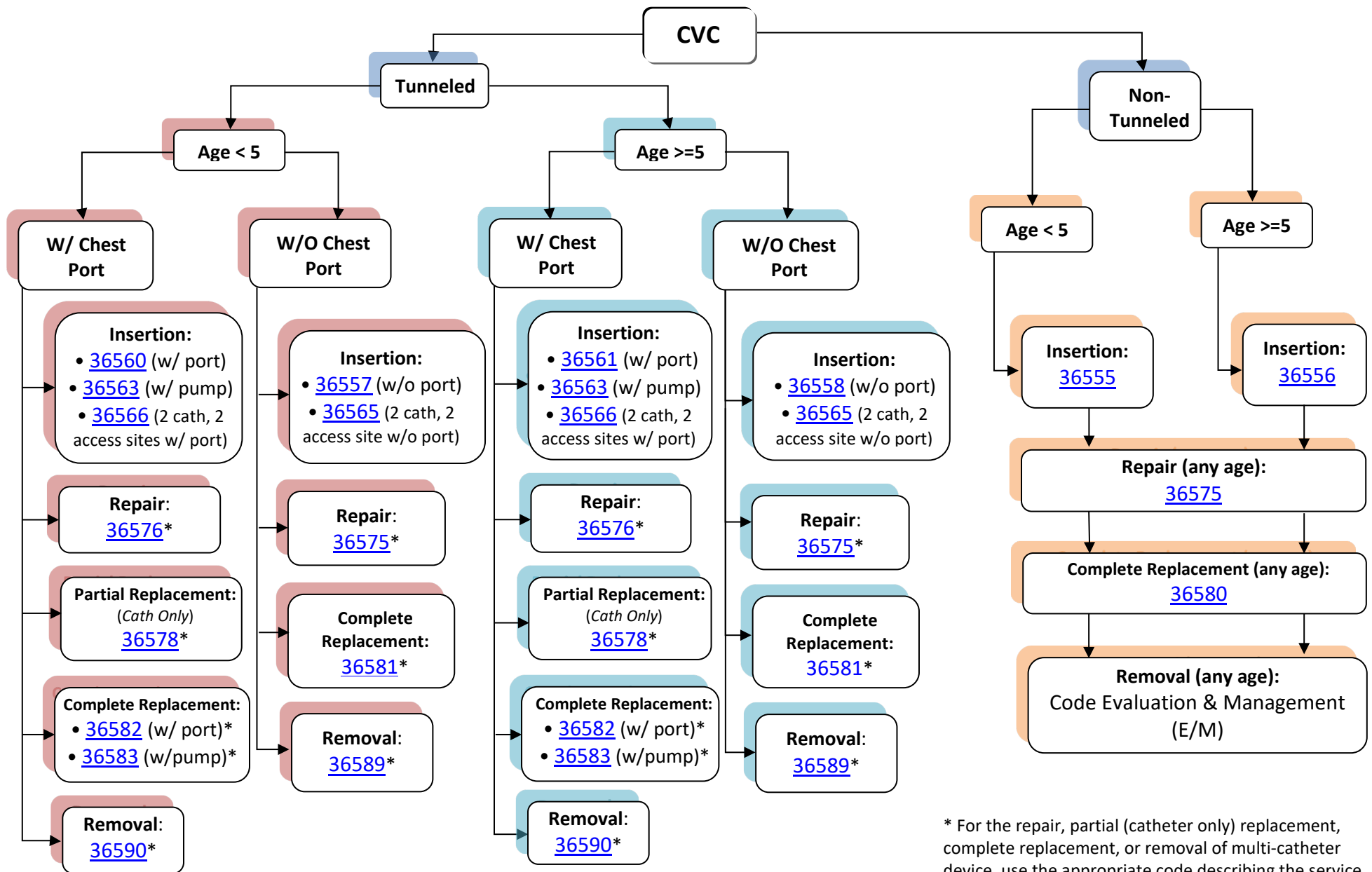


The procedures involving central venous catheter devices fall into five categories:

1. **Insertion** (placement of catheter through a newly established venous access) <sup>5</sup>
2. **Repair** (fixing device without replacement of either catheter or port/pump, other than pharmacologic or mechanical correction of intra-catheter or peri-catheter occlusion [see 36595 or 36596]) <sup>5</sup>
3. **Partial replacement** of only the catheter component associated with a port/pump device, but not entire device <sup>5</sup>
4. **Complete replacement** of entire device via same venous access site (complete exchange) <sup>5</sup>
5. **Removal** of entire device. <sup>5</sup>

\* Do not report [36572](#), [36573](#) in conjunction with [76937](#), [77001](#)<sup>5</sup>

## Centrally Inserted CVC Overview – Example of CPT Coding Flow



\* For the repair, partial (catheter only) replacement, complete replacement, or removal of multi-catheter device, use the appropriate code describing the service with a frequency of two.<sup>5</sup>

## Peripherally Inserted Central Catheter (PICC) Payment

PHYSICIAN, HOSPITAL OPPTS, ASC CODING & PAYMENT (JANUARY 1, 2021 to DECEMBER 31, 2021)

In 2019, the American Medical Association (AMA) revised, added and clarified CPT codes for insertion of peripherally inserted central venous catheters with or without imaging guidance.<sup>5</sup> See 'PICC Notes' below for applicable instructions.

### Medicare 2021 National Average Payment (Not Geographically Adjusted)

Service Provided		Physician Fee Schedule <sup>1</sup>		APC <sup>2</sup> (Status Indicator)	Hospital OPPTS Payment <sup>2</sup>	ASC Payment <sup>3</sup> (Payment Indicator)
CPT <sup>®</sup> Code <sup>4</sup>	CPT <sup>®</sup> Description <sup>4</sup>	Non-Facility <sup>1</sup>	Facility <sup>1</sup>			
<a href="#">↑</a> 36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; younger than 5 years of age	N/A	\$92.82	5182, Level 2 Vascular Procedures (T)	\$1,406.14	\$545.05 (A2)
<a href="#">↑</a> 36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; age 5 years or older	N/A	\$94.91	5182, Level 2 Vascular Procedures (J1)	\$1,406.14	\$545.05 (A2)
<a href="#">↑</a> 36570	Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age	\$1,624.27	\$341.25	5183, Level 3 Vascular Procedures (J1)	\$2,861.66	\$1,365.08 (A2)
<a href="#">↑</a> 36571	Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older	\$1,415.96	\$320.67	5183, Level 3 Vascular Procedures (J1)	\$2,861.66	\$1,365.08 (A2)
<a href="#">↑</a> 36572	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; younger than 5 years of age	\$465.47	\$92.12	5181, Level 1 Vascular Procedures (T)	\$541.62	\$273.69 (G2)
<a href="#">↑</a> 36573	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; age 5 years or older	\$424.30	\$85.48	5182, Level 2 Vascular Procedures (J1)	\$1,406.14	\$545.05 (G2)
<a href="#">↑</a> 36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the replacement	\$367.77	\$60.71	5182, Level 2 Vascular Procedures (J1)	\$1,406.14	\$545.05 (A2)
<a href="#">↑</a> 36585	Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access	\$1,202.77	\$277.40	5183, Level 3 Vascular Procedures (J1)	\$2,861.66	\$1,365.08 (A2)

Click on blue arrow to return to PICC & Midlines Flow-Chart



## PICC notes:

The 2019 AMA CPT Book<sup>5</sup> has issued new guidance for PICCs:

Peripherally inserted central venous catheters (PICCs) may be placed or replaced with or without imaging guidance. When performed without imaging guidance, report using [36568](#) or [36569](#). When imaging guidance (e.g., ultrasound, fluoroscopy) is used for PICC placement or repositioning, bundled service codes [36572](#), [36573](#), [36584](#) include all imaging necessary to complete the procedure, image documentation (representative images from all modalities used are stored to patient's permanent record), associated radiological supervision and interpretation, venography performed through the same venous puncture, and documentation of final central position of the catheter with imaging. Ultrasound guidance for PICC placement should include documentation of evaluation of the potential puncture sites, patency of the entry vein, and real-time ultrasound visualization of needle entry into the vein.<sup>5</sup>

Codes [71045](#), [71046](#), [71047](#), [71048](#) should not be reported for the purpose of documenting the final catheter position on the same day of service as [36572](#), [36573](#), [36584](#). Codes [36572](#), [36573](#), [36584](#) include confirmation of catheter tip location. The physician or other qualified health care professional reporting image-guided PICC insertion cannot report confirmation of catheter tip location separately (e.g., via x-ray, ultrasound). Report [36572](#), [36573](#), [36584](#) with modifier 52 when performed without confirmation of catheter tip location.<sup>5</sup>

"Midline" catheters by definition terminate in the peripheral venous system. They are not central venous access devices and may not be reported as a PICC service. Midline catheter placement may be reported with [36400](#), [36405](#), [36406](#), or [36410](#). PICCs placed using magnetic guidance or any other guidance modality that does not include imaging or image documentation are reported with [36568](#), [36569](#).<sup>5</sup>

## In 2019:

The 2019 CPT® code set added two new codes ([36572](#) and [36573](#)) to report peripherally inserted central venous catheter (PICC) insertion that include all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion. Report [36572](#) for patients younger than 5 years of age and [36573](#) for patients 5 years of age or older. Do not report [36572](#), [36573](#) in conjunction with [76937](#), [77001](#).

Of note, to report a PICC line insertion without imaging guidance, you would report two codes that were revised for 2019: [36568](#) for patients younger than 5 years of age and [36569](#) for patients 5 years of age or older.

**Inpatient hospital Use – This document does not address hospital coding or reimbursement for hospital inpatient procedures.**

## Midline Catheters Payment

### PHYSICIAN, HOSPITAL OPPTS, ASC CODING & PAYMENT (JANUARY 1, 2021 to DECEMBER 31, 2021)

In 2019, AMA issued new guidance for midline catheters.<sup>5</sup> The AMA states: *“Midline” catheters by definition terminate in the peripheral venous system. They are not central venous access devices and may not be reported as a PICC service. Midline catheter placement may be reported with 36400, 36405, 36406, or 36410.*<sup>5</sup>

**Medicare 2021 National Average Payment (Not Geographically Adjusted)**

Service Provided		Physician Fee Schedule <sup>1</sup>		APC <sup>2</sup> (Status Indicator)	Hospital OPPTS Payment <sup>2</sup>	ASC Payment <sup>3</sup> (Payment Indicator)
CPT <sup>®</sup> Code <sup>4</sup>	CPT <sup>®</sup> Description <sup>4</sup>	Non-Facility <sup>1</sup>	Facility <sup>1</sup>			
<a href="#">↑</a> 36400	Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; femoral or jugular vein	\$27.91	\$19.54	No APC code (N)	N/A Packaged	N/A Packaged (N1)
<a href="#">↑</a> 36405	Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; scalp vein	\$23.73	\$15.35	No APC code (N)	N/A Packaged	N/A Packaged (N1)
<a href="#">↑</a> 36406	Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; other vein	\$17.45	\$8.72	No APC code (N)	N/A Packaged	N/A Packaged (N1)
<a href="#">↑</a> 36410	Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)	\$17.80	\$9.42	No APC code (N)	N/A Packaged	N/A Packaged (N1)

Click on blue arrow to return to PICC & Midlines Flow-Chart

## Tunneled Venous Access

PHYSICIAN, HOSPITAL OPPTS, ASC CODING & PAYMENT (JANUARY 1, 2021 to DECEMBER 31, 2021)

Medicare 2021 National Average Payment (Not Geographically Adjusted)						
Service Provided		Physician Fee Schedule <sup>1</sup>		APC <sup>2</sup> (Status Indicator)	Hospital OPPTS Payment <sup>2</sup>	ASC Payment <sup>3</sup> (Payment Indicator)
CPT® Code <sup>4</sup>	CPT® Description <sup>4</sup>	Non-Facility <sup>1</sup>	Facility <sup>1</sup>			
↑ 36557	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; younger than 5 years of age	\$1,245.33	\$329.04	5184, Level 4 Vascular Procedures (J1)	\$4,770.37	\$2,369.15 (A2)
↑ 36558	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older	\$891.17	\$264.14	5183, Level 3 Vascular Procedures (J1)	\$2,861.66	\$1,365.08 (A2)
↑ 36560	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; younger than 5 years of age	\$1,396.42	\$393.59	5183, Level 3 Vascular Procedures (J1)	\$2,861.66	\$1,365.08 (G2)
↑ 36561	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older	\$1,113.09	\$340.91	5183, Level 3 Vascular Procedures (J1)	\$2,861.66	\$1,365.08 (A2)
↑ 36563	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump	\$1,261.39	\$374.05	5184, Level 4 Vascular Procedures (J1)	\$4,770.37	\$2,369.15 (A2)
↑ 36565	Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; without subcutaneous port or pump (e.g., Tesio type catheter)	\$915.59	\$343.00	5183, Level 3 Vascular Procedures (J1)	\$2,861.66	\$1,365.08 (A2)
↑ 36566	Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; with subcutaneous port(s)	\$4,811.41	\$366.73	5184, Level 4 Vascular Procedures (J1)	\$4,770.37	\$2,369.15 (A2)
↑ 36581	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	\$862.21	\$186.33	5183, Level 3 Vascular Procedures (J1)	\$2,861.66	\$1,365.08 (A2)
↑ 36582	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous port, through same venous access	\$1,013.30	\$293.80	5183, Level 3 Vascular Procedures (J1)	\$2,861.66	\$1,365.08 (A2)
↑ 36583	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access	\$1,325.59	\$338.11	5184, Level 4 Vascular Procedures (J1)	\$4,770.37	\$2,369.15 (G2)

Click on orange arrow to return to CVC Flow-Chart



## Non-Tunneled Venous Access

PHYSICIAN, HOSPITAL OPPTS, ASC CODING & PAYMENT (JANUARY 1, 2021 to DECEMBER 31, 2021)











Medicare 2021 National Average Payment (Not Geographically Adjusted)						
Service Provided		Physician Fee Schedule <sup>1</sup>		APC <sup>2</sup> (Status Indicator)	Hospital OPPTS Payment <sup>2</sup>	ASC Payment <sup>3</sup> (Payment Indicator)
CPT® Code <sup>4</sup>	CPT® Description <sup>4</sup>	Non-Facility <sup>1</sup>	Facility <sup>1</sup>			
36555	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age	\$201.68	\$85.49	5183, Level 3 Vascular Procedures (J1)	\$2,861.66	\$1,365.08 (A2)
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	\$228.90	\$85.84	5183, Level 3 Vascular Procedures (J1)	\$2,861.66	\$1,365.08 (A2)
36580	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	\$218.08	\$66.65	5182, Level 2 Vascular Procedures (J1)	\$1,406.14	\$740.71 (J8)

Click on orange arrow to return to CVC Flow-Chart

## Repair, Removal, Partial Replacement Procedures

PHYSICIAN, HOSPITAL OPPTS, ASC CODING & PAYMENT (JANUARY 1, 2021 to DECEMBER 31, 2021)

Medicare 2021 National Average Payment (Not Geographically Adjusted)

Service Provided		Physician Fee Schedule <sup>1</sup>		APC <sup>2</sup> (Status Indicator)	Hospital OPPTS Payment <sup>2</sup>	ASC Payment <sup>3</sup> (Payment Indicator)
CPT® Code <sup>4</sup>	CPT® Description <sup>4</sup>	Non-Facility <sup>1</sup>	Facility <sup>1</sup>			
  36575	Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site	\$167.49	\$34.89	5181, Level 1 Vascular Procedures (T)	\$541.62	\$273.69 (A2)
  36576	Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	\$367.77	\$188.07	5182, Level 2 Vascular Procedures (J1)	\$1,406.14	\$545.05 (A2)
  36578	Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	\$482.92	\$206.57	5183, Level 3 Vascular Procedures (J1)	\$2,861.66	\$1,365.08 (A2)
  36589	Removal of tunneled central venous catheter, without subcutaneous port or pump	\$172.37	\$140.62	5181, Level 1 Vascular Procedures (Q2)	\$541.62	\$273.69 (A2)
  36590	Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion	\$233.09	\$193.66	5182, Level 2 Vascular Procedures (Q2)	\$1,406.14	\$545.05 (A2)

Click on blue arrow to return to PICC & Midlines Flow-Chart

Click on orange arrow to return to CVC Flow-Chart

## Additional Procedures

### PHYSICIAN, HOSPITAL OPPTS, ASC CODING & PAYMENT (JANUARY 1, 2021 to DECEMBER 31, 2021)

Medicare 2021 National Average Payment (Not Geographically Adjusted)						
Service Provided		Physician Fee Schedule <sup>1</sup>		APC <sup>2</sup> (Status Indicator)	Hospital OPPTS Payment <sup>2</sup>	ASC Payment <sup>3</sup> (Payment Indicator)
CPT® Code <sup>4</sup>	CPT® Description <sup>4</sup>	Non-Facility <sup>1</sup>	Facility <sup>1</sup> (26)**			
76000	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time	\$43.62	\$15.70	5523, Level 3 Imaging W/O Contrast (S)	\$230.13	\$27.57 (Z3)
75860	Venography, venous sinus (e.g., petrosal and inferior sagittal) or jugular, catheter, radiological supervision and interpretation	\$136.43	\$55.48	5183, Level 3 Vascular Procedures (Q2)	\$2,861.66	N/A Packaged (N1)
75820	Venography, extremity, unilateral, radiological supervision and interpretation	\$120.38	\$51.64	5182, Level 2 Vascular Procedures (Q2)	\$1,406.14	N/A Packaged (N1)
37799	Unlisted procedure, vascular surgery	Medicare does not set a national payment for unlisted CPT codes. Check with local Medicare contractor		5181, Level 1 Vascular Procedures (T)	\$541.62	Not Covered

## Guidance Procedures

### PHYSICIAN, HOSPITAL OPPTS, ASC CODING & PAYMENT (JANUARY 1, 2021 to DECEMBER 31, 2021)

Medicare 2021 National Average Payment (Not Geographically Adjusted)						
Service Provided		Physician Fee Schedule <sup>1</sup>		APC <sup>2</sup> (Status Indicator)	Hospital OPPTS Payment <sup>2</sup>	ASC Payment <sup>3</sup> (Payment Indicator)
CPT® Code <sup>4</sup>	CPT® Description <sup>4</sup>	Non-Facility <sup>1</sup>	Facility <sup>1</sup> (26)**			
76937*	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)	\$39.08	\$13.96	No APC code (N)	N/A Packaged	N/A Packaged (N1)
77001*	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 primary procedure)	\$105.03	\$18.84	No APC code (N)	N/A Packaged	N/A Packaged (N1)

\*A permanent record or report of the ultrasound guidance must be documented, and multiple sites must be evaluated. \*\* (26) Physician component only, no technical component allowed

## Reimbursement Terminology

Term <sup>2,3</sup>	Description <sup>2,3</sup>
<b>APC</b>	Ambulatory Payment Classification
<b>APC (N)</b>	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.
<b>APC (Q2)</b>	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "T". (2) In other circumstances, payment is made through a separate APC payment.
<b>APC (J1)</b>	Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS status indicator of "F", "G", "H", "L" and "U"; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.
<b>APC (T)</b>	Procedure or Service, Multiple Procedure Reduction Applies. Paid under OPPS; separate APC payment.
<b>ASC</b>	Ambulatory Surgery Center
<b>APC (S)</b>	Procedure or Service, Not Discounted When Multiple. Paid under OPPS; separate APC payment.
<b>ASC (A2)</b>	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.
<b>ASC (G2)</b>	Non-office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight
<b>ASC (J8)</b>	Device-intensive procedure; paid at adjusted rate.
<b>ASC (N1)</b>	Packaged service/item; no separate payment made.
<b>ASC (Z3)</b>	Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS non-facility PE RVUs.
<b>CPT</b>	Current Procedural Terminology
<b>C-Code</b>	Device category codes reported by hospitals in conjunction with outpatient hospital procedures
<b>E/M</b>	Evaluation and Management
<b>Facility</b>	Physician payment level for professional services provided in a facility setting such as a hospital or ambulatory surgery center
<b>Non- Facility</b>	Physician payment level for professional services provided in a non-facility setting such as a physician's office
<b>ICD-10-CM</b>	International Classification of Diseases, 10th Revision, Clinical Modification
<b>ICD-10-PCS</b>	International Classification of Diseases, 10th Revision, Procedure Coding System
<b>IPPS</b>	Inpatient Prospective Payment System
<b>OPPS</b>	Outpatient Prospective Payment System
<b>W MCC</b>	Major Complications and Comorbidities
<b>W CC</b>	With Complications and Comorbidities
<b>W/O CC/MCC</b>	Without complications or comorbidities, and without major complications and comorbidities.
<b>OPPS</b>	Outpatient Prospective Payment System

## References

1. Physician fee schedule rates were calculated using Conversion Factor (34.8931) multiplied by Total Facility & Non-Facility RVUs. Centers for Medicare and Medicaid Services (CMS), <https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf>; CMS-1734-F, Federal Register, Vol. 88, No. 248. Published December 28, 2020; Effective Jan. 1, 2021. Accessed Jan 10, 2021.
2. Centers for Medicare and Medicaid Services (CMS) 1736-F Hospital Outpatient Prospective Payment, " <https://www.govinfo.gov/content/pkg/FR-2020-12-29/pdf/2020-26819.pdf>; Federal Register, Vol. 85, No. 249, Published, December 29, 2020, Effective Jan. 1, 2021. Accessed Jan 10, 2021.
3. CMS, CMS-1736-CN: Ambulatory Surgical Center Payment- Hospital Outpatient Prospective Payment - Correction Notice <https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientppshospital-outpatient-regulations-and-notice/cms-1736-cn> .Posted February 18, 2021, Effective January 1, 2021. Accessed February 24, 2021
4. CPT® © 2021 Professional. American Medical Association (AMA). All rights reserved. CPT® is a registered trademark of the AMA. No fee schedules, basic units, relative values or related listings are included in CPT® including for Category 3 codes. Inclusion of a CPT® code does not represent AMA endorsement or imply any coverage or reimbursement policy. Reimbursement information here is from the Centers for Medicare and Medicaid Services (CMS), see sources below. Applicable FARS/DFARS restrictions apply to Government Use.
5. CPT® 2019 Professional Edition Codebook, "Cardiovascular 33010-39599" Page 267-268, American Medical Association, 2019



USA > 14 Plaza Drive, Latham, NY 12110 > tel: 800-772-6446 or 518-798-1215 > fax: 518-798-1360  
International > Haaksbergweg 75 (Margrietoren), 1101 BR, Amsterdam Z-O > The Netherlands >  
tel: +31 (0)20 753 2949 > fax: +31 (0)20 753 2939

[www.angiodynamics.com](http://www.angiodynamics.com)

AngioDynamics and the AngioDynamics logo are trademarks and/or registered trademarks of AngioDynamics, Inc., an affiliate or subsidiary. All other trademarks are property of their respective owners. CPT® is a registered trademark of the American Medical Association ©2021 AngioDynamics, Inc. US/VA/MS/75 Rev 03 03/2021