Dialysis A-V Access Coding

An overview of some common coding issues and confusions regarding A-V access.

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In an effort to keep readers informed of pertinent issues related to coding and billing, Endovascular Today *provides this semiregular forum in which experts discuss perennially difficult components of the current system and updates that emerge in the future. If there is a specific topic that you would like one of the authors to cover, please contact us at evteditorial@bmctoday.com.*

Dialysis access procedures are coded with component codes. This article addresses several aspects of dialysis access maintenance, including fistulae and A-V grafts. Studies done for A-V grafts and A-V fistulae are coded identically, and the terms will be used interchangeably in this article. The coding described reflects the definitions of the codes when introduced to the CPT Panel. It is acknowledged that individual carriers may accept variations on the coding conventions described here, and one should communicate with the local carrier if there are discrepancies.

DIAGNOSTIC STUDIES OF A-V ACCESS

This section describes the diagnostic studies most frequently done to evaluate the A-V access—its inflow and its outflow. These codes are used irrespective of the type of access (eg, fistula or A-V graft) and of the location (eg, arm, leg).

Fistulagram

Two codes used for fistulagrams:

36145—puncture/catheterization of A-V dialysis access

75790—fistulagram, radiologic supervision and interpretation (RS&I)

36145 is coded once if the graft or fistula is accessed once for the diagnostic study. It may be coded twice if a second puncture is needed to adequately visualize the entire anatomy. If a second puncture is required, most carriers require documentation of the need for a second puncture and require that the –59 modifier is used with the second 36145 code. (If a third puncture is needed, most carriers will deny payment for the third 36145 code.) If the patient comes to the angiographic suite with needles in place (ie, from the dialysis center), 36145 would not be coded because the contrast is injected through an existing access.

If a central problem is suspected but cannot be adequately demonstrated with contrast injection through the needle/catheter placed in the graft or fistula, it may be necessary to advance a catheter more centrally to allow better opacification and visualization of the central veins. In this case, the code 36145 would still be appropriate if the catheter is positioned anywhere proximal to the vena cava. If the catheter must be positioned into the vena cava to complete the diagnostic study, the 36145 code would be dropped, and 36010 would be used instead to describe the additional work of advancing the catheter into the vena cava.

75790, radiologic S&I, is coded once for each graft or fistula. This code includes imaging and evaluation of the entire A-V access, including arterial and venous anastomoses, the body of the graft, outflow vein(s), and central veins. Other venogram codes should not be used to describe the necessary imaging included with the fistulagram (do not use 75820—unilateral extremity venogram, or 75827—superior vena cavagram).

Venography

Venogram codes are used to describe additional studies that may be needed if the fistulagram demonstrates that the existing access cannot be salvaged. Venogram studies may then be needed to define where the next access should be established. These studies are coded as:

36005—puncture of an extremity vein with contrast injection

75820—unilateral extremity venogram (radiologic S&I)

If a bilateral extremity venogram is required, it would be coded as:

36005-50—bilateral venipuncture with contrast injection for venogram
75822—bilateral extremity venogram, radiologic S&I

Arteriography

If an inflow problem is suspected and an inflow study is required, a catheter may need to be advanced retrograde through the arterial anastomosis to allow contrast injection. The 36145 code describes this work if the catheter is placed into the artery but not as far as the aorta. If the catheter is placed retrograde into the aorta for diagnostic injection, the 36200 code would be used and 36145 would be deleted because, in this case, 36200 includes the work of 36145.

To code for the diagnostic extremity arteriogram, the 75710 code would be used (unilateral extremity arteriogram, radiologic S&I). These codes are used irrespective of the type of access (fistula, A-V graft) and irrespective of the location (arm, leg).

INTERVENTIONAL PROCEDURES FOR A-V ACCESS MAINTENANCE

Balloon Angioplasty of Dialysis Access

Balloon angioplasty of an A-V access is coded with venous angioplasty codes as:

35476—balloon angioplasty of vein, each vessel
75978—balloon angioplasty of vein, each vessel, radiologic S&I

For the purposes of definition, the entire dialysis graft and its outflow vein, including both the arterial and venous anastomoses, is considered a single vessel, analogous to how PTA of a superficial femoral artery is defined. The PTA codes are used per vessel, not per lesion. Numerous stenoses may be treated with balloon angioplasty and the venous PTA is coded only once. A balloon angioplasty of the arterial anastomosis is coded as a venous angioplasty because it is considered part of the same vessel as the graft and outflow vein.

A second venous angioplasty may be coded if there is a separate and distinct stenosis in the central vein(s). Veins more central than the axillary vein are considered a separate vessel, so that a stenosis in the subclavian vein or vena cava that needs to be treated may be coded as a second venous angioplasty (ie, 35476, 75978). Most carriers require documentation of the medical need for a second angioplasty.

Arterial angioplasty codes may be used when an inflow stenosis separate from the arterial anastomosis is identified and treated. If the A-V access is in the arm, 35475/75962 would be used. If the A-V access is in the leg, 35474/75962 (femoral artery) or 35473/75962 (iliac artery) would be used.

As with other angioplasty procedures, the access is not included with the angioplasty codes, and one would additionally code for the appropriate access/catheterization of the vessel. If the angioplasty is done through a fistula or graft puncture, the code 36145 would be used in addition to the angioplasty codes.

> "If you are contemplating provision of these services outside a hospital, contact your local carrier medical director [to see if] reimbursement will be allowed."

Stent Placement for Dialysis Access

Stent placement is coded with 37205/75960. In the rare instance in which a second site is also treated with stenting, 37206/75960 would be used. The use of covered stents is coded as 37205/75960. In addition to the stent codes, one usually codes for catheterization, using codes appropriate to the puncture and catheter placement. The 36145 code is used when the graft/fistula is the site of entry for the catheter. Occasionally, a remote entry site is used, such as the femoral vein. If the femoral vein approach is used to stent a subclavian vein, the appropriate access code is 36011 (first-order selective venous catheter placement).

Declotting of Dialysis Access

Declot procedures are coded as 36870, which includes the work of thrombus removal from the access using any and all means of removing the thrombus. This code also encompasses removal of the arterial plug by any means. Arterial PTA codes are not appropriate to use for removal of the arterial plug. The code 36870 includes mechanical thrombectomy, as well as pharmacologic thrombectomy/thrombolysis, and is coded only once even if several different devices or treatment combinations are used. This code has no time dependency, such that even if thrombolysis is performed with infusion over several hours, the appropriate code is 36870 (not 37201).

In addition to the work of thrombus removal from the access, several other components of work are typically required to return the access to functionality. Catheterization of the A-V access is coded separately using the 36145 code (once, if a single catheterization is used, twice, if more than once catheterization is used). There is not a separate radiologic supervision and interpretation code that is paired with 36870, but it is necessary and expected that the entire system is imaged at some point during the procedure to ensure that the underlying cause for graft failure is diagnosed and treated. The 75970 code is used for this combination of images of the entire graft and outflow. Typically, an underlying stenosis is found and treated with balloon angioplasty and is coded with

35476/75978, as described previously. However, occasionally a graft will fail with no underlying stenosis, and if a stenosis is not documented, one should not code for a venous angioplasty.

Thrombolysis Outside the Dialysis Graft

Occasionally, thrombus will extend into the central veins, requiring thrombolytic infusion to try to restore flow. Also, occasionally thrombus may embolize into the arterial system, impeding flow to the hand, which may require thrombolytic infusion. These are special circumstances that do allow the use of thrombolytic coding for reimbursement in addition to the 36870 code for removal of thrombus from the graft. In these two specific instances in which a catheter is advanced to the thrombus distal to the dialysis graft and thrombolytic infusion is done, the 37201 and 75896 codes may also be used.

These thrombolytic codes are specifically not to be used for any removal of thrombus from the dialysis graft itself, even if thrombolytic infusion is required to fully clear the graft. Any thrombolysis done within the graft is coded as 36870.

SERVICES PROVIDED IN AN OUTPATIENT OR FREE-STANDING FACILITY

In the outpatient facility setting, the reimbursement from Medicare for interventions in the dialysis population is not sufficient to cover the technical costs of the procedures, making it difficult to perform all of these procedures in an outpatient facility. Fistulagrams, venograms, Permcath placements, and declots do have practice expense values that may allow adequate reimbursement. Balloon angioplasty and stenting do not have adequate reimbursement. While this issue is being addressed with the PEAC (Practice Expense Advisory Committee of the AMA CPT), it is not yet fully resolved. However, several localities have agreed to pay for interventions done in this population. The patients on dialysis have problems with service in many inpatient facilities, and to better serve these patients and improve their lives, some carriers have agreed to allow services to be provided in a free-standing center. If you are contemplating provision of these services outside a hospital, you should contact your local carrier medical director and discuss whether reimbursement will be allowed, and if so, if it will be enough to cover the expenses. You should also discuss specifically how the facility should be coded (eg, ambulatory surgical center, office facility, free-standing diagnostic center). ■

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