Billing for Dialysis Access: Staying on the Right Side of the OIG

Dr. Abigail Falk discusses common errors in coding and billing for dialysis access procedures, areas of coding confusion, implications for incorrect billing, and recommendations for improvement.

First, in addition to your career in interventional radiology (IR) with specific focus on dialysis access, what can you tell us about your current professional focus?

I have been an interventional radiologist for > 25 years with a specific focus on dialysis access. Currently, I am the Lead Medical Director for Vascular Surgery and Cardiovascular Medicine for Optum Health Solutions Focus Claim Review.

How has your career as an interventional radiologist uniquely prepared you for this role? What are the unique perspectives a clinician can bring to the table?

I have always been active in direct patient care and passionate about conducting research and educating others in addition to performing procedures. This has given me the opportunity to experience the field of IR from all perspectives and various backgrounds. Witnessing the evolution of IR over 25 years has been truly remarkable, and I am proud to be a part of such a dynamic field that has brought about so many positive changes. As a result of these experiences, I have gained a deeper appreciation for the impact that IR has had on patient care and outcomes.

What are some of the most common errors you see in coding and billing for dialysis access procedures? How can they be avoided?

Let us start by looking at the CPT Coding Definitions. The codes were simplified in 2017 to make coding and billing more straightforward. Much of the work is now bundled into each code, with add-on codes for services provided less frequently. This simplification aims to ensure that anyone providing a service may bill for it and receive fair compensation, minimizing disparities in how a single service is billed and paid for.

The dialysis access circuit begins at the arterial anastomosis and extends to the right atrium. This circuit is composed of two segments: the peripheral venous segment and the central venous segment. The peripheral segment begins at the arterial anastomosis and extends through the axillary vein to end at the central segment. This includes the axillary and cephalic veins in upper extremity and the common femoral vein in the lower extremity. The central venous segment includes all draining veins central to the peripheral segment, including the subclavian and brachiocephalic veins through the superior vena cava in the upper extremity and the iliac veins through the inferior vena cava in the lower extremity. The perianastomotic region is a short segment of the parent artery, the anastomosis, and a short segment of the dialysis circuit immediately adjacent to the anastomosis. The perianastomosis is included in the peripheral dialysis segment.

Areas of Coding Confusion

Intravascular ultrasound (IVUS). The use of IVUS is rapidly gaining popularity and becoming increasingly common. IVUS is used to identify and confirm central venous stenosis not adequately defined by angiography, measure central veins prior to stent placement, assess pre- and postangioplasty, confirm absence of stenotic lesions when angiography is negative, assess aneurysm size, and assess central veins during tunneled catheter removal. Overcoding is problematic. There must be a specific medical indication for each reported instance of IVUS. 37252 is coded for the initial vascular segment and 37253 is coded for each additional segment.

Cephalic arch and central venous angioplasty. A stenosis in the central venous segment is distinct and separate from a stenosis in the peripheral segment. The location of the balloon does not dictate this. If a balloon is placed in the terminal portion of the cephalic arch and extends into the subclavian vein, this is a single cephalic arch stenosis and only peripheral segment venous angioplasty (36902) can be coded.

The perianastomosis. Angioplasty within this segment is included in peripheral venous segment angioplasty (36902). An arterial angioplasty (37246 for the initial artery and 37247 for each additional artery) must be distinct from the perianastomosis. The location of the balloon does not dictate this. If a balloon is placed in the arterial anastomosis and extends into the inflow artery, this is peripheral segment angioplasty.

Arterial catheterization and unilateral extremity arteriography. When performed from the hemodialysis access, documentation of catheter placement is a common problem. To appropriately code for 36215, the catheter must be placed clearly in the inflow artery, beyond the perianastomotic segment. Evaluating the arterial inflow requires a distinct medical indication to warrant coding. Code 75710, extremity arteriography, includes the entire upper extremity. If the entire extremity is not imaged, then a -52 modifier added to 75710 (for reduced services) is warranted.

Interventions performed through the dialysis circuit (36901-36909). All interventions performed through the dialysis access circuit include injection of contrast and imaging of the entire circuit, all punctures required to perform the procedure (including antegrade and/or retrograde punctures and direct arterial punctures), all selective catheterizations of venous branches, and all manipulations of the catheter. Catheter placement across the arterial anastomosis for evaluation of the perianastomotic segment is included.

An example of problematic coding for a simple peripheral segment angioplasty and central venous stent placement includes:

- Incorrect coding submitted: 36902, 36908, 36215, 75710, 37252, 37253 (X 5) totaling $5,989.97
- Correct coding (arteriogram and IVUS not indicated): 36902 and 36908 totaling $2,824.91
- Possibly correct coding if IVUS is indicated: 36902, 36908, 37252, 37253 (X 1) totaling $3,850.98

Fibrin sheath angioplasty. 37799 is the appropriate code for fibrin sheath disruption/removal using an angioplasty balloon, not 36595 and 75901 (mechanical removal of pericatheter obstructive material [fibrin sheath] via a separate access site).

Big red flags. The use of multiple codes that are not typically associated with a common procedure causes suspicion and raises red flags. For example, 37187 (percutaneous mechanical venous thrombectomy) and the use of multiple venous angioplasty codes (37248 and 37249) raise suspicions when used with catheter removals and exchanges.

An example of this is 37187 (X 2) (venous thrombectomy), 37248 (venous angioplasty), 37249 (X 2) (additional venous angioplasty), 36589 (tunneled catheter removal), 75860 (venography venous sinus or jugular), 75827 (superior vena caval venography), 75820 (extremity venography), and 77001 (fluoroscopic guidance for central venous access device placement/removal) totaling a charge of $14,474.23 was submitted for a simple catheter removal. Balloon maceration of nonobstructive thrombus during concomitant balloon angioplasty to treat a fibrin sheath and/or venous stenosis raises concern. When treating a lesion with an angioplasty balloon, standard of medical practice requires the documentation of a stenosis prior to the intervention, as well as the postinterventional angiographic findings.

What are the implications of submitting incorrect billing reports and requests?

Allegations, investigations, and charges against vascular access centers have included medically unnecessary procedures, lack of valid orders, compliance programs that are lacking or have gaps, whistleblowers, patient procedures performed every 90 days on the same patient, and lack of corroboration from the dialysis center. These charges have led to sanctions and fines.[1]

Fraudulent billing can lead to serious legal consequences, including lawsuits, fines, exclusion from Medicare, and even criminal charges. The current Department of Justice strategies to identify potential fraud include use of advanced data analytics, use of whistleblowers, a focus on areas of high health care fraud, and identification of common areas of interest. For every $1.00 invested by the Department of Justice Health Care Fraud Unit, the return on investment is $4.30. Identifying, indicting, and convicting those involved in health care fraud is a good investment for our government, with the vascular cases yielding multimillion-dollar settlements.[2-4]

Documentation is key—it is important to avoid cloned notes, document the medical necessity of each CPT code billed, retain images, review the operative note for completeness, and ensure that the coders and billers have access to reference materials. In addition, the dialysis center must provide a signed order clearly stating the procedure requested. Physicians should educate themselves regarding the rules and guidelines of the CPT codes and appropriate billing to avoid both overbilling and underbilling.

Which procedures can be the most challenging for practices in terms of the nuances of proper coding?

Hemodialysis coding (36901-36909) is straightforward and guides best practices. 36901-36906 are built on progressive hierarchies that have more intensive services, which include the less intensive services. Only report one code for these primary procedures:

- 36901 – Fistulogram
- 36902 – Fistulogram and peripheral segment angioplasty
- 36903 – Fistulogram and peripheral segment stent placement (including angioplasty)
- 36904 – Thrombectomy
- 36905 – Thrombectomy with peripheral segment angioplasty
- 36906 – Thrombectomy with peripheral segment stent placement (including angioplasty)

The following codes (36907-36909) are add-on codes and are listed in addition to the code for the primary procedure:

- 36907 – Central venous angioplasty
- 36908 – Central venous stent placement (including angioplasty)
- 36909 – Dialysis circuit embolization of side branches or the circuit itself, includes catheterization codes

Additional interventional codes used include:

- 36215 – Arterial catheterization from the hemodialysis access
- 75710 – Unilateral extremity arteriography
- 37246 – Arterial angioplasty (initial vessel), 37237 each additional vessel
- 37186 – Secondary mechanical thrombectomy (used to treat arterial embolization during thrombectomy procedures)
- 37242 – Arterial embolization (ie, used for distal radial artery embolization secondary to steal syndrome)
- 37607 – Ligation or banding of angio access arteriovenous fistula (AVF)
- 37252 and 37253 – IVUS codes
- 37248 – Venous angioplasty for central venous stenosis angioplasty during catheter exchanges or treatment of central veins from a femoral approach
- 36836 (Ellipsys [Medtronic]) and 36837 (Wavelinq [BD Interventional]) – Percutaneous AVF creation, includes imaging, catheter placement, angioplasty, embolization during creation procedure
- 36558 – Tunneled catheter placement
- 36581 – Tunneled catheter exchange
- 36589 – Tunneled catheter removal
- 76589 – Ultrasound guidance for vascular access including permanent recording

What recommendations can you share for how practices and their billing teams can stay up to date and well educated on proper coding and billing standards? What are the essentials for anyone new to the field to begin with?

If you are new to the field and interested in learning about medical coding practices, a good resource is the American Medical Association's CPT book.[5] This book provides a comprehensive guide to medical coding, including descriptions of procedures and services and the codes used to bill for them. The CPT book is regularly updated to reflect changes in medical practices and billing regulations, making it a valuable resource. The section on the dialysis access circuit is excellent.

In addition, the American Society of Diagnostic and Interventional Nephrology Coding Manual and Annual Updates is a comprehensive resource that provides detailed information on coding for dialysis access intervention.[6] This manual includes 50 illustrative cases for a variety of procedures, including for fistulas, grafts, stents, hemodialysis, and peritoneal dialysis catheters.

To keep up to date with coding regulations, professional societies like the Society of Interventional Radiology (SIR) regularly publish coding updates, such as the SIR Annual Coding Book Update and the Coding Update On-Demand.[7] Additionally, it is important to attend coding seminars and webinars to stay up to date with coding changes. ■

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