

Coding for Endovascular Procedures for Dialysis Access

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Nine new codes for endovascular procedures for dialysis access (36901-36909) were added, and four codes (36147, 36148, 36870, 75791) were deleted in the Current Procedural Terminology (CPT®) 2017 code set. These changes were made in response to a request from the Relative Value Scale Update Committee (RUC) Relativity Assessment Workgroup (RAW) to review the existing codes based on a screen identifying codes frequently reported together as well as a screen identifying rapidly growing services. The new codes bundle services that are commonly performed together. The CPT® 2017 codebook also includes extensive introductory language and parentheticals to help guide the use of this code set. This article discusses these changes and provides guidance on the appropriate use of these new codes.

An understanding of the anatomy of the dialysis circuit is requisite to proper coding of endovascular procedures within the dialysis circuit. These anatomic definitions are as follows:

Dialysis circuit: The arteriovenous (AV) dialysis circuit is the vascular channel used to perform hemodialysis. For coding purposes, the dialysis circuit begins at the arterial anastomosis and extends to the right atrium. The circuit may be created using either an arterial-venous anastomosis, known as an arteriovenous fistula (AVF), or a prosthetic graft placed between an artery and vein, known as an arteriovenous graft (AVG). The dialysis circuit is comprised of two segments, termed the (1) peripheral dialysis segment and (2) central dialysis segment.

Peripheral dialysis segment: The peripheral dialysis segment is the portion of the dialysis circuit that begins at the arterial anastomosis and extends to the central dialysis segment. In the upper extremity, the peripheral dialysis segment extends through the axillary vein (or entire cephalic vein in the case of cephalic venous outflow). In the lower extremity, the peripheral dialysis segment extends through the common femoral vein. The peripheral dialysis segment includes the historic 'peri-anastomotic region.'

Central dialysis segment: The central dialysis segment includes all draining veins central to the peripheral dialysis segment. In the upper extremity, the central dialysis segment includes the veins central to the axillary and cephalic veins, including the subclavian and innominate veins through the superior vena cava. In the lower extremity, the central dialysis segment includes the veins central to the common femoral vein, including the external iliac and common iliac veins through the inferior vena cava. In some cases, the main central veins may be occluded, but the access may continue to function because of the development of large collaterals in the neck and chest, in which case these collaterals are the 'central dialysis segment.'

Peri-anastomotic region: An historic term referring to the region of a dialysis circuit near the arterial anastomosis encompassing a short segment of the parent artery, the anastomosis, and a short segment of the dialysis circuit immediately adjacent to the anastomosis. The peri-anastomotic region is included within the peripheral segment of the dialysis circuit, and all interventions in the peri-anastomotic region are reported as interventions of the peripheral dialysis segment.

Performed through dialysis circuit: Any diagnostic study or therapeutic intervention within the dialysis circuit that is performed through a direct percutaneous access to the dialysis circuit.

Codes 36901-36909 bundle the typical surgical procedure(s) with related radiological supervision and interpretation (RS&I) services. Each of these codes includes direct percutaneous access(es) to the fistula (ie, punctures), catheterizations, catheter manipulations, roadmapping, imaging guidance, contrast injections, completion angiography, and closure of the punctures by any method. The codes are built on a progressive hierarchy, with lesser intensive services included in codes describing higher intensive services. For base codes 36901-36906, diagnostic angiography of the entire dialysis circuit is included, when performed. When interventions are performed, the code that describes the highest intensity service provided should be selected so that only one code is reported. For codes describing stent placement (36903, 36906), balloon angioplasty is included and is not separately reported, even if balloon angioplasty is performed on a separate lesion in the same dialysis segment.

Atypical access (eg, for upper extremity dialysis circuits—common femoral artery/vein, internal jugular vein, brachial artery) is not included in codes 36901-36906, and catheterizations from these locations may be separately reported using existing coding conventions. When separately reporting an atypical access, the medical justification(s) for why an atypical access was necessary to conduct the procedure must be documented, and the dialysis services (36901-36906) must be reported with modifier 52, Reduced Services, appended to indicate the lack of direct percutaneous access to the fistula.

When venous angioplasty and stenting are performed in the dialysis circuit (central segment only) through an atypical access (eg, for upper extremity dialysis circuits—common femoral artery/vein, internal jugular vein, brachial artery), codes 37238 and 37239 (venous stenting) may be reported, and the conventional reporting rules for use of these codes may be followed. For example, these vascular therapeutic codes are reported per anatomic vessel rather than based on the definitions in the descriptors of codes 36901-36909. Thus, if separate lesions are treated with stenting in the subclavian vein, the innominate vein, and the superior vena cava, three codes would be reported to describe this service. It is never appropriate to report peripheral dialysis circuit segment angioplasty and/or stenting with code 37248, 37249, 37238, or 37239.

Some related services are not included in this new dialysis code family, and therefore, may be separately reported when performed for medically necessary indications and when appropriately documented. For example:

- Ultrasound guidance (eg, 76937) for puncture(s) of the vessel(s) to perform these services may be separately reported if required for safe access such as in an immature or failing dialysis access.
- Diagnostic angiography (eg, 75710) of the inflow artery proximal to the peri-anastomotic region may be separately reported if performed. The inflow artery proximal to the peri-anastomotic region is considered a separate vessel for coding purposes and any diagnostic or therapeutic service performed in the inflow artery may be separately reported. Selective catheterization of the inflow artery (36215) may be reported with modifier 59, Distinct Procedural Service, appended when a catheter is placed into the parent artery through direct access to the dialysis circuit. It is never appropriate to report selective catheterization of the parent artery to evaluate the peri-anastomotic

region or to perform peri-anastomotic therapy since these services are included in 39601-36906.

Example: Following a routine dialysis fistulogram (36901), the inflow to a brachiocephalic AVF is studied from a direct retrograde puncture of the AVF to document pathology involving the parent artery separate and distinct from the peri-anastomotic region. A catheter is manipulated beyond the peri-anastomotic region into the parent brachial artery, and upper extremity arteriography is performed. An additional catheterization code (36215) may be reported with modifier 59 appended along with code 75710, using conventional catheterization coding rules. If the catheter is advanced retrograde to the aorta, code 36200, Introduction of catheter, aorta is not reported in addition to code 36215.

- Intravascular ultrasound (IVUS) (37252-37253) may be separately reported when performed.

Code 36901 describes diagnostic angiography of the dialysis circuit (fistulogram). It includes evaluation of the peri-anastomotic segment through the vena cava (when clinically necessary to diagnose the underlying problem). If the catheter tip placed for the fistulogram is advanced retrograde through the arterial anastomosis for better visualization of the peri-anastomotic segment, that additional catheter manipulation is included in code 36901 and is not separately reported.

While in most cases it is necessary to study the entire dialysis circuit, imaging of the entire dialysis circuit is not always clinically required. For example, when a patient presents for decreased flows during dialysis one week after prior perianastomotic angioplasty and a peripheral segment fistulogram demonstrates a recurrent intra-circuit perianastomotic stenosis, imaging may be limited to the peripheral segment. No modifier is required in these circumstances. Likewise, when a therapeutic intervention follows a recent diagnostic fistulogram where the decision to treat was deferred to another day for clinical reasons, a repeat diagnostic examination may not be necessary, and no modifier is required to report the therapeutic service.

Because the services described by code 36901 are included in codes 36902-36906, code 36901 may not be separately reported with those codes. Code 36902 and code 36903 describe therapeutic interventions in the peripheral dialysis segment without concomitant declotting therapy of the dialysis circuit. Code 36902 describes balloon angioplasty, and code 36903 describes stent placement(s) in the peripheral dialysis segment.

Code 36902 describes all balloon angioplasty in the peripheral segment of the dialysis circuit, regardless of the type of balloon(s) used (eg, high-pressure, cutting, drug-eluting, plain balloon). Code 36902 is reported once for all angioplasty performed in the entire peripheral dialysis segment, even if multiple balloons and/or multiple inflations are used, and/or multiple separate lesions are treated. Balloon angioplasty in the peri-anastomotic region is also reported with code 36902, as the peri-anastomotic region is part of the peripheral segment by definition.

Code 36903 is used to report stent placement(s) in the peripheral segment of the dialysis circuit, and includes any balloon angioplasty performed in the peripheral dialysis segment, even if balloon angioplasty alone is used to treat a separate and distinct lesion from the stented lesion(s). Code 36903 describes placement of any type of stent (eg, bare metal, drug-coated, covered stent), and is reported once regardless of the number of stents placed and the number of lesions treated in the peripheral segment. Stent placement in the peri-anastomotic region is also reported with code 36903, as the peri-anastomotic region is part of the peripheral segment by definition.

Codes 36904-36906 describe declotting/thrombectomy procedures of the dialysis circuit. These codes have a hierarchical progression: code 36904 describes a declot with no

additional intervention, code 36905 describes a fistula declot plus peripheral segment balloon angioplasty, and code 36906 describes a declotting procedure plus peripheral segment stent placement with or without balloon angioplasty. Codes 36904-36906 also include all methods used to open a thrombosed access (eg, thrombolytic bolus, thrombolytic infusion, and/or mechanical thrombectomy). Removal of the arterial plug at the arterial anastomosis by any method is also included in codes 36904-36906 and is not separately reported using a balloon angioplasty code (36905 or 36906). Use of a thrombectomy balloon or angioplasty balloon to mechanically dislodge the arterial plug or other clot is not an angioplasty and is not reported as an additional service. Note that these declot codes include all maneuvers to remove thrombus from both the peripheral dialysis segment and central dialysis segment and are reported once even if thrombus involves both segments. Only one of these codes may be reported per patient per day.

Similar to codes 36902 and 36903, codes 36905 and 36906 are reported only once when performed with declotting procedures regardless of the number of lesions treated, the number of balloons or stents used, the number of inflations, or the type of balloon(s) or stents used to open the peripheral segment.

Codes 36907 and 36908 are add-on codes that have a hierarchical progression: code 36907 describes venous angioplasty and code 36908 describes venous stenting with or without angioplasty in the central segment of the dialysis circuit when performed through direct puncture of the dialysis circuit. Codes 36907-36908 include any additional punctures and catheter maneuvers that may be required to perform the intervention beyond those used for the base code and also include all roadmapping, imaging guidance for the intervention, completion angiography, and RS&I for the intervention(s). These add-on codes are usually reported with a base code from the 36901-36906 code series. However, base codes 36818-36833 may also be reported with codes 36907 and 36908 when central venous angioplasty or stenting occurs in association with an open surgical procedure to create, revise, and/or thrombectomize dialysis circuits. Similar to the dialysis base codes, these add-on codes may only be reported once per encounter per day regardless of the number of lesions treated and the numbers/types of balloons and/or stents used/placed. Because the services of code 36907 are inherently included in code 36908, codes 36907 and 36908 may not be separately reported for the same patient on the same day.

Code 36909 (dialysis circuit embolization) is an add-on code that is reported for any embolization within the dialysis circuit to include the circuit itself as well as side branches. Code 36909 must be used for any dialysis circuit embolization whether access is acquired through the dialysis circuit or other access routes. Dialysis circuit embolization is not reported with code 37241, Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles). Consequently, 36909 may be reported with any number of catheterization or diagnostic angiography base codes. In addition, 36909 may only be reported once per session, regardless of the number of branches/vessels that are embolized within the dialysis circuit as well as side branches.

Table 1. Reporting of Dialysis Circuit Codes

CPT Code	Description	Do not report with these codes	Note
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36901	Introduction of needle(s) and/or catheter(s), dialysis circuit with diagnostic angiography of the dialysis circuit	36832, 36833, 36902, 36903, 36904, 36905, 36906	Not reported more than once per operative session
36902	with transluminal balloon angioplasty, peripheral dialysis segment	36903, 36832, 36833, 36904, 36905, 36906	Not reported more than once per operative session
36903	with transcatheter placement of intravascular stent(s), peripheral dialysis segment	36902, 36832, 36833, 36904, 36905, 36906	Not reported more than once per operative session
36904	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit any method	36832, 36833, 36901, 36902, 36903, 36905, 36906	Not reported more than once per operative session
36905	with transluminal balloon angioplasty, peripheral dialysis segment	36832, 36833, 36901, 36902, 36903, 36904, 36906	Not reported more than once per operative session
36906	with transcatheter placement of intravascular (stents), peripheral dialysis segment	36832, 36833, 36901, 36902, 36903, 36904, 36905	Not reported more than once per operative session
+ 36907	Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit	36908, 37238, 37239, 37248, 37249	Report once for all angioplasty performed w/in the central dialysis segment
+ 36908	Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit	36907, 37238, 37239, 37248, 37249	Report once for all stenting performed within the central dialysis segment

+ 36909	Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular	37241	Report once per encounter per day
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