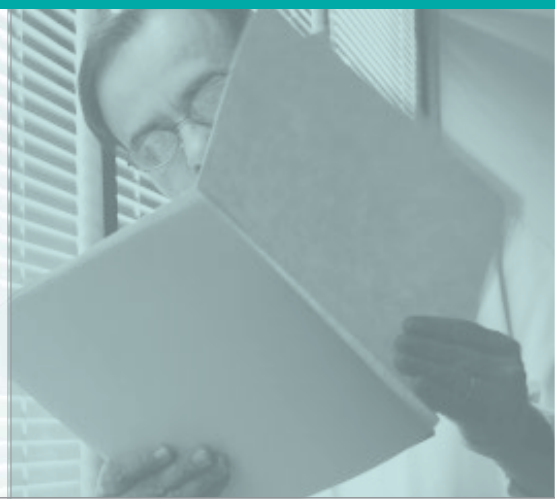
Coding for dialysis circuit interventions



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The American Medical Association (AMA) Current Procedural Terminology (CPT)* Editorial Panel and the AMA Specialty Society Relative Value Scale Update Committee (RUC) Joint Workgroup on Bundled Services is tasked with identifying CPT codes that are frequently reported together in various combinations as part of an effort to eliminate payment for work duplication. In January 2015, the workgroup identified several codes related to dialysis circuit interventions that will require the creation of new "bundled" codes. In October 2015, the CPT Editorial Panel approved deletion of four codes and creation of nine new codes to describe bundled dialysis circuit intervention services. The new codes and coding guidelines took effect January 1. A column in the January issue of the *Bulletin* offered an overview of new CPT codes for 2017.† This article provides more in-depth information about the nine new codes to report angioplasty, stent placement, thrombectomy, embolization, and radiological supervision and interpretation within the dialysis circuit.

Previously, percutaneous maintenance of a dialysis access circuit was reported with a CPT code for the introduction of a needle into the access and additional component coding to appropriately describe endovascular intervention(s) (for example, angioplasty or thrombectomy). Effective in 2017, three codes (36901, 36902, 36903) were created to bundle all work involved in the percutaneous management of a patent dialysis access, and three codes (36904, 36905, 36906) were created to bundle endovascular dialysis access thrombectomy procedures. Both code sets are hierarchical and describe increasing intensity of intervention. In addition, three add-on codes (36907, 36908, 36909) were created to reflect additional work in the central veins and/or branch vessel embolization (see Table 1, page 58).

What is a dialysis circuit?

The arteriovenous (AV) dialysis circuit is designed for easy and repetitive access to perform hemodialysis. It 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 AV fistula, or a prosthetic graft placed between an artery and vein, known as an AV graft. For coding purposes, the dialysis circuit comprises two segments: the peripheral dialysis segment and the central dialysis segment.

The peripheral segment begins at the arterial anastomosis and extends to the central segment. In the upper extremity, the peripheral segment extends up to and includes the axillary vein and entire cephalic vein. In the lower extremity, the peripheral segment extends up to and includes the common femoral vein. In the upper extremity, the central segment includes the subclavian and innominate veins through the superior vena cava. In the lower extremity, the central segment includes the external iliac and common iliac veins through the inferior vena cava.

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†Bothe A, McNally M, Nagle J. 2017 CPT coding changes. *Bull Am Coll Surg.* 2017;102(1):16-25.

TABLE 1. DIALYSIS CIRCUIT INTERVENTION CODES

CPT Code	Descriptor
36901	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report.
36902	with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty.
36903	with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment.
36904	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s).
36905	with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty.
36906	with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit.
+36907	Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty. (List separately in addition to code for primary procedure.)
+36908	Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment. (List separately in addition to code for primary procedure.)
+36909	Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention. (List separately in addition to code for primary procedure.)
Additional codes related to dialysis circuit interventions	
36215	Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family.
75710	Angiography, extremity, unilateral, radiological supervision and interpretation.
75825	Venography, caval, inferior, with serialography, radiological supervision, and interpretation.
75827	Venography, caval, superior, with serialography, radiological supervision, and interpretation.
+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.)

Peripheral dialysis segment imaging and interventions (36901–36906)

Code 36901 (dialysis circuit imaging) describes a traditional diagnostic fistulagram with assessment of the circuit from (and including) the arterial anastomosis through the vena cava. All needle placements, as well as nonselective catheter manipulations within the circuit, are included in 36901 and are not separately reported. If the catheter is advanced to the vena cava, code 36010, *Introduction of catheter, superior or inferior vena cava*, is not reported. Angiography performed during arm access of the superior vena cava (75827) or leg access of the inferior vena cava (75825) is bundled into 36901. However, if ultrasound guidance is required for access into the vessel, this procedure is separately reported with 76937.

Code 36901 and the other primary dialysis circuit intervention codes (36902–36906) include all the necessary catheter placement(s) and manipulation(s) to perform a graft/fistula diagnostic radiological study; however, 36215 is not inherent to the work of these codes. When a catheter is maneuvered from a puncture of the dialysis graft/fistula into the proximal inflow vessel for formal extremity diagnostic arteriography, code 36215 (first order cauterization) and code 75710 (unilateral extremity angiogram) are reported separately.

Code 36902 (peripheral dialysis segment angioplasty) includes all the work included in code 36901. Code 36902 may only be reported once per session. If more than one lesion is treated within the peripheral segment using balloon angioplasty, code 36902 bundles all additional peripheral segment angioplasty regardless of the number of inflations or balloons used. There is no longer any difference between treatments at the arterial anastomosis versus the venous outflow in the peripheral segment.

Code 36903 (peripheral dialysis segment stent placement) includes all of the work described by codes 36901 and 36902, plus all work to deploy an intravascular stent within the peripheral segment. The angioplasty is included even if it treats a lesion within the peripheral segment, but in an area separate and distinct from the stented lesion. For example, if a brachiocephalic fistula is found to have a peri-anastomotic stenosis as well as a stenosis in the mid-cephalic vein, treatment with balloon angioplasty at the peri-anastomotic region followed by a cephalic vein stent would all be reported with 36903. Code 36903 may only be reported once per session, regardless of the number of stents deployed within the peripheral segment. Code 36903 applies to any type of stent deployed, including bare metal, covered, or drug-eluting stents.

Previously, percutaneous thrombectomy of an occluded dialysis access was described by 36870 (deleted for 2017). Any subsequent interventions to ensure patency (such as angioplasty or stenting) were separately reportable. This convention was changed in 2017, and three new codes describing thrombectomy were established (36904–36906). It is important to note that for the purpose of thrombectomy, no distinction is made between the "peripheral" and the "central" dialysis segments; if a clot extends into the central veins, its removal is included in 36904–36906. If angioplasty or a stent is required in the central veins after successful thrombectomy, the central segment angioplasty or stent is separately reportable

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In addition, ACS Surgical Coding Workshop opportunities are available for surgeons and/or their coding staff. For more information or to sign up for one of the 2017 ACS Surgical Coding Workshops, go to *facs.org/advocacy/practmanagement/workshops.*

with codes 36907 or 36908, as detailed later in this article.

Code 36904 incorporates all components of a mechanical or pharmacological declot procedure (for example, mechanical thrombectomy, thrombolytic infusion, or thrombolytic bolus). Thrombectomy of an occluded dialysis access which involves balloon angioplasty in the peripheral segment would be reported with 36905. Similar to code 36902, code 36905 reflects all angioplasty within the peripheral segment regardless of the number of inflations or number of balloons used. Inflating a balloon to push a clot centrally is not considered angioplasty. Code 36905 implies that a stenosis is identified before or after thrombectomy, requiring a therapeutic dilatation to help maintain longer term patency. Stent placement in the peripheral segment would be reported with 36906, which is a comprehensive code involving all stents placed and all balloon angioplasty performed within the peripheral segment during the thrombectomy.

Central dialysis segment interventions (36907 and 36908)

Two add-on codes (36907 and 36908) were created to describe angioplasty or stenting, respectively, performed in the central veins. Catheter placement is bundled into these codes and is not separately reportable. All radiological supervision and interpretation needed to perform an intervention is included in 36907 and 36908 and is not separately reported. Similar to codes 36901–36906, codes 36907 and 36908 may only be reported once per session, regardless of the number of lesions treated. Code 36908 includes all of the work of code 36907; therefore, these two codes may not be reported together. These add-on codes must be reported with a primary procedure—typically one of the percutaneous dialysis circuit codes 36901–36906. However, these add-on codes also may be reported for percutaneous angioplasty or stent placement performed with an open creation (36818–36830) or revision (36831–36833) of an AV fistula or graft. For example, if during an AV graft revision without thrombectomy, a catheter is advanced into the subclavian and a stent is placed for stenosis, code 36832 should be reported for the revision, and add-on code 36908 should be reported for the stent placement.

Embolization of branch vessels (36909)

Add-on code 36909 describes any and all embolization procedures performed on branch or accessory vessel(s) off the hemodialysis circuit. Code 36909 may be reported with any of the base peripheral dialysis segment codes (36901–36906). Code 36909 also may be reported if the embolization is completed from an access other than the dialysis circuit. For example, if a brachiocephalic fistula side-branch is cannulated through an ipsilateral radial artery, code 36909 would be reported for the embolization. Selective venous catheterization(s) of branch vessel(s) (for example, 36011) is included in 36909 and not separately reportable. ♦

Note

Accurate coding is the responsibility of the provider. This summary is intended only to serve as a resource to assist in the billing process.