



## **Creation & Maintenance of Dialysis Vascular Access: Coding Review & Update**

*Melody W. Mulaik, MSHS, CPC, CPC-H, RCC*  
*1-877-6-CODING*  
*melody.mulaik@codingstrategies.com*



### **IMPORTANT**

When a third party payor is involved, the determination of reimbursement for services is the decision of the individual insurance company based on the patient's policy and the third party payor guidelines. No presentation can adequately address reimbursement issues for the hundreds of insurance payors that exist. Therefore, it is essential that each payor be contacted for their individual requirements.

## Agenda

- Compliance vs. Reimbursement
- Pre-surgical Evaluation
- Coding Updates
- Maintenance
- Modifiers
- Coding Operations

## Coding Guidance

- Authoritative guidance
  - American Medical Association
  - Insurance Payors
- Opinions
  - Specialty Societies
  - Other medical groups
  - Healthcare Consultants
  - Billing Companies

## **Local Medical Review Policies (LMRPs) – *Now LCDs***

- **CMS released new rules on LMRPs to ensure that they are developed in an “open and public” process**
- **Carriers are required to list draft LMRPs on their websites**
  - summary of comments received
  - carrier’s response
  - indicated start & stop date of comment period
  - list an e-mail & postal address to which comments should be submitted

## **Pre-Surgical Evaluation *Trailblazers***

- **US (93971) evaluation not address in “Vascular Access for Hemodialysis” policy**
- **Non-Invasive Peripheral Venous Studies policy states “Code V72.83 is to be used only for pre-operative venous mapping for CABG, peripheral artery bypass graft selection, or to determine the integrity of the peripheral venous system prior to the insertion of a cardiovascular catheter.”**

## **Pre-Surgical Evaluation** *Empire*

- **Non-Invasive Diagnostic Studies policy states “Venous mapping is not always indicated as a routine preoperative study. However, if the patient’s clinical evaluation indicates that a vein may not be suitable for creating a dialysis fistula, the venous mapping would be considered medically necessary.”**

## **Pre-Surgical Evaluation** *Empire*

- **“This procedure may also be useful prior to revascularization by reducing the time necessary for surgery.”**
- **Allowed once prior to the surgical procedure**
- **Report 93970 or 93971 and V72.83**

## 2004 Coding Update

- 36838 – Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome)
  - **Not to be reported in conjunction with:**
    - 35512 (bypass graft, with vein subclavian-brachial)
    - 35522 (bypass graft, with vein axillary-brachial)
    - 36832 (Open revision w/o thrombectomy)
    - 37607 (Ligation or banding or angioaccess a/v fistula)
    - 37618 (Ligation, major artery, extremity)

## New CVC Procedure Codes

- Insertion – *New Access*
- Repair – *Fixing device w/o replacement of catheter or port/pump*
- Partial replacement of only the catheter
- Complete exchange
- Remove of entire device

## New Procedure Codes

- No distinction between percutaneous versus cutdown
- No distinction based on catheter size
- Frequency of two for multi-catheter devices
- If existing device is removed and a new device is placed via a separate access, both should be coded
- Assign imaging for fluoro or US

## Fluoroscopic Guidance

**75998**

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 code for primary procedure)

**New Code for 2004**

## Fluoroscopic Guidance

75998

- Do not use 76003 in conjunction with 75998
- If formal extremity venography is performed from a separate venous access and separately interpreted, use 36005 and 75820, 75822, 75825 or 75827

New Code for 2004

## Guidance Procedures

- 76937 Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)

New Code for 2004

# CVC Reference Tool

Central Venous Catheters						
Centrally Inserted				Peripherally Inserted		
Non-Tunneled	Tunneled			w/pump	w/o port or pump (PICC)	
	w/o port or pump	w/port	w/pump		w/o port or pump (PICC)	w/port
Insertion (>5 yrs )	36556	36558 (1 acc) 36565 (2 acc)	36561 (1 acc) 36566 (2 acc)	36563	36569	36571
Repair	36575	36575	36576		36575	36576
Replacement (cath only)			36578	36578		36578
Replacement (complete) through same venous access	36580	36581	36582	36583	36584	36585
Removal		36589	36590	36590		36590
Repositioning under fluoro	36597	36597	36597	36597	36597	36597

Fluoroscopic guidance - 75998    Ultrasound guidance - 76937

# Percutaneous Interventions

- Code separately diagnostic catheter placements, angiography and removal of thrombus.
- “Apex puncture technique” is one (1) puncture into the graft.
- If two separate catheter insertions are made into the fistula, the access code may be assigned twice.

## Dialysis Access

### Procedure Codes

- 36145 - introduction of needle or intracatheter, arteriovenous shunt created for dialysis
- 35475 - transluminal balloon angioplasty, brachiocephalic trunk or branches
- 35476 - ... venous

## Dialysis Access

### S&I Codes

- 75790 - angiography, arteriovenous shunt
- 75962 - transluminal balloon angioplasty, brachiocephalic trunk or branches
- 75978 - transluminal balloon angioplasty, venous

*There is no printed authoritative reference prohibiting the coding of 75820, venography of extremity, with 75790, angiography of arteriovenous shunt.*

*SCVIR supports coding only the shunt angiography (75790) to include venous outflow all the way to the superior vena cava.*

## Declot Dialysis Graft

36870 - thrombectomy,  
percutaneous,  
arteriovenous fistula,  
autogenous or non-  
autogenous graft  
(includes mechanical  
thrombus extraction  
and intra-graft  
thrombolysis)

## Declot Dialysis Graft

A graft is considered to be a single vascular conduit. Coding for a declot, by any method, includes dec clotting the entire graft.

- Multiple passes
- Multiple methods

## Dialysis Intervention *Trailblazers*

- PTA within the segment – single venous PTA
- Only bill 35476 when there is a documented stenosis **proximal to the fistula**. It may not be billed with the dilation of the venous end of the fistula/graft.
- **Use CPT code 37799 when performing a venous stent placement in treatment of a stenotic vessel directly affecting fistula flow.**

## AV Steps

- Puncture the graft – 1 or 2
- Declot the graft if necessary
- PTA of vessel(s) not associated with decлот procedure
- Stent placement(s)
- Imaging of the graft

## Other Maintenance

- Maintenance angioplasty is not covered by Medicare – assign ICD-9 V55.9
- Routine use of US for monitoring status of fistula is regarded as screening and not covered by Medicare
- As part of the dialysis treatment, ESRD facilities are responsible for monitoring access and when occlusions occur, either declotting the access or referring the patient for appropriate treatment.

## Modifiers

- Most procedures associated with A/V grafts have a 90 global period
- Interventions or procedures performed within the 90 day period must be modified appropriately
  - Modifier -78 *Return to the OR for a related procedure during the post-op period*
  - Modifier -79 *Unrelated procedure or service by the same physician during the postoperative period*

# Operational Concerns

## **Charge Capture Concerns**

- Make certain to capture all the charges
  - charge ticket or coder?
  - Is there a reconciliation process?
  
- Add modifier(s) as needed
  - Who is responsible for assignment?
  - When is the modifier assigned?
  - What information is utilized?

## Evaluate Current System

- **Diagnosis Code Assignment**
  - Who is responsible for assignment?
  - What information is utilized?
  - What coding tools are utilized?

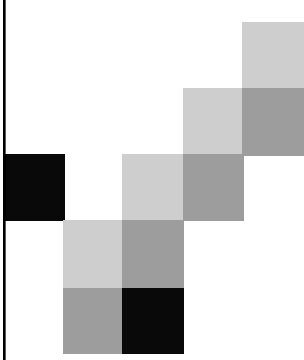
## Evaluate Current System

- **Reject/Denial Follow-Up**
  - How are rejects/denials tracked?
  - Who is responsible for following up on medical necessity or other coding related denials?
  - What policies are in place to dictate how reject/denials will be resolved?



## Protect Yourself

- Avoid upcoding and unbundling
- Carefully document “unlisted” procedures
- Clarify coding ambiguities
- Use modifiers appropriately
- Ensure proficient support system



**This concludes this  
session.  
Thank you!**

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