Deciphering Dialysis Access Maintenance Coding

by Stacie L. Buck, RHIA, CCS-P, LHRM, RCC, CIC

One year after the introduction of two new HCPCS codes for dialysis declotting procedures, confusion remains as to when to report these codes and how to report them in conjunction with other interventions performed during dialysis access maintenance. This article discusses the many facets of dialysis declotting procedure coding, including access, imaging, angioplasty, and thrombectomy.

AV Graft Declotting

Arteriovenous fistulas (AVFs) are surgically created conduits that connect a superficial artery to a venous structure. Often these grafts become occluded and require a therapeutic intervention to restore optimal function to the graft.

AV grafts are treated most commonly by percutaneous angioplasty or thrombectomy. Percutaneous transluminal angioplasty (PTA) eliminates areas of narrowing or occlusion in the graft.

During PTA a balloon catheter is inserted through the skin into a vessel to the site of narrowing. A thrombectomy is a treatment that uses an endovascular device such as an AngioJet or Trerotola to fragment and remove stenoses in occluded vessels.

Access and Fistulagram

A physician most often gains access into the AV graft by direct puncture into the graft (36145). There may also be occasion where the physician chooses to access the AV graft via the brachial artery (36120) or some other point of access. Once the physician gains access, he or she places the catheter at the desired position and injects contrast material to visualize the occlusion. This imaging procedure is referred to as a fistulagram (75790).

If the fistulagram reveals an occlusion in or around the graft, the physician proceeds with angioplasty or thrombectomy to eradicate it. Code 75790 is assigned only one time per encounter. Repeat fistulagrams are not reported separately.

There may be times when the physician needs to enter the graft from the opposite end of the access and will make a second puncture into the graft. If the physician gains access at both the arterial anastomosis and the venous anastomosis, code 36145 is assigned twice.

It is important to note that some payers may require the -59 modifier on the second puncture. The table “Access and Fistulagram Codes,” opposite, provides a list of these codes and their full descriptors.

Angioplasty

A common treatment option for occlusion of an AV graft is angioplasty. In 2007 two HCPCS codes were introduced specifically for reporting these procedures: G0392 for angioplasty at the arterial anastomosis and G0393 for angioplasty at the venous anastomosis.

These codes are required by Medicare; however, other third-party payers may not yet recognize them. If the codes are not recognized by a payer, then the regular angioplasty codes should be reported for these procedures. There are instances where it may be appropriate to report an HCPCS G code in addition to a CPT code for angioplasty. If a separate vessel outside of the graft is treated by angioplasty during the same session, then both a G code and CPT codes may be reported. The CPT codes require a -59 modifier to show that the procedure is separate and distinct.

Guidance on determining a separate vessel for coding purposes may be found in the *Interventional Radiology Coding User's Guide*. The guide advises that "The entire graft from the arterial anastomosis through the venous anastomosis, as well as the outflow vein approximately to the level of the axillary vein, is considered a single vessel. All PTA within this segment should be coded as a single venous PTA, regardless of the number of stenoses treated within the segment."[1]

CPT coding conventions for angioplasty also hold true for angioplasty of an AV graft. Only one angioplasty code is assigned when multiple stenoses are treated in the same vessel or graft.

The AV fistula/graft venous angioplasty codes (G0393 and 75978) are used once even if more than one stenosis is treated within the fistula/graft (at the anastomosis or in the outflow vein in the arm). Angioplasty may be coded a second time when a separate stenosis outside the graft is treated in a central vessel such as the subclavian. The site of, and need for, separate stenosis treatment should be clearly documented in the report.

If an angioplasty of the subclavian vein is performed, codes 35476 and 75978 may be coded for the angioplasty of the subclavian in addition to the angioplasty of the graft. The -59 modifier should be appended to both of these codes to indicate that the angioplasty is separate and distinct from the angioplasty of the AV graft. "Angioplasty Codes," below, provides a list of these codes and their full descriptors.

Although there are two separate codes to describe angioplasty at the arterial anastomosis and the venous anastomosis, only one of these codes may be assigned per encounter. This is consistent with advice from the Society of Interventional Radiology, which considers the entire graft from the arterial anastomosis through the venous anastomosis, as well as the outflow vein approximately to the level of the axillary vein, a single vessel.

Most payers consider AV graft procedures venous procedures, and these interventions are usually coded as such. If a stenosis is treated at the arterial anastomosis in addition to the venous anastomosis, code G0393 should be assigned, since this is considered a single vessel. However, if a stenosis is present at the arterial anastomosis and is treated, and there is no angioplasty performed at the venous anastomosis, some payers may treat the angioplasty of the arterial anastomosis as a peripheral arterial procedure.

Access and Fistulagram Codes

Several codes describe an AV graft declotting, depending on the entry point of the graft and use of a fistulagram.

Code	Descriptor
36120	Introduction of needle or intracatheter; retrograde brachial artery
36145	Introduction of needle or intracatheter; arteriovenous shunt created for dialysis (cannula, fistula, or graft)
75790	Angiography, arteriovenous shunt (e.g., dialysis patient), radiological supervision, and interpretation

Angioplasty Codes

Angioplasty is a common treatment option for occlusion of an AV graft. The codes below describe the different procedures.

Code	Descriptor
*G0392	Transluminal balloon angioplasty, percutaneous; for maintenance of hemodialysis access, arteriovenous fistula or graft; arterial
*G0393	Transluminal balloon angioplasty, percutaneous; for maintenance of hemodialysis access, arteriovenous fistula or graft; venous
35476	Transluminal balloon angioplasty, percutaneous, venous
75978	Transluminal balloon angioplasty, venous (e.g., subclavian stenosis), radiological supervision and interpretation

*Note: Some payers do not recognize G0392 and G0393; therefore the appropriate CPT codes should be used to report angioplasty of the graft: venous (35476, 75978), arterial (35475, 75962)

Thrombectomy

Physicians may opt to perform a thrombectomy to remove an occlusion, and it may be the only therapeutic intervention performed. However, in many instances a thrombectomy is performed during the same session as angioplasty.

Code 36870 describes percutaneous thrombus removal from the AVF. This code includes only the work necessary to remove the thrombus from the AVF, including all mechanical and pharmacological means of thrombus removal.[2] There is no corresponding radiology supervision and interpretation code for 36870. Code 36870 should be reported in addition to the other codes that describe the procedure. The table below provides a full descriptor for code 36870.

In the event that there is a thrombus outside the graft and thrombolysis (infusion of a drug to dissolve a clot) is performed, codes 37201 and 75896 are also assigned for the thrombolytic infusion.

Many times the physician will utilize heparin during a thrombectomy procedure. This is not considered thrombolysis and should not be coded as such. The heparin is used to keep the vessel patent during the procedure.

Coding Thrombectomy

A physician may opt to perform a thrombectomy to remove an occlusion. The code and descriptor are outlined below.

Code	Descriptor

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

Conclusion

It is important to realize that with these procedures, as with all interventional procedures, there may be variations in how a physician performs them as well as variations in anatomy that may affect coding. Coding professionals should always take care to read all reports thoroughly to ensure that all codes that describe the work performed are captured and reported accurately.

Furthermore, the policies of third-party payers may vary, so it is advisable to verify with the facility's various payers whether or not the HCPCS G codes or CPT codes should be used to report these procedures and in what instances reporting an arterial angioplasty may be warranted based on payer policy.

Notes

1. Society of Interventional Radiology, American College of Radiology, Radiology Business Management Association, and the American Healthcare Radiology Administrators. *Interventional Radiology Coding User's Guide*, 13th edition. Reston, VA: Society of Interventional Radiology, 2007.
2. American Medical Association. *CPT Assistant*, May 2001.

Stacie L. Buck (stacie@southeastrad.com) is vice president of Southeast Radiology Management in Stuart, FL.

Article citation:
Buck, Stacie L. "Deciphering Dialysis Access Maintenance Coding" *Journal of AHIMA* 79, no.5 (May 2008): 70-72.