

Intervention(s) for Thrombosed or Jeopardized Hemodialysis Access Grafts

2009 CODING AND REIMBURSEMENT GUIDE

Payment						
Thrombectomy Therapy						
		Ambulatory Surgery Center	Outpatient Hospital		Physician Services	
Code	Procedure Description	Facility Payment ¹	APC	Facility Payment (National Medicare Avg ²)	Fee When Procedure Is Performed in Hospital or ASC (National Medicare Avg ³)	Fee When Procedure Is Performed in Office (National Medicare Avg ³)
36145	Introduction of needle or intracatheter; arteriovenous shunt created for dialysis (cannula, fistula, or graft)	Access is included in the payment allowance for thrombectomy		Items or services are packaged into the payment rate for the thrombectomy procedure	\$101.35	\$466.34
36870	Thrombectomy, percutaneous, arteriovenous fistula; autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)	\$1,598.34	0653	\$3,094.95	\$302.96	\$1,770.15
75790	Angiography, arteriovenous shunt (eg, dialysis patient), radiological supervision and interpretation	Imaging is included in the payment allowance for thrombectomy		Imaging is included in the payment allowance for thrombectomy	\$92.33	\$174.56

Note: 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 and is part of Zone 1.⁴

36870 has a 90 day global restriction. Post-op complications or related evaluation and management services are included in the above-listed payment.

36870 includes mechanical methods such as thrombectomy devices and Fogarty balloon extraction as well as pharmacological methods such as dissolving the clot with thrombolytic agents, including lyse and wait procedure.⁴

36145 may be billed as an additional unit if more than one puncture is made to the graft.⁴

1. 2009 Medicare Ambulatory Surgery Center Fee Schedule
2. 2009 Medicare Outpatient Prospective Payment System (OPPS) Fee Schedule
3. 2009 Medicare Physician Fee Schedule
4. Zielske D, Dunn D. *Dr. Z's Medical Coding Series Interventional Coding Reference. 2008 Edition.* Brentwood, TN: ZHealth Publishing; 2008.

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Disclaimer: The information provided herein reflects Cook's understanding of the procedure(s) and/or device(s) from sources which may include, but are not limited to, the CPT, ICD-9 and MS-DRG coding systems; Medicare payment systems; commercially available coding guides; professional societies; and research conducted by independent coding and reimbursement consultants. This information should not be construed as authoritative. The entity billing Medicare and/or third party payers is solely responsible for the accuracy of the codes assigned to the services and items in the medical record. Cook does not, and should not, have access to medical records, and therefore cannot recommend codes for specific cases. When making coding decisions, we encourage you to seek input from the AMA, AHA, relevant medical societies, CMS, your local Medicare Administrative Contractor and other health plans to which you submit claims. Cook does not promote the off-label use of its devices.

Payment

Angioplasty

Code	Procedure Description	Ambulatory Surgery Center	Outpatient Hospital		Physician Services	
		Facility Payment ¹	APC	Facility Payment (National Medicare Avg ²)	Fee When Procedure Is Performed in Hospital or ASC (National Medicare Avg ³)	Fee When Procedure Is Performed in Office (National Medicare Avg ³)
G0392	Transluminal balloon angioplasty, percutaneous; for maintenance of hemodialysis access, arteriovenous fistula or graft; arterial	\$1,628.76	0083	\$3,194.51	\$449.39	\$2,157.14
G0393	Transluminal balloon angioplasty, percutaneous; for maintenance of hemodialysis access, arteriovenous fistula or graft; venous	\$1,628.76	0083	\$3,194.51	\$314.50	\$1,628.05
75962	Transluminal balloon angioplasty, peripheral artery, radiological supervision and interpretation	Imaging is included in the payment allowance for declotting the fistula graft		Imaging is included in the payment allowance for declotting the fistula graft	\$27.77	\$286.37
75978	Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation	Imaging is included in the payment allowance for declotting the fistula graft		Imaging is included in the payment allowance for declotting the fistula graft	\$27.05	\$281.68

If more than one venous stenosis is treated at the anastomosis or outflow vein of the arm, G0393 can only be used once.⁴

If a stenosis is present at the arterial anastomosis and treated in addition to angioplasty of a venous anastomotic stenosis, only one angioplasty is reported. The fistula graft is considered a single vessel.⁴

If a stenosis is present at the arterial anastomosis and treated, and there is no venous angioplasty performed in the venous anastomosis, providers are urged to contact their local carrier medical director for coding guidance.⁴

Angioplasty is **never** coded for removal of the arterial plug, whether performed using a Fogarty-type balloon or an angioplasty balloon.

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3. 2009 Medicare Physician Fee Schedule

4. Zielske D, Dunn D. *Dr. Z's Medical Coding Series Interventional Coding Reference. 2008 Edition.* Brentwood, TN: ZHealth Publishing; 2008.

Payment

Stenting

Code	Procedure Description	Ambulatory Surgery Center	Outpatient Hospital		Physician Services	
		Facility Payment ¹	APC	Facility Payment (National Medicare Avg ²)	Fee When Procedure Is Performed in Hospital or ASC (National Medicare Avg ³)	Fee When Procedure Is Performed in Office (National Medicare Avg ³)
37205	Transcatheter placement of an intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous; initial vessel	This service is not on Medicare's list of approved procedures in this setting	0229	\$6,093.99	\$444.70	\$4,112.31
+37206	Transcatheter placement of an intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous; each additional vessel (List separately in addition to code for primary procedure)	This service is not on Medicare's list of approved procedures in this setting	0229	\$3,047.00 Multiple procedure reduction applied	\$216.76	\$2,477.41
75960	Transcatheter introduction of intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous and/or open, radiological supervision and interpretation, each vessel	This service is not on Medicare's list of approved procedures in this setting		Imaging is included in the payment allowance for stent placement	\$42.92	\$267.97

(+) in front of a procedure code denotes an add-on code. Add-on codes allow reporting of additional work associated with a primary procedure(s) and must never be reported alone. In addition, physician add-on codes are exempt from multiple procedure reduction.

Vascular access, radiological supervision and interpretation services and thrombolysis are not included in the stent codes and are separately coded.

Angioplasty performed as the method of stent deployment is not a separately coded service.

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2009 physician fees for your local area can be found at the following CMS links:

http://www.cms.hhs.gov/PFSlookup/02_PFSsearch.asp#TopOfPage

or

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSNPAF/list.asp#TopOfPage>



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