Intervention(s) for Thrombosed or Jeopardized Hemodialysis Access Grafts

2018 CODING AND REIMBURSEMENT GUIDE

Coverage, coding and payment for medical procedures and devices can be confusing. This guide was developed to assist with Medicare reporting and reimbursement when performing interventions on thrombosed or jeopardized hemodialysis access grafts. If you have any questions, please contact our reimbursement team at 800.468.1379 or by e-mail at Reimbursement@cookmedical.com.

Coverage

Medicare carriers may issue Local Coverage Decisions (LCD's) listing criteria that must be met prior to coverage. Physicians are urged to review these policies (http://www.cms.hhs.gov/mcd/search.asp) and contact their local medical directors (www.cms.hhs.gov/apps/contacts), or commercial insurers to determine if a procedure is covered.

Coding

In 2017 new bundled CPT codes were created to report procedures performed in the dialysis circuit. Dialysis circuit angiography, angioplasty, stent placement, thrombectomy and embolization are in this family of codes. Imaging and radiological supervision and interpretation is included in all the new codes. For the purpose of coding interventional procedures in the dialysis circuit (both AVF and AVG), the dialysis circuit is artificially divided into two distinct segments: peripheral dialysis segment and central dialysis segment. Peripheral dialysis segment is the portion of the dialysis circuit that begins at the arterial anastomosis and extends to the central dialysis segment. Central dialysis segment includes all draining veins central to the peripheral dialysis segment.

Codes 36901, 36902, 36903, 36904, 36905, 36906 are built on progressive hierarchies that have more intensive services, which include less intensive services. All dialysis circuit puncture required to perform the procedure are included in 36901. All catheterizations required to perform additional interventional service are included in codes 36902 – 36909 and not separately reported. All angiography, fluoroscopic image guidance, roadmapping, and radiological supervision and interpretation required to perform each service are included in each code. Closure of the puncture(s) by any method is included in the service of each individual code. It is never appropriate to report removal of the arterial plug during a declot/thrombectomy procedure as an angioplasty (36905).

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; (Do not report 36901 in conjunction with 36833, 36902, 36903, 36904, 36905, 36906)
36902	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; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty (Do not report 36902 in conjunction with 36903) **36902 would be reported only once per session to describe all angioplasty services performed in the peripheral segment of the dialysis circuit, regardless of the number of distinct lesions treated within that segment, the number of times the balloon is inflated, or the number of balloon catheters or sizes required to open all lesions, and includes angioplasty of the peri-anastomotic segment when performed.**[1]

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Disclaimer: The information provided herein reflects Cook's understanding of the procedure(s) and/or device(s) from sources that may include, but are not limited to, the CPT coding system; 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 you are making coding decisions, we encourage you to seek input from the AMA, 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.

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36903	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; 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 (Do not report 36902, 36903 in conjunction with 36833, 36904, 36905, 36906) (Do not report 36901, 36902, 36903 more than once per operative session) (For transluminal balloon angioplasty within central vein(s) when performed through dialysis circuit, use 36907) (For transcatheter placement of intravascular stent(s) within central vein(s) when performed through dialysis circuit, use 36908)
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); (For open thrombectomy within the dialysis circuit, see 36831, 36833)
36905	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); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty (Do not report 36905 in conjunction with 36904)
36906	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); 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 (Do not report 36906 in conjunction with 36901, 36902, 36903, 36904, 36905) (Do not report 36904, 36905, 36906 more than once per operative session) (For transluminal balloon angioplasty within central vein(s) when performed through dialysis circuit, use 36907) (For transcatheter placement of intravascular stent(s) within central vein(s) when performed through dialysis circuit, use 36908)
+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) (Use 36907 in conjunction with 36818-36833, 36901, 36902, 36903, 36904, 36905, 36906) (Do not report 36907 in conjunction with 36908) (Report 36907 once for all angioplasty performed within the central dialysis segment) **36907 may be reported only once per session with 36901- 36906, as appropriate**
+36908	Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and 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) (Use 36908 in conjunction with 36818-36833, 36901, 36902, 36903, 36904, 36905, 36906) (Do not report 36908 in conjunction with 36907) (Report 36908 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, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure) (36909 includes all permanent vascular occlusions within the dialysis circuit and may only be reported once per encounter per day) (Report 36909 in conjunction with 36901, 36902, 36903, 36904, 36905, 36906) (For open ligation/occlusion in dialysis access, use 37607)

(+) 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.

Ultrasound guidance for puncture of the dialysis circuit access is not typically performed and is not included in 36901- 36906. However, in the case of a new (immature) or failing AVF, ultrasound may be necessary to safely and effectively puncture the dialysis circuit for evaluation, and this may be reported separately with 76937 , if all appropriate elements for reporting 76937 are performed and documented.[1]

For radiological supervision and interpretation of dialysis circuit angiography performed through existing access(es) or catheter-based arterial access, report 36901 with modifier 52.[1]

1. American Medical Association. *CPT 2018 Professional Edition*. Chicago, IL: American Medical Association; 2017:256-258.

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Payment

2018 Medicare Reimbursement for Intervention(s) for Thrombosed or Jeopardized Hemodialysis Access Grafts

		Ambulatory Surgery Center	*Outpatient Hospital*		*Physician Services*	
CPT® Code	Procedure Description	Facility Payment (National Medicare Avg[2])	APC	Facility Payment (National Medicare Avg[3])	Fee When Procedure Is Performed in Hospital or ASC (Estimated National Medicare Avg[4])	Fee When Procedure Is Performed in Office (Estimated National Medicare Avg[4])
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;	$319.15	5181	$612.53	$176.40	$611.27
36902	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; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	$2,524.91	5192	$5,084.66	$251.28	$1,272.23
36903	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; 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	$4,480.73	5193	$10,509.72	$332.64	$5,725.38
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);	$2,524.91	5192	$5,084.66	$388.08	$1,848.94
36905	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); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	$4,480.73	5193	$10,509.72	$465.83	$2,343.57

		Ambulatory Surgery Center	*Outpatient Hospital*		*Physician Services*	
CPT® Code	Procedure Description	Facility Payment (National Medicare Avg[2])	APC	Facility Payment (National Medicare Avg[3])	Fee When Procedure Is Performed in Hospital or ASC (Estimated National Medicare Avg[4])	Fee When Procedure Is Performed in Office (Estimated National Medicare Avg[4])
36906	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); 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	$6,925.53	5194	$16,019.29	$538.19	$6,948.64
+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)	Packaged service/item; no separate payment made			$154.08	$770.03
+36908	Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and 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)	Packaged service/item; no separate payment made			$219.60	$2,762.97
+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)	Packaged service/item; no separate payment made			$217.44	$2,008.06

1. 2018 Medicare Ambulatory Surgery Center Fee Schedule
2. 2018 Medicare Hospital Outpatient Prospective Payment System (OPPS) Fee Schedule
3. 2018 Medicare Physician Fee Schedule

2018 physician fees for your local area can be found at the following CMS links:

http://www.cms.hhs.gov/pfslookup

or

http://www.cms.hhs.gov/PhysicianFeeSched/PFSNPAF/list.asp

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