Maintenance of an Arteriovenous Fistula

An arteriovenous fistula is most often created for dialysis access to facilitate chronic hemodialysis. Keeping these access sites preserved is very important for patients. Problems can arise with an AV fistula, such as stenosis of the graft/vessel or a thrombus in the graft/vessel.

There have been some changes made for 2010 regarding AV fistulas. Codes 36145 (Introduction of needle or intracatheter; AV shunt created for dialysis) and 75790 (imaging of the graft) have been deleted for 2010 and there are now new codes for vascular access and new guidelines that go along with them.

⇒ 36147 – Introduction of needle and/or catheter, AV shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the IVC or SVC
⇒ +36148-......additional access for therapeutic intervention

The code descriptor for CPT 36147 now includes access, injection of contrast and all necessary imaging. It now makes it an all inclusive code, which is the reason for the deletion of CPT 75790. If 36147 indicates the need for a therapeutic intervention requiring a second shunt catheterization, report the new add-on code 36148 in addition to CPT 36147 as stated in a parenthetical note in CPT following this code set.

There are procedures that may be performed to correct various problems with an AV fistula. One would be the declotting of the dialysis access, CPT code 36870. This code includes the work of thrombus removal from the access using any method of removing, including mechanical thrombectomy as well as pharmacologic thrombectomy. It is coded once, even if several different devices or treatment combinations are used.

Balloon Angioplasty is another procedure which could be performed. PTA codes are coded per vessel; this includes the entire dialysis graft and its outflow vein, including the arterial and venous anastomosis. The correct CPT codes to report would be 35476 (Transluminal balloon angioplasty, venous) and 75978 (RS&I).

There may be a time a stent would need to be placed. Report CPT codes 37205 (Transcatheter placement of an intravascular stent(s)) and 75960 (RS&I). Angioplasty is not reported if it is performed only to deploy the stent but PTA can be reported with the stent for the same vessel if the primary angioplasty failed and now the stent needs to be placed. You can only report one stent placement even if multiple stents are deployed within the dialysis graft or shunt. Follow-up angiography after stent placement is not separately reported. Do not code 75898.

CPT code 75791 (Angiography, arteriovenous shunt) is new for 2010. This code includes the complete evaluation of dialysis access, including fluoroscopy, image documentation and report. Only report this code when a fistulagram is performed by injecting contrast through the cannula or if a fistulagram is performed for some reason from an access site which is not a direct puncture of the fistula. A parenthetical note follows stating that CPT code 36147 cannot be reported with 75791.
Panic, but Calmly

Regardless of your opinion of the direction of the health care system in the United States, the one thing that is certain after last week’s passage of the health care reform legislation (and the immediate amendments) is that whether you are ecstatic or massively depressed you are probably overreacting.

As has been discussed in many different venues, the benefits that will be available to the population will be phased in over an extended timeframe, some not occurring until 2018. As a result, the full impact of the bill will not be felt until after the current Congress and administration have had the opportunity to turn over at least once. What is clear is that each of the items in the bill (and in some cases referencing back to the Recovery Act) can have a significant impact on health care diagnosis and treatment, and financing.

Some of the significant changes over the next year which may affect your practice are:

⇒ Coverage of adult children, through age 26. Many of the “uninsured” are young adults who are trying to go without insurance in order to save money. By providing them with the ability to retain coverage through their parents’ policies there will almost certainly be a large number of self pay patients who will suddenly become insured. This is good news for providers and really bad news for insurance companies, and possibly holders of family plan coverage. Simply put, self pay patients will suddenly become insured. Unfortunately for the insurance company, most such insured will come through families that already purchase family coverage and the extension of benefits will be accomplished without additional premiums. Expect some moderate push on family coverage premium levels in order to accommodate this expansion. Luckily for everyone on the insurance front, health care usage levels are nearly the lowest of any age group for the 21-26 crowd.

⇒ No lifetime dollar limits. Most insurance plans limit the total paid benefits during a lifetime. This change will affect only a few patients since such levels are generally quite high (e.g. $1,000,000) but for those patients this will be a godsend. These are often the patients who receive total charity care. Expect some reduction in charity write-offs as a result.

⇒ Several changes are aimed at re-regulating the self funded health care spending (e.g. Flexible spending accounts, MSAs), none of which are expected to have a direct impact on providers.

⇒ The Medicare doughnut hole will be shrunk, ultimately to zero. This will help seniors afford their prescriptions and may lead to better compliance with drug regimens.

⇒ Insurance companies will not be able to disenroll the newly ill and will be unable to bar children from insurance due to preexisting conditions. These steps should also help to reduce the rolls of the medically indigent, reducing self pay bad debt and increasing payments for services rendered. Again, these patients tend to be high service users resulting in a disproportionate impact on practice finances.

⇒ A federal insurance program will be established to help adults with preexisting conditions. Its impact will be similar to that noted above.

So for providers, the outlook is relatively positive. Possibly more patients, definitely more ability for existing patients to move from self pay, bad debt and charity into insured status. Costs to collect accounts should decrease while revenue per account should increase.

If you are an insurance company, this is pretty bad. You have to cover a lot more people for a lot more services and have to do so with a limited ability to raise your premiums. Some of the plans got ahead of the legislation and increased premiums recently, watch for more such press releases. This is very expensive legislation for the insurance companies. Looming in the background are the promised $500 billion in Medicare payment cuts which are to be used to finance some of these benefits, and the expansion of Medicaid coverage which includes a large unfunded State liability (the federal government provides only partial coverage for Medicaid expenditures).

Any bets about the long term impact of this legislation are probably very premature. The fact is that there are probably very few individuals who have taken the time to read and understand the interrelationships between the many facets of this bill and the actual financing and provision of health care in the United States. After passing the Senate Bill, two separate amendments have been passed and signed by the President. We should expect other amendments to wind their way through the legislative process as the consequences, intended and otherwise, of the reform bill become clear.

Even the Recovery Act will come into play as the comparative effectiveness research, authorized and funded by the Recovery Act will be used in the design of minimum plan coverage standards to be issued by the federal government.

The passage of this legislation is certainly a groundbreaking step, what we don’t know as yet is whether this will be the foundation for a great new building, or just a gigantic hole in the ground. The one thing that is certain is that the effect will be small and at the edges for the next year. We will be watching your accounts for the tell tale traces of its impact.