

1. Question: Can you please explain the difference between CPT codes 36147, 36148 and 75791? The code descriptors are similar and it is difficult to understand the appropriate use of each code.

Code 36147 is reported when the physician performs a fistulagram to evaluate a dialysis arteriovenous fistula or graft. This code includes all components of the fistulagram, including the work of the initial puncture into the graft or fistula and all of the necessary imaging from the arterial anastomosis through the entire venous outflow – including the central veins and superior or inferior vena cava. This code also includes all of the catheter manipulation to perform the diagnostic examination, including advancement of the catheter to the cava if necessary to fully visualize the central veins.

Code 36148 was established to describe the placement of a second (additional) access that may be necessary to perform a therapeutic procedure (e.g., percutaneous transluminal angioplasty, thrombolysis). Please note that code 36148 is an add-on code that is reported only in conjunction with code 36147.

Code 75791 is reported to describe the imaging of the arteriovenous dialysis fistula or graft performed through an existing access (e.g., patient presents from the dialysis suite with needles placed into the graft or fistula, or from a remote access such as the femoral artery that is not a direct puncture to the graft, or images from an operative angiogram that are submitted for interpretation only). The imaging includes the entire length of the graft or fistula and all of the outflow veins through the central veins, including the vena cava.

2. Question: The physician diagnosed and treated two different obstructions through two separate accesses — one at the venous anastomosis and one in the subclavian vein. Is this reported with two percutaneous transluminal venous angioplasties (PTAs) or only one?

All balloon angioplasties performed to the arteriovenous (AV) dialysis fistula or graft are coded with one set of angioplasty codes (35476, 75978), no matter how many focal stenoses are treated within the AV dialysis circuit. All lesions treated in the central veins beyond the axillary vein are coded as a separate venous angioplasty, regardless of how many focal lesions are treated.

For therapeutic purposes, the fistula or graft “vessel” is defined as extending from the arterial anastomosis, through the venous anastomosis, and including the outflow veins to the junction of the axillary or cephalic vein and subclavian vein. Therefore, the venous angioplasty of a central vessel (e.g., the subclavian vein) is appropriately reported separately in addition to the

angioplasty of the fistula itself. The clinical indication for treatment of these lesions should be clearly documented in the medical record.

3. Question: If a physician places an access to the dialysis arteriovenous fistula or graft and advances the catheter for selective catheterization into a venous collateral of the extremity, does code 36147 include the selective catheter placement or should the selective catheterization be reported separately?

The new bundled code 36147 (*Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access...*) includes all catheterization within the circuit; however, selective catheterization within branch draining veins off the circuit is NOT bundled into code 36147 and is separately reportable. If the collateral vein is subselected for a clinical purpose (described in the operative report), it may be reported separately. In this case, the selective venous catheterization and the imaging are reported using CPT codes 36011 [*Selective catheter placement, venous system; first order branch (e.g., renal vein, jugular vein)*] and 75791 (*Angiography, arteriovenous shunt (e.g., dialysis patient fistula/graft) complete evaluation of dialysis access...*). Because a more selective catheterization code (36011) is reported, one no longer reports 36147.

4. Question: When a patient comes to the Interventional Radiology suite for radiological evaluation of the fistula or graft with an existing access (e.g., needles placed in dialysis unit), and based on the findings a second access is necessary to perform a therapeutic procedure, what are the correct code(s) to report?

When a patient comes to the Interventional Radiology suite for radiological evaluation of the fistula or graft with an existing access in place and, based on the findings, a second access is necessary to perform a therapeutic procedure, the correct code to report for the access to the dialysis fistula graft is 36147 (*Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access...*). This is considered a single new access, not an additional access. Because CPT code 36147 includes all of the necessary imaging for the diagnostic radiological evaluation of the fistula graft, the initial imaging performed to the existing access is not reported separately. In this scenario, it is inappropriate to report add-on code 36148 (*Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention...*) as this code is reported only in conjunction with code 36147.