

Fistula First Breakthrough Initiative National Coalition

Priority Recommendations



The AV *Fistula First Breakthrough Initiative National Coalition* recommends that all payers implement concrete measures to actively promote:

- ✘ Use of early testing to detect kidney disease and CKD stage;
- ✘ Placement of fistulas, where and when medically feasible and in best interest of the patient; and
- ✘ Proper staff training in the care and maintenance of all vascular accesses.

1. Early Detection of Chronic Kidney Disease (**KDOQI Stages 1-3**) [change concept 2]
Early testing efforts for chronic kidney disease (CKD) should be supported by all payers. Coverage and benefit design should incorporate these profiling opportunities and include laboratory services.

Testing can be incorporated into wellness examinations, diabetic testing events and other such programs for high-risk individuals. Two major components of the testing are urine albumin/creatinine ratio and eGFR, based on the MDRD formula (age, race, gender, Cr), which should be used in these ambulatory evaluation/testing programs.

When testing efforts identify individuals with kidney damage (GFR \leq 60 ml/min), referral to a nephrologist should be made and the person deemed eligible for any vascular access-related management programs and associated drug therapy. For individuals with significant kidney damage (GFR \leq 30 ml.), teaming with a nephrologist should be practiced. Coverage for vascular access evaluation, placement, revisions and complications should be included in benefit design.

2. Timely Referral of CKD Patients to Nephrology Provider and Access Practitioner for Autogenous AV Fistula Assessment (**KDOQI Stage 4**) [change concepts 2-7]
Eligibility and payment for services should include appropriate vascular access evaluation (placement preceded by vessel mapping before dialysis is imminent - fistulas require 4-6 weeks to mature).

Although fistula use is preferred, catheter placement is suitable as a bridge to fistula creation and/or in situations where the patient has no reasonable alternative. Strong encouragement for fistula use can be conveyed by specifying the medical necessity criteria to be met when a catheter or graft is to be inserted without evidence of fistula placement evaluation or vessel mapping. Catheters have the highest infection rate of any access procedure and grafts have the second highest while fistulas have the lowest infection rate and last longer.

Barriers to coverage for services directly related to fistula placement (surgical consultation, vessel mapping [both limbs], oversight and revision procedures) should be revised to allow these in stage 4 and stage 5 renal failure.

3. Referral to Access Surgeon for Autogenous AV Fistula Placement, where feasible (Stage 4) [change concepts 4,5,7]
Vascular access creation should be preceded by vessel mapping documenting venous and arterial anatomy.

Careful consideration of access types should be done in order of preference: fistula, graft, and then catheter. Dual placement of catheter and fistula is reasonable to provide an access for dialysis if needed imminently but the long-term use of a fistula is planned.

Placement of an access other than a fistula in the presence of studies that support fistula placement should have other access procedure payment reduced if medical necessity criteria have not been met.

4. Proper **Cannulation, Maintenance, Monitoring and Early Identification and Referral of Problems by Professional Staff** (Stage 5) [change concepts 1, 8-10]

Case management plans should require cannulation training for all direct patient care personnel with at least annual review of technique or more frequently if skill level requires.

Proper use and care of fistulas must be a standard in all facilities. Facility staff must identify the need for intervention so that the access can be maintained efficiently and with the best outcomes for the patient.

Implementation Suggestions

The Coalition recognizes that all parties involved in the care and reimbursement for services in CKD share the responsibility to support the delivery of quality care, particularly during the early CKD stages and access placement. The examples given below are not all-inclusive but are designed to illustrate different approaches that can result in goal attainment.

Payers

- ✘ In benefit design, include payment for early CKD testing, pre-ESRD vascular mapping and early access creation.
- ✘ Consider implementing an incentive payment at 6-month intervals (rolling 6-month average) for maintaining a fistula rate consistent with patient-centered care and K/DOQI guidelines.
- ✘ A second surgical opinion could be required when the reason for graft or catheter use is not supported by medical evidence.
- ✘ A bonus payment could be made when a fistula is placed early enough to allow maturation and eliminate the need for catheter placement.
- ✘ A higher reimbursement could be designed for care of CKD patients with diabetic and/or cardiovascular complications.
- ✘ Primary care practitioners could receive a bonus for nephrology referral if followed by early fistula placement.
- ✘ Procedures related to early fistula placement could have co-pays reduced or eliminated.
- ✘ The co-pay for a nephrology consult could be eliminated.
- ✘ Travel expenses incurred to have a fistula placed could be reimbursed.
- ✘ The referral required for specialty care could be eliminated and unlimited visits allowed for CKD diabetic patients in stage 3 and non-diabetics in stage 4.
- ✘ Surgeons could be reimbursed for dialysis facility care plan visits.
- ✘ Information about a provider's vascular access rates could be published (by surgeon and facility).

Clinicians

- ✘ Kidney function could be tested at least annually (eGFR[∇]) especially in high-risk individuals (diabetes, hypertension, familial indicators).
- ✘ Practitioners could refer for nephrology consultation those individuals with eGFR <60 ml/min/1.73m².
- ✘ Practitioners could team with the nephrologist for the care of individuals with eGFR <30 ml/min/1.73m².
- ✘ Surgeons could be invited to become active participants in patient care planning.
- ✘ Staff could benefit from periodic review of cannulation technique to assure greater proficiency and better patient outcomes.
- ✘ Each facility could assure that the vascular access coordinator function is assigned.
- ✘ Practitioners could foster use of the health care team with defined roles and responsibilities.
- ✘ Excellence in care delivery could be recognized within each facility.

[∇] eGFR is **estimated Glomerular Filtration Rate**, usually based on serum creatinine level, age, sex, and race. The most widely used method for this is the abbreviated MDRD equation.

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