Medicare Fee, Payment, Procedure code, ICD, Denial

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CPT 93922 - 93923, 93925 , 93970, 93971 - Non-Invasive Peripheral Arterial Studies

procedure code and description

93922 LIMITED BILATERAL NONINVASIVE PHYSIOLOGIC STUDIES OF UPPER OR LOWER EXTREMITY ARTERIES, (EG, FOR LOWER EXTREMITY: ANKLE/BRACHIAL INDICES AT DISTAL POSTERIOR TIBIAL AND ANTERIOR TIBIAL/DORSALIS PEDIS ARTERIES PLUS BIDIRECTIONAL, DOPPLER WAVEFORM RECORDING AND ANALYSIS AT 1-2 LEVELS, OR ANKLE/BRACHIAL INDICES AT DISTAL POSTERIOR TIBIAL AND ANTERIOR TIBIAL/DORSALIS PEDIS ARTERIES PLUS VOLUME PLETHYSMOGRAPHY AT 1-2 LEVELS, OR ANKLE/BRACHIAL INDICES AT DISTAL POSTERIOR TIBIAL AND ANTERIOR TIBIAL/DORSALIS PEDIS ARTERIES WITH, TRANSCUTANEOUS OXYGEN TENSION MEASUREMENT AT 1-2 LEVELS) - average fee payment - $90 - $100

93923 NONINVASIVE PHYSIOLOGIC STUDIES OF UPPER OR LOWER EXTREMITY ARTERIES, MULTIPLE LEVELS OR WITH PROVOCATIVE FUNCTIONAL MANEUVERS, COMPLETE BILATERAL STUDY (EG, SEGMENTAL BLOOD PRESSURE MEASUREMENTS, SEGMENTAL DOPPLER WAVEFORM ANALYSIS, SEGMENTAL VOLUME PLETHYSMOGRAPHY, SEGMENTAL TRANSCUTANEOUS OXYGEN TENSION MEASUREMENTS, MEASUREMENTS WITH POSTURAL PROVOCATIVE TESTS, MEASUREMENTS WITH REACTIVE HYPEREMIA)

93924 NONINVASIVE PHYSIOLOGIC STUDIES OF LOWER EXTREMITY ARTERIES, AT REST AND FOLLOWING TREADMILL STRESS TESTING, (IE, BIDIRECTIONAL DOPPLER WAVEFORM OR VOLUME PLETHYSMOGRAPHY RECORDING AND ANALYSIS AT REST WITH ANKLE/BRACHIAL INDICES IMMEDIATELY AFTER AND AT TIMED INTERVALS FOLLOWING PERFORMANCE OF A STANDARDIZED PROTOCOL ON A MOTORIZED TREADMILL PLUS RECORDING OF TIME OF ONSET OF CLAUDICATION OR OTHER SYMPTOMS, MAXIMAL WALKING TIME, AND TIME TO RECOVERY) COMPLETE BILATERAL STUDY

93925 DUPLEX SCAN OF LOWER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS; COMPLETE BILATERAL STUDY

93926 DUPLEX SCAN OF LOWER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS; UNILATERAL OR LIMITED STUDY

93930 DUPLEX SCAN OF UPPER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS; COMPLETE BILATERAL STUDY

93931 DUPLEX SCAN OF UPPER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS; UNILATERAL OR LIMITED STUDY

Overview

Non-invasive peripheral arterial vascular studies utilize ultrasonic Doppler and physiologic studies to assess the irregularities in blood flow in arterial systems. These noninvasive peripheral arterial vascular studies include the patient care required to perform the studies, supervision of the studies, and interpretation of study results, with copies for patient records of test results and analysis of all data, including bi-directional vascular flow or imaging when provided.

Diagnostic tests must be ordered by the physician who is treating the beneficiary and the results used in the management of the beneficiary's specific medical problem. Services are deemed medically necessary when all of the following conditions are met:
Signs/symptoms of ischemia or altered blood flow are present;

The information is necessary for appropriate medical and/or surgical management;

The test is not redundant of other diagnostic procedures that must be performed. Although, in some circumstances, non-invasive vascular tests are complimentary, such as MRA and duplex, where the latter may confirm an indeterminate finding or demonstrate the physiologic significance of an anatomic stenosis (especially in the lower extremity arterial system).

Coverage Indications, Limitations, and/or Medical Necessity

Noninvasive peripheral arterial studies include two types of testing, noninvasive physiologic studies and duplex scans.Non-invasive physiologic studies are functional measurement procedures that include Doppler ultrasound studies, blood pressure measurements, transcutaneous oxygen tension measurements, or plethysmography. A complete extremity physiologic study includes pressure measurements and an additional physiologic technique, e.g., Doppler ultrasound study or plethysmography.

Plethysmography implies volume measurement procedures including air impedance or strain gauge methods. Plethysmography involves the measurement and recording (by one of several methods) of changes in the size of a body part as modified by the circulation of blood in that part.

Noninvasive physiologic studies are performed using equipment separate and distinct from the duplex scanner. Duplex scanning combines the information provided by two-dimensional imaging with pulsed-wave doppler techniques which allows analysis of the blood flow velocity.

Vascular studies include patient care required to perform the studies, supervision of the studies and interpretation of study results with copies for patient records of hard copy output with analysis of all data, including bidirectional vascular flow or imaging when provided. The display may be a two-dimensional image with spectral analysis and color flow or a plethysmographic recording that allows for quantitative analysis.

Indications

In general, noninvasive arterial studies are indicated when endovascular or other invasive correction is contemplated, but not to follow noninvasive medical treatment regimens or to monitor unchanged symptomatology. The latter may be followed with

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physical findings, including Ankle/Brachial Indices (ABIs), and/or progression or relief of signs and/or symptoms.

Noninvasive physiologic studies of the upper or lower extremity arteries performed to establish the level and/or degree of arterial occlusive disease, will be considered medically necessary if a) significant signs and/or symptoms indicate a high likelihood of limb ischemia, and b) the patient is a candidate for invasive therapeutic procedures under any of the following circumstances:

• Claudication of less than one block or of such severity that it interferes significantly with the patient's occupation or lifestyle.

• Rest pain of ischemic origin(typically including the forefoot), associated with absent pulses, which becomes increasingly severe with elevation and diminishes with placement of the leg in a dependent position.

• Tissue loss defined as gangrene or pre-gangrenous changes of the extremity, or ischemic ulceration of the extremity occurring in the absence of pulses.

• Aneurysmal disease of the extremity.

• Evidence of thromboembolic events in an extremity.

• Evidence of compression/occlusion of the vascular structures supplying the upper or lower extremities.

• Blunt or penetrating trauma of the extremities (including complications of diagnostic and/or therapeutic procedures of an extremity).

• Follow-up studies post-operative conditions:

In the immediate post-operative period if re-established pulses are lost, become equivocal, or if the patient develops related signs and/or symptoms of ischemia with impending repeat intervention.

Following bypass surgery or post-angioplasty with or without stent placement at three months, six months and one year when clinically indicated.

Subsequent studies may be allowed if there is clinical evidence of recurrent vascular disease evidenced by signs (i.e. decreased ABI from previous exam) or symptoms (i.e., recurrence of claudication symptoms that interfere significantly with the patient’s occupation or lifestyle). For postoperative surveillance, either a limited Duplex or multi-level Doppler with pressures is usually sufficient, but it is not considered necessary to do both.

Transcutaneous oxygen tension measurements (Tp02) are utilized in conditions for which hyperbaric oxygen therapy (HBO) is being considered, as well as for monitoring the course of HBO therapy. The following conditions are considered medically indicated uses for Tp02 testing prior to, and during the course of HBO therapy:

· Acute traumatic peripheral ischemia

· Crush injuries and suturing of severed limbs

· Progressive necrotizing infections (necrotizing fasciitis)

· Acute peripheral arterial insufficiency

· Preparation and preservation of compromised skin grafts (not for primary management of wounds)

· Soft tissue radionecrosis as an adjunct to conventional treatment

· Tp02 used to determine a line of demarcation between viable and non-viable tissue when surgery or amputation is anticipated

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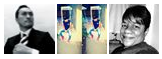


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Limitations

A routine history and physical examination, which includes Ankle/Brachial Indices (ABIs), can readily document the presence or absence of ischemic disease in a majority of cases. It is not medically necessary to proceed beyond the physical examination for minor signs and symptoms such as hair loss, absence of a single pulse, relative coolness of a foot, shiny thin skin, or lack of toe nail growth unless related signs and/or symptoms are present which are severe enough to require possible invasive intervention.

An ABI is not a separately reimbursable procedure when performed by itself and would be considered part of the physical examination. When the ABI is abnormal (i.e., <0 .9="" accompanied="" ankle="" another="" appropriate="" at="" be="" before="" blood="" by="" complete="" elevated="" except="" font="" in="" indication="" it="" more="" must="" or="" patients="" pressure.="" proceeding="" rest="" severely="" sophisticated="" studies="" to="" with="">

Examples of additional signs and symptoms that do not indicate medical necessity include:

• Continuous burning of the feet is considered to be a neurologic symptom.

• "Leg pain, nonspecific" or "Pain in limb" as single diagnoses are too general to warrant further investigation unless they can be related to other signs and symptoms.

• Edema rarely occurs with arterial occlusive disease unless it is in the immediate postoperative period, in association with another inflammatory process or in association with rest pain.

• Absence of relatively minor pulses (eg, dorsalis pedis or posterior tibial) in the absence of ischemic symptoms. The absence of pulses is not an indication to proceed beyond the physical examination unless related signs and/or symptoms are present which are severe enough to require possible invasive intervention.

• Screening of an asymptomatic patient is not covered.

In general, non-invasive studies of the arterial system are to be utilized when invasive correction is contemplated, but not to follow non-invasive medical treatment regimens (eg, to evaluate pharmacologic intervention) or to monitor unchanged symptomatology. The latter may be followed with physical findings including ABIs and/or progression or relief of signs and/or symptoms.

Noninvasive vascular testing studies are medically necessary only if the outcome will potentially impact the clinical management of the patient. For example, if a patient is (or is not) proceeding on to other diagnostic and/or therapeutic procedures regardless of the outcome of non-invasive studies, and non-invasive vascular procedures will not provide any unique diagnostic information that would impact patient management, then the non-invasive procedures are not medically necessary. If it is obvious from the findings of the history and physical examination that the patient is going to proceed to angiography, then non-invasive vascular studies are not medically necessary. It is also expected that the studies are not redundant of other diagnostic procedures that must be performed.

When an uninterpretable study (i.e., poor quality or not in accordance with regulatory standards)results in performing another type of study, only the successful study should be billed. For example, when an uninterpretable non-invasive physiologic study (CPT code 93922, 93923 or 93924) is performed which results in performing a duplex scan (CPT codes 93925 or 93926), only the duplex scan should be billed.

Noninvasive vascular procedures will not be covered when performed based on internal protocols of the testing facility; a referral for one noninvasive study is not a blanket referral for all studies. Each procedure must be specifically ordered by the physician/nonphysician practitioner treating the patient and the medical necessity criteria specified in this LCD must be met.

Typically, it is appropriate for follow-up studies post-angioplasty, with or without stent placement to be performed at three months, six months and one year. Subsequent

studies may be allowed if there is clinical evidence of recurrent vascular disease evidenced by signs (i.e. decreased ABI from previous exam) or symptoms (i.e. recurrence of claudication). For postoperative surveillance, either a limited Duplex or multi-level Doppler with pressures is usually sufficient, but it is not considered necessary to do both.

Performance of both a physiological test (CPT codes 93922, 93923, 93924) and duplex scanning (CPT codes 93925, 93926) of extremity arteries during the same encounter would not generally be expected. Consequently, documentation must clearly support the medical necessity if both procedures are performed during the same encounter, and be available upon request. Note: Reimbursement of physiologic testing will not be allowed after a duplex scanning has been performed.

Since the signs and symptoms of arterial occlusive disease and venous disease are so divergent, the performance of simultaneous arterial and venous studies during the same encounter should be rare. Consequently, documentation must clearly support the medical necessity of both procedures if performed during the same encounter.

Performance of both non-invasive extracranial arterial studies (CPT code 93880 or 93882) and non-invasive evaluation of extremity arteries (CPT codes 93922, 93923, 93924) during the same encounter is not appropriate as a general practice or standing protocol, and therefore, would not generally be expected. Consequently, documentation must clearly support the medical necessity if both procedures are performed during the same encounter, and be available upon request.

Methods Not Acceptable for Reimbursement

The following methods are not covered per CMS Manual System, Pub 100-3, Medicare National Coverage Determinations, Chapter 1, Section 20.14 as these methods have not yet reached a level of development such as to allow their routine use in the evaluation of suspected peripheral vascular disease:

· Inductance Plethysmography

· Capacitance Plethysmography

· Mechanical Oscillometry

· Photoelectric Plethysmography

Also, the use of a simple hand-held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of bidirectional vascular flow, is considered to be part of the physical examination of the vascular system and is not separately reported (CPT 2010, page 471). The appropriate assignment of a specific ultrasound CPT code is not solely determined by the weight, size, or portability of the equipment, but rather by the extent, quality, and documentation of the procedure. If an examination is performed with hand-carried equipment, the quality of the exam, printout, and report must be in keeping with accepted national standards. Doppler procedures performed with zero-crossers (e.g., analog [strip chart recorder] analysis) are also considered to be part of the evaluation and management service and should not be reported separately.

TRAINING REQUIREMENTS

The accuracy of non-invasive vascular diagnostic studies depends on the knowledge, skill and experience of the technologist and the physician performing the interpretation of the study. Consequently, the technologist and the physician must maintain proof of training and experience.

All non-invasive vascular diagnostic studies must be: (1) performed by a qualified physician, or (2) performed under the general supervision of a qualified physician by a technologist who has demonstrated minimum entry level competency by being credentialed in vascular technology, and/or (3) performed in a laboratory accredited in vascular technology.

Examples of certification in vascular technology for non-physician personnel include:

- Registered Vascular Technologist (RVT) credential
- Registered Vascular Specialist (RVS) credential

These credentials must be provided by nationally recognized credentialing organizations such as:

- The American Registry of Diagnostic Medical Sonographers (ARDMS) which provides RDMS and RVT credentials
- The Cardiovascular Credentialing International (CCI) which provides RVS credential

However, if the facility has a documented process for grand-fathering experienced technicians who have performed the services referenced in this LCD (a process addressing years of service and experience with number of supervised cases), this documentation should be available upon request; otherwise the provider must have documentation available upon request which indicates that the technician meets the credentialing requirements as stated above or is in the process of obtaining this credentialing.

Appropriate nationally recognized laboratory accreditation bodies include:

- Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL)
- American College of Radiology (ACR)

Additionally, the transcutaneous oxygen tension measurements (Tp02) may be performed by personnel credentialed as a certified hyperbaric registered nurse (CHRN) or certified hyperbaric technologist (CHT) by the National Board of Diving and Hyperbaric Medical Technology (NBDHMT).

General Supervision means the procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually performs the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

Note: In accordance with 42 CFR 410.33, noninvasive vascular studies performed in an Independent Diagnostic Testing Facility (IDTF) include credentialing requirements that supersede those above. Noninvasive vascular studies performed in an IDTF must follow the supervision and credentialing guidelines set forth in the LCD for Independent Diagnostic Testing Facility (IDTF).

Notice: This LCD imposes diagnosis limitations that support diagnosis to procedure code automated denials. However, services performed for any given diagnosis must meet all of the indications and limitations stated in this LCD, the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules.

Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:

- Safe and effective;
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000 which meet the requirements of the Clinical Trials NCD are considered reasonable and necessary); and
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:

  Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
  Furnished in a setting appropriate to the patient's medical needs and condition;
  Ordered and furnished by qualified personnel;
  One that meets, but does not exceed, the patient's medical need; and
  At least as beneficial as an existing and available medically appropriate alternative

Procedure/HCPCS Codes

93922© Extremity study - Fee schedule amount - $87.83

93923© Extremity study -Fee schedule amount - $136.96

93924© Extremity study Fee schedule amount - $171.41

93925© Lower extremity study Fee schedule amount - $187.30

93926© Lower extremity study Fee schedule amount - $151.47

93930© Upper extremity study -Fee schedule amount - $188.71

93931© Upper extremity study Fee schedule amount - $127.91

Coding Guidelines

1. Use the appropriate procedure code and modifiers.

2. Indicate the diagnoses for which the testing is being performed.

3. No paper documentation is required on initial claims submission unless required by an audit or the case deserves special case-by-case review. Place information on claim form as EMC narrative where indicated in the policy, e.g., follow-up studies.

4. Upper and lower extremity physiologic studies (CPT-4 codes 93922 and 93923), Lower extremity studies (CPT-4 codes 93925 and 93926), and Upper extremity duplex studies (CPT-4 codes 93930 and 93931) .

Billing and Coding Guide for CPT CODE 93922 AND 93923

This code can be billed as long as the ankle brachial indices are performed. The key components of limited bilateral noninvasive physiologic studies are:

• Volume plethysmography
• Bidirectional doppler waveform
• Ankle brachial indices (ABI)
• Transcutaneous oxygen tension measurement (SP-02)
With these components, you can bill CPT Code 93922 with no billing issues.

Procedure code 93922 Limited bilateral noninvasive physiologic studies of upper or lower arteries (e.g. for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with transcutaneous oxygen tension measurements at 1-2 levels)

** Use Procedure code 93922 as the default code for ABI studies

** Procedure code 93922 and Procedure code 93923 should not be ordered on the same request nor billed together for the same date of service.

** Procedure code 93924 and 3922 and/or 93923 should not be ordered on the same request and generally should not be billed together for the same date of service

Procedure code 93923 Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (e.g. for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental

blood pressure measurements with bidirectional, Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels, or single level study with provocative functional maneuvers e.g., measurements with postural provocative tests, or measurements with reactive hyperemia).

CMS has determined the following list of procedures require general physician supervision effective July 1 2001:
93875 & TC, 93880 & TC, 93882 & TC, 93886 & TC, 93888 & TC, 93922 & TC, 93923 & TC, 93924 &
TC, 93925 & TC, 93926 & TC, 93930 & TC, 93965 & TC, 93970 & TC, 93971 & TC

Upper and lower extremity physiologic studies (CPT-4 codes 93922 and 93923),
Lower extremity studies (CPT-4 codes 93925 and 93926), and
Upper extremity duplex studies (CPT-4 codes 93930 and 93931)

If studies are performed on the upper and lower extremities on the same day, the services should be submitted on separate detail lines. When claims are submitted electronically, it should be indicated in Item19 of field N-4 (old format) or in record HAO-05 of the National Standard format, that upper AND lower studies were performed. If paper claims are still being submitted, this information must appear on the CMS-1500 claim form.

Indications for venous examinations are separated into three major categories: deep vein thrombosis, chronic venous insufficiency, and venous mapping.

Deep Vein Thrombosis (DVT)

DVT is the most common vascular disorder that develops in hospitalized patients, and can develop after trauma, surgery or prolonged immobility (sitting or bed rest). Unfortunately, the signs and/or symptoms of DVT are relatively non-specific and, due to the risk associated with pulmonary embolism (PE), objective testing is allowed in patients that are candidates for anti-coagulation or invasive therapeutic procedures for one of the following indications:

Clinical signs and/or symptoms of DVT including edema, tenderness, inflammation and/or erythema;
Clinical signs and/or symptoms of PE including hemoptysis, chest pain, apnea, hypoxia, respiratory failure and/or dyspnea;
Unexplained lower extremity edema status-post major surgical procedures. Bilateral limb edema in the presence of signs and/or symptoms of congestive heart failure, exogenous obesity and/or arthritis should rarely be an indication;
High risk patients: hip surgery, multiple trauma, malignancy, etc;
Follow-up for patients with known venous thrombosis; and
Preoperative evaluation of lower extremities prior to vein harvesting for bypass surgery.

Chronic Venous Insufficiency

Symptomatic incompetent veins or perforating veins can require study. It is not medically necessary to study asymptomatic varicose veins. Objective test of venous function treatment may be indicated in patients with ulceration suspected to be secondary to venous insufficiency. Evaluation is medically necessary in patients with symptoms of recurrent DVT.

Venous Mapping

Venous mapping is performed to:

Identify suitable vessels for creating a hemodialysis access.
In preparation for vein harvesting for coronary artery bypass graft (CABG) or for peripheral arterial bypass surgery.
Indications for Evaluation of Dialysis Access

Duplex ultrasound can demonstrate findings such as: reduced fistula flow below 600 cc per minute; stenosis as demonstrated by doubling of peak systolic velocity (PSV).

Evaluation of a graft or fistula may be indicated with demonstrated compromised flow, occlusion, or thrombosis. Evaluations for compromised flow may occur with conditions such as:

Swelling of the extremity,

Development of pseudoaneurysms,

Prolonged bleeding following needle removal,

Inefficient dialysis,

Recirculation percentage greater than 10-15% (normal recirculation should be 0%),

Limitations

Routine monitoring of a patient's vascular access/system/device/bypass graft/angioplasty or stenting/etc. is not covered.

The accuracy of noninvasive vascular diagnostic studies depends on the knowledge, skills and experience of the technologist and interpreting physician. Noninvasive vascular diagnostic studies must be either:

Performed by a technologist who has demonstrated competency in ultrasound by receiving one of the following credentials in vascular ultrasound technology:

Registered Vascular Specialist (RVS) or Registered Phlebology Sonographer (RPhS) provided by Cardiovascular Credentialing International (CCI),
Registered Vascular Technologist (RVT) provided by the American Registry of Diagnostic Medical Sonographers (ARDMS),
Vascular Sonographer (VS) provided by the American Registry of Radiologic Technologists (ARRT), Sonography (ARRT)(S), or

Performed by or under the personal supervision of a physician who has demonstrated documented training through recent residency training or post-graduate Continuing Medical Education (CME) and maintains that documentation for medical review, or
Performed in facilities with laboratories accredited in vascular technology by one of the following nationally recognized accreditation organizations:

American College of Radiology (ACR) Vascular Ultrasound Accreditation Program.

Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL).

Transcutaneous oxygen tension measurement, when done as part of 93922 or 93923, should be performed by individuals possessing the following credentials obtained from the National Board of Diving and Hyperbaric Medicine Technology (NBDHMT):

Certified Hyperbaric Technologist (CHT).
Certified Hyperbaric Registered Nurse (CHRN).

Ankle brachial index (ABI) and transcutaneous oxygen tension measurements should not be separately billed.

G0365 (Vessel mapping of vessels for hemodialysis access) and 93990 (Duplex scan of hemodialysis access) include both arterial and venous studies. If only one or the other is done, the service should be billed with modifier 52.

Fully automated arterial and/or venous testing with automated interpretation results does not meet the descriptions of the CPT codes for the procedures addressed in this LCD. This service would be considered part of the Evaluation and Management (E&M) service and not separately payable.

ICD-10 Codes that Support Medical Necessity

D78.01 Intraoperative hemorrhage and hematoma of the spleen complicating a procedure on the spleen
D78.02 Intraoperative hemorrhage and hematoma of the spleen complicating other procedure
D78.11 Accidental puncture and laceration of the spleen during a procedure on the spleen
D78.12 Accidental puncture and laceration of the spleen during other procedure
D78.21 Postprocedural hemorrhage and hematoma of the spleen following a procedure on the spleen
D78.22 Postprocedural hemorrhage and hematoma of the spleen following other procedure
E36.01 Intraoperative hemorrhage and hematoma of an endocrine system organ or structure complicating an endocrine system procedure
E36.02 Intraoperative hemorrhage and hematoma of an endocrine system organ or structure complicating other procedure
E36.11 Accidental puncture and laceration of an endocrine system organ or structure during an endocrine system procedure
E36.12 Accidental puncture and laceration of an endocrine system organ or structure during other procedure
G97.31 Intraoperative hemorrhage and hematoma of a nervous system organ or structure complicating a nervous system procedure
G97.32 Intraoperative hemorrhage and hematoma of a nervous system organ or structure complicating other procedure
G97.48 Accidental puncture and laceration of other nervous system organ or structure during a nervous system procedure
G97.49 Accidental puncture and laceration of other nervous system organ or structure during other procedure
G97.51 Postprocedural hemorrhage and hematoma of a nervous system organ or structure following a nervous system procedure
G97.52 Postprocedural hemorrhage and hematoma of a nervous system organ or structure following other procedure

H59.111 Intraoperative hemorrhage and hematoma of right eye and adnexa complicating an ophthalmic procedure

H59.112 Intraoperative hemorrhage and hematoma of left eye and adnexa complicating an ophthalmic procedure

H59.113 Intraoperative hemorrhage and hematoma of eye and adnexa complicating an ophthalmic procedure, bilateral

H59.119 Intraoperative hemorrhage and hematoma of unspecified eye and adnexa complicating an ophthalmic procedure

H59.121 Intraoperative hemorrhage and hematoma of right eye and adnexa complicating other procedure

H59.122 Intraoperative hemorrhage and hematoma of left eye and adnexa complicating other procedure

H59.123 Intraoperative hemorrhage and hematoma of eye and adnexa complicating other procedure, bilateral

H59.129 Intraoperative hemorrhage and hematoma of unspecified eye and adnexa complicating other procedure

H59.211 Accidental puncture and laceration of right eye and adnexa during an ophthalmic procedure

H59.212 Accidental puncture and laceration of left eye and adnexa during an ophthalmic procedure

H59.213 Accidental puncture and laceration of eye and adnexa during an ophthalmic procedure, bilateral

H59.219 Accidental puncture and laceration of unspecified eye and adnexa during an ophthalmic procedure

H59.221 Accidental puncture and laceration of right eye and adnexa during other procedure

H59.222 Accidental puncture and laceration of left eye and adnexa during other procedure

H59.223 Accidental puncture and laceration of eye and adnexa during other procedure, bilateral

H59.229 Accidental puncture and laceration of unspecified eye and adnexa during other procedure

H59.311 Postprocedural hemorrhage and hematoma of right eye and adnexa following an ophthalmic procedure

H59.312 Postprocedural hemorrhage and hematoma of left eye and adnexa following an ophthalmic procedure

H59.313 Postprocedural hemorrhage and hematoma of eye and adnexa following an ophthalmic procedure, bilateral

H59.319 Postprocedural hemorrhage and hematoma of unspecified eye and adnexa following an ophthalmic procedure

H59.321 Postprocedural hemorrhage and hematoma of right eye and adnexa following other procedure

H59.322 Postprocedural hemorrhage and hematoma of left eye and adnexa following other procedure

H59.323 Postprocedural hemorrhage and hematoma of eye and adnexa following other procedure, bilateral

H59.329 Postprocedural hemorrhage and hematoma of unspecified eye and adnexa following other procedure

H95.21 Intraoperative hemorrhage and hematoma of ear and mastoid process complicating a procedure on the ear and
mastoid process

H95.22 Intraoperative hemorrhage and hematoma of ear and mastoid process complicating other procedure

ICD-9-CM Codes that Support Medical Necessity

The CPT/HCPCS codes included in this policy will be subjected to "procedure to diagnosis" editing. The following lists include only those diagnoses for which the identified CPT/HCPCS procedures are covered. If a covered diagnosis is not on the claim, the edit will automatically deny the service as not medically necessary.

Medicare is establishing the following limited coverage for **HCPCS/CPT codes 93922, 93923, 93924, 93925, 93926, 93930 and 93931**:

Covered for:

250.70–250.73 Diabetes with peripheral circulatory disorders

353.0 Thoracic outlet syndrome

410.20–410.22* Acute myocardial infarction of inferolateral wall

410.30–410.32* Acute myocardial infarction of inferoposterior wall

410.40–410.42*	Acute myocardial infarction of other inferior wall
410.50–410.52*	Acute myocardial infarction of other lateral wall
410.60–410.62*	Acute myocardial infarction, true posterior wall infarction
410.70–410.72*	Acute myocardial infarction, subendocardial infarction
410.80–410.82*	Acute myocardial infarction, other specified sites
411.0–411.1*	Other acute and subacute forms of ischemic heart disease
411.81*	Acute coronary occlusion without myocardial infarction
411.89*	Other acute and subacute forms of ischemic heart disease other
412*	Old myocardial infarction
413.0–413.1*	Angina pectoris
413.9*	Other and unspecified angina pectoris
414.10–414.12*	Aneurysm and dissection of heart
414.19*	Other aneurysm of heart
414.8*	Other specified forms of chronic ischemic heart disease
435.2	Subclavian steal syndrome
440.0	Atherosclerosis of aorta
440.20–440.24	Atherosclerosis of the extremities
440.30–440.32	Atherosclerosis of bypass graft of extremities
440.4	Chronic total occlusion of artery of the extremities
441.00–441.03	Dissection of aorta
441.1–441.7	Aortic aneurysm and dissection
442.0	Other aneurysm of artery of upper extremity
442.2–442.3	Other aneurysm
442.82	Aneurysm of subclavian artery
443.0–443.1	Other peripheral vascular disease
443.21–443.24	Other arterial dissection
443.29	Dissection of other artery
443.81–443.82	Other specified peripheral vascular diseases
443.89	Other specified peripheral vascular diseases
443.9	Peripheral vascular disease, unspecified
444.0–444.1	Arterial embolism and thrombosis
444.21–444.22	Arterial embolism and thrombosis, of arteries of the extremities
444.81	Arterial embolism and thrombosis of iliac artery
444.89	Arterial embolism and thrombosis of other specified artery
444.9	Arterial embolism and thrombosis of unspecified artery
445.01–445.02	Artherothrombolic microembolism
445.81	Artherothrombolic microembolism, of other sites, kidney
445.89	Artherothrombolic microembolism, of other site
446.5	Giant cell arteritis
446.7	Takayasu's disease
447.0–447.2	Other disorders of arteries and arterioles

447.5–447.6	Other disorders of arteries and arterioles
447.8–447.9	Other disorders of arteries and arterioles
449	Septic arterial embolism
585.3–585.6	Chronic kidney disease (CKD)
707.10–707.15	Ulcer of lower limbs, except decubitus
707.19	Ulcer of other part of lower limb
707.8	Chronic ulcer of other specified sites
710.1	Systemic sclerosis (scleroderma)
719.45	Pain in joint involving pelvic region and thigh
729.5*	Pain in limb
729.71–729.72*	Nontraumatic compartment syndrome
747.60	Anomaly of peripheral vascular system, unspecified site
747.63–747.64	Other anomalies of peripheral vascular system
785.4	Gangrene
789.30–789.37	Abdominal or pelvic swelling mass or lump
894.0–894.2	Multiple and unspecified open wound of lower limb
903.00–903.02	Injury to blood vessels of upper extremity, axillary vessel(s)
903.1–903.5	Injury to blood vessels of upper extremity
903.8–903.9	Injury to blood vessels of upper extremity
904.0–904.3	Injury to blood vessels of lower extremity and unspecified sites
904.40–904.42	Injury to popliteal blood vessels
904.50–904.54	Injury to tibial blood vessels
904.6–904.9	Injury to blood vessels of lower extremity and unspecified sites
996.1	Mechanical complication of other vascular device, implant, and graft
996.62	Infection and inflammatory reaction due to other vascular device implant and graft
996.70–996.78	Other complications of internal (biological) (synthetic) prosthetic device, implant and graft
996.80–996.87	Complications of transplanted organ
996.90–996.96	Complications of reattached extremity or body part
997.2	Peripheral vascular complications not elsewhere classified
998.11–998.13	Hemorrhage or hematoma or seroma complicating a procedure
998.2	Accidental puncture or laceration during a procedure
998.30–998.33	Disruption of operation wound
V43.4	Blood vessel replaced by other means
V45.81–V45.82	Other postprocedure status
V58.49	Other specified aftercare following surgery
V58.73	Aftercare following surgery of the circulatory system not elsewhere classified
V67.09	Follow-up examination, following other surgery

Diagnoses that Support Medical Necessity

Medicare expects that one of the "V"-codes listed below be billed as the primary diagnosis when billing **CPT/HCPCS codes 93922, 93923, 93924, 93925, 93926, 93930 and 93931** for preoperative examination of patients with clinically suspected vascular disease who will undergo a lower extremity surgical procedure for which healing will be compromised without vascular intervention. The claim should also include one of the ICD-9-CM codes identified with an asterisks (*) in the limited coverage list above for CPT codes 93922, 93923, 93924, 93925, 93926, 93930 and 93931.

V72.81 Pre-operative cardiovascular examination

V72.83 Other specified pre-operative examination

Labels: CPT / HCPCS

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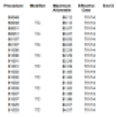
Top Medicare billing tips

CPT CODE 90791, 90792 ,90785 - Psychiatric diagnostic evaluation
CPT CODE and Description 90785 - Interactive complexity (List separately in addition to the code for primary procedure) 90791 - Psychi...

J code list and How to Bill J Codes Correctly by the "UNITS" with example -
This post has Most used J code list and we are constantly updating with example . If you are looking particular J code, use search button. ...

Electrocardiogram (ECG or EKG) - CPT 93000, 93005, 93010 - ICD 10 CODE R94.31
Procedure code and description 93000 - Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report -average fee...

Sleep Study CPT codes list 95806, 95810, 95811, 95807
Procedure code and description 95806 - Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory air...



CPT 81001, 81002, 81003 AND 81025 - urinalysis
CPT CODES and Description 81000 Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitr...

CPT code 11400, 11401, 11402 and 11406 - Excision benign lesion
Procedure code and description 11400- Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion di...

CPT code venipuncture - 36415 and 36416 -Billing Tips - Not seperately paid
Procedure Codes and Definitions 36415 Collection of venous blood by venipuncture - Fee schedule amount $3.10 36416 Collection of capi...

Nail Avulsion CPT code 11730 ,11732, 11750, 11765
Coverage Indications, Limitations, and/or Medical Necessity This LCD describes conditions under which the coverage of nail avulsion/ex...

Cardiovascular Stress Testing CPT code 93015, 93016, 93017, J2785 - lexiscan
Procedure code and description 93015 (cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous ele...

CPT 93922 - 93923, 93925 , 93970, 93971 - Non-Invasive Peripheral Arterial Studies
procedure code and description 93922 LIMITED BILATERAL NONINVASIVE PHYSIOLOGIC STUDIES OF UPPER OR LOWER EXTREMITY ARTERIES, (EG, FOR LOW...

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Collecting Medicare deductible and coinsurance

Can provider collect Medicare deductible upfront?

Yes, we could collect the payment but it has to be refunded promptly if you are collecting excess payment or collected incorrectly. See the ...

AMA

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ICD-9 to ICD-10
ICD-10 to ICD-9
GO

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