Priority Health	BILLING POLICY No. 149
Non-Invasive Abdominal/Visceral Vascular Studies	
Date of origin: September 2025	**Review dates:**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

Non-invasive abdominal/visceral vascular studies utilize ultrasonic Doppler and physiological principles to assess the irregularities in blood flow in renal, iliac, and femoral artery systems.

Duplex scan: An ultrasonic scanning procedure with display of both two-dimensional structure and motion with time and Doppler ultrasonic signal documentation with spectrum analysis and/or color flow velocity mapping or imaging.

Physiologic studies: Functional measurement procedures that include Doppler ultrasound studies, blood pressure measurements, transcutaneous oxygen tension measurement, or plethysmography.

Transcranial Doppler: Pulsed Doppler ultrasound is used to interrogate the intracranial vasculature of the Circle of Willis. Its value has been established in detecting severe stenosis in the major intracranial arteries, assessing patterns and extent of collateral circulation in patients with known regions of severe stenosis or occlusion and evaluating and following patients with vasoconstriction particularly after subarachnoid hemorrhage.

For Medicare

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

Coding specifics

The diagnosis code(s) must best describe the patient's condition for which the service was performed. For diagnostic tests, report the result of the test if known; otherwise, the symptoms prompting the performance of the test should be reported.

CPT Codes: 93985 or 93986 should be used for the initial autogenous access vessel mapping. CPT codes 93970 and 93971 may be used if done for monitoring purposes, No separate payment for non-

invasive vascular studies for monitoring the access site of an ESRD patient, whether coded as the access site or peripheral site, is permitted.

HCPCS codes 93985 or 93986 and CPT code 93990 (modifier TC) performed in End-Stage Renal Disease (ESRD) facilities or for ESRD patients is included in payment This is a comprehensive payment that includes all services, equipment, supplies and certain laboratory tests and drugs that are necessary for dialysis treatment.

Services performed on ESRD patients by entities outside the ESRD facility must bill the ESRD facility for payment of monitoring procedures.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

26: Professional component
TC: Technical component

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

REFERENCES

https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=56758&ver=58

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require

industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made