Priority Health	BILLING POLICY No. 169
NON-INVASIVE CEREBROVASCULAR STUDIES	
Date of origin: October 2025	**Review dates: 09/2026**

POLICY OVERVIEW

This policy provides guidelines for billing, coding, and documentation for non-invasive cerebrovascular studies, ensuring claims are processed according to contractual agreements and industry standards."

DEFINITIONS

Non-invasive cerebrovascular studies are diagnostic procedures (such as transcranial Doppler (TCD) and carotid ultrasound) that evaluate blood flow in the arteries and veins of the head and neck without the use of needles, radiation, or contrast agents. These painless tests utilize ultrasound technology to visualize circulation, detect blockages, and identify abnormalities within the brain's vascular system, helping physicians make informed decisions about diagnosis and treatment.

MEDICAL POLICY

- *Not Applicable*

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Thorough documentation is critical to ensure high-quality patient care and to validate the medical necessity of non-invasive cerebrovascular studies.

Coding specifics

Priority Health complies with Centers for Medicare & Medicaid Services (CMS) documents that govern coverage criteria fon non-invasive cerebrovascular studies, including but not limited to, Medicare National Coverage Determinations (NCDs), applicable Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs), Benefit Policy Manuals, and Claims Processing Manuals for all items, services and/or procedures that are covered benefits under Medicare.

Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply coverage or reimbursement. Please refer to the specific contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual. The following codes for treatments and procedures applicable to this policy are included below for informational purposes.

CPT/HCPCS Code	Description
93880	Duplex scan of extracranial arteries; complete bilateral study
93882	Unilateral duplex ultrasound of the carotid and/or vertebral arteries to evaluate blood flow and detect stenosis or other vascular abnormalities
93888	Limited transcranial Doppler (TCD) ultrasound study of the intracranial arteries, focusing on selected vessels or specific arterial segments.
93892	Transcranial Doppler study for emboli detection without intravenous microbubble injection
93896	Add-on code for a vasoreactivity study performed in conjunction with a complete transcranial Doppler (TCD) study of intracranial arteries.
93897	Non-invasive emboli detection study performed as an add-on to a complete cerebrovascular Doppler ultrasound
93898	Venous-arterial shunt detection using intravenous microbubble injection, performed as an add-on to a complete transcranial Doppler (TCD) study of intracranial arteries.

CMS is establishing the following limited coverage for CPT codes 93880 and 93882 and full list can be found in LCD reference article A52992.

Modifiers

All non-invasive vascular study CPT codes are considered bilateral codes unless otherwise indicated in the CPT definition. The 150% payment adjustment for bilateral procedures does not apply. Modifier -50 and/or the anatomic modifiers -LT/-RT should not be used.

Append the modifier –52 to report a unilateral study as appropriate. Information explaining the reduced service should be included in Item 19 of the CMS-1500 form or the electronic equivalent. Any appropriate documentation may be submitted with the claim to support the reduced service.

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Please use Priority Health Provider Manual as a reference. See link below:
Using code modifiers | Priority Health

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.

Documentation requirements

- Record of the study and its interpretation.
- Detailed description of the procedures performed, including any use of contrast media or radiopharmaceuticals.
- Notations of any significant patient reactions or complications during or after the procedure.
- Comparative analysis with prior relevant studies, addressing both normal and abnormal findings.
- Documentation of deviations from normal, supported by measurements.
- Responses to specific clinical questions posed by the referring provider. If a question cannot be answered, the reason must be documented.
- Retention of ultrasound images must align with clinical needs and comply with legal and facility-specific requirements.

Additionally:

- If the performing provider is different from the ordering provider, they must retain:
  - A copy of the test results and interpretation.
  - The original order, which must include the clinical indication and justification for the study.

- All test results must be shared with the referring provider.
- Repeat or multiple imaging studies must be justified with clear documentation of medical necessity.
- Frequency of follow-up studies should reflect the patient's condition and treatment response, and be supported in the medical record.

Each diagnostic study must be medically justified based on the patient's condition and response to treatment. Medicare requires that the medical necessity for each reported study be clearly documented in the patient's medical record.

Key utilization guidelines include:

- Follow-up frequency is subject to review and must be supported by clinical documentation. It is the provider's responsibility to maintain records that justify the timing and repetition of studies.
- Preoperative Doppler scans: Only one scan is typically considered reasonable and necessary before bypass surgery. If a second scan is needed due to a change in condition or difficulty stabilizing a patient with multiple comorbidities, the medical record must clearly support its necessity.
- Carotid stenosis re-evaluation:
    - Patients with >50% diameter reduction and symptoms, or >60% without symptoms, are generally followed annually.
    - If symptoms of carotid disease develop, repeat duplex scans are allowed regardless of the annual schedule.
- Post-carotid endarterectomy follow-up (outside the global period):
    - Duplex ultrasonography is typically performed on the affected side at 6 weeks, 6 months, and annually.
    - During the first year, studies should focus on the ipsilateral side, unless symptoms or prior disease in the contralateral artery warrant a bilateral study.
- Multiple procedures during the same encounter may be covered if medical necessity is clearly documented.

FAQ

Not available.

Resources

- Article - Billing and Coding: Non-Invasive Cerebrovascular Arterial Studies (A52992)

Related policies

- Using code modifiers | Priority Health

Related denial language

Include any denial language here

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. 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 standards, 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 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 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
October 2025	Policy created
September 2026	Policy Overview, Definitions, Coding Specifics, Place of Service, and Modifiers sections have been added.