Priority Health	BILLING POLICY No. 169
Non-Invasive Cerebrovascular Studies	
Date of origin: October 2025	**Review dates: NA**

DEFINITION

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.

POLICY SPECIFIC INFORMATION

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

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.

Resources

https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=57592&ver=17&=

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 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
October 2025	Policy created