

LCD for Noninvasive Peripheral Arterial Studies (L24339)

Contractor Information

Contractor Name

Noridian Administrative Services

Contractor Number

03102

Contractor Type

MAC - Part B

LCD Information

LCD ID Number

L24339

LCD Title

Noninvasive Peripheral Arterial Studies

Contractor's Determination Number

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CMS National Coverage Policy

Title XVIII of the Social Security Act, Section 1862(a)(1)(A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act, Section 1833(e). This section prohibits Medicare payment for any claim, which lacks the necessary information to process the claim.

National Coverage Determinations 20.14 and 220.5. These sections are on coverage of Plethysmography and Ultrasound Diagnostic Procedures.

Primary Geographic Jurisdiction

Arizona

Oversight Region

Region VIII

Original Determination Effective Date

For services performed on or after 12/01/2006

Original Determination Ending Date

Revision Effective Date

For services performed on or after 10/01/2008

Revision Ending Date

Indications and Limitations of Coverage and/or Medical Necessity

Noninvasive peripheral arterial studies are useful in detecting extremity arterial compromise, functional severity and hemodynamic significance of atherosclerosis. These procedures help to differentiate claudication from pain of non-vascular etiologies. Lower extremity noninvasive testing is also a valuable tool in monitoring graft complications including occlusions, early flow compromise secondary to technical problems, or chronic reoccurrence of anastomatic or distal disease and aneurysmal diseases of the artery. Information regarding collateral circulation can also be gained.

"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 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." (End of Quote) (CPT 2007, p 398)

The two basic modalities of evaluation are:

1. The **indirect** methods (e.g. Ankle/Brachial Index (ABI), segmental limb pressures, transcutaneous oxygen tension measurement (TcPO₂), CW bi-dimensional Doppler and plethysmographic waveforms) that provide information regarding functional severity of disease.
2. The **direct** method of evaluation which is color-duplex imaging (CDI), the duplex scan that provides more specific anatomic and physiologic information.

Ankle/Brachial Index

The most common test is the Ankle-Brachial Index (ABI). This test measures the blood pressure at the ankle and elbow, and is performed using a Doppler stethoscope. While inflating cuffs placed on arms and legs, the technician positions the Doppler at a 45-degree angle to three arteries: the dorsalis pedis, posterior tibia, and brachial of the right and left sides.

Single Level Pressure and Physiologic Waveform

Blood pressure and physiologic waveform (Doppler velocity signal or plethysmography tracing) recordings are obtained bilaterally at a single level (usually the ankle).

Segmental Pressure and Physiologic Waveform

Blood pressures at various limb levels are measured to identify areas of regional hypotension. Physiologic waveforms (Doppler velocity signals or plethysmography tracings) are recorded at the same level to localize the level of disease to the inflow/outflow or runoff vessels.

Transcutaneous Oxygen Tension Measurement (TcPO₂)

The quantity of oxygen available for diffusion to the skin depends on the quantity delivered by the influx of blood and what is extracted to meet metabolic demands. TcPO₂ (Oxygen Tension) levels provide an index of the adequacy of tissue perfusion. Measurement may be made from any region of interest, usually the dorsum of the foot or upper calf. Whereas many claudicants have resting values in the normal range, measurements made from the feet of patients with limb-threatening ischemia are usually less than 20 mm Hg and frequently approach zero. This test is used in assessing the healing potential of wounds.

Stress Testing

Exercise testing provides a medium for evaluating the functional significance of arterial occlusive disease. Upon completion of a maximum appropriate stress testing, arterial signals and blood pressures are reassessed at the ankle level. A patient with arterial occlusive disease will respond to exercise with a decrease in the ankle blood pressure. The magnitude of the decrease and time to return to baseline establish the severity and functional significance of arterial obstruction. Stress testing is useful in differentiating the pain of arterial insufficiency from that of other conditions such as arthritis and neuropathies. It also will identify those patients whose symptoms of fatigue are due to coronary or pulmonary disease rather than arterial insufficiency.

Color-Flow Doppler Duplex Scanning

The AMA CPT 2007 states, on page 398, that a "Duplex scan (e.g., 93880, 93882) describes an ultrasonic scanning procedure for characterizing the pattern and direction of blood flow in arteries or veins with the production of real time images integrating B-mode two-dimensional vascular structure with spectral and/or color flow Doppler mapping or imaging."

Color-flow scanning adds Doppler information encoded as color to the conventional duplex scan to survey the arteries throughout their course. This test is used in those patients being evaluated for an invasive interventional procedure (laser, angioplasty or surgery). It can identify stenosis or occlusion, estimate the percentage of diameter reduction and determine the length of the lesion. Color flow Doppler can be used to enhance conventional data acquisition.

Noninvasive peripheral arterial examinations performed to establish the level and/or degree of arterial occlusive disease are reasonable and necessary if significant signs and/or symptoms of possible limb ischemia are present and the patient is a candidate for invasive therapeutic procedures.

Indications for peripheral arterial evaluations:

1. Claudication of less than one block or such severity that interferes significantly with the patient's occupation or lifestyle.
 2. Rest pains (typically including the forefoot), usually associated with diminished or absent pulses, which become increasingly severe with elevation and diminishes with placement of the leg in a dependent position.
- Diagnosis 729.5, Pain in limb, should only be billed when the patient's symptoms meet this criteria.**
3. Tissue loss defined as gangrene or pre-gangrenous changes of the extremity or ischemic ulceration of the extremity occurring with diminished or absent pulses.
 4. Aneurysmal disease.
 5. Evidence of thromboembolic events.
 6. Blunt or penetrating trauma (including complications of diagnostic and/or therapeutic procedures).
 7. Lower extremities surgical procedure where vascular disease is clinically suspected.
 8. For the patient with chronic renal failure and for whom an A/V fistula is planned
 9. For radial artery evaluation in a patient scheduled for CABG.

Follow-up studies for post-operative conditions:

1. In the immediate post-operative period, patients may be studied if reestablished pulses are lost, become equivocal, or if the patient develops related signs and/or symptoms of ischemia with impending repeat intervention.
2. With regards to autogenous lower extremity vein bypass surgeries, a study can be performed at three-month intervals during the first year, and at six-month intervals thereafter.
3. Follow-up studies more frequent than every 6 months are not reasonable and necessary post-angioplasty in the absence of signs and symptoms of ischemia. Synthetic grafts may be studied if the patient develops signs and/or symptoms of occlusive disease.

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 reasonable and necessary to proceed beyond the physical examination for minor signs and symptoms unless related signs and/or symptoms are present which are severe enough to require possible invasive intervention.

Examples of signs and symptoms that do not indicate reasonableness and necessity:

1. Continuous burning of the feet is considered to be a neurologic symptom.
2. "Leg pain, nonspecific" and "Pain in Limb" as a single diagnosis is too general to warrant further investigation unless they can be related to other signs and symptoms.
3. 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.
4. Absence of relatively minor pulses (i.e., dorsalis pedis or posterior tibial) in the absence of symptoms. The absence of pulses is not an indication to proceed beyond the physical examination unless it is related to other signs and/or symptoms.
5. Minor symptoms such as hair loss, relative coolness of a foot, shiny thin skin.
6. Screening of an asymptomatic patient is not covered by Medicare.

ABIs, as separate procedures, are not reimbursable. An abnormal ABI (i.e., <0.9 at rest) must be accompanied by another appropriate indication before proceeding to more sophisticated or complete studies, except in patients with severe elevated ankle blood pressure.

If an arteriogram is planned, an abnormal ABI should be sufficient to determine its necessity. In some instances, ABI may prove inadequate because of a stovepipe vessel with ischemic signs and symptoms; a digital pressure study could be done. A few patients that have borderline ABIs would qualify for exercise studies to determine if there was a significant drop in pressure after exercise and an increase in symptoms. These qualify for further segmental studies.

In planning for foot and/or ankle surgery, a Transcutaneous Oximetry (TcPO₂) or special waveform analysis should be considered adequate for determination of possible healing problems and extensive noninvasive vascular studies would not be required. This statement remains true for any surgery of the distal lower extremity in patients where healing is a concern. It is expected that the frequency will be no greater than twice in any 60-day period. Repetition of the test is only necessary when there is a need to modify treatment. Documentation to indicate reasonableness and necessity must be kept and made available to Medicare upon request.

Procedures rendered not meeting the criteria stated in the Indications and Limitations of Coverage and/or Medical Necessity section of this policy will be denied as not reasonable and necessary.

Methods not acceptable for reimbursement:

1. Mechanical oscillometry
2. Inductance plethysmography
3. Capacitance plethysmography
4. Photoelectric plethysmography
5. Thermography (CPT 93762)

CPT 93922 must include the ABIs and at least one of the other elements of the code. CPT 93923 must include the segmental blood pressure measurements with 1), one of the following: segmental Doppler waveform analysis, segmental volume plethysmography, segmental transcutaneous oxygen tension measurements, or 2), one of the following; measurements with postural provocative tests, measurements with reactive hyperemia.

An ABI, done without further vascular studies, is not separately billable, but is included in the office visit services.

Duplex scan for post-interventional follow-up which is typically limited in scope and unilateral in nature should use the unilateral or "limited study" codes (i.e., 93926 or 93931). Consequently, the "complete" duplex scan codes (i.e., 93925 or 93930) should seldom be used except in patients who had bilateral interventions.

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. Therefore, documentation clearly supporting reasonableness and necessity of both procedures performed during the same encounter must be available for post-payment audit.

Duplex scanning and physiologic studies are reimbursed during the same encounter if the physiologic studies are abnormal and/or to evaluate vascular trauma, thromboembolic events or aneurysmal disease.

Hemodialysis Access Examination (CPT Code 93990)

Limited coverage has been established for duplex scanning of hemodialysis access sites in patients with end-stage renal disease (ESRD). These procedures are medically necessary only in the presence of signs or symptoms of possible failure of the access site and when the results may impact the clinical course of the patient. Furthermore, when services are provided by the ESRD physician of record, services are considered renal-related and are therefore part of the physician's monthly capitated fee and are not separately reportable. Services performed by a Medicare-approved ESRD facility are covered services under the composite rate of the facility and therefore are not separately reimbursable.

For dialysis to take place, there must be a means of access so that the exchange of waste products may occur. As part of the dialysis treatment, ESRD facilities are responsible for monitoring access, and when occlusions occur, either declot the access or refer the patient for appropriate treatment. Procedures associated with monitoring access involve taking venous pressure, aspirating thrombus, observing elevated recirculation time, reduced urea reduction ratios, or collapsed shunt, etc. All such procedures are covered under the composite rate.

ESRD facilities are monitoring access through noninvasive vascular studies such as duplex and Doppler flow scans and billing separately for these procedures. Noninvasive vascular studies are not covered as a separately billable service if used to monitor a patient's vascular access site. Medicare pays for the technical component of the procedure in the composite payment rate.

An ESRD facility must furnish all necessary services, equipment, and supplies associated with a dialysis treatment, either directly or under arrangements that make the facility financially responsible for the service. If an ESRD facility or a renal physician decides to monitor the patient's access site with a noninvasive vascular study and does not have the equipment to perform the procedure, the facility or physician may arrange for the service to be furnished by another source. The alternative source, such as an independent diagnostic testing facility must look to the ESRD facility for payment. No separate payment for noninvasive vascular studies for monitoring the access site of an ESRD patient, whether coded as the access site or peripheral site, is permitted to any entity.

Where there are signs and symptoms of vascular access problems, Doppler flow studies may be used as a means to obtain diagnostic information to permit medical intervention to address the problem. Doppler flow studies may be considered medically necessary in the presence of signs or symptoms of possible failure of the ESRD patient's vascular access site, and when the results are used in determining the clinical course of the treatment for the patient.

The only CPT billing code for noninvasive vascular testing of a hemodialysis access site is Code 93990. Deny separate billing of the technical component of this code if it is performed on any patient for whom the ESRD composite rate for dialysis is being paid unless there is appropriate medical indication of the need for a Doppler flow study.

When a dialysis patient exhibits signs and symptoms of compromise to the vascular access site, Doppler flow studies may provide diagnostic information that will determine the appropriate medical intervention. Medicare considers a Doppler flow study medically necessary when the beneficiary's dialysis access site manifests signs or symptoms associated with vascular compromise, and when the results of this test are necessary to determine the clinical course of treatment.

Appropriate indications for duplex scan of hemodialysis access sites include:

ICD-9-CM Code 996.73: Complication (complication NOS, occlusion NOS, embolism, fibrosis, hemorrhage, pain, stenosis, thrombosis) due to renal dialysis device, implant, and graft

Clear documentation in the dialysis record of signs of chronic (i.e., three successive dialysis sessions) abnormal function

Examples of supporting the medical necessity of Doppler flow studies include:

Elevated dynamic venous pressure greater than 200mmHg when measured during dialysis with the blood pump set on a 200cc/min pump

Access recirculation of 12 percent or greater

An otherwise unexplained urea reduction rate of less than 60 percent

An access with a palpable "water hammer" pulse on examination (which implies venous outflow obstruction)

Routine evaluation on a daily or weekly basis without evidence of the above is considered screening and is not a covered service. Billing for monitoring of hemodialysis access using CPT codes for noninvasive vascular studies other than Code 93990 is considered a misrepresentation of the service actually provided.

Unless the documentation is provided supporting the necessity of more than one study, Medicare will limit payment to either a Doppler flow study or an arteriogram (fistulogram, venogram), but not both.

An example of when both studies may be clinically necessary is when a Doppler flow study demonstrates reduced flow (blood flow rate less than 800cc/min or a decreased flow of 25 percent or greater from previous study) and the physician requires an arteriogram to further define the extent of the problem. The patient's medical record must provide documentation supporting the need for more than one imaging study.

Compliance with the provisions in this policy is subject to monitoring by post payment data analysis and subsequent medical review.

Coverage Topic

Diagnostic Tests and X-Rays

Doctor Office Visits

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

99999 Not Applicable

CPT/HCPCS Codes

93922	NONINVASIVE PHYSIOLOGIC STUDIES OF UPPER OR LOWER EXTREMITY ARTERIES, SINGLE LEVEL, BILATERAL (EG, ANKLE/BRACHIAL INDICES, DOPPLER WAVEFORM ANALYSIS, VOLUME PLETHYSMOGRAPHY, TRANSCUTANEOUS OXYGEN TENSION MEASUREMENT)
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, 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
93990	DUPLEX SCAN OF HEMODIALYSIS ACCESS (INCLUDING ARTERIAL INFLOW, BODY OF ACCESS AND VENOUS OUTFLOW)

ICD-9 Codes that Support Medical Necessity

Note: Diagnosis codes are based on the current ICD-9-CM codes that are effective at the time of LCD publication. Any updates to ICD-9-CM codes will be reviewed by NAS, and coverage should not be presumed until the results of such review have been published/posted.

These are the only ICD-9-CM codes that Support Medical Necessity:

Group 1

Only one of the following diagnoses is required:

249.70	SECONDARY DIABETES MELLITUS WITH PERIPHERAL CIRCULATORY DISORDERS, NOT STATED AS UNCONTROLLED, OR UNSPECIFIED
249.71	SECONDARY DIABETES MELLITUS WITH PERIPHERAL CIRCULATORY DISORDERS, UNCONTROLLED
250.70	DIABETES WITH PERIPHERAL CIRCULATORY DISORDERS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED
250.71	DIABETES WITH PERIPHERAL CIRCULATORY DISORDERS, TYPE I [JUVENILE TYPE], NOT STATED AS UNCONTROLLED
250.72	DIABETES WITH PERIPHERAL CIRCULATORY DISORDERS, TYPE II OR UNSPECIFIED TYPE, UNCONTROLLED
250.73	DIABETES WITH PERIPHERAL CIRCULATORY DISORDERS, TYPE I [JUVENILE TYPE], UNCONTROLLED
435.2	SUBCLAVIAN STEAL SYNDROME
440.0	ATHEROSCLEROSIS OF AORTA
440.20	ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES UNSPECIFIED
440.21	ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES WITH INTERMITTENT CLAUDICATION
440.22	ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES WITH REST PAIN
440.23	

	ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES WITH ULCERATION
440.24	ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES WITH GANGRENE
440.29	OTHER ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES
440.30	ATHEROSCLEROSIS OF UNSPECIFIED BYPASS GRAFT OF THE EXTREMITIES
440.31	ATHEROSCLEROSIS OF AUTOLOGOUS VEIN BYPASS GRAFT OF THE EXTREMITIES
440.32	ATHEROSCLEROSIS OF NONAUTOLOGOUS BIOLOGICAL BYPASS GRAFT OF THE EXTREMITIES
440.4*	CHRONIC TOTAL OCCLUSION OF ARTERY OF THE EXTREMITIES
441.00	DISSECTION OF AORTA ANEURYSM UNSPECIFIED SITE
441.01	DISSECTION OF AORTA THORACIC
441.02	DISSECTION OF AORTA ABDOMINAL
441.03	DISSECTION OF AORTA THORACOABDOMINAL
441.1	THORACIC ANEURYSM RUPTURED
441.2	THORACIC ANEURYSM WITHOUT RUPTURE
441.3	ABDOMINAL ANEURYSM RUPTURED
441.4	ABDOMINAL ANEURYSM WITHOUT RUPTURE
441.5	AORTIC ANEURYSM OF UNSPECIFIED SITE RUPTURED
441.6	THORACOABDOMINAL ANEURYSM RUPTURED
441.7	THORACOABDOMINAL ANEURYSM WITHOUT RUPTURE
441.9	AORTIC ANEURYSM OF UNSPECIFIED SITE WITHOUT RUPTURE
442.0	ANEURYSM OF ARTERY OF UPPER EXTREMITY
442.2	ANEURYSM OF ILIAC ARTERY
442.3	ANEURYSM OF ARTERY OF LOWER EXTREMITY
442.82	ANEURYSM OF SUBCLAVIAN ARTERY
443.0	RAYNAUD'S SYNDROME
443.1	THROMBOANGIITIS OBLITERANS (BUERGER'S DISEASE)
443.21	DISSECTION OF CAROTID ARTERY
443.22	DISSECTION OF ILIAC ARTERY
443.23	DISSECTION OF RENAL ARTERY

443.24	DISSECTION OF VERTEBRAL ARTERY
443.29	DISSECTION OF OTHER ARTERY
443.81	PERIPHERAL ANGIOPATHY IN DISEASES CLASSIFIED ELSEWHERE
443.89	OTHER PERIPHERAL VASCULAR DISEASE
443.9	PERIPHERAL VASCULAR DISEASE UNSPECIFIED
444.0	EMBOLISM AND THROMBOSIS OF ABDOMINAL AORTA
444.1	EMBOLISM AND THROMBOSIS OF THORACIC AORTA
444.21	ARTERIAL EMBOLISM AND THROMBOSIS OF UPPER EXTREMITY
444.22	ARTERIAL EMBOLISM AND THROMBOSIS OF LOWER EXTREMITY
444.81	EMBOLISM AND THROMBOSIS OF ILIAC ARTERY
444.89	EMBOLISM AND THROMBOSIS OF OTHER ARTERY
444.9	EMBOLISM AND THROMBOSIS OF UNSPECIFIED ARTERY
445.01	ATHEROEMBOLISM OF UPPER EXTREMITY
445.02	ATHEROEMBOLISM OF LOWER EXTREMITY
446.5	GIANT CELL ARTERITIS
446.7	TAKAYASU'S DISEASE
447.0	ARTERIOVENOUS FISTULA ACQUIRED
447.1	STRICTURE OF ARTERY
447.2	RUPTURE OF ARTERY
447.5	NECROSIS OF ARTERY
447.6	ARTERITIS UNSPECIFIED
447.8	OTHER SPECIFIED DISORDERS OF ARTERIES AND ARTERIOLES
447.9	UNSPECIFIED DISORDERS OF ARTERIES AND ARTERIOLES
459.9	UNSPECIFIED CIRCULATORY SYSTEM DISORDER
585.3	CHRONIC KIDNEY DISEASE, STAGE III (MODERATE)
585.4	CHRONIC KIDNEY DISEASE, STAGE IV (SEVERE)
585.5	CHRONIC KIDNEY DISEASE, STAGE V
585.6	END STAGE RENAL DISEASE
707.10	UNSPECIFIED ULCER OF LOWER LIMB
707.11	ULCER OF THIGH
707.12	ULCER OF CALF

707.13	ULCER OF ANKLE
707.14	ULCER OF HEEL AND MIDFOOT
707.15	ULCER OF OTHER PART OF FOOT
707.19	ULCER OF OTHER PART OF LOWER LIMB
707.8	CHRONIC ULCER OF OTHER SPECIFIED SITES
719.45	PAIN IN JOINT INVOLVING PELVIC REGION AND THIGH
729.5*	PAIN IN LIMB
729.71	NONTRAUMATIC COMPARTMENT SYNDROME OF UPPER EXTREMITY
729.72	NONTRAUMATIC COMPARTMENT SYNDROME OF LOWER EXTREMITY
747.60	ANOMALY OF THE PERIPHERAL VASCULAR SYSTEM UNSPECIFIED SITE
747.63	UPPER LIMB VESSEL ANOMALY
747.64	LOWER LIMB VESSEL ANOMALY
782.0	DISTURBANCE OF SKIN SENSATION
785.4	GANGRENE
785.9	OTHER SYMPTOMS INVOLVING CARDIOVASCULAR SYSTEM
789.30	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP UNSPECIFIED SITE
789.31	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP RIGHT UPPER QUARDANT
789.32	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP LEFT UPPER QUADRANT
789.33	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP RIGHT LOWER QUADRANT
789.34	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP LEFT LOWER QUADRANT
789.35	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP PERIUMBILIC
789.36	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP EPIGASTRIC
789.37	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP GENERALIZED
789.39	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP OTHER SPECIFIED SITE
884.0	MULTIPLE AND UNSPECIFIED OPEN WOUND OF UPPER LIMB WITHOUT COMPLICATION
884.1	MULTIPLE AND UNSPECIFIED OPEN WOUND OF UPPER LIMB COMPLICATED

884.2	MULTIPLE AND UNSPECIFIED OPEN WOUND OF UPPER LIMB WITH TENDON INVOLVEMENT
894.0	MULTIPLE AND UNSPECIFIED OPEN WOUND OF LOWER LIMB WITHOUT COMPLICATION
894.1	MULTIPLE AND UNSPECIFIED OPEN WOUND OF LOWER LIMB COMPLICATED
894.2	MULTIPLE AND UNSPECIFIED OPEN WOUND OF LOWER LIMB WITH TENDON INVOLVEMENT
903.00	INJURY TO AXILLARY VESSEL(S) UNSPECIFIED
903.01	INJURY TO AXILLARY ARTERY
903.02	INJURY TO AXILLARY VEIN
903.1	INJURY TO BRACHIAL BLOOD VESSELS
903.2	INJURY TO RADIAL BLOOD VESSELS
903.3	INJURY TO ULNAR BLOOD VESSELS
903.4	INJURY TO PALMAR ARTERY
903.5	INJURY TO DIGITAL BLOOD VESSELS
903.8	INJURY TO OTHER SPECIFIED BLOOD VESSELS OF UPPER EXTREMITY
903.9	INJURY TO UNSPECIFIED BLOOD VESSEL OF UPPER EXTREMITY
904.0	INJURY TO COMMON FEMORAL ARTERY
904.1	INJURY TO SUPERFICIAL FEMORAL ARTERY
904.2	INJURY TO FEMORAL VEINS
904.3	INJURY TO SAPHENOUS VEINS
904.40	INJURY TO POPLITEAL VESSEL(S) UNSPECIFIED
904.41	INJURY TO POPLITEAL ARTERY
904.42	INJURY TO POPLITEAL VEIN
904.50	INJURY TO TIBIAL VESSEL(S) UNSPECIFIED
904.51	INJURY TO ANTERIOR TIBIAL ARTERY
904.52	INJURY TO ANTERIOR TIBIAL VEIN
904.53	INJURY TO POSTERIOR TIBIAL ARTERY
904.54	INJURY TO POSTERIOR TIBIAL VEIN
904.6	INJURY TO DEEP PLANTAR BLOOD VESSELS
904.7	INJURY TO OTHER SPECIFIED BLOOD VESSELS OF LOWER EXTREMITY
904.8	INJURY TO UNSPECIFIED BLOOD VESSEL OF LOWER EXTREMITY
904.9	INJURY TO BLOOD VESSELS OF UNSPECIFIED SITE

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	OTHER COMPLICATIONS DUE TO UNSPECIFIED DEVICE IMPLANT AND GRAFT
996.71	OTHER COMPLICATIONS DUE TO HEART VALVE PROSTHESIS
996.72	OTHER COMPLICATIONS DUE TO OTHER CARDIAC DEVICE IMPLANT AND GRAFT
996.73	OTHER COMPLICATIONS DUE TO RENAL DIALYSIS DEVICE IMPLANT AND GRAFT
996.74	OTHER COMPLICATIONS DUE TO OTHER VASCULAR DEVICE IMPLANT AND GRAFT
996.75	OTHER COMPLICATIONS DUE TO NERVOUS SYSTEM DEVICE IMPLANT AND GRAFT
996.76	OTHER COMPLICATIONS DUE TO GENITOURINARY DEVICE IMPLANT AND GRAFT
996.77	OTHER COMPLICATIONS DUE TO INTERNAL JOINT PROSTHESIS
996.78	OTHER COMPLICATIONS DUE TO OTHER INTERNAL ORTHOPEDIC DEVICE IMPLANT AND GRAFT
996.79	OTHER COMPLICATIONS DUE TO OTHER INTERNAL PROSTHETIC DEVICE IMPLANT AND GRAFT
996.80	COMPLICATIONS OF UNSPECIFIED TRANSPLANTED ORGAN
996.81	COMPLICATIONS OF TRANSPLANTED KIDNEY
996.82	COMPLICATIONS OF TRANSPLANTED LIVER
996.83	COMPLICATIONS OF TRANSPLANTED HEART
996.84	COMPLICATIONS OF TRANSPLANTED LUNG
996.85	COMPLICATIONS OF TRANSPLANTED BONE MARROW
996.86	COMPLICATIONS OF TRANSPLANTED PANCREAS
996.87	COMPLICATIONS OF TRANSPLANTED ORGAN INTESTINE
996.89	COMPLICATIONS OF OTHER SPECIFIED TRANSPLANTED ORGAN
996.90	COMPLICATIONS OF UNSPECIFIED REATTACHED EXTREMITY
996.91	COMPLICATIONS OF REATTACHED FOREARM
996.92	COMPLICATIONS OF REATTACHED HAND

996.93	COMPLICATIONS OF REATTACHED FINGER(S)
996.94	COMPLICATIONS OF REATTACHED UPPER EXTREMITY OTHER AND UNSPECIFIED
996.95	COMPLICATION OF REATTACHED FOOT AND TOE(S)
996.96	COMPLICATION OF REATTACHED LOWER EXTREMITY OTHER AND UNSPECIFIED
996.99	COMPLICATION OF OTHER SPECIFIED REATTACHED BODY PART
997.2	PERIPHERAL VASCULAR COMPLICATIONS NOT ELSEWHERE CLASSIFIED
997.79	VASCULAR COMPLICATIONS OF OTHER VESSELS
998.11	HEMORRHAGE COMPLICATING A PROCEDURE
998.12	HEMATOMA COMPLICATING A PROCEDURE
998.13	SEROMA COMPLICATING A PROCEDURE
998.2	ACCIDENTAL PUNCTURE OR LACERATION DURING A PROCEDURE NOT ELSEWHERE CLASSIFIED
998.31	DISRUPTION OF INTERNAL OPERATION (SURGICAL) WOUND
998.32	DISRUPTION OF EXTERNAL OPERATION (SURGICAL) WOUND
998.33	DISRUPTION OF TRAUMATIC INJURY WOUND REPAIR
998.83	NON-HEALING SURGICAL WOUND
999.2	OTHER VASCULAR COMPLICATIONS OF MEDICAL CARE NOT ELSEWHERE CLASSIFIED
V43.4	BLOOD VESSEL REPLACED BY OTHER MEANS
V45.81	POSTSURGICAL AORTOCORONARY BYPASS STATUS
V45.82	PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY 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

*729.5 should only be billed when the patient's symptoms meet the criteria listed under Indications and Limitations of Coverage and/or Medical Necessity, Indications for peripheral arterial evaluations.

* 2008 ICD-9-CM Updates - diagnosis code 440.4 was added to the policy for Group

1, effective 10/1/2007.

Group 2

Two diagnoses are required:

Either

V72.81 or V72.83

plus

410.00-414.9

410.00*	ACUTE MYOCARDIAL INFARCTION OF ANTEROLATERAL WALL EPISODE OF CARE UNSPECIFIED
410.01*	ACUTE MYOCARDIAL INFARCTION OF ANTEROLATERAL WALL INITIAL EPISODE OF CARE
410.02*	ACUTE MYOCARDIAL INFARCTION OF ANTEROLATERAL WALL SUBSEQUENT EPISODE OF CARE
410.10*	ACUTE MYOCARDIAL INFARCTION OF OTHER ANTERIOR WALL EPISODE OF CARE UNSPECIFIED
410.11*	ACUTE MYOCARDIAL INFARCTION OF OTHER ANTERIOR WALL INITIAL EPISODE OF CARE
410.12*	ACUTE MYOCARDIAL INFARCTION OF OTHER ANTERIOR WALL SUBSEQUENT EPISODE OF CARE
410.20*	ACUTE MYOCARDIAL INFARCTION OF INFEROLATERAL WALL EPISODE OF CARE UNSPECIFIED
410.21*	ACUTE MYOCARDIAL INFARCTION OF INFEROLATERAL WALL INITIAL EPISODE OF CARE
410.22*	ACUTE MYOCARDIAL INFARCTION OF INFEROLATERAL WALL SUBSEQUENT EPISODE OF CARE
410.30*	ACUTE MYOCARDIAL INFARCTION OF INFEROPOSTERIOR WALL EPISODE OF CARE UNSPECIFIED
410.31*	ACUTE MYOCARDIAL INFARCTION OF INFEROPOSTERIOR WALL INITIAL EPISODE OF CARE
410.32*	ACUTE MYOCARDIAL INFARCTION OF INFEROPOSTERIOR WALL SUBSEQUENT EPISODE OF CARE

410.40*	ACUTE MYOCARDIAL INFARCTION OF OTHER INFERIOR WALL EPISODE OF CARE UNSPECIFIED
410.41*	ACUTE MYOCARDIAL INFARCTION OF OTHER INFERIOR WALL INITIAL EPISODE OF CARE
410.42*	ACUTE MYOCARDIAL INFARCTION OF OTHER INFERIOR WALL SUBSEQUENT EPISODE OF CARE
410.50*	ACUTE MYOCARDIAL INFARCTION OF OTHER LATERAL WALL EPISODE OF CARE UNSPECIFIED
410.51*	ACUTE MYOCARDIAL INFARCTION OF OTHER LATERAL WALL INITIAL EPISODE OF CARE
410.52*	ACUTE MYOCARDIAL INFARCTION OF OTHER LATERAL WALL SUBSEQUENT EPISODE OF CARE
410.60*	TRUE POSTERIOR WALL INFARCTION EPISODE OF CARE UNSPECIFIED
410.61*	TRUE POSTERIOR WALL INFARCTION INITIAL EPISODE OF CARE
410.62*	TRUE POSTERIOR WALL INFARCTION SUBSEQUENT EPISODE OF CARE
410.70*	SUBENDOCARDIAL INFARCTION EPISODE OF CARE UNSPECIFIED
410.71*	SUBENDOCARDIAL INFARCTION INITIAL EPISODE OF CARE
410.72*	SUBENDOCARDIAL INFARCTION SUBSEQUENT EPISODE OF CARE
410.80*	ACUTE MYOCARDIAL INFARCTION OF OTHER SPECIFIED SITES EPISODE OF CARE UNSPECIFIED
410.81*	ACUTE MYOCARDIAL INFARCTION OF OTHER SPECIFIED SITES INITIAL EPISODE OF CARE
410.82*	ACUTE MYOCARDIAL INFARCTION OF OTHER SPECIFIED SITES SUBSEQUENT EPISODE OF CARE
410.90*	ACUTE MYOCARDIAL INFARCTION OF UNSPECIFIED SITE EPISODE OF CARE UNSPECIFIED
410.91*	ACUTE MYOCARDIAL INFARCTION OF UNSPECIFIED SITE INITIAL EPISODE OF CARE
410.92*	ACUTE MYOCARDIAL INFARCTION OF UNSPECIFIED SITE SUBSEQUENT EPISODE OF CARE
411.0*	POSTMYOCARDIAL INFARCTION SYNDROME
411.1*	INTERMEDIATE CORONARY SYNDROME

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*	ANGINA DECUBITUS
413.1*	PRINZMETAL ANGINA
413.9*	OTHER AND UNSPECIFIED ANGINA PECTORIS
414.00*	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED TYPE OF VESSEL NATIVE OR GRAFT
414.01*	CORONARY ATHEROSCLEROSIS OF NATIVE CORONARY ARTERY
414.02*	CORONARY ATHEROSCLEROSIS OF AUTOLOGOUS VEIN BYPASS GRAFT
414.03*	CORONARY ATHEROSCLEROSIS OF NONAUTOLOGOUS BIOLOGICAL BYPASS GRAFT
414.04*	CORONARY ATHEROSCLEROSIS OF ARTERY BYPASS GRAFT
414.05*	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED BYPASS GRAFT
414.06*	CORONARY ATHEROSCLEROSIS OF NATIVE CORONARY ARTERY OF TRANSPLANTED HEART
414.07*	CORONARY ATHEROSCLEROSIS OF BYPASS GRAFT (ARTERY) (VEIN) OF TRANSPLANTED HEART
414.10*	ANEURYSM OF HEART (WALL)
414.11*	ANEURYSM OF CORONARY VESSELS
414.12*	DISSECTION OF CORONARY ARTERY
414.19*	OTHER ANEURYSM OF HEART
414.2*	CHRONIC TOTAL OCCLUSION OF CORONARY ARTERY
414.3	CORONARY ATHEROSCLEROSIS DUE TO LIPID RICH PLAQUE
414.8*	OTHER SPECIFIED FORMS OF CHRONIC ISCHEMIC HEART DISEASE
414.9*	CHRONIC ISCHEMIC HEART DISEASE UNSPECIFIED
V72.81*	PRE-OPERATIVE CARDIOVASCULAR EXAMINATION
V72.83*	

OTHER SPECIFIED PRE-OPERATIVE EXAMINATION

***Note:**

Two ICD-9-CM Codes are required for payment. Either V72.81 or V72.83 plus any of 410.00-414.9.

* 2008 ICD-9-CM Updates - diagnosis code 414.2 was added to the policy for Group 2, effective 10/1/2007.

Diagnoses that Support Medical Necessity

All ICD-9-CM codes listed in this policy under ICD-9-CM Codes that Support Medical Necessity above.

ICD-9 Codes that DO NOT Support Medical Necessity

All ICD-9-CM codes not listed in this policy under ICD-9-CM Codes that Support Medical Necessity above.

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

All ICD-9-CM codes not listed in this policy under ICD-9-CM Codes that Support Medical Necessity above.

General Information

Documentation Requirements

The provider must ensure that documentation showing reasonableness and necessity of the procedures is kept on file and made available to NAS on request.

The accuracy of noninvasive vascular diagnostic studies depends on the knowledge, skills and experience of the technologist and physician performing and interpreting the studies. It is recommended that noninvasive vascular studies either be rendered in a physician's office by/or under the direct supervision of persons credentialed in the specific type of procedure being performed or performed in laboratories accredited in the specific type of evaluation. Noninvasive vascular studies done in an IDTF facility or vascular laboratory are subject to the rules and regulations governing the facility.

Noridian Administrative Services (NAS) is not a credentialing body; therefore, this LCD will recommend certification, but not recommend certifying bodies.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary under Section 1862(a)(1) of the Social Security Act.

When requesting a written redetermination (formerly appeal), providers must include all relevant documentation with the request.

Appendices

Utilization Guidelines

Sources of Information and Basis for Decision

1. Color Duplex Ultrasonography in the Diagnosis of Temporal Arteritis. The New England Journal of Medicine, Nov. 6, 1997; Vol.337 No.19: 1336-1342.
2. ICAVL Essentials and Standards for Accreditations in Noninvasive Vascular Testing; Part II Vascular Laboratory Operations, Peripheral Arterial Testing, 1997.
3. Non-operative Management of Lower-Extremity Arterial Disease, Part II, **Surgical Clinics of North America**, Vol. 78 No. 4 Aug 1998.
4. Non-invasive Vascular Diagnostic Studies, in Physician? Current Procedural Terminology 1995, American Medical Associations pps. 543-544, 1995.)
5. Peripheral Arterial Occlusive Disease, Part I: Navigating a Bottleneck, SpringNet. February, 1998. (<http://www.springnet.com/ce/p802a.htm>)
6. Principles of Surgery. 1999 pp 936-937.
7. Screening for Peripheral Arterial Disease. (<http://home.mdconsult.com/das/article/body/jorg=journal&source=&sp=10134837&sud.../1.htm>)
8. Summer, David. Vascular Diagnostics. **Surgery: Scientific Principles and Practice**. 1997 Chapter 75, pp. 1668-1677.
9. The Ankle Brachial Index Independently Predicts Walking Velocity and Walking Endurance in Peripheral Arterial Disease. Journal of the American Geriatric Society, Vol.46; No11, Nov., 1998.
10. Medicare consultants and Contractor Medical Directors
11. Other Carrier Policies.
12. NAS Carrier Advisory Committee Members

Advisory Committee Meeting Notes

This medical policy was presented at the Medicare Part B Open Public Meeting held on 05/08/2007 and discussed at the following Carrier Advisory Committee meetings:

Arizona 06/12/2007
Montana 06/20/2007
North Dakota 06/05/2007
South Dakota 06/07/2007
Utah 06/07/2007
Wyoming 06/08/2007

This policy does not reflect the sole opinion of the contractor or the Contractor Medical Director(s). Although the final decision rests with the contractor, this policy was developed in cooperation with the Carrier Advisory Committee(s), which include representatives of various medical specialty societies.

The Section titled "Does the 'CPT 30% Rule' apply?" needs clarification. This rule comes from the AMA (American Medical Association), the organization that holds the copyrights for all CPT codes. The rule states that if, in a given section (e.g., **surgery**) or subsection (e.g., surgery, **integumentary**) of the CPT Manual, more than 30% of the codes are listed in the LCD, then the short descriptors must be used rather than the long descriptors found in the CPT Manual.

This policy is subject to the reasonable and necessary guidelines and the limitation of liability provision.

This medical policy consolidates and replaces all previous policies and publications on this subject by Noridian Administrative Services (NAS) and its predecessors for Medicare B.

NAS' Responses to Provider Recommendations (for comment period ending 10/31/2006):

1. There is a group of patients who present with chronic leg pain that is difficult to characterize. Neurological examination and lumbar MRI may be equivocal, or may not clearly explain symptoms. In these patients, even though they do not have the level of claudication noted above, or do not have true rest pain, it is still appropriate to perform a complete examination. ABI's are inadequate to exclude borderline inflow disease, and the pulse volume recordings and doppler signals are frequently helpful in either unmasking vascular disease that is borderline compensated, or in directing the diagnosis back to neuromuscular causes.

The LCD contains several scenarios when the study of the "borderline" patient would be considered reasonable and necessary. For example "It is not reasonable and necessary to proceed beyond the physical examination for minor signs and symptoms unless related signs and/or symptoms are present which are severe enough to require possible invasive intervention." NAS notes that intention to proceed with treatment would be a factor in payment for such a patient.

2. Several individuals and national specialty societies pushed for credentialing requirements for those performing and/or interpreting studies.

At this time, NAS has not received instruction from CMS to utilize credentialing criteria. This area remains under review and discussion.

3. Several ICD-9-CM Code additions were requested.

NAS has added those that meet medical necessity for the tests.

4. There was a request for NAS to confirm support for the PADnet system for testing patients with suspected or actual peripheral vascular disease in the primary care setting with an off site reading specialist.

NAS would expect that any system used would comply with the requirements of this LCD. Recommendation for a specific system is not in the purview of an LCD. As with all "systems" in this category, screening is not a Medicare benefit.

NAS' Responses to Provider Recommendations (for comment period ending 08/10/2007):

1. There were requests that NAS change the policy of recommendation for credentialing of noninvasive ultrasound studies to one of requirement for credentialing of individuals and/or institutions providing such studies. The majority of these requests came from organizations that stand to benefit from such a requirement rather than from the providers in the states that NAS administers Part B Medicare.

NAS has reviewed this issue and the literature provided. NAS will leave the issue of credentialing as recommendation at this time. NAS recognizes that at the current time, it is not able to consistently enforce such a requirement. Thus, it would place an undue burden and expense upon providers to meet criteria that could not be applied on a consistent basis.

Start Date of Comment Period

05/08/2007

End Date of Comment Period

08/10/2007

Start Date of Notice Period

10/10/2007

Revision History Number

R3

Revision History Explanation

J3 CB2006.07

This LCD is the combination of the NAS (Noridian Administrative Services) Noninvasive Peripheral Arterial Studies Policy, which is in effect in four of the J3 MAC (Medicare Administrative Contract) Medicare Part B states, the Montana Vascular Studies, Noninvasive Policy, and the Utah ESRD Monitoring Policy. The NAS policy covered much of the subject instructions well and had an extensive list of ICD-9-CM codes. However, it lacked specificity in ESRD monitoring. The Montana policy was best here and included all of the Utah information so the Montana policy serves as the basis for the ESRD instructions. The ICD-9-CM codes were combined except for three deemed too vague to be effective.

11/18/2006 - The description for CPT/HCPCS code 93922 was changed in group 1

11/18/2006 - The description for CPT/HCPCS code 93923 was changed in group 1

11/18/2006 - The description for CPT/HCPCS code 93924 was changed in group 1

Provider recommendations and NAS' responses to them were incorporated.

J3 CB2006.07 R1

2008 ICD-9-CM Updates - diagnosis code 440.4 was added to the policy, Group 1, effective 10/01/2007.

J3 CB2006.07 R2

This is the finalization of this revised LCD after being presented at the local CAC Meetings in 06/2007 (see above for exact dates). Several ICD-9-CM codes (410.00-414.9) were removed from Group 1 as they were inadvertently placed there previously. In addition, provider comments and NAS' responses to those comments were incorporated.

Additional 2008 ICD-9-CM Updates – diagnosis code 414.2 was added to the policy, Group 2, effective 10/01/2007.

J3 CB2006.07 R3

2008-2009 ICD-9-CM updates were applied. ICD-9-CM codes 249.70, 249.71, 998.33 were added to Group 1 effective 10/01/08. ICD-9-CM code 414.3 was added to Group 2 effective 10/01/08.

Reason for Change

ICD9 Addition/Deletion

Last Reviewed On Date

09/16/2008

Related Documents

This LCD has no Related Documents.

LCD Attachments

Coding Guidelines - Noninvasive Peripheral Arterial Studies - J3 CB2006.07 (PDF - 27,300 bytes)
Coding Guidelines - Noninvasive Peripheral Arterial Studies - J3 CB2006.07 R1 (PDF - 10,623 bytes)
Coding Guidelines - Noninvasive Peripheral Arterial Studies - J3 CB2006.07 R2 (PDF - 10,648 bytes)
Coding Guidelines - Noninvasive Peripheral Arterial Studies - J3 CB2006.07 R3 (PDF - 9,749 bytes)

Other Versions

Updated on 09/23/2008 with effective dates 10/01/2008 - N/A
Updated on 08/10/2008 with effective dates 12/01/2007 - 09/30/2008
Updated on 10/04/2007 with effective dates 12/01/2007 - N/A
Updated on 09/20/2007 with effective dates 10/01/2007 - 11/30/2007
Updated on 11/22/2006 with effective dates 12/01/2006 - N/A