## Non-Invasive Cerebrovascular Extracranial Artery Studies (93880, 93882) L35753

**Indications Overview:**

Diagnostic tests must be ordered by the physician who is treating the beneficiary and who will use the results in the management of the beneficiary's specific medical problem. Services are deemed medically necessary when all of the following conditions are met:

1. Signs/symptoms of ischemia or altered blood flow are present;
2. The information is necessary for appropriate medical and/or surgical management;
3. 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 carotids and lower extremity arterial system).

**Extracranial Artery Study Indications:**

Testing methods that include (real-time) duplex scans and Doppler ultrasound waveform with spectral analysis are covered for the following:

1. Cervical bruits.
2. Amaurosis fugax (transient monocular blindness).
3. Focal cerebral or ocular transient ischemic attacks.
4. Drop attack or syncope is only covered with vertebrobasilar or bilateral carotid artery disease as suggested by the patient's history. If an echocardiogram is negative for a cardiac or cardiac valvular cause, it may be medically appropriate to perform extracranial arteries studies for the drop attack or syncope.
5. Subclavian steal syndrome (symptoms usually associated with it are a bruit in the subclavian fossa, unequal radial pulses, arm claudication following minimal exercise, and a difference of 20 mm Hg or more between the systolic blood pressures in the arms).
6. Evaluation of blunt or penetrating neck trauma or injury to the carotid artery.
7. Follow-up after a carotid endarterectomy or carotid stenting.
8. Suspected aneurysm of the carotid artery. Patients with swelling of the neck particularly if occurring post carotid endarterectomy.
9. Re-evaluation of existing carotid stenosis.
10. Evaluation of pulsatile neck mass.
11. Preoperative evaluation of patient scheduled for major cardiovascular surgical procedure when there is evidence of systemic atherosclerosis.
12. Preoperatively validate the degree of carotid stenosis of patients whose previous duplex scan revealed a greater than 60% diameter reduction. The duplex is only covered when the surgeon questions the validity of the previous study, and the repeat test is performed in lieu of a carotid arteriogram.
13. Ocular micro embolism (optic nerve/retinal arterial - Hollenhorst plaques/ocular).
14. Evaluation of suspected dissection.

15. Recent stroke (defined as less than six months) for determining the cause of the stroke.
16. Vasculitis involving the extracranial carotid arteries.
17. Diagnosis of carotid disease on medical management and cerebrovascular symptoms are reoccurring.

Pulsatile tinnitus with other symptoms involving the cardiovascular system.

**Limitations:**

Tests may not be considered medically necessary if performed for the following signs and symptoms:

1. Dizziness is not a typical indication unless associated with other localizing neurologic signs or symptoms.
2. Headaches including migraines.
3. Temporarily blurred vision.

**Utilization (Frequency) Guidelines for Extracranial Artery Studies:**

Each patient's condition and response to treatment must medically warrant the number of services reported for payment. Medicare requires the medical necessity for each study reported to be clearly documented in the patient's medical record.

Frequency of follow-up studies will be carefully monitored for medical necessity, and it is the responsibility of the physician/provider to maintain documentation of medical necessity in the patient's medical record.

**Only one Doppler preoperative scan is considered reasonable and necessary for bypass surgery.** If a more current preoperative scan is indicated for a patient with multiple comorbidities having difficulty being stabilized for surgery or a change in condition, the medical record would need to support the medical necessity of the second scan.

**Re-evaluation of existing carotid stenosis. Patients demonstrating a diameter reduction of greater than 50% with symptoms and those patients with > 60% with no symptoms are normally followed on an annual basis**. If patients become symptomatic of carotid disease repeat duplex scans are allowed without regard to the above schedule.

**Follow-up after a carotid endarterectomy** (outside the global period). **These patients are normally followed with duplex ultrasonography on the affected side at 6 weeks, 6 months, and annually thereafter unless symptoms develop.** During the first year, follow-up studies should be on the ipsilateral side unless signs and symptoms or previously identified disease in the contralateral carotid artery provide indications for a bilateral procedure.

Multiple cerebrovascular procedures may be allowed during the same encounter given the physician/non-physician can demonstrate medical necessity as documented in the patient's medical record.

**Preventive and/or screening services unless covered in Statute are not covered by Medicare.**

| **Most Common Diagnoses for Extracranial Arteries 93880, 93882 (which meet medical necessity) *** | |
|---|---|
| G45.9 | Transient cerebral ischemic attack |
| I63.12 | Cerebral embolism of basilar artery |
| I63.231 | Cerebral infarction due to occlusion or stenosis of right carotid arteries |
| I63.232 | Cerebral infarction due to occlusion or stenosis of left carotid arteries |
| I63.421 | Cerebral infarction due to embolism of right anterior cerebral artery |
| I63.422 | Cerebral infarction due to embolism of left anterior cerebral artery |
| I63.431 | Cerebral infarction due to embolism of right posterior cerebral artery |
| I63.432 | Cerebral infarction due to embolism of left posterior cerebral artery |
| I63.511 | Cerebral infarction due to occlusion or stenosis of right middle cerebral artery |
| I63.512 | Cerebral infarction due to occlusion or stenosis of left middle cerebral artery |
| I65.01 | Occlusion and stenosis of right vertebral artery |
| I65.02 | Occlusion and stenosis of left vertebral artery |
| I65.03 | Occlusion and stenosis of bilateral vertebral artery |
| I65.21 | Occlusion and stenosis of right carotid artery |
| I65.22 | Occlusion and stenosis of left carotid artery |
| I65.23 | Occlusion and stenosis of bilateral carotid arteries |
| I67.2 | Cerebral atherosclerosis |
| I67.82 | Cerebral ischemia |
| I72.0 | Aneurysm of carotid artery |
| R09.89 | Carotid bruit |
| R22.1 | Pulsatile neck mass |
| R26.81 | Unsteadiness on feet |
| R26.89 | Other abnormalities of gait and mobility |
| R29.810 | Facial weakness |
| R42 | Dizziness |
| R47.01 | Aphasia |
| R47.02 | Dysphasia |
| R47.1 | Dysarthria and anarthria |
| R47.81 | Slurred speech |
| R55 | Syncope and collapse |

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| Z01.810 | Encounter for cardiovascular examination |
| Z01.818 | Encounter for preprocedural examination |
| Z09 | Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm |
| Z48.812 | Encounter for surgical aftercare following surgery on the circulatory system |
| Z86.73 | Personal history of TIA, and cerebral infarction without residual deficits |

*See the complete list of Medicare covered diagnoses and payment rules:
https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=57592&ver=14

To see the complete coverage indications and limitations:
https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=35753

The above CMS and WPS-GHA guidelines are current as of: 04/01/2025.