Program Memorandum Intermediaries/Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal AB-01-129 **Date: September 15, 2001**

CHANGE REQUEST 1855

SUBJECT: Medicare Coverage of Non-Invasive Vascular Studies for End Stage Renal Disease (ESRD) Patients

Medicare pays for outpatient maintenance dialysis services furnished by ESRD facilities based on a composite payment rate. This rate is a comprehensive payment and includes all services, equipment, supplies, and certain laboratory tests and drugs that are necessary to furnish a dialysis treatment.

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.

A number of ESRD facilities are monitoring access through non-invasive vascular studies such as duplex and Doppler flow scans and billing separately for these procedures. Non-invasive 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 non-invasive 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 non-invasive 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 Current Procedural Terminology (CPT) billing code for non-invasive vascular testing of a hemodialysis access site is 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.

Examples supporting the medical necessity for Doppler flow studies include:

a. Elevated dynamic venous pressure >200mm HG when measured during dialysis with the blood pump set on a 200cc/min.,
b. Access recirculation of 12 percent or greater,
c. An otherwise unexplained urea reduction ratio <60 percent, and
d. An access with a palpable "water hammer" pulse on examination, (which implies venous outflow obstruction).

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% or greater from previous study) and the physician requires an arteriogram to further define the extent of the problem. The patient's medical record(s) must provide documentation supporting the need for more than one imaging study.

This policy is applicable to claims from ESRD facilities and all other sources, such as independent diagnostic testing facilities, and hospital outpatient departments.

Develop LMRP for Doppler flow studies if this service meets the criteria listed in the Program Integrity Manual, Chapter 1, Section 2.3.1. The Program Integrity Manual, Chapter 1, Section 2.1.(c) provides guidance to contractors on the scope, purpose, and meaning of LMRP.

The professional component of the procedure is included in the monthly capitation payment (MCP) (see §15060.1 of Medicare Carriers Manual, Part 3). The professional component should be denied for code 93990 if billed by the MCP physician. Medically necessary services that are included or bundled into the MCP (e.g., test interpretations) are separately payable when furnished by physicians other than the MCP physician. (See §§15060.1 and 15060.2 of the Medicare Carriers Manual, Part 3.)

If the claim is denied, report this on a remittance advice with group code "CO", and claim adjustment reason code 24, "Payment for charges denied. Charges are covered under a capitation agreement."

The Medicare Summary Notice denial message number is 16.32; "Medicare does not pay separately for this service." (See §3726.14A of the Medicare Intermediary Manual, Part 3.)

Billing for monitoring of hemodialysis access using CPT codes for non-invasive vascular studies other than 93990 is considered a misrepresentation of the service actually provided and should be considered for fraud investigation. Conduct data analysis on a periodic basis for non-invasive diagnostic studies of the extremities (including CPT codes 93922, 93923, 93924, 93925, 93926, 93930, 93931, 93965, 93970, 93971). Handle aberrant findings under normal program safeguard processes by taking whatever corrective action you deem necessary.

The *effective date* for this Program Memorandum (PM) is July 1, 2001.

The *implementation date* for this PM is December 6, 2001.

These instructions should be implemented within your current operating budget.

This PM may be discarded after January 1, 2003.

If you have any questions, contact Jacqueline Johnson, (410) 786-4560 or Lana Price, (410 786-4533.