Codify
BY AAPC

Internal Medicine Coding Alert

READER QUESTIONS: ABI Needs Printout to Not Be E/M

Question: Can I separately report ankle brachial index (ABI) in addition to the E/M service code?

New Jersey Subscriber

Answer: It depends on the type of equipment used during the procedure. If your ABI machine (for instance, a Doppler ultrasound, which is commonly known as the Doppler probe) has printed outputs, then consider using this code: 93922 (Noninvasive physiologic studies of upper or lower extremity arteries, single level, bilateral [e.g., ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement]).

ABI as a form of vascular study is used to evaluate blood pressure in the lower extremities as compared to the upper extremities in order to evaluate presence of arterial or venous complications arising from other metabolic or systemic diseases (for instance, diabetes mellitus, PAD, etc.). Vascular studies must have a printout or a hard copy for this to be billable. CPT states, "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."

ABI is considered as part of the general physical exam if your doctor performs this procedure with a machine that has no printouts, or that does not permit analysis of bidirectional vascular flow. In this case, the ABI is part of the E/M service.

CPT clearly points out that "the use of a simple handheld 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." Therefore, only the applicable E/M service code may be reported.

Remember: To be covered, the test must have a printed result. Providers further require your physician to document that the procedure was "medically necessary." You may need to look into Medicare's local coverage determination (LCD) on 93922 to ensure which diagnoses are payable in your area.