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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Prevent Transcranial Doppler Denials With AMA Approved Guidelines

Missing CPT requirements for 93893 can cost you.

In 1993, the Office of Inspector General published findings that Medicare carriers' transcranial Doppler (TCD) policies were inconsistent.

If you report these services,you may feel like times haven't changed much. But with our experts' timesaving tips on where to go for supporting information,you can put your best foot forward.

Size Up Complete and Limited TCD

The exam: TCD is a noninvasive diagnostic ultrasound evaluation of the intracranial arteries.Neurologists and other physicians may order the test to determine whether there is an artery occlusion or stenosis that could result in cerebrovascular diseases such as stroke and brain hemorrhages. Physicians also may order the test as a screening study for children with particular conditions, such as sickle cell anemia. To report the procedure, CPT offers specific codes:

• 93886 -- Transcranial

Doppler study of the intracranial arteries; complete study

• 93888 -- ... limited study

• 93890 -- ... vasoreactivity study

• 93892 -- ... emboli detection without intravenous microbubble injection

• 93893 -- ... emboli detection with intravenous microbubble injection.

Complete: CPT guidelines for "Cerebral Arterial Studies" explain that to qualify as complete (93886), documentation must show "ultrasound evaluation of the right and left anterior circulation territories and the posterior circulation territory (to include vertebral arteries and basilar artery)."

The anterior circulation includes the internal carotid arteries and their branches, including the right and left anterior cerebral arteries and middle cerebral arteries. The posterior circulation includes the bilateral vertebral arteries, the basilar artery, and the posterior cerebral artery.

Limited: To report limited code 93888, you need ultrasound evaluation of one or two of those areas.

Term tip: "Ultrasound evaluation" has a specific meaning for TCD codes. CPT states that "ultrasound evaluation is a reasonable and concerted attempt to identify arterial signals through an acoustic window."

Lesson learned: Be sure youhave clear documentation of these required components before you submit your claim.

93890-93893 May Not Be What You Expect

CPT added 93890-93893 in 2005. Note that these codes don't represent components of the complete TCD code. To the contrary, the services 93890-93893 represent require expertise, lab time, and equipment not included in the complete and limited codes. And a note with the TCD codes tells you not to report 93890-93893 with 93888.

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Cerebrovascular reactivity (93890) evaluates carotid and verebrobasilar stenosis or occlusion, according to CPT Changes 2005: An Insider's View. You may see this study referred to as a CO2 challenge because some protocols involve flow measurement before and after the patient inhales CO2-enriched air.

Embolus detection code 93892 requires specialized equipment (hardware and software) and training by the physician to detect embolic events.

Code 93893 adds the element of "with intravenous microbubble injection," which refers to intravenous injection of agitated saline (or commercial microbubble contrast) "to identify right to left cardiac,pulmonary, and other extracardiac shunts potentially inherent" in conditions such as deep vein thrombosis and pulmonary embolism, according to CPT Changes 2005.

Bottom line: If the documentation doesn't reflect these additional requirements, double check whether 93890-93893 are appropriate codes for your claim.

Prep to Clear the Medical Necessity Hurdle

Successful reimbursement for this procedure may be challenging if documentation and coding are not clear enough to support medical necessity for the procedure, says **Marianne Wink, RHIT,CPC, ACS-EM,** with the University of Rochester Medical Center in Rochester, N.Y.

For example: Your physician may document a complete TCD (93886) for a presenting condition such as dizziness (780.4, Dizziness and giddiness) in a patient who may have additional risk factorsfor stroke.

Many payers won't pay the claim if you use 780.4 as the primary diagnosis code, Wink says.

The reason: "Complete documentation of the presenting conditions that highlight medical necessity for the diagnostic procedure must include evidence of a condition that supports the need for the test," Wink explains.

This means you must have positive evidence of signs, symptoms, or conditions that can be determined to be causes of potential cerebrovascular disease."Coding conditions with generalized symptom codes such as 780.4 do not support the need for a TCD," Wink adds. Dizziness can be an indicator of many less acute conditions, such as an inner ear infection, and therefore does not indicate medical necessity for a diagnostic study such as a TCD.

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