Non-Invasive Abdominal/Visceral Vascular Studies

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plans supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

Non-invasive abdominal/visceral vascular studies use ultrasonic Doppler technology and physiological principles to evaluate irregularities in blood flow within the renal, iliac, and femoral artery systems. These tests are also employed for the diagnosis of aortic aneurysms. The comprehensive scope of noninvasive abdominal/visceral vascular studies encompasses patient care during the procedure, study supervision, and the interpretation of the study results. Additionally, copies of the test results and data analysis, including bi-directional vascular flow or imaging if provided, are documented for inclusion in the patient's records.

It is imperative to note that diagnostic tests must be requisitioned by the attending physician responsible for the member's care and who intends to utilize the results in managing the member's specific medical condition.

Medically necessary services are determined by meeting the following conditions:

1. The presence of signs or symptoms indicative of ischemia or altered blood flow.
2. Necessity for the acquired information in guiding appropriate medical and/or surgical interventions.
3. Avoidance of redundancy with other essential diagnostic procedures, although in select cases, non- invasive vascular tests may be used in conjunction. For example, combining MRA (Magnetic Resonance Angiography) and duplex can be beneficial, with the latter confirming inconclusive results or revealing the physiological significance of an anatomical stenosis in renal, iliac, and/or femoral arteries.

Reimbursement Guidelines

Please be aware that incorrectly billed claims, as outlined in the referenced documents, may result in the denial of claims or the retrieval of payments made in error. Molina Healthcare will only reimburse for non-invasive visceral vascular study services when there is a diagnosis of relevant signs, symptoms, or diseases, and when these services are billed with the corresponding diagnosis codes. In cases where the combination of diagnosis and procedure codes is submitted inaccurately, Molina Healthcare retains the authority to assess, decline, and recoup any erroneously disbursed claims.

Supplemental Information

Definitions

Term	Definitions
CMS	The Centers for Medicare & Medicaid Services. It is a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer

	Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.

Documentation History

Type	Date	Action
Initial Creation Date	09/08/2023	New Policy
Revised Date	12/14/2024	Updated Template
Revised Date	09/09/2025	Updated to new Molina Template and References

References

This policy was developed using:

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

Reference	Link
CMS Article	Article A54402
CMS LCD	LCD L35755
CMS Article	A57591
CMS NCD	NCD 220.5

*__CODING DISCLAIMER.__ Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.