CLINICAL GUIDELINES

PVD Imaging Policy

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eviCore healthcare Clinical Decision Support Tool Diagnostic Strategies: This tool addresses common symptoms and symptom complexes. Imaging requests for individuals with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist and/or individual's Primary Care Physician (PCP) may provide additional insight.

Peripheral Vascular Disease (PVD) Imaging Guidelines

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PVD-1.1: General Information

- A current clinical evaluation (within 60 days), including medical treatments, are required prior to considering advanced imaging, which includes:
  - Relevant history and physical examination including:
    - The palpation of pulses
    - Evaluation for the presence of arterial bruits
    - Appropriate laboratory studies
    - Non-advanced imaging modalities, such as recent ABIs (within 60 days) after symptoms started or worsened
  - Unless there is documented need for routine imaging that is supported by the guidelines.
  - Other meaningful contact (telephone call, electronic mail or messaging) by an established patient can substitute for a face-to-face clinical evaluation.
- The same general risk factors for coronary disease also apply to vascular disease
  - Diabetes is a particularly high risk factor.
  - Age > 50, with at least one risk factor, are considered “at risk” for vascular disease.
  - Erectile dysfunction can be associated with vascular disease.
  - See also: **PV-17: Impotence/Erectile Dysfunction** in the Pelvis Imaging Guidelines.
- Simultaneous venous and arterial systems evaluation are unusual but are occasionally needed.
- Post angioplasty/reconstruction: follow-up imaging is principally guided by symptoms. See also:
  - **PVD-6: Aortic Disorders, Renal Vascular Disorders, and Visceral Artery Aneurysms**
  - **CH-29: Thoracic Aorta** in the Chest Imaging Guidelines.
  - **PVD-7.3: Post-Procedure Surveillance Studies**

        - Functional disability (e.g. exercise impairment sufficient to threaten the patient's employment or to require significant alterations in the patient's lifestyle)
    - Potentially limb-threatening vascular disease evidenced by:
        - Skin breakdown
        - Non-healing ischemic ulcers
        - Resting leg pain
        - Gangrene
    - Blue Toe Syndrome:
        - Emboli from aortic plaque or mural thrombus
        - Hyperviscosity syndrome
        - Hypercoagulable states
        - Vasculitis
    - Preoperative planning for an invasive procedure (endovascular or open surgery)
    - **Note**: MRA Pelvis should not be requested/billed with CPT® 74185, CPT® 73725 and CPT® 73725

Practice Notes

Claudication symptoms usually remain stable (70% to 80% of patients) and do not worsen or improve at rapid rates.[9] Repeat studies to assess the efficacy of medical therapy are not indicated unless there is a negative change in clinical status.

PVD-7.2: Popliteal Artery Entrapment Syndrome

- Diagnosis of popliteal artery stenosis or occlusion due to compression by adjacent muscle and tendons seen in young men (ages 20 to 40).[10]
    - Ultrasound (CPT® 93926 unilateral study), CTA Lower extremity (CPT® 73706), or MRA Lower extremity (CPT® 73725).
    - CT or MRI of the lower extremity (contrast as requested) if requested by the operating surgeon.

PVD-7.3: Post-Procedure Surveillance Studies

- Intervals determined by a Vascular Specialist
    - Resting (CPT® 93922), and post-exercise ABI (CPT® 93924)
        - Angioplasty, aortoiliac and infrainguinal
        - Synthetic graft (e.g. PTFE), lower extremity bypass graft
- Scheduled Interval
    - ABI (CPT® 93922) is generally appropriate following any revascularization procedure.
    - Venous conduit, lower extremity bypass graft
        - ABI (CPT® 93922) or Duplex ultrasound (CPT® 93926 unilateral study) at each routine follow up is appropriate.
        - Further imaging studies such as CTA or MRA can be considered based on the evaluation by the vascular specialist, but not both annually.
    - Endovascular stenting

PVD-9: Arteriovenous Malformations (AVMs)

See: **PEDPVD-2.5: Arteriovenous Malformations (AVMs) and Fistulas**

PVD-10: Nuclear Medicine

- Nuclear medicine
  - Nuclear medicine studies are rarely used in the evaluation of peripheral vascular disorders, but are indicated in the following circumstances:
    - Lymphoscintigraphy (CPT® 78195) is indicated for evaluation of lower extremity lymphedema when a recent Doppler ultrasound is negative for valvular insufficiency.
    - Vascular flow imaging (CPT® 78445) is an obsolete study that has been replaced by MRA, CTA, or Duplex ultrasonography, and is not supported for any indication at this time.
    - Venous thrombosis imaging (CPT® 78456, CPT® 78457, and CPT® 75458) are obsolete studies that have been replaced by MRA, CTA, or Duplex ultrasonography, and are not supported for any indication at this time.
    - Indium 111 (^{111}In)–labeled white blood cell (WBC) or Gallium-67 citrate studies (CPT® 78805, CPT® 78806, or CPT® 78807) can be approved for evaluation of the following:
      - Mycotic aneurysms.
      - Vascular graft infection.
      - Infection of central venous catheter or other indwelling device.