HealthWright TECHNOLOGIES

PHYSICIAN RESOURCE

The Physician's Guide to In-Office ANS and ABI Testing

What in-office vascular and autonomic testing involves, what it looks like operationally, and what to ask any vendor before you commit.

WHY PRACTICES BRING VASCULAR AND AUTONOMIC TESTING IN OFFICE

Most independent practices already have the patients for vascular and autonomic testing: the diabetes, hypertension, and cardiovascular risk factors you manage every week. For patients with these risk factors and relevant symptoms, this assessment can be a medically necessary part of their evaluation. The open question is usually where it happens. When testing happens inside your practice instead of a referral out, the visit, the results, and the follow-up plan stay in your chart and under your clinical judgment.

This guide covers the three measurement families involved, what testing looks like operationally, and what to ask any vendor before you commit.

THE THREE MEASUREMENT FAMILIES

Ankle-brachial index (ABI), CPT 93923. A noninvasive comparison of blood pressures at the ankle and arm, used in the assessment of peripheral arterial disease. Medicare's published 2026 fee schedule lists $133.60 (national, non-facility). The code covers upper or lower extremity studies, so when both are performed and documented it is reported twice, with modifier 59 on the second line. Medicare pays the second study at a reduced rate of $105.55, because it reduces the technical component of additional same day cardiovascular studies by 25 percent.

Sudomotor function, CPT 95923. Evaluation of the sympathetic skin response, one component of autonomic nervous system assessment. Medicare's published 2026 fee schedule lists $122.63 (national, non-facility).

Cardiovagal (autonomic) function testing, CPT 95921. Assessment of parasympathetic function using heart rate response to paced breathing, standing, and related maneuvers. Medicare's published 2026 fee schedule lists $90.18 (national, non-facility).

With the upper and lower extremity studies both performed, these tests total about $450 on the 2026 Medicare fee schedule ($133.60 plus $105.55 plus $122.63 plus $90.18). They are addressed under Medicare Local Coverage Determinations when medical necessity is documented. Confirm coverage and documentation requirements under your Medicare Administrative Contractor's LCD with your billing team before billing.

WHAT TESTING LOOKS LIKE IN A WORKING CLINIC

A combined test session takes about 8 to 10 minutes and is typically administered by a medical assistant or technician after brief training. Practices that run testing smoothly tend to do a few things consistently:

1. Patients complete a short symptoms questionnaire first, which supports medical necessity documentation before any test is run.
2. Scheduling adds a set block of time to visits where testing is planned, so the day does not back up.
3. Results are recorded in the chart and on the superbill the same day, which keeps billing and follow-up scheduling accurate.

A FOLLOW-UP PATTERN THAT WORKS

A structured re-evaluation ladder keeps results actionable: an abnormal result is rechecked on a defined short cycle, an improving result moves to a longer one, and a normal result is rechecked annually.

One HealthWright partner practice structures re-evaluation around the test score itself: an initial abnormal result is rechecked in three months, a persistently abnormal result stays on a three month cycle, a mildly improved result moves to six months, and a normal result is rechecked annually. That practice reports that 90% of scheduled patients follow through with testing.

Whatever cadence a practice adopts, each re-evaluation must independently meet medical necessity criteria and inform clinical management; repeat testing solely to monitor a score is not billable.

WHAT TO ASK ANY VENDOR

1. Is the device FDA cleared for the specific measurements you will bill?
2. Who trains your staff, and is training a defined program or a manual in a box?
3. What billing documentation support do you get, and who answers questions after month one?
4. Are supplies readily available, and what do they cost over a year?
5. Where do results live, and can your staff pull a prior report during a follow-up visit without calling support?

WHERE HEALTHWRIGHT FITS

HealthWright Technologies provides the CMAT Advantage program: a testing platform built on FDA-cleared component devices, along with staff training, implementation, and ongoing support. It also includes a 90 day buyback commitment tied to Medicare reimbursement: if your practice bills correctly under the coverage criteria and Medicare does not reimburse, we buy the system back.

The fastest way to evaluate fit is a 25 minute overview demonstration with your decision makers present. Call our sales line at **(706) 460-2633** or email **contact@healthwrighttechnologies.com**.

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