

Contractor Name

Wisconsin Physicians Service (WPS)

Contractor Number**Contractor Type**

Carrier - B

MAC - A B

Intermediary - A

LCD Database ID Number**LCD Version Number****LCD Title**

Cardiovascular Stress Testing

Contractor's Determination Number

CV-004

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CMS National Coverage Policy

Title XVIII of the Social Security Act section 1862 (a)(1)(A). This section allows coverage and payment of those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act section 1862 (a)(7). This section excludes routine physical examinations and services

Title XVIII of the Social Security Act section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Primary Geographic Jurisdiction

Legacy A: Alaska, Alabama, Arizona, California - Entire State, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Iowa, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Maryland, Maine, Michigan, Minnesota, Missouri - Entire State, Mississippi, Montana, North Carolina, North Dakota, Nebraska, New Hampshire, New Jersey, New Mexico, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Vermont, Washington, Wisconsin, West Virginia, Wyoming

Legacy B: Wisconsin, Illinois, Michigan, Minnesota

MAC AB: Iowa, Missouri, Nebraska, Kansas

Oversight Region

Original Determination Effective Date

| | |
|------------|--|
| Legacy A | |
| Legacy B | |
| J 5 MAC AB | |

Revision Effective Date

Indications and Limitations of Coverage and/or Medical Necessity

LCD Abstract

Cardiovascular stress testing is a well-established procedure that has been in widespread clinical use for many decades. Stress testing is adjunctive to the history and physical examination in the diagnosis and treatment of the patient who has known or suspected heart disease. Cardiovascular stress testing uses cardiac physiological monitoring (including ECG, B/P and HR) during and after stress; with or without subsequent imaging such as echocardiography or nuclear cardiac imaging. Exercise testing is considered the standard of care for most patients when cardiovascular stress testing is indicated. Exercise may be in the form of a treadmill or cycle ergometry device. Pharmacologic agents are used when the patient is unable to perform exercise. Pharmacologic stress is typically performed with the use of dipyridamole, adenosine or dobutamine. A diseased heart responds abnormally to stress allowing a diagnostic determination to be made. Although exercise testing is generally a safe procedure, both myocardial infarction and death have been reported. Good clinical judgment, therefore, need to be used in deciding which patient should undergo exercise testing.

Indications and Limitations of Coverage and/or Medical Necessity

Cardiovascular stress testing is covered by Medicare when reasonable and necessary and in the absence of absolute contraindications. The safety of the patient must be assured.

- A. Covered indications for cardiovascular stress testing include the following:
 - 1. Exercise Testing in the Diagnosis of Obstructive Coronary Artery Disease.
 - The vast majority of treadmill exercise testing is performed in adults with symptoms of known or suspected ischemic heart disease. The exercise test may be used if the diagnosis of CAD is uncertain. Myocardial ischemia is the most important cause of chest pain or discomfort and is most commonly a consequence of underlying coronary disease.
 - 2. Risk Assessment and Prognosis in Patients with Symptoms or a Prior History of Coronary Artery Disease.
 - Risk stratification with the exercise test does not take place in isolation but as part of a process that includes more readily accessible data from the clinical exam and other tests. Thus, the value of exercise testing for risk stratification must be considered in light of what is added to that which is already known about the patient's risk status.
 - Unless cardiac catheterization is indicated, patients with suspected or known CAD and new or changing symptoms suggesting ischemia should undergo exercise testing to assess the risk of future cardiac events.
 - There is no compelling evidence, in patient's who are classified as low risk based on clinical and exercise testing information, that an imaging modality adds significant new prognostic information to a standard exercise test.

- Exercise or pharmacologic stress testing should generally be an integral part of the evaluation of low-risk patients with unstable angina who are evaluated on an outpatient basis. In most cases testing should be performed within 72 hours of presentation.
 - The results of exercise testing may be used to titrate medical therapy up to a desirable level. The other management step addressed by exercise testing is whether to proceed with additional testing. Patients with a low-risk exercise test result can be treated medically without need for referral to cardiac catheterization. Patients with high-risk exercise test should usually be referred for cardiac catheterization. Patients with an intermediate result should be referred for additional testing, either cardiac catheterization or an exercise imaging study.
3. After Myocardial Infarction:
- The post-MI evaluation is limited by the severity of the disease.
- Exercise testing is useful in evaluation and treatment of patients after myocardial infarction. Exercise testing yields information on prognosis, functional capacity and assessment of adequacy of medical therapy and the need to employ other diagnostic or treatment options.
4. Valvular Heart Disease:
- In symptomatic patients with documented valvular stenosis or regurgitation, the course of treatment is usually clear and exercise testing is not required. The primary value of exercise testing in valvular heart disease is to objectively assess atypical symptoms, exercise capacity, and extent of disability, which may have implications for medical, surgical, and social decision making. This is particularly of importance in the elderly, who are often asymptomatic because they are inactive.
5. Exercise Testing Before and After Revascularization
- Patients who undergo myocardial revascularization should have documented ischemic or viable myocardium, especially if they are asymptomatic.
 - There are two phases after revascularization. In the early phase the goal of exercise testing is to determine the immediate result of revascularization. In the second phase the goal is to assist in guiding an appropriate cardiac rehabilitation program and return-to-work decisions.
 - After coronary bypass graft surgery, in symptomatic patients, exercise testing may be used to distinguish between cardiac and noncardiac causes of recurrent chest pain.
 - Restenosis remains the single major limitation of percutaneous coronary intervention. Unfortunately, symptom status is an unreliable index to development of restenosis; many patients complain of noncardiac pain after angioplasty, and many persons experience silent ischemia. Silent restenosis is a common clinical manifestation, with 25% of asymptomatic patients documented as having ischemia on exercise testing. The exercise ECG is an insensitive predictor of restenosis, with sensitivities ranging from 40% to 55%, significantly less than those obtainable with SPECT or exercise echocardiography.
6. Investigation of Heart Rhythm Disturbances
- Use of exercise testing in patients with syncope may identify those with CAD, although this is usually not the cause of syncope.

- The usefulness of exercise testing in patients with VT is variable, according to the cause of the tachycardia.
- Exercise testing is useful as a prelude to electrophysiological testing. Testing may be of prognostic value in these patients: 12 month mortality is three times greater in persons exhibiting exercise-induced ectopy than those with ectopy at rest only.
- In patients on antiarrhythmic therapy, sustained exercise-induced VT is associated with a high risk of sudden death.
- Patients developing supraventricular arrhythmias during exercise often display marked tachycardia due to their heightened adrenergic state. In patients with Wolff-Parkinson-White syndrome, exercise testing may be used to help evaluate the risk of developing rapid ventricular response during atrial arrhythmias.
- In patients with atrial fibrillation, effective rate control at rest does not necessarily signify rate control during exercise and the titration of additional drugs may be facilitated by exercise testing.
- Exercise testing may distinguish resting bradycardia with a normal exercise heart rate response from sinus node dysfunction with resting bradycardia and in patients who fail to make an exercise response.
- The development of adaptive rate pacing using various physiologic sensors has led to study of the exercise response being an important constituent in fine-tuning these pacemakers.

7. Silent Ischemia

- To evaluate patients with previously documented silent ischemia where further therapeutic or clinical management decisions are expected.
- To evaluate patients in whom silent ischemia is considered highly probable (i.e. a patient with neuropathic interference with normal sensation of pain).

8. Evaluation of Hypertension

- Exercise testing has been used to identify patients with abnormal blood pressure response destined to develop hypertension. Identification of such patients may allow preventive measures that would delay or prevent the onset of this disease. Cardiovascular stress testing will be covered when the results of the exercise test are necessary for the management of the patient. Severe hypertension is a relative contraindication but when the benefit outweighs the risk, exercise testing could be appropriate. According to the ACC Guidelines, in asymptomatic normotensive subjects, an exaggerated peak exercise systolic blood pressure greater than 214 mm Hg, or elevated systolic and diastolic blood pressure at 3 minutes into recovery is associated with significant increased long-term risk for hypertension

B.

C. Stress Echocardiography

1. As currently practiced (with the aid of digital acquisition and storage of relevant images), stress echocardiography is both sensitive and specific for detecting inducible myocardial ischemia in patients with intermediate to high pretest probability of coronary artery disease. In patients with a significant clinical suspicion of CAD, stress echocardiography is appropriate when standard exercise testing is likely to be non-diagnostic. Examples include conditions likely to reduce the validity of ST-segment analysis, such as the presence of resting ST-T wave abnormalities, left bundle branch block, ventricular paced rhythms, LV hypertrophy/strain, or digitalis treatment. When a noncardiac limitation

precludes adequate exercise testing, pharmacological stress echocardiography is an appropriate alternative. Dobutamine stress echocardiography has substantially higher sensitivity than vasodilator stress echocardiography for detecting coronary stenoses. Treadmill stress echocardiography may have lowered sensitivity if there is a delay from the end of exercise to the acquisition of postexercise images. In patients with unstable angina who undergo revascularization by surgery or angioplasty, the completeness of revascularization and the functional significance of residual lesions can be determined using exercise or pharmacological stress echocardiography.

2. Graded stress echocardiography using intravenous dobutamine can help in assessing myocardial viability early after myocardial infarction.

Occasionally, transesophageal stress echocardiogram is medically necessary in some patients who have a poor acoustic window and all other transthoracic indications are met. When these circumstances are met, the service is billable with the CPT code 93799 instead of the transthoracic stress echocardiography code (when a transthoracic approach is attempted and unsuccessful, only the completed procedure, e.g., transesophageal, is billable; it is inappropriate to bill both).

- D. The following services are considered not medically necessary:
1. Stimulus to motivate changes in lifestyle; e.g., weight loss or exercise programs do not meet the Medicare medical necessity criteria
 2. Sports medicine
 3. Routine follow-up tests for MI, CABG, or PTCA in the absence of symptoms or clinical indications (e.g., annual stress tests are not covered in the absence of individualized clinical indications).
 4. Occupational fitness.

D. **Contraindications**

Absolute:

1. Acute myocardial infarction (within 2 days)
2. High-risk unstable angina i.e. Patients exhibiting signs of unstable progressive angina. This includes the patient who has long periods of angina of fairly recent onset while at rest.
3. Uncontrolled cardiac arrhythmias causing symptoms or hemodynamic compromise
4. Symptomatic severe aortic stenosis
5. Uncontrolled symptomatic heart failure
6. Acute pulmonary embolus or pulmonary infarction
7. Acute myocarditis or pericarditis
8. Acute aortic dissection
9. Patients with second- or third- degree heart block and patients with known severe left main disease.
10. Acutely ill patients, such as those with infections, hyperthyroidism, or severe anemia.

Relative (relative contraindications can be superseded if the benefits of exercise outweigh the risks.

1. Left main coronary stenosis
2. Moderate stenotic valvular heart disease
3. Electrolyte abnormalities
4. Severe arterial hypertension

5. Tachyarrhythmia/bradyarrhythmia
 6. Hypertrophic cardiomyopathy or other forms of outflow obstruction
- E. A preoperative cardiovascular stress test is reasonable and necessary only if there is a cardiac condition diagnosed or suspected that may affect the decision to operate or the choice of the operation. That condition must be identified on the claim, using an appropriate ICD-9-CM code. If such a condition does not exist, then preoperative testing is considered screening and is not a covered test.
- F. Stress tests performed for the purposes of preoperative or other screening, or when done at the request of a third party (e.g., insurance exam, admission screening, occupational screening, etc.), or for other purposes not covered by Medicare, should not be submitted to Medicare. Screening for coronary disease; the presence of risk factors alone is not a Medicare-payable indication.

Claims for these services should not be submitted to Medicare. If the patient requests the claim to be submitted for a non-covered or screening denial, use the GY modifier to ensure an appropriate denial. An ICD-9 code to indicate a screening service (example: V70.0, V70.3, V70.5) must be the only code on the claim form if you wish to receive a non-covered denial using ICD-9 codes without the GY modifier

- G. Stress testing by multiple modalities (e.g., treadmill ECG, echocardiogram, SPECT) for the same clinical event is covered only when the first modality was inconclusive or uninterpretable. Stress testing can be performed in conjunction with other cardiac diagnostic tests when medically necessary, including echocardiography and nuclear medicine studies. The general rules of this policy apply, but refer to those specific policies for details of coverage. Only the most appropriate tests necessary to determine information should be performed.
- H. Pharmacologic ECG stress testing is indicated only when the patient is unable to exercise adequately. Documentation in the patient's record must clearly indicate that the patient is unable to exercise, as well as the reason(s) why the patient cannot undergo exercise stress testing. (A review of records may be performed to determine if drugs are being used appropriately.) The drugs used in cardiovascular testing are potent drugs with many side effects, and must be used with appropriate caution.
1. Dobutamine
 - HCPCS code J1250 - per 250 mg
 - Dosage is calculated according to the patient's weight (beginning at 5-10 mcg/kg/min) and increased (titrated) to reach the maximum heart rate for 2-5 minutes (for a 200-lb person, the total dose is not to exceed 35 mg).
 2. Dipyridamole (Persantine)
 - HCPCS code J1245 - per 10 mg
 - Dosage is calculated according to the patient's weight (0.142 mg/kg/minute) and infused IV over approximately 4 minutes. The maximum dose is not to exceed 60 mg.
 3. Adenosine (Adenoscan)
 - HCPCS code J0152 - per 30mg
 - Dosage is calculated according to the patient's weight (140 mcg/kg/minute) for 6 minutes. The total dose is not to exceed 0.84 mg/kg (for a 200-lb person, the total maximum dose would equal 76 mg).

Note: Code J0150 – Adenosine (Adenocard) 6mg. It is inappropriate to use this code when billing Medicare Part B in conjunction with a stress test. This drug is indicated for treatment of supraventricular tachycardia (SVT) 427.0, 427.31, 427.32 and will be denied as not medically necessary when billed in conjunction with cardiac stress testing.

4. Arbutamine
 - HCPCS code J0395 - 1 mg
 - The maximum infusion rate delivered by its accompanying device is 0.8 mg/kg/min and the maximum total dose is 10mcg/kg.
5. Regadenoson (Lexiscan)
 - HCPCS code J3490 – Unclassified Drug (06/24/2008)
 - Recommended dose of Regadenoson (Lexiscan) is 5mL (0.4 mg Regadenoson) by rapid (approximately 10 seconds) injection; followed immediately by saline flush and radiopharmaceutical. Regadenoson (Lexiscan) is indicated for radionuclide myocardial perfusion imaging (MPI) in patients unable to undergo adequate exercise stress.

Since these drugs may be billed for indications other than pharmacological stress agents with cardiovascular testing, the use of these drugs is not subject to the list of diagnoses listed in ICD-9 Codes That Support Medical Necessity. There may be a payable diagnostic indication for stress testing listed that would be considered a contraindication for the use of a specified drug. In this case, the drug itself may be denied. The indications for the use of these drugs must be documented in the patient's record as well as the appropriate ICD-9 code that describes the patient's condition.

- I. The place of service is limited to a hospital inpatient, hospital outpatient or in a physician-directed clinic (office).
- J. Cardiac stress testing must be performed under the direct supervision of a physician who provides the following:
 - Medical expertise required for performance of the test
 - Medical treatment for complications and side effects of the test
 - Medical services required as part of the test such as injections of medications
 - Medical expertise in the interpretation of the test, some of which has to be provided during the test and before the patient is discharged from the testing suite

Direct supervision requires that the physician is present in the same office or suite as the patient and is immediately available, if needed, for emergencies or questions. The supervising physician is responsible for assuring that the non-physician performing the test is qualified.

Coverage Topic

Medicine; Cardiovascular

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type.

Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

- 12x Hospital-inpatient or home health visits (Part B only)
- 13x Hospital-outpatient (HHA-A also) (under OPPTS 13X must be used for ASC claims submitted for OPPTS payment – effective 7/00)
- 18x Hospital-swing beds
- 21x SNF-inpatient, Part A
- 71x Clinic-rural health
- 75x Clinic-CORF
- 83x Special facility or ASC surgery-ambulatory surgical center (Discontinued for Hospitals Subject to Outpatient PPS; hospitals must use 13X for ASC claims submitted for OPPTS payment -- effective 7/00)
- 85x Special facility or ASC surgery-rural primary care hospital (effective 10/94)

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination.

Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Note: We have identified the Type of Bill (TOB) and Revenue Center (RC) codes applicable for use with the CPT/HCPCS codes included in this LCD. Providers are reminded that not all CPT/HCPCS codes listed can be billed with all TOB and/or RC codes listed. CPT/HCPCS codes are required to be billed with specific TOB and RC codes. Providers are encouraged to refer to the CMS *Internet Only Manual (IOM)* Pub 100-04, *Claims Processing Manual*, for further guidance.

- 0480 - Cardiology-general classification
- 0482 - Cardiology-stress test
- 0483 - Cardiology-Echocardiology
- 0636 - Drugs requiring specific identification-detailed coding (eff 3/92)

CPT/HCPCS Codes

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| 93015 | Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous ECG monitoring, and or pharmacological stress; with physician supervision, with interpretation and report. |
| 93016 | ----- physician supervision only; without interpretation and report |
| 93017 | ----- tracing only; without interpretation and report |
| 93018 | ----- interpretation and report only |
| 93350 | Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and or pharmacologically induced stress, with interpretation and report |
| 93799 | Unlisted cardiovascular procedure |
| J0152 | Injection, adenosine for diagnostic use, 30mg (not to be used to report adenosine phosphate compounds; instead use A9270) |
| J1245 | Injection, dipyridamole 10 mg |

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| J1250 | Injection, dobutamine hydrochloride, per 250 mg |
| J0395 | Injection; arbutamine HCL, 1mg |
| J3490 | Unclassified Drug (to be used with Regadenoson (Lexiscan) per 0.4 mg |

Does the CPT 30% Rule Apply

No

ICD-9 Codes that Support Medical Necessity

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| 250.60-250.63 | Diabetes with neurological manifestations |
| 250.90-250.93 | Diabetes with unspecified complication |
| 394.0-394.9 | Diseases of mitral valve |
| 395.0-395.2 | Diseases of aortic valve |
| 396.0-396.3 | Disease of mitral and aortic valve |
| 396.8 | Multiple involvement of mitral and aortic valves |
| 401.1 | Essential Hypertension; Benign |
| 401.9 | Essential Hypertension; Unspecified |
| 410.02-410.82 | Myocardial Infarction |
| 411.0 | Postmyocardial Infarction syndrome |
| 411.1 | Intermediate coronary syndrome |
| 411.81 | Coronary occlusion without MI |
| 411.89 | Coronary insufficiency |
| 413.0 | Angina decubitus |
| 413.1 | Prinzmetal angina |
| 413.9 | Angina unspecified |
| 414.00-414.05, 414.07 | Coronary Atherosclerosis, unspecified vessel |
| 414.8 | Specified chronic ischemic heart disease |
| 424.0 | Mitral valve disorder |
| 424.1 | Aortic valve disorder |
| 424.2 | Tricuspid valve disorder |
| 424.3 | Pulmonary valve disorder |
| 425.0-425.9 | Cardiomyopathy |
| 426.10-426.9 | Conduction Disorders |
| 427.0-427.89 | Cardiac dysrhythmias |
| 428.0-428.9 | Heart failure |
| 429.0 | Myocarditis, unspecified |
| 429.1 | Myocardial degeneration |
| 429.2 | Cardiovascular disease, unspecified |
| 429.3 | Cardiomegaly |
| 429.4 | Disturbances following cardiac surgery |
| 429.83 | Takotsubo syndrome (also called transient left ventricular (LV) apical ballooning) |
| 433.10 | Occlusion/stenosis carotid artery |
| 433.11 | Occlusion/stenosis carotid artery |
| 440.0 | Atherosclerosis aorta |
| 440.20-440.9 | Atherosclerosis of extremities |
| 441.00-441.9 | Aortic aneurysm |
| 745.2-745.5 | Tetralogy of Fallot, Common ventricle, Ventricular septal defect ASD |
| 746.00-746.7 | Congenital anomalies of heart |
| 746.81 | Subaortic stenosis |
| 746.85 | Coronary artery anomaly |
| 780.2 | Syncope |

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| 785.1 | Palpitations |
| 786.02 | Orthopnea |
| 786.05 | Shortness of breath |
| 786.09 | Dyspnea |
| 786.50 | Chest pain, unspecified |
| 786.51 | Precordial pain |
| 786.59 | Other chest pain |
| 794.30 | Abnormal cardiovascular function study |
| 794.31 | Abnormal EKG |
| 995.20 | Adverse effect of drug |
| 996.02 | Mechanical complication due to heart valve prosthesis |
| 996.03 | Mechanical complication Due to coronary bypass graft |
| 996.1 | Mechanical complication of graft |
| 996.61 | Infectious complication of graft |
| 996.71 | Complications to heart valve prosthesis |
| 996.72 | Complication due to cardiac graft |
| 996.83 | Complication due to heart transplant |
| V45.11 | Aorto-coronary bypass, post surgical status |
| V42.1 | Heart transplant |
| V42.2 | Heart valve replacement |
| V43.3 | Heart valve |
| V58.69 | Aftercare for long-term high-risk drugs currently used |
| V67.51 | Follow-up care for treatment with high-risk medications |
| V45.81 | Aorto-coronary bypass, post surgical status |
| V72.81 | Preoperative cardiovascular exam |

Note: ICD-9 codes must be coded to the highest level of specificity.

Diagnoses that Support Medical Necessity

ICD-9 Codes that DO NOT Support Medical Necessity

Any code not listed above

Diagnoses that DO NOT Support Medical Necessity

Any diagnosis not listed above

Documentation Requirements

The medical record must document the elements of the history, examination and/or test results that justify the diagnosis on the claim form. The clinical condition that is claimed to justify this test must be clearly documented in the record.

The rationale for selecting stress imaging instead of conventional stress ECG must be indicated in the record.

The rationale for performing both a stress echocardiogram and stress myocardial perfusion study on an individual patient must be indicated in the record.

The rationale for selecting pharmacologic stress rather than exercise stress must be indicated in the record.

The medical record must be made available to Medicare upon request.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary under Section 1862(a)(1) of the Social Security Act.

When requesting a written determination, (formerly appeal) providers must include all relevant documentation with the request.

Utilization Guidelines

Stress testing is covered only at a frequency appropriate for the patient’s condition. Documentation in the patient’s progress notes must indicate medical necessity for the frequency.

If V67.09 is used as the diagnosis, providers must include the date of the surgery and the procedure code for the surgery performed in Item 19 on the CMS-1500 claim form (or electronic equivalent) for payment.

Sources of Information and Basis for Decision

Rodgers, et al, CLINICAL COMPETENCE STATEMENT ON STRESS TESTING; JACC Vol. 36, 2000: 1441-53 (American College of Cardiology/American Heart Association Clinical Competence Statement on Stress Testing)

Gibbons et al, EXERCISE TESTING GUIDELINES; JACC Vol. 30, No. 1, July 1997:260-315 (ACC/AHA Guidelines for Exercise Testing)

ACC/AHA Task Force Report. Guidelines for Preoperative Cardiovascular Evaluation for Noncardiac Surgery; JACC 1996; 27(4): 910-948

ACC/AHA 2002 Guideline Update for Exercise Testing.

Drugs Facts and Comparisons; 2002

Advisory Committee Meeting Notes

Meeting Dates:

Legacy B

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| Wisconsin: | pending |
| Illinois: | pending |
| Michigan: | pending |
| Minnesota: | pending |

MAC AB

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| Iowa | pending |
| Missouri | pending |
| Kansas | pending |
| Nebraska | pending |

Legacy A

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| All states listed under primary jurisdiction | |
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Start Date of Comment Period

Wisconsin:
 Illinois:
 Michigan:
 Minnesota:

MAC AB

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| Iowa | |
| Missouri | |
| Kansas | |
| Nebraska | |

Legacy A

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| All states listed under primary jurisdiction | |
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End Date of Comment Period

Wisconsin: 11/10/2003; pending
 Illinois: 11/10/2003; pending
 Michigan: 11/10/2003; pending
 Minnesota: 11/10/2003; pending

MAC AB

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| Iowa | pending |
| Missouri | pending |
| Kansas | pending |
| Nebraska | pending |

Legacy A

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| All states listed under primary jurisdiction | |
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Start Date of Notice Period

Wisconsin Existing policy; 06/01/1996; Article 10/01/1996; Article 01/01/1997; 09/01/1997; Article 08/01/1998; Article 09/01/1999; Article 04/01/2002; 02/01/2003; Article 04/01/2003; Article 06/01/2003; Article 10/01/2003; Article 12/01/2003; Article 05/01/2006; *09/01/2006 Article

Illinois: 11/15/1997; 11/01/1999; 04/01/2000; 10/01/2000; 01/01/2001; 03/01/2001; 04/01/2001; Article 07/01/2002; Formerly ILMI 057; 02/01/2003; Article 04/01/2003; Article 06/01/2003; Article 10/01/2003; Article 12/01/2003; Article 05/01/2006; *09/01/2006 Article

Michigan: 11/15/1997; 11/01/1999; 04/01/2000; 10/01/2000; 01/01/2001; 03/01/2001; 04/01/2001; Article 07/01/2002; Formerly ILMI 057; 02/01/2003; Article 04/01/2003; Article 06/01/2003; Article 10/01/2003; Article 12/01/2003; Article 05/01/2006; *09/01/2006 Article

Minnesota 02/01/2003; Article 04/01/2003; Article 06/01/2003; Article 10/01/2003; Article 12/01/2003; Article 05/01/2006; *09/01/2006 Article

MAC AB

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| Iowa | | |
| Missouri | | |
| Kansas | | |
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Legacy A

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| All states listed under primary jurisdiction | |
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Revision History Number and Explanation

Wisconsin *10/01/2006 (2007 ICD-9 update); 05/01/2006 (clarification of billing contrast agents); 01/01/2004, HCPCS update - J0152) thirteen; 10/01/2003 twelve (04 ICD-9 UD); 06/01/2003 eleven (ICD-9 update); 04/01/2003 ten (ICD-9code update), nine; 02/01/2003, eight (Formerly CV-005); 04/01/2002, seven (code update & supervision revised) 07/20/1999, six (code update); 06/17/1998, five; 07/01/1997, four; 11/15/1996, three (code update); 09/01/1996, two; 01/15/1996, one

Illinois: *10/01/2006 (2007 ICD-9 update); 05/01/2006 (clarification of billing contrast agents); 01/01/2004, HCPCS update - J0152) thirteen; 10/01/2003 twelve (04 ICD-9 UD); 06/01/2003 eleven (ICD-9 update); 04/01/2003 ten (ICD-9code update), nine; 02/01/2003, eight (Formerly ILMI 057); 11/01/1999, one & two (added, corrected ICD-9s); 10/01/2000, three (added ICD-9s); 01/01/2001, four (reprint, ICD-9s added); 01/01/2001, five (corrected ICD-9); 05/01/2001, six (ICD-9s added);07/01/2002 seven (code update)

Michigan: *10/01/2006 (2007 ICD-9 update); 05/01/2006 (clarification of billing contrast agents); 01/01/2004, HCPCS update - J0152) thirteen; 10/01/2003 twelve (04 ICD-9 UD); 06/01/2003 eleven(ICD-9 update); 04/01/2003 ten(ICD-9code update), nine; 02/01/2003, eight (Formerly ILMI 057); 11/01/1999, one & two (added, corrected ICD-9s); 10/01/2000, three (added ICD-9s); 01/01/2001, four (reprint, ICD-9s added); 01/01/2001, five (corrected ICD-9); 05/01/2001, six (ICD-9s added), 07/01/2002 seven (code update)

Minnesota *10/01/2006 (2007 ICD-9 update); 05/01/2006 (clarification of billing contrast agents); 01/01/2004, HCPCS update - J0152) four; 10/01/2003 three (04 ICD-9 UD); 06/01/2003 two (ICD-9 update); 04/01/2003 one(ICD-9code update)

MAC AB

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| Iowa | | |
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| Kansas | | |
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Legacy A

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| All states listed under primary jurisdiction | |
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Last Reviewed On

Notes

[See Coding and Billing Guidelines](#)

Does this LCD contain a "Least Costly Alternative" Provision?
No

DRAFT