Local Coverage Determination (LCD)

LCD - Transthoracic Echocardiography (TTE) (L33577)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
National Government Services, Inc.	MAC - Part A	06101 - MAC A	J - 06	Illinois
National Government Services, Inc.	MAC - Part B	06102 - MAC B	J - 06	Illinois
National Government Services, Inc.	MAC - Part A	06201 - MAC A	J - 06	Minnesota
National Government Services, Inc.	MAC - Part B	06202 - MAC B	J - 06	Minnesota
National Government Services, Inc.	MAC - Part A	06301 - MAC A	J - 06	Wisconsin
National Government Services, Inc.	MAC - Part B	06302 - MAC B	J - 06	Wisconsin
National Government Services, Inc.	A and B and HHH MAC	13101 - MAC A	J - K	Connecticut
National Government Services, Inc.	A and B and HHH MAC	13102 - MAC B	J - K	Connecticut
National Government Services, Inc.	A and B and HHH MAC	13201 - MAC A	J - K	New York - Entire State
National Government Services, Inc.	A and B and HHH MAC	13202 - MAC B	J - K	New York - Downstate
National Government Services, Inc.	A and B and HHH MAC	13282 - MAC B	J - K	New York - Upstate
National Government Services, Inc.	A and B and HHH MAC	13292 - MAC B	J - K	New York - Queens
National Government Services, Inc.	A and B and HHH MAC	14111 - MAC A	J - K	Maine
National Government Services, Inc.	A and B and HHH MAC	14112 - MAC B	J - K	Maine
National Government Services, Inc.	A and B and HHH MAC	14211 - MAC A	J - K	Massachusetts

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
National Government Services, Inc.	A and B and HHH MAC	14212 - MAC B	J - K	Massachusetts
National Government Services, Inc.	A and B and HHH MAC	14311 - MAC A	J - K	New Hampshire
National Government Services, Inc.	A and B and HHH MAC	14312 - MAC B	J - K	New Hampshire
National Government Services, Inc.	A and B and HHH MAC	14411 - MAC A	J - K	Rhode Island
National Government Services, Inc.	A and B and HHH MAC	14412 - MAC B	J - K	Rhode Island
National Government Services, Inc.	A and B and HHH MAC	14511 - MAC A	J - K	Vermont
National Government Services, Inc.	A and B and HHH MAC	14512 - MAC B	J - K	Vermont

LCD Information

Document Information

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Transthoracic Echocardiography (TTE)

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CMS National Coverage Policy

Language quoted from Centers for Medicare and Medicaid Services (CMS), National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See Section 1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act (SSA):

Section 1862(a)(1)(A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1862(a)(7) of Title XVIII of the Social Security Act excludes routine physical examination, unless otherwise covered by statute.

Section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Code of Federal Regulations:

42 CFR, Section 410.32, indicates that diagnostic tests may only be ordered by the treating physician (or other treating practitioner acting within the scope of his or her license and Medicare requirements) who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician (or other qualified non-physician provider) who is treating the beneficiary are not reasonable and necessary (see Sec. 411.15(k)(1) of this chapter).

42 CFR 410.33 provides credentialing requirements for testing performed in an IDTF by technicians.

CMS Publications:

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9:

100 General Billing Requirements

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12:

30.4 Cardiovascular System (Codes 92950-93799)

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Abstract:

Transthoracic Echocardiography is the ultrasonic examination of the heart through the chest wall. Two-dimensional (2D) TTE may allow visualization of the cardiac chambers, cyclic variation in myocardial wall thickness, valvular structure and function, the proximal great vessels and the pericardium.

Doppler flow evaluation uses the changes in frequency when a transmitted ultrasound wave is reflected from moving surfaces (e.g., heart valves, red blood cells) and allows measurement of blood flow velocity which can be used to identify valvular stenosis or regurgitation, estimate cardiac output and intracardiac pressures, or identify the presence of intracardiac shunts.

In order to qualify as a valid echocardiographic service, the study must be done for an accepted clinical indication by a properly trained examiner and must include a permanent record of the findings, data sufficient to support the conclusions and an appropriate interpretation and written report. Such a study would meet the standards required for a complete echocardiographic examination, regardless of the size or portability of the instrument used to perform the study.

This policy addresses the medically necessary and appropriate application of TTE, including stress echocardiography. Transesophageal echocardiography (TEE) is the subject of a separate policy statement.

Indications:

Echocardiography is indicated in the evaluation of derangements of valvular, myocardial and pericardial structure and function. The general applications for coverage include:

Transthoracic Echocardiogram

INDICATIONS:

Ventricular Function, Cardiomyopathies and Heart Failure

1. "When the etiology is in doubt, echocardiography can document or rule out the common cardiac causes of pulmonary congestion: left-sided valvular disease, depressed systolic or diastolic function, and cardiomyopathy. In this regard, echocardiography is the preferred initial diagnostic test when the history, physical examination, and routine laboratory tests suggest (or cannot eliminate) cardiac disease." (ACC/AHA/ASE 2003 Guideline Update, pg. 35)
2. "Echocardiography is recommended for patients with edema with clinical signs of elevated central venous pressure when a potential cardiac etiology is suspected or when central venous pressure cannot be estimated with confidence and clinical suspicion of heart disease is high." TTE is also recommended for patients experiencing "dyspnea with clinical signs of heart disease."(ACC/AHA/ASE 2003 Guideline Update, pg. 37)
3. "Echocardiography is not recommended in patients with edema when the jugular venous pressure does not appear to be elevated." (ACC/AHA/ASE 2003 Guideline Update, pg. 35).

Hypertensive Cardiovascular Disease

1. Evaluating the cardiac effects of systemic hypertension (ACC/AHA/ASE 2003 Guideline Update, pg. 42)
2. In young individuals and in individuals with borderline hypertension, the decision to commit to long-term antihypertensive therapy may be determined by the presence of left ventricular hypertrophy and /or left

ventricular mass calculation.

Acute Myocardial Infarction and Coronary Insufficiency

1. Evaluation of regional motion, systolic thickening perturbations and mural thinning
2. Evaluation of right ventricular ischemia and/or infarction
3. Diagnosis or evaluation of complications of acute infarction (e.g., mural thrombi, papillary muscle dysfunction and rupture, septal defects, true or false aneurysm and myocardial rupture)
4. Following an initial TTE in the setting of acute infarction, repetition frequency will typically be dictated by the acute clinical course. The medical record should document the medical necessity of the frequency for TTE assessment.
5. "Evaluation of chest pain in patients with suspected acute myocardial ischemia, when baseline ECG and other laboratory markers are nondiagnostic and when study can be obtained during pain or within minutes after its abatement" is recommended in the ACC/AHA/ASE 2003 Guideline Update.
6. Diagnosis of acute myocardial infarction when the clinical history and ECG findings are nondiagnostic. (ACC/AHA/ASE 2003 Guideline Update, pg. 15)

Exposure to Cardiotoxic Agents (chemotherapeutic and external)

An initial complete TTE may be performed prior to first administration of the agent with the frequency of repeat studies determined by the patient's clinical course and the toxicity profile of the agent being administered, although tests performed bimonthly during chemotherapy and at six (6) months following therapy are generally considered medically appropriate.

Cardiac Transplant and Rejection Monitoring

1. TTE is an integral part of the cardiac donor-selection and donor-recipient matching process. Evaluation focuses on analysis of ventricular function and valvular integrity.
2. TTE in the management of allograft recipients is typically performed weekly for the first four to eight (4-8) weeks following transplant, with reduced frequency over time. Absent acute rejection episodes, approximately two (2) TTE examinations are typically performed yearly in chronic transplant recipients. TTE of cardiac allografts is most appropriately serially performed at transplant centers by examiners with expertise in the management of cardiac allograft recipients. Uses in excess of the generally accepted frequency will be expected to have appropriate medical necessity documentation provided.

Native Valvular Heart Disease

1. TTE is well established as a technique of primary choice for the evaluation of valvular pathology and its effect upon global myocardial function.
2. In some patients, Doppler echocardiography is the only noninvasive method capable of identifying the cause of a heart murmur. (ACC/AHA/ASE 2003 Guideline Update, pg. 7)
3. Absent acute intervention, or a discrete change in otherwise stable clinical signs and symptoms, it is not medically necessary to repeat these examinations more frequently than annually. When the patient's clinical status shows evidence of change or the plan of care includes consideration for imminent valvular surgery, more frequent exams may be necessary.

Prosthetic Heart Valves (Mechanical & Bio-prostheses)
TTE assessment after prosthetic valve implant to establish a baseline structural and hemodynamic profile with reassessment following convalescence (3-6 months). Thereafter, re-evaluation of patients with suspected dysfunction, thrombosis or a change in clinical status or symptoms is indicated.

Acute Endocarditis

1. Diagnostic and evaluation of suspected endocarditis or complications or sequelae of acute infective endocarditis.
2. Examination frequency in the acute phase of illness is dictated by the individual clinical course. When the acute process has been stabilized, the frequency of serial TTE evaluation will be determined by the residual pathophysiology and discrete clinical events, analogous to the serial assessment of chronic valvular dysfunction and/or normally functioning prosthetic valves.

Pericardial Disease

1. Detection and quantitation of the amount of pericardial effusion.
2. To characterize the hemodynamic consequences of pericardial fluid accumulation.
3. As an adjunct during the removal of pericardial fluid and creation of pericardial windows.
4. Diagnosis of pericardial constriction and differentiating it from restrictive myocardial disease (may require Doppler).
5. The acute clinical status will dictate examination frequency. In a patient with evolving pericardial pathology, a limited focused TTE exam may be appropriate.

Abnormalities of the Great Vessels

1. Evaluation of acute or chronic aortic pathology (Note: TEE is often a more determinative study unless images suitable for serial quantitation can be obtained by TTE).
2. Routine (yearly) evaluation is indicated in patients with severe aortic stenosis or regurgitation, in whom the information obtained will be used in determining or modifying the plan of care.
3. With ascending aortic dilatation or aneurysms, a focused limited follow-up exam to serially measure ascending aortic diameters may be indicated.
4. Evaluation of the main pulmonary artery segment and the proximal right and left pulmonary arteries.
5. Evaluation of the vena cavae and diagnosing congenital and acquired abnormalities such as vena caval thrombosis, vena caval dilation, and thrombosis or extension of tumors from the inferior vena cava to the right-heart chambers.

Congenital Heart Disease

1. TTE with Doppler hemodynamic measurements for diagnosis and noninvasive serial assessment of most congenital heart diseases.
2. When the disease process and therapy are stable, assessment more often than annually requires medical necessity documentation.
3. In asymptomatic patients following repair of ASD, PFO, VSD or PDA follow up examination is only indicated within the first year after correction.

Suspected Cardiac Thrombi and Embolic Sources
TTE is indicated for the evaluation for cardiovascular source of embolic events (PFO/ASD, atrial or ventricular thrombus, intracardiac tumor) in evaluation for patients with abrupt occlusion of a major peripheral or visceral artery or for with neurological events without evidence of cerebrovascular disease or other obvious cause.

Cardiac Tumors and Masses

1. Diagnosis and assessment of cardiac tumors.
2. Serial TTEs may be medically necessary to monitor tumor size or tumor recurrence.

Critically Ill and Trauma Patients

1. Diagnosis of suspect aortic or central pulmonary pathology, cardiac contusion, or pericardial effusion.
2. Assessment of volume status.
3. The frequency of these typically acute studies will be dictated by the clinical circumstances.

Arrhythmias and Palpitations

1. Transthoracic echocardiography is useful in defining cardiac function in which arrhythmias occur, and may be useful in the management of cardiac arrhythmias. Some arrhythmias are frequently associated with underlying organic heart disease or may predispose the patient to hemodynamic deterioration. Atrial fibrillation and atrial flutter are examples of arrhythmias in which echocardiography may be appropriate to assess the underlying disorder. Echocardiographic studies are appropriate only when there is evidence of heart disease.
2. Palpitations without evidence of arrhythmias, or minor arrhythmias (e.g., isolated APC's or VPC's) without evidence of heart disease, are not covered indications for transthoracic echocardiography.

Syncope
In the initial evaluation of syncope and when other findings are suggestive of valvular heart disease or obstructive cardiomyopathy.

Pulmonary
To assess right ventricular size and performance, and quantify the severity of pulmonary hypertension using Doppler flow in unexplained pulmonary hypertension, and pulmonary emboli with suspected right atrial or right ventricular sources of emboli.

Contrast Echocardiography
Contrast echocardiography is indicated when a conventional study has failed to provide adequate and critically needed information on left ventricular function. A contrast agent is considered medically necessary when it is used to improve the delineation of the left ventricular endocardial borders in a patient whose non-contrast study is inadequate or suboptimal, and for whom the LV function information is essential to the management of the patient. Contrast is indicated when more than two (2) contiguous segments of the left ventricular border are not visualized.

LIMITATIONS:

1. Echocardiography performed for screening purposes is not covered. Screening includes testing performed on

patients who present with risk factors (including the risk factor as having a positive family history, e.g., familial history of Marfan's disease). A screening service for high-risk patients is considered good medical practice but is not covered by Medicare. When the result of the test is abnormal, subsequent services may be billed with the test-result diagnosis; however, the initial screening test must be listed as screening, even though the result of the screening test may be a covered condition.

The following indications (#2-15) are deemed to be not medically necessary and are therefore not reimbursable:

2. Routine (yearly) evaluation of asymptomatic patients with corrected ASD, VSD or PDA more than one year after successful correction.

3. Routine (yearly) re-evaluation of mitral valve prolapse in patients with no or mild mitral regurgitation and no change in clinical status.

4. Routine (yearly) re-evaluation of an asymptomatic patient with mild native aortic stenosis or mild-moderate native mitral stenosis and no change in clinical status.

5. Routine (yearly) re-evaluation of native valvular regurgitation in an asymptomatic patient with mild regurgitation, no change in clinical status and normal left ventricular size.

6. Routine (yearly) evaluation of a patient with a prosthetic valve in whom there is no suspicion of valvular dysfunction and no change in clinical status.

7. Routine (yearly) re-evaluation of patients with heart failure (systolic or diastolic) in whom there is no change in clinical status.

8. Routine (yearly) evaluation of hypertrophic cardiomyopathy in a patient with no change in clinical status.

9. Patients who have isolated APC or VPC without other evidence of heart disease.

10. Evaluation of LV function with prior ventricular function within the past year with normal (such as prior echocardiogram, left ventriculogram, SPECT, cardiac MRI) in patients in whom there has been no change in clinical status.

11. Initial evaluation of patient with suspected pulmonary embolism in order to establish diagnosis.

12. Evaluation of native and/or prosthetic valves in patients with transient fever but without evidence of bacteremia or new murmur.

13. Re-evaluation of a patient with known hypertensive heart disease without a change in clinical status.

14. Routine evaluation of patients with systemic hypertension without suspected hypertensive heart disease.

15. Evaluation of a patient with atrial fibrillation/flutter for left atrial thrombus or spontaneous contrast when a decision has been made to anticoagulate and not to perform cardioversion.

[Items 2-15, see ACCF/ASE/ACEP/ASNC/SCAI/SCCT/SCMR 2007 Appropriateness Criteria for Transthoracic and Transesophageal Echocardiography, JACC 2007].

Follow-up Studies or Limited Studies

INDICATIONS AND LIMITATIONS

A complete study includes a full evaluation of all aspects of the heart, including the cardiac chambers, valves, blood flow, and great vessels. The images are reviewed, measured, analyzed and interpreted by the physician. A report is prepared for the patient's record. When a less than complete examination is performed for the purpose of evaluation of one specific cardiac problem, or region of the heart, the service performed is reported as follow-up or limited studies. When a limited service is performed, or the patient's condition requires only a limited examination, these codes must be used to indicate the appropriate service.

Examples of appropriate use of a follow-up study of a patient with pericardial effusion following heart surgery, to evaluate progression or resolution of the effusion; or a serial evaluation of left ventricular function during antineoplastic chemotherapy.

Examples of appropriate use of recording tricuspid regurgitant velocity in order to estimate pulmonary artery systolic pressure; or sequential evaluation of the transmitral velocity profile in a patient with mitral stenosis, in order to evaluate for a change in gradient or valve area.

Doppler Color Flow Velocity Mapping

INDICATIONS AND LIMITATIONS
Spectral Doppler echocardiography and Doppler color flow-velocity mapping may be necessary in addition to an echocardiogram when the examination could contribute significant information to the patient's condition or treatment plan. Typically, Doppler is indicated in the evaluation of some heart murmurs, valvular problems, shunts, suspected congenital heart disease, complications of myocardial infarction, or cardiomyopathy. Doppler should be medically necessary for the evaluation and management of the patient.

"Color/spectral Doppler may not be useful or appropriate in certain relatively small and well-defined patient populations when there is a recent comprehensive examination and the test is being ordered for re-evaluation of a limited problem." (ASE comment).

The use of the Doppler is inherent in the ultrasonic cardiac evaluation. However, if the test reports fail to document the use of this technique to assess these structures and function (e.g., measurement of valvular insufficiency or stenosis, myocardial diastolic function, etc. as described by the ASE), or if the medical records fail to document that the examination was "clinically necessary" (e.g., follow-up of pericardial effusion size) then the Doppler portion of the test may be considered medically unnecessary and denied.

Limited Capability Ultrasound Scanners

INDICATIONS AND LIMITATIONS

Some small scanners have more limited capabilities and lack either the permanent recording capabilities or some of the functional capabilities needed to perform a complete examination. Such a study may be quite useful as an extension of the physical examination. However, an examination that does not meet the standards required for a complete diagnostic echocardiographic examination – whether performed with a "conventional" scanner or a limited capability ultrasound scanner - will not be recognized as a valid echocardiographic service and will be non-covered.

Stress Echocardiography

Stress Echocardiography may be necessary when the evaluation could contribute significant information to the patient's condition or treatment plan. A nonimaging stress test focuses on the hemodynamic and electrocardiographic responses to stress. To enhance the diagnostic specificity, the stress test may be combined with echocardiographic imaging or scintigraphic imaging. A contrast agent may be used with echocardiographic imaging to enhance

endocardial visualization and diagnostic accuracy. When two (or more) imaging studies (e.g., ultrasound and scintigraphy) are billed without a supporting clinical indication for each, one of the services will be denied as not medically necessary.
This section addresses the echocardiographic imaging that is done in association with a stress test.

INDICATIONS

Stress echocardiography may be indicated in the care of patients with real or suspected ischemic heart disease in the following clinical settings:

1. To detect coronary artery disease in patients presenting with chest pains including atypical chest pains and exertional dyspnea when the suspicion of CAD is high.
2. To assess prognosis and functional capacity in patients following an acute myocardial infarction.
3. To evaluate the extent of exercise induced ischemia in patients who have had a revascularization procedure (PCTA, stent or coronary bypass) or patients who have known CAD disease.
4. In women, stress imaging has been recommended as the "initial test."
5. To evaluate a prior nondiagnostic or abnormal ECG exercise test as a substitute for a nuclear perfusion study.
6. To evaluate patients who are at high risk for myocardial infarction prior to a scheduled major surgical procedure (e.g., aneurysm, vascular surgery, surgeries with large volume shifts, etc) or transplant procedure.
7. To evaluate patients presenting with various arrhythmias (atrial and/or ventricular) or syncope (near or pre), when the suspicion of occult coronary artery disease is high.
8. To evaluate patients when an indicated standard exercise ECG is likely to be non-diagnostic, including patients with an abnormal resting ECG, orthostatic or hyperventilation induced ECG changes, nonspecific ST-T abnormalities due to ventricular hypertrophy drugs or associated intraventricular conduction defect.
9. To assess myocardial viability (hibernating myocardium) for planned revascularization or functional significance of coronary lesions (if not already known) in planning percutaneous transluminal coronary angioplasty.
10. To evaluate cardiomyopathy when the evaluation could reasonably be expected to contribute significant information regarding the patient's condition or treatment plan.
11. To evaluate ventricular dysfunction due to post-transplant rejection when the evaluation could reasonably be expected to contribute significant information regarding the patient's condition or treatment plan.
12. To evaluate congenital heart disease, when stress echocardiography helps to determine systemic and right ventricular function at rest and following stress and the presence of any other structural abnormalities, including valvular lesions that may be accentuated with stress.
13. Additionally the test may combined with Doppler intervention to evaluate exercise hemodynamics in patients with mitral stenosis, mitral regurgitation, pulmonary hypertension, aortic stenosis/regurgitation, prosthetic valves and other conditions where symptoms suggest a more severe impairment than the assessment done at rest.
14. Dobutamine stress echo may be indicated to detect low gradient, low output (aortic stenosis) or clinically silent transplant coronary disease.

LIMITATIONS

1. Stress echocardiography used as a screening test for ischemic heart disease in a patient without signs or symptoms is not covered.
2. "An echocardiographic study is not indicated when the pathology and/or systolic ventricular function have been adequately defined by other techniques, making the echocardiographic study redundant." (ACC/AHA/ASE 2003 Guideline Update, pg. 5).
3. Since echocardiography, nuclear testing, magnetic resonance imaging (MRI), and positron emission tomography can yield overlapping if not identical information, often with similar or comparable accuracy, when two or more of these tests provide equivalent information, one (but not both/all) will be covered when medically necessary.

4. Stress tests by multiple modalities (e.g. stress echocardiography, nuclear SPECT) for the same clinical event are covered only if the preceding test was inconclusive or uninterpretable.
5. Studies with or without contrast will be considered a single study, whether performed on the same or subsequent days.
6. Contrast echocardiography is not covered when used to evaluate perfusion. Contrast is not indicated unless more than two (2) contiguous segments of the left ventricular border are not visualized.
7. A stress test must be ordered by a physician or qualified non-physician provider.
8. The resting 12 lead EKG and rhythm strip are considered to be part of the stress test. These services are not separately reimbursable.
9. The initiation of an intravenous line and infusion of a pharmacological agent are considered to be a part of the test, and are not separately reimbursable.

3-Dimensional Echocardiography

INDICATIONS AND LIMITATIONS

Three-dimensional echocardiography performed in conjunction with transthoracic echocardiography is indicated for:

1. Pre-operative planning in patients who will be having surgery to repair mitral valve prolapse (in addition to a diagnosis for a pre-operative examination, a secondary diagnosis of mitral valve prolapse is required on the claim).
2. Monitoring the mitral valve area in patients with moderate to severe mitral stenosis.

Three-dimensional echocardiography provides improved calculation of volumetric studies when compared to 2D echocardiography. However, its value in affecting clinical outcomes is not yet proven and is therefore not considered medically necessary.

Training Requirements

Medicare expects a satisfactory level of competence from providers who submit claims for services rendered.

The acceptable levels of competence are outlined as follows:
For the technical portion, an acceptable level of competence is fulfilled when the image acquisition is obtained under any one of the following conditions:

1. The service is performed by a physician; or
2. The technical service is performed by an individual who is credentialed as either a Registered Diagnostic Cardiac Sonographer (RDCS) through the American Registry of Diagnostic Medical Sonographers or as a Registered Cardiac Sonographer (RCS) through the Cardiovascular Credentialing International; or
3. The service is performed at a laboratory (e.g. office, IDTF), credentialed by the Intersocietal Commission for the Accreditation of Echocardiography Laboratories (ICAEL). *Any non-physician personnel used by an IDTF to perform tests must demonstrate the basic qualifications to perform the tests in question and have training and proficiency as evidenced by licensure or certification by the appropriate State health or education department. In the absence of a State licensing board, the technician must be certified by an appropriate national credentialing body. The IDTF must maintain documentation available for review that these requirements are met.*

For the professional portion, an acceptable level of competence is fulfilled when the interpretation is performed by a physician meeting any one of the following requirements:

- The physician is board certified in Cardiovascular Diseases; or
- The physician has Level II training in transthoracic echocardiography, as defined by the American College of Cardiology/American Heart Association/ American College of Physicians Task Force on Clinical Competence in Echocardiography, or the equivalent of Level II training as set forth in that document, or has been credentialed for this procedure by the hospital where the physician performs this service.
  For Facilities, quality requirements should encompass approved ACC/AHA/ASE training standards for physicians, accreditation by ICAEL for facilities, and certification of cardiac sonographers by recognized national credentialing organizations as the appropriate quality standards.
  The submission of claims for echocardiography will be considered an attestation that both the technical and professional components of the service were provided within the context of the above stated credentials.
  The requirements have been in effect in New York and Connecticut since prior to 2011 and were effective in Illinois (for Part B providers), Maine, Massachusetts, Minnesota, New Hampshire, Rhode Island, Vermont and Wisconsin (for Part B providers) as of January 1, 2015.

Summary of Evidence

N/A

Analysis of Evidence (Rationale for Determination)

N/A

General Information

Associated Information

N/A

Sources of Information

This bibliography presents those sources that were obtained during the development of this policy. National Government Services is not responsible for the continuing viability of Web site addresses listed below.

ACCF/ASE/ACEP/ASNC/SCAI/SCCT/SCMR 2007 Appropriateness criteria for transthoracic and transesophageal echocardiography. http://www.acc.org/qualityandscience/clinical/pdfs/TTE.TEE.pdf. Accessed February 24, 2007.

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Bibliography

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
10/01/2019	R15	This LCD was converted to the new "no-codes" format. There has been no change in coverage with this LCD revision.	• Revisions Due To Code Removal
08/01/2019	R14	Consistent with Change Request 10901, all coding information, National coverage provisions, and Associated Information (Documentation Requirements, Utilization	• Other

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		Guidelines) have been removed from the LCD and placed in the related Billing and Coding Article, A56781. There has been no change in coverage with this LCD revision.	
10/01/2018	R13	LCD revised for annual ICD-10 updates. ICD-10 code I63.8 was deleted and replaced by I63.81 and I63.89 in Group 1. ICD-10 codes T81.4XXA, T81.4XXD, and T81.4XXS were deleted and replaced by T8140XA, T8141XA, T8142XA, T8143XA, T8144XA, T8140XD, T8141XD, T8142XD, T8143XD, T8144XD, T8140XS, T8141XS, T8142XS, T8143XS, and T8144XS in Group 1. *DATE (10/01/2018): At this time, the 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.*	• Revisions Due To ICD-10-CM Code Changes
11/01/2017	R12	Formatting changes made	• Other
11/01/2017	R11	ICD-10 codes I05.1, I05.8, I06.0, I06.1, I06.2, I08.0, I08.2, and I08.8 have been added as payable for Group 4 (codes 93350, 93351, 93352, C8928, C8930). *DATE (11/01/2017): At this time, the 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this* — Request for Coverage by a Practitioner (Part B)	• Request for Coverage by a Practitioner (Part B)

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		policy.	
10/01/2017	R10	Correction to Revision 9: this change was listed in error for Group 4: *Deleted code I27.2 was replaced by I27.20-I27.29.* Group 4 does not include this range of codes. *DATE (10/01/2017): At this time, the 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.*	• Typographical Error
10/01/2017	R9	LCD revised for annual ICD-10 updates for 2018. • For Group 1, (CPT codes 93306, 93307, 93308, C8923, C8924, C8929) deleted code E85.8 was replaced by E85.81, E85.82, and E85.89. Deleted code I27.2 was replaced by I27.20-I27.29. ICD-10 codes I21.9, I21.A1, I21.A9, I50.810-I50.814, I50.82-I50.89 and R06.03 were added. • For Group 2 (CPT codes 93303, 93304, C8921, C8922) deleted code P29.3 was replaced by P29.30 and P29.38. • For Group 4 (CPT codes 93350, 93351, 93352, C8928, C8930), Deleted code I27.2 was replaced by I27.20-I27.29. ICD-10 codes I21.9, I21.A1, I21.A9, I50.810-I50.814, I50.82-I50.89 and R06.03 were added. *DATE (10/01/2017): At this time, the 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.*	• Revisions Due To ICD-10-CM Code Changes

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
07/01/2017	R8	The following statement has been added to ICD-10 groups 1, 2, 3 and 4: coverage criteria and diagnosis restrictions apply to both the base codes [listed above] and related add-on codes.	• Provider Education/Guidance
04/01/2017	R7	*ICD-10 codes I08.1, I08.3, I08.9, I34.0, I34.1, I34.8, and I34.9 are payable when billed with CPT codes 93306, 93307, or 93308 only. *ICD-10 code Q23.4 is payable when billed with CPT codes 93303, 93304 only. Wording changes have been made throughout for clarity.	• Provider Education/Guidance • Request for Coverage by a Practitioner (Part B)
10/01/2016	R6	Multiple ICD-10 codes added for annual ICD-10 updates. Added ICD-10 code Z51.81 to Group 1 and instructions for coding TTE done for monitoring effects of chemotherapy.	• Provider Education/Guidance • Revisions Due To ICD-10-CM Code Changes
07/01/2016	R5	CPT/HCPCS Group 2 paragraph was revised as follows to clarify the use of the codes listed: "These stress agents can be billed with stress test codes 93350, 93351, 93352, C8928, and C8930."	• Provider Education/Guidance
10/01/2015	R4	ICD-10 code Z08 was added to Group 1 diagnoses, payable for HCPCS codes 93306, 93307, 93308, 93321, 93325, C8923, C8924, and C8929, effective 10/1/2015.	• Request for Coverage by a Practitioner (Part B)
10/01/2015	R3	ICD-10 codes were revised to add the 7th digit for D=subsequent encounter and S=sequela, where the 7th digit, A=initial encounter was already included.	• Provider Education/Guidance
10/01/2015	R2	An asterisk was added to ICD-10 code Z01.810 in Group 1.	• Typographical Error
10/01/2015	R1	LCD updated with changes made since it was initially posted.	• Other

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Articles

A56781 - Billing and Coding: Transthoracic Echocardiography (TTE)

Related National Coverage Documents

N/A

Public Versions

UPDATED ON	EFFECTIVE DATES	STATUS
09/17/2019	10/01/2019 - N/A	Currently in Effect (This Version)
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.		

Keywords

- Echo
- Cardiac