Medical Policy
Cardiokymography

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Policy Number: 049
BCBSA Reference Number: N/A
NCD/LCD: National Coverage Determination (NCD) for Displacement Cardiography (20.24)

Related Policies
None

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO BlueSM and Medicare PPO BlueSM Members

Cardiokymography may be MEDICALLY NECESSARY only when it is used as an adjunct to electrocardiographic stress testing in evaluating coronary artery disease and only when the following clinical indications are present:

- Male patients with atypical angina pectoris or non-ischemic chest pain, or
- Female patients with typical or atypical angina.

National Coverage Determination (NCD) for Displacement Cardiography (20.24)

Prior Authorization Information
Pre-service approval is required for all inpatient services for all products. See below for situations where prior authorization may be required or may not be required for outpatient services:
Yes indicates that prior authorization is required.
No indicates that prior authorization is not required.
N/A indicates that this service is primarily performed in an inpatient setting.
Outpatient

<table>
<thead>
<tr>
<th>Commercial Managed Care (HMO and POS)</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial PPO and Indemnity</td>
<td>No</td>
</tr>
<tr>
<td>Medicare HMO Blue&lt;sup&gt;SM&lt;/sup&gt;</td>
<td>No</td>
</tr>
<tr>
<td>Medicare PPO Blue&lt;sup&gt;SM&lt;/sup&gt;</td>
<td>No</td>
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**CPT Codes / HCPCS Codes / ICD Codes**

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

**HCPCS Codes**

<table>
<thead>
<tr>
<th>HCPCS codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>Q0035</td>
<td>Cardiokymography</td>
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</table>

**Description**

Cardiokymography (CKG) is a noninvasive procedure used to detect stress-induced abnormalities in the left wall of the heart. This procedure provides an additional means for the diagnosis and assessment of coronary artery disease. Although CKG may be performed as an independent test, the greatest benefit of this test is achieved through its adjunctive use with electrocardiographic (ECG) stress testing.

**Summary**

This procedure provides an additional means for the diagnosis and assessment of coronary artery disease and cardiac ischemia. Although CKG may be performed as an independent test, the greatest benefit of this test is achieved through its adjunctive use with electrocardiographic (ECG) stress testing. CKG is a simple, relatively inexpensive add-on test to the standard exercise test; BCBSMA considers the test medically necessary in the specific circumstances described in the policy statement.

**Policy History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>8/2015</td>
<td>Clarified coding language.</td>
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</table>

**Information Pertaining to All Blue Cross Blue Shield Medical Policies**

Click on any of the following terms to access the relevant information:

- [Medical Policy Terms of Use](#)
- [Managed Care Guidelines](#)
- [Indemnity/PPO Guidelines](#)
References

Endnotes