

PROVIDERALERT



To: AmeriHealth Caritas Louisiana Providers

Date: April 12, 2022

Subject: Updated Clinical Guidelines

Summary: Updated Clinical Guidelines for Magellan/National Imaging Associates.

Content

AmeriHealth Caritas Louisiana would like to make you aware of the updated Magellan/National Imaging Associates clinical guidelines that have been approved by the Louisiana Department of Health in accordance with La. R.S. 46:460.54 and will become effective **May 12, 2022**. The new guidelines can be found at the following link: <https://www1.radmd.com/all-health-plans/amerihealth-caritas-louisiana.aspx> [radmd.com].

Guideline Number: **NIA_CG_062: CT Coronary Angiography (CCTA)**

Questions: Thank you for your continued support and commitment to the care of our members. If you have questions about this communication, please contact AmeriHealth Caritas Louisiana Provider Services at 1-888-922-0007 or your [Provider Network Management Account Executive](#).

Missed an alert?

You can find a complete listing of provider alerts on the [Provider Newsletters and Updates](#) page of our website.

Where can I find more information on COVID-19?

AmeriHealth Caritas Louisiana has updated its website to streamline communications and important notifications about COVID-19. Please visit <http://amerihealthcaritasla.com/covid-19> for up-to-date information for both providers and members, including frequently asked questions, and important provider alerts from AmeriHealth Caritas Louisiana and the Louisiana Department of Health.



AmeriHealth Caritas Louisiana

National Imaging Associates, Inc.*	
Clinical guideline: CT CORONARY ANGIOGRAPHY (CCTA)	Original Date: October 2009
CPT Codes: 75574	Last Revised Date: <u>January 2022</u>
Guideline Number: NIA_CG_062	Implementation Date: <u>TBD</u>

GENERAL INFORMATION

It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.

INDICATIONS FOR CORONARY COMPUTED TOMOGRAPHIC ANGIOGRAPHY (CCTA)

(Fihn, 2012; Gulati, 2021; Montalescot, 2013; Taylor, 2010; Wolk, 2014)

Evaluation in Suspected Coronary Artery Disease (CAD)

(Cheng, 2011; Douglas, 2015; Fordyce, 2016; Newby, 2015)

- Intermediate and high pretest probability patients (Gulati, 2021)
- Exercise ECG stress test with intermediate Duke Treadmill Score (- 10 to + 4)
- Equivocal, borderline, or discordant stress imaging evaluation with continued symptoms concerning for CAD
- Repeat testing in patient with new or worsening symptoms since prior normal stress imaging (Taylor, 2010; Wolk, 2013)
- Asymptomatic patients without known CAD
 - Previously unevaluated ECG evidence of possible myocardial ischemia including ischemic ST segment or T wave abnormalities
 - Previously unevaluated pathologic Q waves
 - Previously unevaluated left bundle branch block
- Newly diagnosed clinical systolic heart failure (ejection fraction [EF] < 50%) or diastolic heart failure without recent CAD evaluation, in the presence of angina or an anginal equivalent

* National Imaging Associates, Inc. (NIA) is a subsidiary of Magellan Healthcare, Inc.

symptoms, as an alternative to invasive coronary arteriography (Patel, 2012; Patel, 2013; Taylor, 2010; Wolk, 2013)

- Before valve surgery or transcatheter intervention as an alternative to coronary angiography (Baumgartner, 2017; Chaikriangkrai, 2018; Nishimura, 2014)
- To establish the etiology of mitral regurgitation (Nishimura, 2014)
- Evaluation of coronary anomaly or aneurysm (Bluemke, 2008; Grani, 2017; Newburger, 2016; Sachdeva, 2020)
 - Evaluation prior to planned repair
 - Evaluation due to change in clinical status and/or new concerning signs or symptoms
- Evaluation of coronary artery bypass grafts, to assess (Eisenberg, 2017; Taylor, 2010):
 - Patency and location when invasive coronary arteriography was either nondiagnostic or not performed
 - Location prior to cardiac or another chest surgery

BACKGROUND

Coronary computed tomographic angiography (CCTA) is a noninvasive imaging study that uses intravenously administered contrast material and high-resolution, rapid imaging computed tomography (CT)(Nakamura, 2018; Pontone, 2018).

Stable patients without known CAD fall into 2 categories (Fihn, 2012; Montalescot, 2013; Wolk, 2013):

- **Asymptomatic**, for whom global risk of CAD events can be determined from coronary risk factors, using calculators available online (see [Risk Calculators](#) in the [Overview](#) section).
- **Symptomatic**, for whom we estimate the pretest probability that their chest-related symptoms are due to clinically significant CAD.

The Three Types of Chest Pain or Discomfort:

- **Typical Angina (Definite)** is defined as including all **3** characteristics:
 - Substernal chest pain or discomfort with characteristic quality and duration
 - Provoked by exertion or emotional stress
 - Relieved by rest and/or nitroglycerin
- **Atypical Angina (Probable)** has only **2** of the above characteristics
- **Nonanginal Chest Pain/Discomfort** has only **0 - 1** of the above characteristics
- Once the type of chest pain has been established from the medical record, the Pretest Probability of significant CAD is estimated from the Diamond Forrester Table below, recognizing that additional coronary risk factors could increase pretest probability (Wolk, 2013):

Age (Years)	Gender	Typical/Definite Angina Pectoris	Atypical/Probable Angina Pectoris	Nonanginal Chest Pain
≤ 39	Men	Intermediate	Intermediate	Low
	Women	Intermediate	Very low	Very low
40 – 49	Men	High	Intermediate	Intermediate
	Women	Intermediate	Low	Very low
50 – 59	Men	High	Intermediate	Intermediate
	Women	Intermediate	Intermediate	Low
≥ 60	Men	High	Intermediate	Intermediate
	Women	High	Intermediate	Intermediate

- **Very Low:** < 5% pretest probability of CAD
- **Low:** 5 - 10% pretest probability of CAD
- **Intermediate:** 10% - 90% pretest probability of CAD
- **High:** > 90% pretest probability of CAD

OVERVIEW

The *2021 AHA/ACC/ASE/CHEST/SAEM/SCCT/SCMR Guideline for the Evaluation and Diagnosis of Chest Pain* **has given** a Class 1 recommendation with level of evidence of A for patients with stable and acute chest pain, who have no known coronary artery disease (CAD)(Gulati, 2021).

Patient selection and contraindications to CCTA must be considered and may be inappropriate for the following:

- Known history of severe and/or anaphylactic contrast reaction
- Inability to cooperate with scan acquisition and/or breath-hold instructions
- Pregnancy
- Clinical instability (e.g., acute myocardial infarction, decompensated heart failure, severe hypotension)
- Renal impairment as defined by local protocols
- Image quality depends on keeping HR optimally < 60 bpm, a regular rhythm, limited coronary calcification, stents > 3.0 mm in diameter, ≥ 5 second breath hold, and vessels requiring imaging ≥ 1.5 mm diameter (Abbara, 2016).

Scenarios that can additionally support a CCTA over a regular exercise treadmill test in the low probability scenario

(Henzlova, 2016)

Inability to Exercise

- Physical limitations precluding ability to exercise for at least 3 full minutes of Bruce protocol

- The patient has limited functional capacity (< 4 METS) **such as one** of the following:
 - Unable to take care of their activities of daily living (ADLs) or ambulate
 - Unable to walk 2 blocks on level ground
 - Unable to climb 1 flight of stairs
 - Unable to vacuum, dust, do dishes, sweep, or carry a small grocery bag

Other Comorbidities

- Prior cardiac surgery (coronary artery bypass graft or valvular)
- Left ventricular ejection fraction $\leq 50\%$
- Severe chronic obstructive pulmonary disease (COPD) with pulmonary function test (PFT) documentation, severe shortness of breath on minimal exertion, or requirement of home oxygen during the day
- Poorly controlled hypertension, with systolic blood pressure (BP) > 180 or Diastolic BP > 120

ECG and Echo-Related Baseline Findings

- Pacemaker or implantable cardioverter defibrillator (ICD)
- Resting wall motion abnormalities on echocardiography
- Complete LBBB

Risk-Related

- Intermediate or high global risk in patients requiring type IC antiarrhythmic drugs
- Arrhythmia risk with exercise

ECG Stress Test Alone versus Stress Testing with Imaging

Prominent scenarios suitable for an ECG stress test WITHOUT imaging (i.e., exercise treadmill ECG test) require that the patient can exercise for at least 3 minutes of Bruce protocol with achievement of near maximal heart rate AND has an interpretable ECG for ischemia during exercise (Wolk, 2013):

- The (symptomatic) low pretest probability patient who can exercise and has an interpretable ECG (Wolk, 2014)
- The patient who is under evaluation for exercise-induced arrhythmia
- The patient who requires an entrance stress test ECG for a cardiac rehab program or for an exercise prescription
- For the evaluation of syncope or presyncope during exertion (Shen, 2017)

Duke Exercise ECG Treadmill Score (Mark, 1987)

Calculates risk from ECG treadmill alone:

- The equation for calculating the Duke treadmill score (DTS) is: $DTS = \text{exercise time in minutes} - (5 \times \text{ST deviation in mm or } 0.1 \text{ mV increments}) - (4 \times \text{exercise angina score})$, with angina score being 0 = none, 1 = non-limiting, and 2 = exercise-limiting

- The score typically ranges from - 25 to + 15. These values correspond to low-risk (with a score of $\geq + 5$), intermediate risk (with scores ranging from - 10 to + 4), and high-risk (with a score of $\leq - 11$) categories

An uninterpretable baseline ECG includes (Fihn, 2012):

- ST segment depression of 1 mm or more (not for non-specific ST - T wave changes)
- Ischemic looking T wave inversions of at least 2.5 mm
- LVH with repolarization abnormalities, WPW, a ventricular paced rhythm, or left bundle branch block
- Digitalis use with associated ST - T abnormalities
- Resting HR under 50 bpm on a beta blocker and an anticipated suboptimal workload
- Note: RBBB with less than 1 mm ST depression at rest may be suitable for EKG treadmill testing

Global Risk of Cardiovascular Disease

Global risk of CAD is defined as the probability of manifesting cardiovascular disease over the next 10 years and refers to **asymptomatic** patients without known cardiovascular disease. It should be determined using one of the risk calculators below. A high risk is considered greater than a 20% risk of a cardiovascular event over the ensuing 10 years.

High global risk by itself generally lacks scientific support as an indication for stress imaging (Cheng, 2011).

There are rare exemptions, such as patients requiring IC antiarrhythmic drugs, who might require coronary risk stratification prior to initiation of the drug, when global risk is moderate or high.

- **CAD Risk—Low**
10 - year absolute coronary or cardiovascular risk less than 10%
- **CAD Risk—Moderate**
10 - year absolute coronary or cardiovascular risk between 10% and 20%
- **CAD Risk—High**
10 - year absolute coronary or cardiovascular risk of greater than 20%

Websites for Global Cardiovascular Risk Calculators*

*Patients who have already manifested cardiovascular disease are already at high global risk and are not applicable to the calculators.
(Arnett, 2019; D'Agostino, 2008; Goff, 2014; McClelland, 2015; Ridker, 2007)

Risk Calculator	Websites for Online Calculator
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Framingham Cardiovascular Risk	https://reference.medscape.com/calculator/framingham-cardiovascular-disease-risk
Reynolds Risk Score Can use if no diabetes Unique for use of family history	http://www.reynoldsriskscore.org/
Pooled Cohort Equation	http://clincalc.com/Cardiology/ASCVD/PooledCohort.aspx?example
ACC/AHA Risk Calculator	http://tools.acc.org/ASCVD-Risk-Estimator/
MESA Risk Calculator With addition of Coronary Artery Calcium Score, for CAD-only risk	https://www.mesa-nhlbi.org/MESACHDRisk/MesaRiskScore/RiskScore.aspx

Definitions of Coronary Artery Disease

(Fihn, 2012; Lofti, 2018; Mintz, 2016; Montalescot, 2013; Patel, 2017)

- Percentage stenosis refers to the reduction in diameter stenosis when angiography is the method and can be estimated or measured using angiography or more accurately measured with intravascular ultrasound (IVUS).
- Coronary artery calcification is a marker of risk, as measured by Agatston score on coronary artery calcium imaging. It is not a diagnostic tool so much as it is a **risk stratification** tool. Its incorporation into global risk can be achieved by using the MESA risk calculator.
- Stenoses $\geq 70\%$ are considered obstructive coronary artery disease (also referred to as clinically significant), while stenoses $\leq 70\%$ are considered non-obstructive coronary artery disease (Patel, 2017).
- Ischemia-producing disease (also called hemodynamically or functionally significant disease, for which revascularization might be appropriate) generally implies at least one of the following:
 - Suggested by percentage diameter stenosis $\geq 70\%$ by angiography; borderline lesions are 40 - 70% (Fihn, 2012)
 - For a left main artery, suggested by a percentage stenosis $\geq 50\%$ or minimum luminal cross-sectional area on IVUS ≤ 6 square mm (Fihn, 2012; Lofti, 2018; Mintz, 2016)
 - FFR (fractional flow reserve) ≤ 0.80 for a major vessel (Lofti, 2018; Mintz, 2016)

- iFR (instantaneous wave-free ratio) ≤ 0.89 for a major vessel (Davies, 2017; Gotberg, 2017; Lofti, 2018)
- Demonstrable ischemic findings on stress testing (ECG or stress imaging), that are at least mild in degree
- A major vessel would be a coronary vessel that would be amenable to revascularization, if indicated. This assessment is made based on the diameter of the vessel and/or the extent of myocardial territory served by the vessel.
- FFR is the distal to proximal pressure ratio across a coronary lesion during maximal hyperemia induced by either intravenous or intracoronary adenosine. Less than or equal to 0.80 is considered a significant reduction in coronary flow.
- Newer technology that estimates FFR from CCTA images is covered under the separate NIA Guideline for FFR-CT.

Anginal Equivalent

(Fihn, 2012; Moya, 2009; Shen, 2017)

Development of an anginal equivalent (e.g., shortness of breath, fatigue, or weakness) either with or without prior coronary revascularization should be based upon the documentation of reasons that symptoms other than chest discomfort are not due to other organ systems (e.g., dyspnea due to lung disease, fatigue due to anemia), by presentation of clinical data such as respiratory rate, oximetry, lung exam, etc. (as well as d-dimer, chest CT(A), and/or PFTs, when appropriate), and then incorporated into the evaluation of coronary artery disease as would chest discomfort. Syncope per se is not an anginal equivalent.

Abbreviations

ACS	Acute coronary syndrome
CABG	Coronary artery bypass grafting surgery
CAD	Coronary artery disease
CCS	Coronary calcium score
CCTA	Coronary computed tomography angiography
ECG	Electrocardiogram
MI	Myocardial infarction
MPI	Myocardial Perfusion Imaging
PCI	Percutaneous coronary intervention
SE	Stress echocardiography
TTE	Transthoracic echocardiography

POLICY HISTORY

Date	Summary
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<u>January 2022</u>	<ul style="list-style-type: none"> • <u>Deleted the requirement for stress echocardiography.</u> • <u>Changed to Intermediate and High probability chest pain patients now allowable as first line testing</u> • <u>Intermediate DTS patients now allowable for CCTA</u> • <u>Removed EF < 40%, keeping the existing EF< 50% systolic dysfunction, and adding symptomatic diastolic heart failure with no prior workup</u> • <u>Added a paragraph explaining the changes, new guidelines of November 2021 with contraindications within the overview section</u> • <u>Added section on when CCTA is preferred over ETT in low-risk patients</u> • <u>Deleted the phrasing ‘scenarios that support MPI over SE’ as it would no longer apply here. Replaced with ‘Scenarios that can additionally support a CCTA over a regular exercise treadmill test in the low probability scenario’.</u> • <u>Deleted statement that MPI may be supported over CCTA in Poorly controlled atrial fibrillation/ectopy</u> • <u>Took out the word ‘intermediate’ in the phrase “The (symptomatic) low pretest probability patient who is able to exercise and has an interpretable ECG”</u> • <u>Removed section on Coronary Artery calcium scoring</u>
March 2021	<ul style="list-style-type: none"> • Deleted: Appropriate exercise ECG stress test with low Duke Treadmill Score (≥ 5) and continued symptoms concerning for CAD • Added: High pretest probability as an alternative to coronary angiography (can also do MPI) • Removed statement about low Duke treadmill score and continuing symptoms
March 2020	<ul style="list-style-type: none"> • Added general information section as Introduction which outlines requirements for documentation of pertinent office notes by a licensed clinician, and inclusion of laboratory testing and relevant imaging results for case review • Added further details for imaging of coronary anomaly or aneurysm to include the following: <ul style="list-style-type: none"> ○ Evaluation prior to planned repair ○ Evaluation due to change in clinical status and/or new concerning signs or symptoms • Added edits to the Coronary Artery Disease definition section • Updated and added references

July 2019	<ul style="list-style-type: none"> • CCTA can be used as an alternative to coronary angiography in appropriate patients prior to valve surgery or transcatheter intervention • Noted CMR is favored over CCTA in young patients for evaluation of coronary anomaly or aneurysm • Global Risk of Cardiovascular Disease information expanded in background section for additional clarification
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REFERENCES:

Abbara S, Blanke P, Maroules CD, et al. SCCT Guidelines for the performance and acquisition of coronary computed tomographic angiography: A report of the Society for Cardiovascular Computed Tomography Guidelines Committee Endorsed by the North American Society for Cardiovascular Imaging (NASCI). *J Cardiovasc Comput Tomogr*. 2016; 10(6): 435-449.

Arnett DK, Blumenthal RS, Albert MA, Buroker AB, Goldberger ZD, Hahn EJ, Himmelfarb CD, Khera A, Lloyd-Jones D, McEvoy JW, Michos ED, Miedema MD, Muñoz D, Smith SC Jr, Virani SS, Williams KA Sr, Yeboah J, Ziaeian B. 2019 ACC/AHA guideline on the primary prevention of cardiovascular disease: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines *J Am Coll Cardiol*. 2019; 74:e177–232.

Baumgartner H, Falk V, Bax JJ et al. 2017 ESC/EACTS guidelines for the management of valvular heart disease, The Task Force for the Management of Valvular Heart Disease of the European Society of Cardiology (ESC) and the European Association for Cardio-Thoracic Surgery (EACTS). *Eur Heart J*. 2017;38:2739–2791.

Bluemke DA, Achenbach S, Budoff M, et al. Noninvasive coronary artery imaging: magnetic resonance angiography and multidetector computed tomography angiography: a scientific statement from the American Heart Association committee on cardiovascular imaging and intervention of the council on cardiovascular radiology and intervention, and the councils on clinical cardiology and cardiovascular disease in the young. *Circulation*. 2008; 118:586–606.

Chaikriangkrai K, Jhun HY, Shantha GPS, et al. Diagnostic accuracy of coronary computed tomography before aortic valve replacement: systematic review and meta-analysis. *J Thorac Imaging*. 2018;33(4):207-216. doi:10.1097/RTI.0000000000000322.

Cheng VY, Berman DS, Rozanski A, et al. Performance of the traditional age, sex, and angina typicality-based approach for estimating pretest probability of angiographically significant coronary artery disease in patients undergoing coronary computed tomographic angiography: results from the multinational coronary CT angiography evaluation for clinical outcomes: an international multicenter registry (CONFIRM). *Circulation*. 2011; 124(22):2423-32

D'Agostino RB Sr, Vasan RS, Pencina MJ, et al. General cardiovascular risk profile for use in primary care: The Framingham Heart Study. *Circulation*. 2008; 117:743-753.

Davies JE, Sen S, Dehbi HM, et al. Use of the instantaneous wave-free ratio or fractional flow reserve in PCI. *N Engl J Med*. 2017; 376:1824–34.

Doherty JU, Kort S, Mehran R, et al. ACC/AATS/AHA/ASE/ASNC/HRS/SCAI/SCCT/SCMR/STS 2019 Appropriate Use Criteria for multimodality imaging in the assessment of cardiac structure and function in nonvalvular heart disease. *J Am Coll Cardiol*. 2019; 25682. doi: 10.1016/j.jacc.2018.10.038

Douglas PS, Hoffmann U, Patel MR, et al. Outcomes of anatomical versus functional testing for coronary artery disease. *N Engl J Med*. 2015; 372:1291–1300.

Eisenberg C, Hulten E, Bittencourt MS, et al. Use of CT angiography among patients with prior coronary artery bypass grafting surgery. *Cardiovasc Diagn Ther*. 2017; 7(1):102-105.

Fihn SD, Gardin JM, Abrams J, et al. 2012 ACCF/AHA/ACP/AATS/PCNA/SCAI/STS Guideline for the diagnosis and management of patients with stable ischemic heart disease: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines, and the American College of Physicians, American Association for Thoracic Surgery, Preventive Cardiovascular Nurses Association, Society for Cardiovascular Angiography and Interventions, and Society of Thoracic Surgeons. *Circulation*. 2012; 126(25):e354-471.

Fordyce CB, Newby DE, Douglas PS, et al. Diagnostic strategies for the evaluation of chest pain: Clinical implications from SCOT-HEART and PROMISE. *J Am Coll Cardiol*. 2016; 67(7):843-852.

Goff DC, Lloyd-Jones, DM, Bennett G, et al. 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: A report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines Endorsed by the American Association of Cardiovascular and Pulmonary Rehabilitation, American Society for Preventive Cardiology, American Society of Hypertension, Association of Black Cardiologists, National Lipid Association, Preventive Cardiovascular Nurses Association, and Women Heart: The National Coalition for Women With Heart Disease. *J Am Coll Cardiol*. 2014; 63(25):2935-2959.

Götberg M, Christiansen EH, Gudmundsdottir IJ, et al., Instantaneous wave-free ratio versus fractional flow reserve to guide PCI. *N Engl J Med*. 2017; 376:1813–23.

Götberg M, Cook CM, Sen S, et al. The evolving future of instantaneous wave-free ratio and fractional flow reserve. *J Am Coll Cardiol*. 2017; 70 (11):1379-1402.

Grani C, Buechel RR, Kaufmann PA, et al. Multimodality Imaging in Individuals with Anomalous Coronary Arteries. *J Am Coll Cardiol*. 2017; 10(4):471-581.

Greenland P, Alpert JS, Beller GA, et al. ACCF/AHA Guideline for Assessment of Cardiovascular Risk in Asymptomatic Adults: Executive Summary: A Report of the American College of

Cardiology Foundation/American Heart Association Task Force on Practice Guidelines Developed in Collaboration With the American Society of Echocardiography, American Society of Nuclear Cardiology, Society of Atherosclerosis Imaging and Prevention, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Computed Tomography, and Society for Cardiovascular Magnetic Resonance. *J Am Coll Cardiol*. 2010; 56(25):2182-2199. Available at: <http://content.onlinejacc.org/article.aspx?articleid=1143998>.

Gulati M, Levy PD, Mukherjee D, et al. 2021 AHA/ACC/ASE/CHEST/SAEM/SCCT/SCMR Guideline for the Evaluation and Diagnosis of Chest Pain: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *J Am Coll Cardiol*. Nov 30 2021;78(22):e187-e285. doi:10.1016/j.jacc.2021.07.053.

Henzlova MJ, Duvall WL, Einstein, AJ, et al. ASNC imaging guidelines for SPECT nuclear cardiology procedures: Stress, protocols, and tracers. *J Nucl Cardiol*. 2016; 23:606–39. Available at: <https://link.springer.com/content/pdf/10.1007/s12350-015-0387-x.pdf>.

Kongkiat C, Yeon JH, Subash SGP, et al. Diagnostic accuracy of coronary computed tomography before aortic valve replacement: Systematic review and meta-analysis. *Journal of Thoracic Imaging*. 2018; 33(4): 207-216.

Lotfi A, Davies JE, Fearon WF, et al. Focused update of expert consensus statement: Use of invasive assessments of coronary physiology and structure: A position statement of the society of cardiac angiography and interventions. *Catheter Cardiovasc Interv*. 2018 Jul 3.

Mark DB, Hlatky MA, Harrell FE Jr, et al. Exercise treadmill score for predicting prognosis in coronary artery disease. *Ann Intern Med*. 1987; 106(6):793-800.

Mark DB, Berman DS, Budoff MJ, et al. ACCF/ACR/AHA/NASCI/SAIP/SCAI/SCCT 2010 Expert Consensus Document on coronary computed tomographic angiography. A report of the American College of Cardiology Foundation Task Force on Expert Consensus Documents. American College of Cardiology Foundation Representative; American Society of Nuclear Cardiology Representative; Society of Cardiovascular Computed Tomography Representative; Society of Atherosclerosis Imaging and Prevention Representative; American College of Radiology Representative; American Heart Association Representative; North American Society for Cardiovascular Imaging Representative; Society for Cardiovascular Angiography and Interventions Representative. *J Am Coll Cardiol*. 2010; 55(23):2663-2698.

McClelland RL, Jorgensen NW, Budoff M, et al. 10-Year coronary heart disease risk prediction using coronary artery calcium and traditional risk factors: Derivation in the MESA (Multi-Ethnic Study of Atherosclerosis) with validation in the HNR (Heinz Nixdorf Recall) Study and the DHS (Dallas Heart Study). *J Am Coll Cardiol*. 2015; 66(15):1643-53.

Mintz GS. IVUS in PCI Guidance. *Am Coll Cardiol, Cardiosource*, June 13, 2016. Available at: <http://www.acc.org/latest-in-cardiology/articles/2016/06/13/10/01/ivus-in-pci-guidance>.

Montalescot G, Sechtem U, Achenbach S, et al. 2013 ESC guidelines on the management of stable coronary artery disease: The Task Force on the management of stable coronary artery disease of the European Society of Cardiology. *Eur Heart J*. 2013; 34(38):2949–3003. Available at: <https://academic.oup.com/eurheartj/article/34/38/2949/442952>.

Moya A, Sutton R, Ammirati F, et al. Guidelines for the diagnosis and management of syncope: Task Force for the Diagnosis and Management of Syncope. *Eur Heart J*. 2009; 30:2631–71. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3295536/>

Nakamura S, Kitagawa K, Goto Y, et al. Incremental prognostic value of myocardial blood flow quantified with stress dynamic computed tomography perfusion imaging. *JACC Cardiovasc Imaging*. 2019; 12(7 Pt 2):1379-1387.

Newburger JW, Takahashi M, Burns JC. Kawasaki Disease. *JACC*. 2016; 67(14):1738-1749. Available at: <http://content.onlinejacc.org/article.aspx?articleid=2510781>.

Newby D, Williams M, Hunter A, et al. CT coronary angiography in patients with suspected angina due to coronary heart disease (SCOT-HEART): an open-label, parallel-group, multicentre trial. *Lancet*. 2015; 385:2383-2391. Available at: [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(15\)60291-4.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(15)60291-4.pdf).

Nishimura RA, Otto CM, Bonow RO, et al. 2014 AHA/ACC Guideline for the Management of Patients with Valvular Heart Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol*. 2014; 63(22):e57-e185.

Patel MR, Bailey SR, Bonow RO, et al. ACCF/SCAI/AATS/AHA/ASE/ASNC/HFSA/HRS/SCCM/SCCT/SCMR/STS 2012 Appropriate use criteria for diagnostic catheterization: A report of the American College of Cardiology Foundation Appropriate Use Criteria Task Force, Society for Cardiovascular Angiography and Interventions, American Association for Thoracic Surgery, American Heart Association, American Society of Echocardiography, American Society of Nuclear Cardiology, Heart Failure Society of America, Heart Rhythm Society, Society of Critical Care Medicine, Society of Cardiovascular Computed Tomography, Society for Cardiovascular Magnetic Resonance, and Society of Thoracic Surgeons. *J Am Coll Cardiol*. 2012; 59(22):1995-2027.

Patel MR, Calhoon JH, Dehmer GJ, et al. ACC/AATS/AHA/ASE/ASNC/SCAI/SCCT/STS 2017 Appropriate Use Criteria for Coronary Revascularization in Patients with Stable Ischemic Heart Disease. *J Am Coll Cardiol*. 2017; 69(17):2212-2241.

Patel MR, White RD, Abbara S, et al. 2013 ACCF/ACR/ASE/ASNC/SCCT/SCMR Appropriate utilization of cardiovascular imaging in heart failure, A Joint Report of the American College of Radiology Appropriateness Criteria Committee and the American College of Cardiology Foundation Appropriate Use Criteria Task Force. *J Am Coll Cardiol*. 2013; 61(21): 2207-2231.

Pontone G, Baggiano A, Andreini D, et al. Stress Computed Tomography Perfusion Versus Fractional Flow Reserve CT Derived in Suspected Coronary Artery Disease. *JACC Cardiovasc Imaging*. 2018 Oct 12. pii: S1936-878X(18)30751-4. doi: 10.1016/j.jcmg.2018.08.023. [Epub ahead of print].

Ridker PM, Buring JE, Rifai N, et al. NIH Estimate of 10 year coronary artery disease risk from Framingham Risk Score: Development and validation of improved algorithms for the assessment of global cardiovascular risk in women: the Reynolds Risk Score. *JAMA*. 2007; 297(6):611-619. Available at: <http://jama.jamanetwork.com/article.aspx?articleid=205528>

Rybick FJ, Udelson JE, Peacock WF, et al. ACR/ACC/AHA/AATS/ACEP/ASNC/NASCI/SAEM/SCCT/SCMR/SCPC/SNMMI/STR/STS Appropriate utilization of cardiovascular imaging in emergency department patients with chest pain. *JACC*. 2016; 67(7):853-879.

Sachdeva R, Valente AM, Armstrong AK, et al. ACC/AHA/ASE/HRS/ISACHD/SCAI/SCCT/SCMR/SOPE 2020 Appropriate Use Criteria for Multimodality Imaging During the Follow-Up Care of Patients with Congenital Heart Disease. *J Am Coll Cardiol*. 2020 Jan 06. Epub. DOI:10.1016/j.jacc.2019.10.002

Shen W, Sheldon RS, Benditt DG, et al. 2017 ACC/AHA/HRS Guideline for the evaluation and management of patients with syncope: A report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Rhythm Society. *J Am Coll Cardiol*. 2017; 70(5):620-663.

Taylor AJ, Cerqueira MC, Hodgson JM, et al. ACCF/SCCT/ACR/AHA/ASE/ASNC/NASCI/SCAI/SCMR 2010 Appropriate use criteria for cardiac computed tomography: A report of the American College of Cardiology Foundation Appropriate Use Criteria Task Force, the Society of Cardiovascular Computed Tomography, the American College of Radiology, the American Heart Association, the American Society of Echocardiography, the American Society of Nuclear Cardiology, the North American Society for Cardiovascular Imaging, the Society for Cardiovascular Angiography and Interventions, and the Society for Cardiovascular Magnetic Resonance. *J Am Coll Cardiol*. 2010; 56(22):1864-1894.

Wolk MJ, Bailey SR, Doherty JU, et al. ACCF/AHA/ASE/ASNC/HFSA/HRS/SCAI/SCCT/SCMR/STS 2013 multimodality appropriate use criteria for the detection and risk assessment of stable ischemic heart disease: A report of the American College of Cardiology Foundation Appropriate Use Criteria Task Force, American Heart Association, American Society of Echocardiography, American Society of Nuclear Cardiology, Heart Failure Society of America, Heart Rhythm Society, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Computed Tomography, Society for Cardiovascular Magnetic Resonance, and Society of Thoracic Surgeons. *J Am Coll Cardiol*. 2014; 63(4):380-406. Available at: <http://content.onlinejacc.org/article.aspx?articleid=1789799>.

Yancy C, Jessup M, Bozkurt B, et al. 2013 ACCF/AHA guideline for the management of heart failure: A report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol*. 2013; 62(16):e147-237.

Reviewed / Approved by NIA Clinical Guideline Committee

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