Instructions for use
The following coverage policy applies to health benefit plans administered by Cigna. Coverage policies are intended to provide guidance in interpreting certain standard Cigna benefit plans and are used by medical directors and other health care professionals in making medical necessity and other coverage determinations. Please note the terms of a customer’s particular benefit plan document may differ significantly from the standard benefit plans upon which these coverage policies are based. For example, a customer’s benefit plan document may contain a specific exclusion related to a topic addressed in a coverage policy.

In the event of a conflict, a customer’s benefit plan document always supersedes the information in the coverage policy. In the absence of federal or state coverage mandates, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of:

1. The terms of the applicable benefit plan document in effect on the date of service
2. Any applicable laws and regulations
3. Any relevant collateral source materials including coverage policies
4. The specific facts of the particular situation

Coverage policies relate exclusively to the administration of health benefit plans. Coverage policies are not recommendations for treatment and should never be used as treatment guidelines.

This evidence-based medical coverage policy has been developed by eviCore, Inc. Some information in this coverage policy may not apply to all benefit plans administered by Cigna.

These guidelines include procedures eviCore does not review for Cigna. Please refer to the Cigna CPT code list for the current list of high-tech imaging procedures that eviCore reviews for Cigna.

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**PEDCD-1.1: Pediatric Cardiac Imaging Age Considerations**

- Heart disease in the pediatric population involves predominantly congenital lesions. Pediatric individuals can have acquired heart disease unique to children. For those diseases which occur in both pediatric and adult populations, differences exist in management due to individual age, comorbidities, and differences in disease natural history between children and adults.
- Individuals who are <18 years old should be imaged according to the Pediatric Cardiac Imaging Guidelines, and individuals who are ≥18 years should be imaged according to the Cardiac Imaging Guidelines, except where directed otherwise by a specific guideline section.

**PEDCD-1.2: Pediatric Cardiac Imaging Appropriate Clinical Evaluation**

- A recent (within 60 days) face-to-face evaluation should be performed prior to considering advanced imaging, unless the individual is undergoing guideline-supported scheduled follow-up imaging evaluation. This evaluation should include:
  - A detailed history
  - Physical examination
  - Appropriate laboratory studies
- Individuals for whom routine imaging is anticipated at the next visit (for example on year follow-up echo for a 10 year old with a VSD) may have these imaging studies approved without face-to-face evaluation if study was already indicated
- Unless otherwise stated in a specific guideline section, the use of advanced imaging to screen asymptomatic individuals for disorders involving the heart is not supported.
- Individuals starting ADHD medications, in the absence of other appropriate indications listed in these guidelines, imaging is not indicated.
- Asymptomatic individuals with known or suspected syndromes, which may be associated with congenital heart disease, can have an initial echocardiogram.
- Asymptomatic individuals with family history of aortopathy, cardiomyopathy, congenital heart disease with known inheritance pattern, can have an echocardiogram as an initial study. Additional studies are determined based on findings.
- Asymptomatic individuals with exposure to cardiotoxic drugs can have serial echocardiograms as per **PEDONC-19.2: Cardiotoxicity and Echocardiography**
- Advanced imaging of the heart should only be approved in individuals who have documented active clinical signs or symptoms of disease involving the heart or as follow-up for findings on echocardiograms.
- Unless otherwise stated in a specific guideline section, repeat imaging studies of the heart are not necessary unless:
  - There is evidence for progression of disease
  - New onset of disease and/or documentation of how repeat imaging will affect individual management or treatment decisions.
**PEDCD-1.3: Pediatric Cardiac Imaging Modality General Considerations**

- **MRI**
  - MRI and MRA studies are frequently indicated for evaluation of congenital heart defects not well visualized on echocardiography, thoracic arteries and veins not visualized on echocardiography, cardiomyopathies, and right ventricular disease, as well as in follow-up for these indications.
  - Due to the length of time for image acquisition and the need for the individuals to be motionless during the acquisition, anesthesia is required for almost all infants and young children (age <7 years), as well as older children with delays in development or maturity. In this individual population, MRI imaging sessions should be planned with a goal of avoiding a short-interval repeat anesthesia exposure due to insufficient information using the following considerations:
    - MRI is typically performed without and with contrast.
    - If multiple body areas are supported by eviCore guidelines for the clinical condition being evaluated, MRI of all necessary body areas should be obtained concurrently in the same anesthesia session.

- **CT**
  - CT is primarily used to evaluate the coronary and great vessels in congenital heart disease if cardiac MR is contraindicated.
  - Coding considerations are listed in [PEDCD-10: CT Heart and Coronary Computed Tomography Angiography (CCTA- Other Indications)](https://www.eviCore.com).

- **Ultrasound**
  - Echocardiography is the primary modality used to evaluate the anatomy and function of the pediatric heart, and is generally indicated before considering other imaging modalities.
  - Coding considerations are listed in [PEDCD-8: Echocardiography- Other Indications](https://www.eviCore.com).

The guidelines listed in this section for certain specific indications are not intended to be all-inclusive; clinical judgment remains paramount and variance from these guidelines may be appropriate and warranted for specific clinical situations.

**References**


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Pediatric Cardiac Imaging Guidelines

PEDCD-2.1: Congenital Heart Disease General Considerations

- Congenital heart disease accounts for the majority of cardiac problems occurring in the pediatric population. Individuals may be diagnosed any time spanning prenatal evaluation to adolescence. For individuals over 18 years of age, see CD-11: Adult Congenital Heart Disease in the Cardiac Imaging Guidelines.

- There are a number of variables that influence the modality and timing of imaging individuals with congenital heart disease, which results in a high degree of individuality in determining the schedule for imaging these individuals, including:
  - Gestational age
  - Individual age
  - Physiologic effects of the defect
  - Status of interventions (catheterization and surgical)
  - Rate of individual growth
  - Stability of the defect on serial imaging
  - Comorbid conditions
  - Activity level

PEDCD-2.2: Congenital Heart Disease Echocardiography Coding

- ANY of the following echocardiography code combinations are appropriate for re-evaluation of individuals with known congenital heart disease:
  - CPT® 93303, CPT® 93320, and CPT® 93325
  - CPT® 93304, CPT® 93321, and CPT® 93325
  - CPT® 93303
  - CPT® 93304

- CPT® 93306 is not indicated in the evaluation of known congenital heart disease.

- All requested CPT® combinations other than those listed in this section should be forwarded for Medical Director Review.

PEDCD-2.3: Congenital Heart Disease Modality Considerations

- Echocardiography is the primary imaging modality used for diagnosing and monitoring congenital heart disease and is generally required before other imaging modalities are indicated unless otherwise indicated in a specific guideline section.

- Cardiac MRI either without contrast (CPT® 75557) or without and with contrast (CPT® 75561) is indicated, when a recent echocardiogram is inconclusive, needs confirmation of findings, or does not completely define the disease (for subsequent follow-up studies, a recent echocardiogram is not a requirement):
  - CPT® 75565 is also indicated for individuals with valvular disease or a need to evaluate intracardiac blood flow. These individuals will usually have CPT® 93320 and CPT® 93325 performed with their echocardiography studies.
  - MRA Chest (CPT® 71555) may be added if the aorta or pulmonary artery needs to be visualized beyond the root, or if aortopulmonary collaterals, pulmonary veins, or systemic veins need to be visualized.
- MRA Chest alone (CPT® 71555) should be performed if the individual cannot cooperate with full cardiac MRI exam.

- MRA Chest (CPT® 71555) is assessment of the great arteries, pulmonary veins, and systemic chest veins, including the following:
  - Coarctation of the aorta, tetralogy of Fallot, anomalous pulmonary veins, Transposition of the great arteries, Truncus arteriosus, vascular rings, and other lesions of the great arteries, with inconclusive recent echocardiography findings.

- CT imaging is indicated, when recent echocardiogram is inconclusive, for the following:
  - Report CPT® 75574 for evaluating coronary artery anomalies
  - Report CPT® 75573 for congenital heart disease
  - CPT® 71275 Determination of vascular extra-cardiac anatomy in individuals with complex congenital heart disease
  - Pulmonary artery (PA) and Pulmonary vein (PV) assessment
  - CTA Chest is indicated to assess Coarctation of the aorta, tetralogy of Fallot, anomalous pulmonary veins, and other lesions of the great arteries, vascular rings, with inconclusive recent echocardiography findings.

**PEDCD-2.4: Congenital Heart Disease Timing Considerations**

- Echocardiography is repeated frequently throughout a child’s life, and can generally be approved regardless of symptoms according to the following schedule, with some modifications listed below:
  - Individuals 0-2 months:
    - Can have one repeat echocardiogram if prior echocardiogram is abnormal (either in hospital or as newborn outpatient)
  - Individuals age 0 to 2 years:
    - Every 3 months
  - Individuals with single ventricle physiology (e.g., Hypoplastic left heart syndrome [HLHS], Mitral atresia, Unbalanced atrioventricular septal defect [uAVSD]) may require echocardiograms very frequently:
    - Birth to 6 months of life: every 2 weeks
    - 7-12 months of life: 1 per month
    - Then every 3 months until 2 years of age
  - Individuals with unrepaired asymptomatic isolated secundum atrial septal defect (ASD) without syndromes (such as Down Syndrome) or evidence of pulmonary hypertension:
    - Every 3 months until they are 1 year
    - Then once a year, unless consideration for surgery
  - Individuals age 3 to 12 years:
    - Non-ASD individuals: every 6 months
    - Individuals with unrepaired asymptomatic isolated secundum atrial septal defect (ASD), without syndromes (such as Down Syndrome) or evidence of pulmonary hypertension:
      - Follow the above schedule until they are 1 year
Then they can have echocardiogram once a year, unless consideration for surgery
- Individuals age 13 years and older: every 12 months
- Modifiers to the above schedule:
  - Some congenital conditions may require more frequent testing, especially with more complex heart disease, congestive heart failure, obstructive heart lesions, ductal dependent lesions, changes in clinical status, repeat interventions, and/or in neonates.
  - Any individual being treated for heart failure, with consideration for changing medical regimen can have an echocardiogram

Echocardiography is performed during the physician office visit, and these studies should not be denied because of lack of contact within 60 days.

References


PEDCD-3.1: Heart Murmur General

- The following echocardiography code combinations for evaluation of any pathologic murmur or any innocent murmur with associated cardiac signs or symptoms:
  - CPT® 93303, CPT® 93306, CPT® 93320, and CPT® 93325
  - CPT® 93303, CPT® 93306
  - CPT® 93306, CPT® 93320 and CPT® 93325 are included with CPT® 93306 and should not be approved separately.

- Repeat echocardiography is not indicated if the initial echocardiogram was normal and the murmur has not changed in quality.

Background and Supporting Information

Heart murmurs are extremely common in pediatric individuals. The thinner chest wall in children allows clearer auscultation of blood flowing through the chambers of the heart, which may result in a murmur on physical exam.

The majority of murmurs are innocent and do not require further evaluation. More than 30% of children may have an innocent murmur detected during physical examination

Innocent murmurs are typically systolic ejection murmurs with a vibratory or musical quality, and generally change in quality when the individual changes position.

Other types of murmurs can be pathologic and require additional evaluation, usually by a pediatric cardiologist. Echocardiography is indicated, and is performed as part of the office visit. When evaluating an individual with a murmur for the first time, it will not be known whether the individual has congenital heart disease or not. The cardiologist only submits charges for the procedure actually performed.

References

5. Allen, Hugh D.; Shaddy, Robert E.; Penny, Daniel J.; Feltes, Timothy F.; Cetta, FrankTitle: Moss and Adams' Heart Disease in Infants, Children, and Adolescents: Including the Fetus and Young Adult, 9th Edition Copyright ©2016 Lippincott Williams & Wilkin.
6. Advances in Cardiovascular Imaging Multimodality Noninvasive Imaging for Assessment of Congenital Heart Disease Ashwin Prakash, MD; Andrew J. Powell, MD; Tal Geva.
7. Uptodate Approach to the infant or child with a cardiac murmur Author: Robert L Geggel, MDS Section Editors: David R Fulton, MD Martin I Lorin, MD Deputy Editor: Carrie Armsby, MD, MPH Literature review current through: Jun 2018. | This topic last updated: Jun 01, 2017.
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<td>PEDCD-4.1: Chest Pain General</td>
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**PEDCD-4.1: Chest Pain General**

- A recent (within 60 days) face-to-face evaluation including a detailed history, physical examination, EKG, and appropriate laboratory studies should be performed prior to considering advanced imaging.

- Echocardiography is indicated for pediatric individuals with chest pain and one or more of the following:
  - Exertional chest pain
  - Non-exertional chest pain with abnormal EKG
  - Chest pain with signs or symptoms of pericarditis
  - First-degree relative with sudden unexplained death or cardiomyopathy
  - Recent onset of fever
  - Recent illicit drug use
  - Other signs or symptoms of cardiovascular disease

- Echocardiography is performed as part of the office visit. When evaluating an individual for the first time, it will not be known whether the individual has congenital heart disease or not. The cardiologist only submits charges for the procedure actually performed.

- The following echocardiography code combinations for evaluation of chest pain:
  - CPT® 93303, CPT® 93306, CPT® 93320, and CPT® 93325
  - CPT® 93303, CPT® 93306
  - CPT® 93306
    - CPT® 93320 and CPT® 93325 are included with CPT® 93306 and should not be approved separately.

- Repeat echocardiography is not indicated if the initial echocardiogram is normal unless one of the following conditions is present:
  - Increased severity or change in quality of the chest pain
  - New signs or symptoms of cardiovascular disease other than pain
  - New abnormality on EKG

- Cardiac MR is indicated for chest pain if prior evaluation suggests any coronary artery abnormalities, cardiomyopathy, myocarditis or aortic dissection. Cardiac MR with stress if ischemia is suggested on prior evaluation.

**Background and Supporting Information**

Chest pain in pediatric individuals is caused by a cardiac etiology in <5% of cases, yet causes great anxiety for parents resulting in requests for testing.
References


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**PEDCD-5.1: Syncope**

- A recent (within 60 days) face-to-face evaluation including a detailed history, physical examination, EKG, and appropriate laboratory studies should be performed prior to considering advanced imaging.

- Echocardiography is not indicated for most individuals with isolated syncope.

- Echocardiography is indicated for pediatric individuals with syncope and one or more of the following:
  - Exertional syncope
  - Unexplained post-exertional syncope
  - Abnormal EKG
  - First-degree relative with any of the following before age 50:
    - Sudden cardiac arrest or death
    - Pacemaker or implantable defibrillator placement
  - First-degree relative with cardiomyopathy
  - Known congenital heart disease
  - History of Kawasaki disease, or other coronary pathology
  - Pathologic murmur, irregular rhythm, gallop, or click on physical examination

- Echocardiography is performed as part of the office visit. When evaluating an individual for the first time, it will not be known whether the individual has congenital heart disease or not. The cardiologist only submits charges for the procedure actually performed.

- The following echocardiography code combinations for evaluation of syncope:
  - CPT® 93303, CPT® 93306, CPT® 93320, and CPT® 93325
  - CPT® 93303, CPT® 93306
  - CPT® 93306
    - CPT® 93320 and CPT® 93325 are included with CPT® 93306 and should not be approved separately.

- Repeat echocardiography is not indicated if the initial echocardiogram is normal unless one of the following conditions is present:
  - Increased severity or change in quality of the syncope
  - New signs or symptoms of cardiovascular disease other than syncope
  - New abnormality on EKG

- Cardiac MR is indicated for syncope if prior evaluation suggests any coronary artery abnormalities, cardiomyopathy, myocarditis or aortic dissection. Cardiac MR with stress if ischemia is suggested on prior evaluation.

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**Background and Supporting Information**

Syncope in pediatric individuals is common, with up to 15% of individuals experiencing at least one episode by age 21. Syncope is caused by neurocardiogenic syndrome (vasovagal syncope) in 75 to 80% of cases, which is a benign and self-limiting condition. Despite this, syncope causes great anxiety for parents resulting in requests for testing.
References
### PEDCD-6: Kawasaki Disease

| PEDCD-6.1: Kawasaki Disease Initial Imaging          | 22 |
| PEDCD-6.2: Acute Phase                             | 22 |
| PEDCD-6.3: Chronic phase                           | 25 |
**PEDCD-6.1: Kawasaki Disease Initial Imaging**

- A recent (within 60 days) face-to-face evaluation including a detailed history, physical examination, and appropriate laboratory studies should be performed prior to considering advanced imaging.
- Scheduled indicated follow-up imaging does not require 60 day contact, if indicated based on the below follow-up schedule.
- Echocardiography (CPT® 93306) is indicated for initial assessment for suspected or known Kawasaki disease
  - Coronary CTA (CPT® 75574), Cardiac MRI without contrast (CPT® 75557), Cardiac MRI without and with contrast (CPT® 75561), or MRA Chest (CPT® 71555) is indicated for evaluation of inconclusive echocardiogram findings, or significant coronary artery abnormalities.
  - Screening of other body areas for aneurysms is not routinely indicated in Kawasaki disease, but MRA or CTA (contrast as requested) of the affected body area can be approved for evaluation of signs or symptoms suggesting aneurysm development.
  - See acute and chronic phase for imaging

**Background and Supporting Information**

- Kawasaki disease (KD) is the leading cause of acquired pediatric cardiac disease in the developed world. It is an acute febrile illness characterized by a medium vessel vasculitis, which predominantly affects the coronary arteries.
- Individuals who do not fulfill the diagnostic criteria for classic KD may be considered to have incomplete (atypical) KD.
- If Kawasaki disease is strongly suspected, treatment will often begin even before cardiac evaluation, since early treatment is associated with a lower risk for coronary aneurysm development.

**PEDCD-6.2: Acute Phase**

- Echocardiography should be performed when the diagnosis of KD is considered
  - Uncomplicated patients, echocardiography can be repeated after treatment both:
    - Within 1 to 2 weeks
    - Within 4 to 6 weeks
  - For patients with important and evolving coronary artery abnormalities (Z score >2.5) detected during the acute illness, more frequent echocardiography (at least twice per week) should be performed until luminal dimensions have stopped progressing to determine the risk for and presence of thrombosis.
  - Expanding large or giant aneurysms:
    - Twice per week while dimensions are expanding rapidly
    - Once weekly after dimension is stabilized for the first 45 days of illness
    - Then monthly until the third month after illness onset
It is reasonable to obtain advanced imaging studies such as computed tomographic angiography (CTA), cardiac magnetic resonance imaging (CMRI), or invasive angiography on patients’ severe proximal coronary artery abnormalities in the acute phase when results will impact management decisions.

Transesophageal echocardiography, invasive angiography, CMRI, and CTA can be of value in the assessment of selected patients but are not routinely indicated for diagnosis and management of the acute illness.

- Invasive angiography is rarely performed during the acute illness. Transesophageal echocardiography, CTA, and CMRI can be useful for the evaluation of older children and adolescents in whom visualization of the coronary arteries with transthoracic echocardiography is inadequate and results will impact immediate management decisions.

- These requests will be forwarded to Medical Director Review for evaluation.

Evaluation of potential aneurysmal involvement in other arterial beds can be assessed with CMRI, CTA, and, rarely, invasive angiography after recovery from the acute illness for patients with severe coronary artery involvement or symptoms or signs, such as the presence of a pulsatile axillary mass. All other requests during the acute phase will be forwarded for Medical Director Review.

Atypical or incomplete Kawasaki. Echo is indicated when atypical KD is being considered, may require repeat echocardiograms if treatment decisions will be affected by results (e.g., treating with ivig), if new signs or symptoms (such as typical peeling) develop.

**Background and Supporting Information**

The acute phase of Kawasaki disease (KD) can last up to 4-6 weeks from the onset of fever until acute systemic inflammation has resolved and coronary artery dimensions are no longer expanding.

Based on AHA recommendations, the following classifications are used in risk stratification of coronary artery abnormalities:

- **Z-Score classification** accounts for the effects of body size and age through use of baseline coronary dimensions adjusted for body surface area. The Z score value represents the number of standard deviation above the mean. (e.g., z=0 pt. has coronary artery dimension value equal to mean, z=2 person has value 2 standard deviation above the mean, based on age, gender, BSA).

- **Coronary Artery Abnormalities Risk Classification based on Z-Score:**
  - 1 No involvement at any time point (Z score always <2)
  - 2 Dilation only (Z score 2 to <2.5)
  - 3 Small aneurysm (Z score ≥2.5 to <5)
    - 3.1 Current or persistent
    - 3.2 Decreased to dilation only or normal luminal dimension
  - 4 Medium aneurysm (Z score ≥5 to <10, and absolute dimension <8 mm)
    - 4.1 Current or persistent
    - 4.2 Decreased to small aneurysm
    - 4.3 Decreased to dilation only or normal luminal dimension
5 Large and giant aneurysm (Z score ≥10, or absolute dimension ≥8 mm)
   5.1 Current or persistent
   5.2 Decreased to medium aneurysm
   5.3 Decreased to small aneurysm
   5.4 Decreased to dilation only or normal luminal dimension

Additional Clinical Features That May Increase the Long-Term Risk of Myocardial Ischemia
   Greater length and distal location of aneurysms that increase the risk of flow stasis
   Greater total number of aneurysms
   Greater number of branches affected
   Presence of luminal irregularities
   Abnormal characterization of the vessel wall (calcification, luminal myofibroblastic proliferation)
   Presence of functional abnormalities (impaired vasodilation, impaired flow reserve)
   Absence or poor quality of collateral vessels
   Previous revascularization performed
   Previous coronary artery thrombosis
   Previous myocardial infarction
   Presence of ventricular dysfunction

Reference
**PEDCD-6.3: Chronic phase**

- Long-term management begins at the end of the acute illness, usually at 4 to 6 weeks after fever onset. Management is based on two pieces of data:
  - The dimensions of the largest Aneurysm at any point during the disease
  - The dimensions of the largest current aneurysm

- Additional risk factors that may be considered for imaging:
  - Greater length and distal location of aneurysms that increase the risk of flow stasis
  - Greater total number of aneurysms
  - Greater number of branches affected
  - Presence of luminal irregularities
  - Abnormal characterization of the vessel wall (calcification, luminal myofibroblastic proliferation)
  - Presence of functional abnormalities (impaired vasodilation, impaired flow reserve)
  - Absence or poor quality of collateral vessels
  - Previous revascularization performed
  - Previous coronary artery thrombosis
  - Previous myocardial infarction
  - Presence of ventricular dysfunction
  - Long term routine surveillance in asymptomatic imaging for Kawasaki disease—see chart

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**Long term routine surveillance in asymptomatic imaging for Kawasaki disease**

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<tr>
<th>AHA risk level</th>
<th>largest aneurysm at any point</th>
<th>Largest current aneurysm</th>
<th>Routine echo</th>
<th>Routine stress imaging</th>
<th>Routine coronary imaging</th>
</tr>
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<tbody>
<tr>
<td>All</td>
<td></td>
<td></td>
<td>All risk levels 4-6 weeks after acute illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Normal</td>
<td>Normal</td>
<td>One echo 2-12 months after acute illness</td>
<td>None</td>
<td>None</td>
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<tr>
<td>2</td>
<td>Dilation</td>
<td>Dilation</td>
<td>6 months One year If dilation remains echo every 2-5 years until resolves</td>
<td>None</td>
<td>None</td>
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<tr>
<td></td>
<td>Normal</td>
<td></td>
<td>After acute illness: 2-12 months One echocardiogram at one year No echocardiogram after one year</td>
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<tr>
<td>3.1</td>
<td>Small</td>
<td>Small</td>
<td>6 months 12 months Then yearly</td>
<td>2-3 years</td>
<td>3-5 years</td>
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<tr>
<td>3.2</td>
<td>Small</td>
<td>Normal or dilated</td>
<td>6 months 12 months Then yearly</td>
<td>3-5 years</td>
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### Table: AHA Risk Level and Imaging Schedule

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<th>Routine echo</th>
<th>Routine stress imaging</th>
<th>Routine coronary imaging</th>
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<tr>
<td>4.1 Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>3 months</td>
<td>1-3 years</td>
<td>2-5 years</td>
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<td></td>
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<td>6 months</td>
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<td></td>
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<td>12 months</td>
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<td></td>
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<td>Every 6-12 months after that</td>
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<tr>
<td>4.2 Medium</td>
<td>Small</td>
<td>Small</td>
<td>6 months and 12 months, Every 1 year.</td>
<td>2-3 years</td>
<td>3-5 years</td>
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<tr>
<td>4.3 Medium</td>
<td>Normal or dilated</td>
<td>Normal or dilated</td>
<td>Every 1-2 yrs</td>
<td>2-4 years</td>
<td>None</td>
</tr>
<tr>
<td>5.1 Large</td>
<td>Large</td>
<td>Large</td>
<td>1 month</td>
<td>6-12 months</td>
<td>At 2-6 months, every 1-5 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>9 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Then every 3-6 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2 Large</td>
<td>Medium</td>
<td>Medium</td>
<td>Every 6-12 months</td>
<td>Yearly</td>
<td>2-5 years</td>
</tr>
<tr>
<td>5.3 Large</td>
<td>Small</td>
<td>Small</td>
<td>6-12 months</td>
<td>1-2 years</td>
<td>2-5 years</td>
</tr>
<tr>
<td>5.4 Large</td>
<td>Normal or dilation</td>
<td>Normal or dilation</td>
<td>1-2 years</td>
<td>2-5 years</td>
<td>None</td>
</tr>
</tbody>
</table>

- **Symptomatic individuals**
  - Echocardiogram can be performed at any time with new or progressing cardiac symptoms
  - Stress imaging when there are new or progressing symptoms of ischemia or ventricular dysfunction
  - Invasive or coronary imaging Coronary angiography (CT, MRI, invasive) when the above studies are positive, inconclusive, or otherwise lead to a conclusion that intervention is needed

References
A recent (within 60 days) face-to-face evaluation including a detailed history, physical examination, and appropriate laboratory studies should be performed prior to considering advanced imaging.

Chest x-ray, EKG, and echocardiography (CPT® 93306, or CPT® 93303 with CPT® 93320, and CPT® 93325, See PEDCD-8.1: Transthoracic Echocardiography (TTE) Coding for echocardiography coding considerations) for initial evaluation if pulmonary hypertension is suspected.

Repeat echocardiography intervals are variable depending on age of individual, etiology, and severity.
- After a comprehensive initial evaluation, echocardiograms using PH-specific protocols may be performed every 4 to 6 months.
- Echocardiography is indicated at any time for new or worsening symptoms or to evaluate a recent change in therapy.
- Right heart and/or left heart catheterization may be utilized for PAH individuals, including before and after initiation of PAH-targeted therapy, and for individuals with concomitant congenital heart disease.

CT Chest (CPT® 71250) may be indicated in addition to CTA Chest (CPT® 71275) or MRA Chest (CPT® 71555) for initial evaluation of all pediatric individuals with pulmonary hypertension to evaluate for pulmonary vascular or interstitial disease or other intrathoracic causes.

Cardiac MRI without and with contrast (CPT® 75561) is indicated for evaluation of inconclusive echocardiogram findings, or for monitoring right ventricular function during follow-up.

Stress echocardiograms may be indicated (as in adult guidelines) See CD-2.7: Stress Echocardiography – Indications, other than ruling out CAD in the Cardiac Imaging Guidelines.

**Background and Supporting Information**

Pulmonary hypertension in children can be caused by cardiac, pulmonary, or systemic diseases, and idiopathic disease occurs as well.
References
## PEDCD-8: Echocardiography - Other Indications

| PEDCD-8.1: Transthoracic Echocardiography (TTE) Coding | 32 |
| PEDCD-8.2: Initial Transthoracic Echocardiography (TTE) Indications | 33 |
| PEDCD-8.3: Repeat Transthoracic Echocardiography Indications | 34 |
| PEDCD-8.4: Transesophageal Echocardiography (TEE) | 34 |
**PEDCD-8.1: Transthoracic Echocardiography (TTE) Coding**

- CPT® codes for echocardiography are listed in **PEDCD-1: General Guidelines**

<table>
<thead>
<tr>
<th>Echocardiogram coding Notes</th>
<th>CPT®</th>
</tr>
</thead>
<tbody>
<tr>
<td>The most commonly performed study is a complete transthoracic echocardiogram with spectral and color flow Doppler (CPT® 93306).</td>
<td>93306</td>
</tr>
<tr>
<td>CPT® 93306 includes CPT® 93320 and CPT® 93325, so those codes should not be approved along with CPT® 93306.</td>
<td></td>
</tr>
<tr>
<td>Doppler codes (CPT® 93320, CPT® 93321, and CPT® 93325) are add-on codes and are assigned in addition to code for the primary procedure, and should not be approved alone.</td>
<td>+93320</td>
</tr>
<tr>
<td>+93321</td>
<td>+93325</td>
</tr>
<tr>
<td>For a 2D transthoracic echocardiogram without Doppler, report CPT® 93307.</td>
<td>93307</td>
</tr>
<tr>
<td>A limited transthoracic echocardiogram is reported with CPT® 93308.</td>
<td>93308</td>
</tr>
<tr>
<td>Limited transthoracic echocardiogram should be billed if the report does not &quot;evaluate or document the attempt to evaluate&quot; all of the required structures.</td>
<td></td>
</tr>
<tr>
<td>Unlike CPT® 93306, the Doppler CPT® 93321 and CPT® 93325 are not included with CPT® 93308.</td>
<td></td>
</tr>
<tr>
<td>CPT® 93321 (not CPT® 93320) should be reported with CPT® 93308 if Doppler is included in the study.</td>
<td></td>
</tr>
<tr>
<td>CPT® 93325 should also be reported with CPT® 93308 if color flow Doppler is included in the study.</td>
<td></td>
</tr>
<tr>
<td>For individuals with known congenital heart disease, a limited transthoracic echocardiogram is reported with CPT® 93304, +/- CPT® 93321 and CPT® 93325.</td>
<td>93304</td>
</tr>
</tbody>
</table>

- Providers performing an initial echo on a pediatric individual will not know what procedure codes they will be reporting until the initial study is completed.
  - If congenital heart disease is found on the initial echo, a complete echo is reported with codes CPT® 93303, CPT® 93320, and CPT® 93325 because CPT® 93303 does NOT include Doppler and color flow mapping.
  - If no congenital issue is discovered, then CPT® 93306 is reported alone and includes 2-D, Doppler and color flow mapping.

- Since providers may not know the appropriate code/s that will be reported at the time of the pre-authorization request, they may request multiple codes.
  - The following echocardiography code combinations for any initial echocardiogram:
    - CPT® 93303, CPT® 93306, CPT® 93320, and CPT® 93325
    - CPT® 93303, CPT® 9306
    - CPT® 93306
      - CPT® 93320 and CPT® 93325 are included with CPT® 93306 and should not be approved separately.
  - Post-service audits may be completed to ensure proper claims submission.
PEDCD-8.2: Initial Transthoracic Echocardiography (TTE) Indications

In addition to indications listed in previous guideline sections, initial TTE evaluation is indicated for any of the following:

- Any signs/symptoms that are possibly cardiac in nature, including (but not limited to) central cyanosis, dyspnea, edema, poor peripheral pulses, feeding difficulty, decreased urine output, hepatomegaly, or desaturation on pulse oximetry.
- Abnormal EKG or cardiac biomarkers
- Abnormal chest x-ray suggesting cardiovascular disease
- Palpitations and one of the following:
  - Abnormal EKG
  - First-degree relative with any of the following before age 50:
    - Sudden cardiac arrest or death
    - Pacemaker or implantable defibrillator placement
  - First-degree relative with cardiomyopathy
- Supraventricular Tachycardia (SVT), Ventricular Tachycardia, or Premature Ventricular Contractions (PVCs)
- Known or suspected valvular dysfunction
- Persistent systemic hypertension
- Obesity (BMI >30) with additional cardiovascular risk factors
- Stroke
- Renal failure
- Preoperative evaluation of individuals with chest wall deformities or scoliosis
- Known or suspected vascular ring
- Planned administration of cardiotoxic chemotherapy
  - Generally anthracyclines (doxorubicin, daunorubicin, mitoxantrone, idarubicin, epirubicin)
- Planned radiation therapy involving heart muscle or hematopoietic stem cell transplant
- Sickle cell disease or other hemoglobinopathy causing chronic anemia
- Known or suspected vasculitis, acute rheumatic fever, or other systemic autoimmune disease
- Muscular dystrophy
- Metabolic, mitochondrial, and storage disorders
- Abnormalities of cardiac or other viscera situs
- Signs, symptoms, or blood culture suggestive of endocarditis
- Known or suspected mass lesion involving heart or great vessels
- Known or suspected clot in atrium or ventricle
- Known or suspected pulmonary hypertension
- Known or suspected pericardial effusion
- Complications during prenatal development:
  - Known or suspected cardiovascular abnormality on fetal echocardiogram
  - Maternal phenylketonuria (PKU)
  - Maternal diabetes with no fetal echo
  - Maternal teratogen exposure
  - Maternal infection during pregnancy with potential cardiac sequelae
- Genetic abnormality known to be associated with cardiovascular disease
First-degree relative family history of:
- Unexplained sudden death before age 50
- Hypertrophic cardiomyopathy
- Non-ischemic dilated cardiomyopathy
- Genetic abnormality known to be associated with cardiovascular disease
- Congenital left-sided heart lesion
- Heritable pulmonary arterial hypertension

**PEDCD-8.3: Repeat Transthoracic Echocardiography Indications**

- Repeat echocardiograms may be required for individuals with no new symptoms.
- In addition to indications listed in previous guideline sections, repeat TTE evaluation is indicated for ANY of the following:
  - New or worsening symptoms in an individual with known cardiac disease, previously normal echocardiogram with one of the following:
    - New or worsening cardiac symptoms
    - New EKG abnormality
    - Newly recognized family history suggestive of heritable heart disease
  - Every 12 months for individuals age 12 to 18 years with first-degree family history of hypertrophic cardiomyopathy.
  - Individuals who are status post heart transplant can have echocardiograms repeated as often as requested by heart transplant team.
  - Every 12 months for individuals receiving active therapy for ventricular hypertrophy, valvular dysfunction, cardiomyopathy.
    - One time repeat TTE can be approved at 6 months to assess response to a change in therapy.
  - Every 12 months for individuals with chronic pericardial effusions
  - Every 12 months for sickle cell disease or other hemoglobinopathy causing chronic anemia and one of the following:
    - High risk genotype (Hgb SS or Sß0, severe thalassemia, etc.)
    - History of acute chest syndrome or intrinsic lung disease
    - History of stroke
    - Receiving chronic transfusion therapy
- As needed for monitoring cardiotoxicity during chemotherapy administration
- After completion of chemotherapy and/or radiation therapy. See [PEDONC-19.2: Cardiotoxicity and Echocardiography](#) for imaging guidelines.

**PEDCD-8.4: Transesophageal Echocardiography (TEE)**

- Transesophageal echocardiography imaging indications in pediatric individuals are identical to those for adult individuals. See [CD-2.5: Transesophageal Echocardiography (TEE)](#) in the Cardiac Imaging Guidelines.
References


## PEDCD-9: Cardiac MRI - Other Indications

| PEDCD-9.1: General Guidelines                  | 37 |
| PEDCD-9.2: Cardiac MRI - Coding               | 37 |
| PEDCD-9.3: Indications for Cardiac MRI         | 37 |
| PEDCD-9.4: Aortic Root and Aorta               | 39 |
| PEDCD-9.5: Evaluation of Pericardial Effusion or Diagnosis of Pericardial Tamponade | 39 |
**PEDCD-9.1: General Guidelines**

- Requests for Cardiac MRI that contain only one CPT® code can be completed by the Nurse Reviewer. If the request contains more than one cardiac/chest MRI CPT® code, it should be forwarded for Medical Director Review.

**PEDCD-9.2: Cardiac MRI - Coding**

<table>
<thead>
<tr>
<th>Cardiac MRI</th>
<th>CPT®</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac magnetic resonance imaging for morphology and function without contrast.</td>
<td>75557</td>
</tr>
<tr>
<td>Cardiac magnetic resonance imaging for morphology and function without and with contrast and further sequences.</td>
<td>75561</td>
</tr>
<tr>
<td>Cardiac magnetic resonance imaging for morphology and function without contrast; with stress imaging (rarely used in pediatrics).</td>
<td>75559</td>
</tr>
<tr>
<td>Cardiac magnetic resonance imaging for morphology and function without and with contrast and further sequences; with stress imaging (rarely used in pediatrics).</td>
<td>75563</td>
</tr>
<tr>
<td>Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure).</td>
<td>+75565</td>
</tr>
</tbody>
</table>

- Only one procedure code from the set: CPT® 75557, CPT® 75559, CPT® 75561, and CPT® 75563 should be reported per session.
- Only one flow velocity measurement (CPT® +75565) should be reported per session.

**PEDCD-9.3: Indications for Cardiac MRI**

- In addition to indications listed in previous guideline sections, Cardiac MRI evaluation is indicated for any of the following, when a recent TTE is inconclusive:
  - Assessment of global ventricular function and mass if a specific clinical question is left unanswered by recent TTE and the MRI results will affect management of the individual’s condition.
  - Individuals with complex congenital heart disease (e.g. Tetralogy of Fallot [TOF], single ventricle, truncus arteriosis, Transposition of the Great Arteries [TGA]) may require a baseline MRI, or routine Cardiac MRI, especially as they approach their teenage years, due to poor imaging windows on echocardiogram, and the need for specific clinical information not seen on prior echocardiograms due to these known limitations, and these studies should be forwarded for Medical Director Review. Once these individuals reach age 18, they can be imaged by adult congenital heart disease guideline.
  - Clinical suspicion of arrhythmogenic right ventricular dysplasia (ARVD) or arrhythmogenic cardiomyopathy (ARVC).
  - For pericardial disease (including constrictive pericarditis, restrictive pericarditis, and perimyocarditis), MRI should not be utilized to diagnose pericarditis but only to answer the question regarding possible constriction or restriction suggested clinically or by other techniques (TTE, etc.).
    - MRI without and with contrast (CPT® 75561) is considered the optimal test for this disorder.
  - Evaluate cardiac tumor or mass.
MRI without and with contrast (CPT® 75561) is considered the optimal test for this disorder.

- Evaluate anomalous coronary artery
  - MRI without and with contrast (CPT® 75561) or CCTA (CPT® 75574), after echocardiogram, is considered the optimal test for this disorder.
- For Fabry's disease, late enhancement MRI may predict the effect of enzyme replacement therapy on myocardial changes that occur with this disease.
  - MRI without and with contrast (CPT® 75561) is considered the preferred test for this disorder.
- For Cardiomyopathy, Cardiac MRI can be performed to evaluate individuals with congenital cardiomyopathy (muscular dystrophy, glycogen storage disease, fatty acid oxidation disorders, mitochondrial disorders, etc.) or unexplained cases of cardiomyopathy in order to characterize the myocardium.
- Cardiac stress perfusion study (CPT® 75559 or CPT® 75563) can be considered on a case by case basis for individuals with ANY of the following:
  - Anomalous coronary artery
  - Kawasaki disease
  - TGA
  - Ross operation
  - Other disorder with the potential for coronary ischemia
  - Individuals in whom an exercise stress test (EST) without imaging is indicated, but they cannot perform
  - Individuals in whom an exercise stress test (EST) is equivocal, positive, or concern for a false negative
- Assessment of cardiac iron overload such as in hemochromatosis, thalassemia, sickle cell (either CPT® 75557 or CPT® 71550, T2* MRI, contrast not necessary).
  - Screening imaging may be approved every 12 months
  - Imaging may be approved every 3 months for treatment response in individuals receiving active treatment (chelation +/- phlebotomy)
  - Frequently performed along with MRI Abdomen (CPT® 74181) to assess liver iron deposition. See PEDAB-19.2: Transfusion-Associated (Secondary) Hemochromatosis in the Abdomen Imaging Guidelines.
**PEDCD-9.4: Aortic Root and Aorta**

- For screening due to family history of aortic aneurysm or dissection, See PVD-2.2: Screening for Vascular Related Genetic Connective Tissue Disorders (Familial Aneurysm Syndromes/Spontaneous Coronary Artery Dissection (SCAD)/Ehlers-Danlos/Marfan/Loeys-Dietz) in the Peripheral Vascular Disease Imaging Guidelines.

- For individuals who have both cardiac and ascending aorta abnormalities (e.g., truncus arteriosus), the following studies may be indicated following TTE:
  - Cardiac MRI (CPT® 75557 or CPT® 75561) when TTE is inconclusive
  - MRI Chest (CPT® 71552) or MRA Chest (CPT® 71555) if aorta is involved.

- For individuals with aortic abnormalities without cardiac abnormalities, ANY of the following studies is indicated:
  - MRI Chest (CPT® 71552)
  - MRA Chest (CPT® 71555)

**PEDCD-9.5: Evaluation of Pericardial Effusion or Diagnosis of Pericardial Tamponade**

- Echocardiogram is the initial imaging study of choice to evaluate pericardial effusions or diagnose pericardial tamponade.

- If a specific clinical question is left unanswered by another recent imaging study and the answer to the clinical question will affect the management of the individual’s clinical condition, contrast-enhanced cardiac MRI is useful for evaluating:
  - Pericarditis,
  - Neoplastic effusion,
  - Tamponade,
  - Myocardial infiltration

- Cancers that can metastasize to the pericardium or myocardium and can cause a malignant effusion include lung, breast, renal cell, lymphoma and melanoma.

**References**


**PEDCD-10: CT Heart and Coronary Computed Tomography Angiography (CCTA) - Other Indications**

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
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<td>General Considerations</td>
<td>42</td>
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<tr>
<td>PEDCD-10.2</td>
<td>Anomalous Coronary Artery</td>
<td>42</td>
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<td>PEDCD-10.3</td>
<td>Indications for CCTA (CPT® 75574)</td>
<td>43</td>
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<td>Indications for Cardiac CT (CPT® 75572)</td>
<td>43</td>
</tr>
<tr>
<td>PEDCD-10.5</td>
<td>Radiation Dose</td>
<td>44</td>
</tr>
</tbody>
</table>
**PEDCD-10.1: General Considerations**

- Metal artifact reduces the accuracy of CCTA. Devices that can cause this issue include, but are not limited to:
  - Surgical clips
  - Pacemaker devices
  - Defibrillator devices
  - Tissue expanders
- Cardiac testing that does not involve exposure to ionizing radiation should be strongly considered.
- Contraindications to CCTA include:
  - Very obese individuals (body mass index > 40 kg/m²)
  - Elevated calcium score: CCTA should not be performed if there is extensive coronary calcification (calcium score > 1000).
  - Renal insufficiency
  - Inability to follow breath holding instructions

**PEDCD-10.2: Anomalous Coronary Artery**

- CCTA or Cardiac MRI is indicated for evaluating coronary artery anomalies and other complex congenital heart disease of cardiac chambers or great vessels.
  - Report CPT® 75574 for evaluating coronary artery anomalies
  - Report CPT® 75573 for congenital heart disease
  - CTA Chest (CPT® 71275) can be added to evaluate great vessels
- Congenital anomalies of the coronary arteries are an important cause of sudden death in pediatric individuals. Coronary arteries may arise from the wrong coronary artery cusp leading to ischemic changes during exercise. These lesions may be found incidentally during a murmur evaluation. Anomalous coronary arteries may be seen on echocardiogram during an evaluation for chest pain or syncope or palpitations. In addition individuals with no echocardiographic findings, but symptoms concerning for angina chest pain may require stress testing. Individuals who have positive echocardiographic findings, regardless of symptoms, and individuals who have classical typical angina chest pain regardless of echocardiographic findings, may require treadmill stress testing, stress imaging, of advanced imaging such as Cardiac MRI, Stress echocardiogram, PET, Cardiac CT, and/or cardiac catheterization.
- Individuals with congenital heart disease such as TOF, Truncus Arteriosus, and TGA have increased incidence of coronary artery anomalous and may require the above imaging as well
- Individuals with confirmed coronary artery anomalies may require repeat imaging based on the clinical scenario.
- CCTA to rule out anomalous coronary artery should be limited to one of the following:
  - Individuals who need to have an anomalous coronary artery mapped prior to an invasive procedure.
Individuals who have not had a previous imaging study that clearly demonstrates an anomalous coronary artery.
Individuals with a history that includes one or more of the indications in PEDCD-10.3: Indications for CCTA (CPT® 75574)

PEDCD-10.3: Indications for CCTA (CPT® 75574)

- In addition to indications listed in previous guideline sections, CCTA is indicated for any of the following, when a recent TTE and/or MRI is inconclusive:
  - Persistent exertional chest pain and normal stress test
  - Full sibling(s) with history of sudden death syndrome before age 30 or with documented anomalous coronary artery
  - Resuscitated sudden death and contraindication to conventional coronary angiography
  - Unexplained new onset of heart failure if CCTA will replace conventional invasive coronary angiography
  - Documented ventricular tachycardia (6 beat runs or greater) if CCTA will replace conventional invasive coronary angiography
  - Equivocal coronary artery anatomy on conventional cardiac catheterization
  - In infants: otherwise unexplained dyspnea, tachypnea, wheezing, episodic pallor, irritability, sweating, poor feeding, and/or failure to thrive
    - The presence of other congenital heart disease is not a separate indication for CCTA to rule out anomalous coronary artery (except when coronary artery surgery is pending, i.e. Transposition of the great arteries, Tetralogy of Fallot, Truncus arteriosus, aortic root surgery)
  - Evaluation of the arterial supply and venous drainage in children with bronchopulmonary sequestration

PEDCD-10.4: Indications for Cardiac CT (CPT® 75572)

- In addition to indications listed in previous guideline sections, CCTA is indicated for any of the following, when a recent TTE and/or MRI is inconclusive:
  - Cardiac or pericardial mass
  - Pericarditis
  - Complications of cardiac surgery or evaluation of post-operative anatomy
  - Cardiac thrombus in individuals with technically limited TTE, TEE, or MRI
  - Clinical suspicion of arrhythmogenic right ventricular dysplasia (ARVD) or arrhythmogenic cardiomyopathy (ARVC)
  - Native aortic abnormalities if echocardiogram is indeterminate
**PEDCD-10.5: Radiation Dose**

- ACR–NASCI–SPR Practice Parameter For The Performance And Interpretation Of Cardiac Computed Tomography (CT) states “Cardiac CT should be performed only for a valid medical indication and with the minimum radiation exposure that provides diagnostic image quality”

- ACR–NASCI–SPR Practice Parameter for the Performance of Quantification of Cardiovascular Computed Tomography (CT) And Magnetic Resonance Imaging (MRI) states “In younger patients, MRI may be the preferred modality, particularly when functional assessment with CT would require retrospective ECG gating and relatively high radiation doses. Further, the use of time-resolved MRA and phase contrast MRI methods offer significant advantages whose relative importance will depend on the specific application”


**References**


<table>
<thead>
<tr>
<th>PEDCD-11: Cardiac Catheterization</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEDCD-11.1: Cardiac Catheterization - General Information</td>
</tr>
<tr>
<td>PEDCD-11.2: Cardiac Catheterization - Indications</td>
</tr>
</tbody>
</table>
### PEDCD-11.1: Cardiac Catheterization - General Information

<table>
<thead>
<tr>
<th>Cardiac Cath Procedures</th>
<th>CPT®</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congenital Heart Disease Code “Set”</td>
<td>93530-93533</td>
</tr>
<tr>
<td>Right Heart Catheterization (CHD)</td>
<td>93530</td>
</tr>
<tr>
<td>Right/Left Heart Catheterization (CHD)</td>
<td>93531</td>
</tr>
<tr>
<td>Right/Left Heart Catheterization (CHD-TS)</td>
<td>93532</td>
</tr>
<tr>
<td>Right/Left Heart Catheterization (CAD-ASD)</td>
<td>93533</td>
</tr>
<tr>
<td>Anomalous coronary arteries, patent foramen ovale, mitral valve prolapse, and bicuspid aortic valve</td>
<td>93451-93464, 93566-93568</td>
</tr>
<tr>
<td>RHC without LHC or coronaries</td>
<td>93451</td>
</tr>
<tr>
<td>LHC without RHC or coronaries</td>
<td>93452</td>
</tr>
<tr>
<td>RHC and retrograde LHC without coronaries</td>
<td>93453</td>
</tr>
<tr>
<td>Native coronary artery catheterization;</td>
<td>93454</td>
</tr>
<tr>
<td>with bypass grafts</td>
<td>93455</td>
</tr>
<tr>
<td>with RHC</td>
<td>93456</td>
</tr>
<tr>
<td>with RHC and bypass grafts</td>
<td>93457</td>
</tr>
<tr>
<td>with LHC</td>
<td>93458</td>
</tr>
<tr>
<td>with LHC and bypass grafts</td>
<td>93459</td>
</tr>
<tr>
<td>with RHC and LHC</td>
<td>93460</td>
</tr>
<tr>
<td>with RHC and LHC and bypass grafts</td>
<td>93461</td>
</tr>
<tr>
<td>LHC by trans-septal or apical puncture</td>
<td>+93462</td>
</tr>
<tr>
<td>Angiography of non-coronary arteries and veins performed as a distinct service</td>
<td></td>
</tr>
</tbody>
</table>

CPT® 93530 to CPT® 93533 are appropriate for invasive evaluation of congenital heart disease

- These guidelines apply to individuals with stable conditions and who are not in the acute setting. Individuals in acute settings or with unstable angina should be handled as medical emergencies.
- Pediatric catheterizations are done for many purposes, including diagnosis and intervention of congenital and acquired heart disease.
- When device placement is planned (ASD/VSD device, transcatheter valve implantation, pda device), the procedure codes for those devices include all cardiac catheterization(s), intraprocedural contrast injection(s), fluoroscopic radiological supervision and interpretation, and imaging guidance performed to complete the procedure. For coarctation or aortic arch stenting, or other endovascular procedures with no intracardiac issues that require clarification by left heart cath, a left heart cath is not required along with these endovascular procedures. A right heart cath for pulmonary artery interventions (e.g., stents, coils).
PEDCD-11.2: Cardiac Catheterization - Indications

Diagnostic catheterization is indicated:

- When other advanced imaging has failed to resolve a clinical issue and results will impact individual management
- For preoperative assessment in complex heart disease
  - Norwood procedure
  - Bidirectional Glenn shunt
  - Fontan procedure
  - Pulmonary atresia
- Pulmonary hypertension
- With some interventions such as:
  - Valvuloplasty
  - Stents
- See PEDCD-6: Kawasaki Disease for specific intervals in Kawasaki Disease
- On an individual who is having a device placed when:
  - A diagnostic catheterization, or stenting is needed in addition to the device
  - The diagnostic catheterization is indicated separate from the device placement

References

# Procedure Codes Associated with Cardiac or PVD Imaging

<table>
<thead>
<tr>
<th>MRI/MRA</th>
<th>CPT®</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac magnetic resonance imaging for morphology and function without contrast material</td>
<td>75557</td>
</tr>
<tr>
<td>Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging</td>
<td>75559</td>
</tr>
<tr>
<td>Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences</td>
<td>75561</td>
</tr>
<tr>
<td>Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging</td>
<td>75563</td>
</tr>
<tr>
<td>Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure)</td>
<td>75565</td>
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<table>
<thead>
<tr>
<th>CT</th>
<th>CPT®</th>
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<tbody>
<tr>
<td>Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium</td>
<td>75571</td>
</tr>
<tr>
<td>Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)</td>
<td>75572</td>
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<tr>
<td>Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)</td>
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<tr>
<td>Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission, analysis of fluid dynamics and simulated maximal coronary hyperemia, generation of estimated FFR model, with anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report</td>
<td>0501T</td>
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<tr>
<td>Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission</td>
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<td>Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; analysis of fluid dynamics and simulated maximal coronary hyperemia, and generation of estimated FFR model</td>
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<tr>
<td>Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report</td>
<td>0504T</td>
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<tr>
<td>Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)</td>
<td>75574</td>
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<tr>
<td>Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing</td>
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<table>
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<tr>
<th>Ultrasound</th>
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<tr>
<td>Transthoracic echocardiography for congenital cardiac anomalies; complete</td>
<td>93303</td>
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<tr>
<td>Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study</td>
<td>93304</td>
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<tr>
<td>Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography</td>
<td>93306</td>
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<tr>
<td>Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography</td>
<td>93307</td>
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<td>Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study</td>
<td>93308</td>
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<tr>
<td>Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report</td>
<td>93312</td>
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<tr>
<td>Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only</td>
<td>93313</td>
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<tr>
<td>Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only</td>
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<tr>
<td>Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report</td>
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<tr>
<td>Transesophageal echocardiography (TEE) for congenital cardiac anomalies; placement of transesophageal probe only</td>
<td>93316</td>
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<tr>
<td>Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only</td>
<td>93317</td>
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<tr>
<td>Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete</td>
<td>93320</td>
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<tr>
<td>Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study (List separately in addition to codes for echocardiographic imaging)</td>
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<tr>
<td>Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)</td>
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<tr>
<td>Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report</td>
<td>93350</td>
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<tr>
<td>Procedure</td>
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<td>---------------------------------------------------------------------------</td>
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<tr>
<td>Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional</td>
<td>93351</td>
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<tr>
<td>Use of echocardiographic contrast agent during stress echocardiography (List separately in addition to code for primary procedure)</td>
<td>+ 93352</td>
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<tr>
<td>Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; complete</td>
<td>C8921</td>
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<tr>
<td>Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; follow-up or limited study</td>
<td>C8922</td>
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<tr>
<td>Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color doppler echocardiography</td>
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<tr>
<td>Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording when performed, follow-up or limited study</td>
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<tr>
<td>Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report</td>
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<tr>
<td>Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report</td>
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<tr>
<td>Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report</td>
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<td>Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral doppler echocardiography, and with color flow doppler echocardiography</td>
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<tr>
<td>Transthoracic echocardiography, with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision</td>
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<tr>
<td>Myocardial strain imaging (quantitative assessment of myocardial mechanics using image-based analysis of local myocardial dynamics) (List separately in addition to code for primary procedure)</td>
<td>+ 0399T</td>
</tr>
<tr>
<td>Myocardial contrast perfusion echocardiography, at rest or with stress, for assessment of myocardial ischemia or viability (List separately in addition to code for primary procedure)</td>
<td>+ 0439T</td>
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<tr>
<td>Cardiac Catheterization Procedure Codes</td>
<td>Codes</td>
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<tr>
<td>Right Heart Catheterization (CHD)</td>
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<tr>
<td>Right/Left Heart Catheterization (CHD)</td>
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<tr>
<td>Right/Left Heart Catheterization (CHD-TS)</td>
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<tr>
<td>Right/Left Heart Catheterization (CAD-ASD)</td>
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<tr>
<td>RHC without LHC or coronaries</td>
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<tr>
<td>LHC without RHC or coronaries</td>
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<tr>
<td>RHC and retrograde LHC without coronaries</td>
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<tr>
<td>Native coronary artery catheterization;</td>
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<tr>
<td>with bypass grafts</td>
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<tr>
<td>with RHC</td>
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<tr>
<td>with RHC and bypass grafts</td>
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<tr>
<td>with LHC</td>
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<tr>
<td>with LHC and bypass grafts</td>
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<tr>
<td>with RHC and LHC</td>
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<tr>
<td>with RHC and LHC and bypass grafts</td>
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<tr>
<td>LHC by transseptal or apical puncture</td>
<td>+93462</td>
</tr>
</tbody>
</table>