



CLINICAL GUIDELINES

Cardiac Imaging Guidelines

Version 2.0

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eviCore healthcare Clinical Decision Support Tool Diagnostic Strategies: This tool addresses common symptoms and symptom complexes. Imaging requests for individuals with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist and/or individual's Primary Care Physician (PCP) may provide additional insight.

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Abbreviations for Cardiac Imaging Guidelines

ACC	American College of Cardiology
ACS	acute coronary syndrome
AHA	American Heart Association
ASCOT	Anglo-Scandinavian Cardiac Outcomes Trial
ASD	atrial septal defect
BMI	body mass index
CABG	coronary artery bypass grafting
CAD	coronary artery disease
CHF	congestive heart failure
COPD	chronic obstructive pulmonary disease
CT	computed tomography
CCTA	coronary computed tomography angiography
CTA	computed tomography angiography
EBCT	electron beam computed tomography
ECP	external counterpulsation (also known as EECP)
ECG	electrocardiogram
ECP	external counterpulsation
ETT	exercise treadmill stress test
FDG	Fluorodeoxyglucose, a radiopharmaceutical used to measure myocardial metabolism
HCM	hypertrophic cardiomyopathy
IV	intravenous
LAD	left anterior descending coronary artery
LDL-C	low density lipoprotein cholesterol
LHC	left heart catheterization
LV	left ventricle
LVEF	left ventricular ejection fraction
MI	myocardial infarction
MPI	myocardial perfusion imaging (SPECT study, nuclear cardiac study)
MRA	magnetic resonance angiography
MRI	magnetic resonance imaging
mSv	millisievert (a unit of radiation exposure) equal to an effective dose of a joule of energy per kilogram of recipient mass
MUGA	multi gated acquisition scan of the cardiac blood pool
PCI	percutaneous coronary intervention (includes percutaneous coronary angioplasty (PTCA) and coronary artery stenting)
PET	positron emission tomography
PTCA	percutaneous coronary angioplasty

RHC	right heart catheterization
SPECT	single photon emission computed tomography
TEE	transesophageal echocardiogram
TIA	Transient Ischemic Attack
VSD	ventricular septal defect

Glossary

Agatston Score: a nationally recognized calcium score for the coronary arteries based on Hounsfield units and size (area) of the coronary calcium

Angina: principally chest discomfort, exertional (or with emotional stress) and relieved by rest or nitroglycerine

Anginal variants or equivalents: a manifestation of myocardial ischemia which is perceived by patients to be (otherwise unexplained) dyspnea, unusual fatigue, more often seen in women and may be unassociated with chest pain

ARVD/ARVC – Arrhythmogenic Right Ventricular Dysplasia/Cardiomyopathy: a potentially lethal inherited disease with syncope and rhythm disturbances, including sudden death, as presenting manifestations

BNP: B-type natriuretic peptide, blood test used to diagnose and track heart failure (n-T-pro-BNP is a variant of this test)

Brugada Syndrome: an electrocardiographic pattern that is unique and might be a marker for significant life-threatening dysrhythmias

Double Product (Rate Pressure Product): an index of cardiac oxygen consumption, is the systolic blood pressure times heart rate, generally calculated at peak exercise; over 25000 means an adequate stress load was performed

Fabry's Disease: an infiltrative cardiomyopathy, can cause heart failure and arrhythmias

Hibernating myocardium: viable but poorly functioning or non-functioning myocardium which likely could benefit from intervention to improve myocardial blood supply

Optimized Medical Therapy should include (where tolerated): antiplatelet agents, calcium channel antagonists, partial fatty acid oxidase inhibitors (e.g. ranolazine), statins, short-acting nitrates as needed, long-acting nitrates up to 6 months after an acute coronary syndrome episode, beta blocker drugs (optional), angiotensin-converting enzyme (ACE) inhibitors/angiotensin receptor blocking (ARB) agents (optional)

Platypnea: shortness of breath when upright or seated (the opposite of orthopnea) and can indicate cardiac malformations, shunt or tumor

Silent ischemia: cardiac ischemia discovered by testing only and not presenting as a syndrome or symptoms

Syncope: loss of consciousness; near-syncope is not syncope

Takotsubo cardiomyopathy: apical dyskinesia oftentimes associated with extreme stress and usually thought to be reversible

Troponin: a marker for ischemic injury, primarily cardiac

CD-1: General Guidelines

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Practice Estimate of Effective Radiation Dose chart for Selected Imaging Studies

Imaging Study	Estimate of Effective Radiation Dose
Sestamibi myocardial perfusion study (MPI)	9-12 mSv
PET myocardial perfusion study:	
Rubidium-82	3 mSv
NH3	2 mSv
Thallium myocardial perfusion study (MPI)	22-31 mSv
Diagnostic conventional coronary angiogram (cath)	5-10 mSv
Computed tomography coronary angiography (CTCA) (with prospective gating)	5-15 mSv Less than 5 mSv
CT of Abdomen and pelvis	8-14 mSv
Chest x-ray	<0.1 mSv

CD-1.0: General Guidelines

- A current clinical evaluation (within 60 days) is required prior to considering advanced imaging, which includes:
 - ◆ Relevant history and physical examination and appropriate laboratory studies and non-advanced imaging modalities, such as recent ECG (within 60 days), chest x-ray or ECHO/ultrasound, after symptoms started or worsened.
 - Effort should be made to obtain copies of reported “abnormal” ECG studies in order to determine whether the ECG is uninterpretable for ischemia on ETT
 - Most recent previous stress testing and its findings should be obtained
 - Other meaningful contact (telephone call, electronic mail or messaging) by an established patient can substitute for a face-to-face clinical evaluation.
 - ◆ Vital signs, height, and weight or BMI or description of general habitus is needed.
 - ◆ Advanced imaging should answer a clinical question which will affect management of the patient's clinical condition.
- Cardiac imaging is not indicated if the results will not affect patient management decisions. If a decision to perform cardiac catheterization or other angiography has already been made, there is often no need for imaging stress testing
- Assessment of ischemic symptoms can be determined by **Table-1**:

Table-1

Pre-Test Probability of CAD by Age, Sex, and Symptoms					
Age (years)	Sex	Typical / Definite Angina Pectoris	Atypical / Probable Angina Pectoris	Non- anginal Chest Pain	Asymptomatic
39 and younger	Men	Intermediate	Intermediate	Low	Very low
	Women	Intermediate	Very low	Very low	Very low
40 - 49	Men	High	Intermediate	Intermediate	Low
	Women	Intermediate	Low	Very low	Very low
50 - 59	Men	High	Intermediate	Intermediate	Low
	Women	Intermediate	Intermediate	Low	Very low
60 and over	Men	High	Intermediate	Intermediate	Low
	Women	High	Intermediate	Intermediate	Low
High	Greater than 90% pre-test probability				
Intermediate	Between 10% and 90% pre-test probability				
Low	Between 5% and 10% pre-test probability				
Very Low	Less than 5% pre-test probability				

- For purposes in this guideline ischemic symptoms can be defined as the following:
 - ◆ Typical angina (definite):
 - Angina pectoris is classified as typical when all of the following are present:
 - Substernal chest discomfort (generally described as pressure, heaviness, burning, or tightness)
 - Brought on by exertion or emotional stress
 - Relieved by rest or nitroglycerin
 - May radiate to the left arm or jaw
 - When clinical information is received indicating that a patient is experiencing chest pain that is "exertional" or "due to emotional stress" and relieved with rest, this meets the typical angina definition under the Pre-Test Probability Grid. No further description of the chest pain is required (location within the chest is not required).
 - The Pre-Test Probability Grid (**Table-1**) is based on age, sex, and symptoms. All factors must be considered in order to approve for stress testing with imaging using the Pre-Test Probability Grid.

- ◆ Atypical angina (probable):
 - Chest pain or discomfort (arm or jaw pain) that lacks one of the characteristics of definite or typical angina.
 - DOE can be considered
- ◆ Non-anginal chest pain:
 - Chest pain or discomfort that meets one or none of the typical angina characteristics.
- ◆ Anginal equivalents:
 - Symptoms consistent with patient's known angina pattern in an individual with a history of CABG or PCI.
- Other signs and symptoms suggestive of potential cardiac etiology:
 - ◆ Dyspnea
 - ◆ Orthopnea
 - ◆ Paroxysmal nocturnal dyspnea
 - ◆ Dependent Edema
 - ◆ Palpitations
 - ◆ Syncope
 - ◆ Heart failure
 - ◆ Murmur
- For the purpose of this guideline, evidence documenting the presence of CAD includes any of the following:
 - ◆ Prior heart catheterization or CCTA showing obstructive coronary stenosis defined as any of the following:
 - $\geq 50\%$ stenosis of the left main coronary artery
 - $\geq 70\%$ stenosis for other coronary arteries
 - Significant stenosis defined by an FFR of <0.80
 - ◆ Documentation of a prior MI with either:
 - Presence of diagnostic Q waves on an ECG
 - A fixed perfusion defect on MPI
 - Akinetic or dyskinetic wall motion on echocardiogram
 - Area of Late Gadolinium Enhancement (LGE) on cardiac MRI suggesting scar
 - ◆ History of a prior PCI or CABG
- Findings that may alter the ECG changes during exercise or are uninterpretable for ischemia on a stress test:
 - ◆ Complete Left Bundle Branch Block (bifascicular block involving right bundle branch and left anterior hemiblock does not render ECG uninterpretable for ischemia)
 - ◆ Ventricular paced rhythm
 - ◆ Pre-excitation pattern such as Wolff-Parkinson-White
 - ◆ Greater or equal to 1.0 mm ST segment depression (NOT nonspecific ST/T wave changes)
 - ◆ LVH with repolarization abnormalities, also called LVH with strain (NOT without repolarization abnormalities or by voltage criteria)

- ◆ T wave inversion in the inferior and/or lateral leads. This includes leads II, AVF, V5 or V6. (T wave inversion isolated in lead III or T wave inversion in lead V1 and V2 are not included).
- ◆ Patient on digitalis preparation

CD-1.2: Stress Testing without Imaging – Procedures

The Exercise Treadmill Test (ETT) is without imaging.

- Necessary components of an ETT include:
 - ◆ ECG that can be interpreted for ischemia.
 - ◆ Patient capable of exercise on a treadmill or similar device (generally at 4 METs or greater; see functional capacity below).
- An abnormal ETT (exercise treadmill test) includes any one of the following:
 - ◆ ST segment depression (usually described as horizontal or downsloping, greater or equal to 1.0 mm below baseline)
 - ◆ Development of chest pain
 - ◆ Significant arrhythmia (especially ventricular arrhythmia)
 - ◆ Hypotension during exercise
- Functional capacity greater than or equal to 4 METs equates to the following:
 - ◆ Can walk four blocks without stopping
 - ◆ Can walk up a hill
 - ◆ Can climb one flight of stairs without stopping
 - ◆ Can perform heavy work around the house

Practice Note

An observational study found that, compared with the Duke Activity Status Index, subjective assessment by clinicians generally underestimated exercise capacity

CD-1.3: Stress Testing with Imaging – Procedures

- Imaging Stress Tests include any one of the following:
 - ◆ Stress Echocardiography see **CD-2.6: Stress Echocardiography (Stress Echo) – Coding**
 - ◆ MPI see **CD-3.1: Myocardial Perfusion Imaging (MPI) – Coding**
 - ◆ Stress perfusion MRI see **CD-5.3: Cardiac MRI – Indications for Stress MRI**
- Stress testing with imaging can be performed with maximal exercise or chemical stress (adenosine, dipyridamole, dobutamine, or regadenoson) and does not alter the CPT® codes used to report these studies.

CD-1.4: Stress Testing with Imaging – Indications

➤ Stress echo, MPI or stress MRI, can be considered if there are **new, recurrent, or worsening** symptoms consistent with ischemia and **any** of the following:

- ◆ High pretest probability (greater than 90% probability of CAD) per **Table-1**
- ◆ A history of CAD as defined in **CD-1.0: General Guidelines**
- ◆ Evidence of ventricular tachycardia

High suspicion of ventricular tachycardia such as unheralded syncope (not near syncope)

- ◆ Age 40 years or greater and known diabetes mellitus
- ◆ Coronary calcium score ≥ 100
- ◆ Poorly controlled hypertension defined as systolic BP greater than or equal to 180mmhg, if provider feels strongly that CAD needs evaluation prior to BP being controlled.
- ◆ ECG is uninterpretable for ischemia due to any one of the following:
 - Complete Left Bundle Branch Block (bifascicular block involving right bundle branch and left anterior hemiblock does not render ECG uninterpretable for ischemia)
 - Ventricular paced rhythm
 - Pre-excitation pattern such as Wolff-Parkinson-White
 - Greater or equal to 1.0 mm ST segment depression (NOT nonspecific ST/T wave changes)
 - LVH with repolarization abnormalities, also called LVH with strain (NOT without repolarization abnormalities or by voltage criteria)
 - T wave inversion in the inferior and/or lateral leads. This includes leads II, AVF, V5 or V6. (T wave inversion isolated in lead III or T wave inversion in lead V1 and V2 are not included).
 - Patient on digitalis preparation
- ◆ Continuing symptoms in a patient who had a normal or submaximal exercise treadmill test and there is suspicion of a false negative result.
- ◆ Patients with recent equivocal, borderline, or abnormal stress testing where ischemia remains a concern
- ◆ Heart rate less than 50 bpm in patients, including those on beta blocker, calcium channel blocker, or amiodarone, where it is felt that the patient may not achieve an adequate workload for a diagnostic exercise study.
- ◆ Inability to safely use a treadmill or exercise bicycle, for example, the need for ambulatory assistance (wheelchair, cane, walker, etc.) or significant neurologic or orthopedic issue
- ◆ Inadequate ETT:
 - Physical (musculoskeletal or neurological) inability to achieve target heart rate (85% MPPHR or 220-age. Target heart rate is calculated as 85% of the maximum age predicted heart rate (MPPHR). MPPHR is estimated as 220 minus the patient's age.
 - History of false positive exercise treadmill test: a false positive ETT is one that is abnormal however the abnormality does not appear to be due to macrovascular CAD.

- Stress echo, MPI or stress MRI, can be considered regardless of symptoms for **any** of the following:
 - ◆ Within 3 months of an acute coronary syndrome (e.g. ST segment elevation MI [STEMI], unstable angina, non-ST segment elevation MI [NSTEMI]), one imaging stress test can be performed to evaluate for inducible ischemia if all of the following related to the most recent acute coronary event apply:
 - Individual is hemodynamically stable
 - No recurrent chest pain symptoms and no signs of heart failure
 - No prior coronary angiography or imaging stress test since the current episode of symptoms
 - ◆ Assessing myocardial viability in patients with significant ischemic ventricular dysfunction (suspected hibernating myocardium) and persistent symptoms or heart failure such that revascularization would be considered.
 - MRI, cardiac PET, MPI, or Dobutamine stress echo can be used to assess myocardial viability depending on physician preference.
 - See **CD-6.4: Cardiac PET – Metabolic – Indications**.
 - ◆ Asymptomatic patient with an uninterpretable ECG as described in **CD 1.0: General Guidelines** that either:
 - Has never been evaluated
 - Is a new uninterpretable change
 - ◆ Patient with an elevated cardiac troponin.
 - ◆ One routine study 2 years or more after a stent
 - Except with a left main stent where it can be done at 1 year.
 - ◆ One routine study at 5 years or more after CABG, without cardiac symptoms.
 - ◆ Every 2 years if there was documentation of previous “silent ischemia” on the imaging portion of a stress test but not on the ECG portion.
 - ◆ To assess for CAD prior to starting a Class IC antiarrhythmic agent (flecainide or propafenone) and annually while taking the medication.
 - ◆ Prior to starting Interleukin-2
 - ◆ Prior anatomic imaging study (coronary angiogram or CCTA) demonstrating coronary stenosis in the proximal or mid-portion of a major coronary branch, which is of uncertain functional significance, can have one stress test with imaging.
- Evaluating new, recurrent, or worsening left ventricular systolic dysfunction
- Cardiac perfusion PET (CPT® 78430, 78431, 78491, 78492) can be considered in place of stress echo, MPI, or stress MRI when any of the indications for stress testing with imaging have been met and there is documentation of either:
 - ◆ Individual is severely obese (for example BMI ≥ 40 kg/m²) or
 - ◆ Individual has large breasts or implants
 - ◆ See also **CD-6.2: Cardiac PET – Perfusion – Indications** for additional indications for cardiac PET perfusion

CD-1.5: Stress Testing with Imaging – Preoperative

- There are **2** steps that determine the need for imaging stress testing in (stable) pre-operative patients:
 - ◆ Step 1: Would the patient qualify for imaging stress testing independent of planned surgery?
 - If yes, proceed to stress testing guidelines **CD-1.4: Stress Testing with Imaging – Indications**
 - If no, go to step 2
 - ◆ Step 2: Is the surgery considered high, moderate or low risk? (see **Table-2**) If high or moderate-risk, proceed below. If low-risk, there is no evidence to determine a need for preoperative cardiac testing.
 - **High Risk Surgery**: All patients in this category should receive an imaging stress test if there has not been an imaging stress test within 1 year* unless the patient has developed new cardiac symptoms or a new change in the EKG since the last stress test.
 - **Intermediate Surgery**: One or more risk factors and unable to perform an ETT per guidelines if there has not been an imaging stress test within 1 year* unless the patient has developed new cardiac symptoms or a new change in the EKG since the last stress test.
 - **Low Risk**: Preoperative imaging stress testing is not supported.
 - ◆ Clinical Risk Factors (for cardiac death & non-fatal MI at time of non-cardiac surgery)
 - Planned high-risk surgery (open surgery on the aorta or open peripheral vascular surgery)
 - History of ischemic heart disease (previous MI, previous positive stress test, use of nitroglycerin, typical angina, ECG Q waves, previous PCI or CABG)
 - History of compensated previous congestive heart failure (history of heart failure, previous pulmonary edema, third heart sound, bilateral rales, chest x-ray showing heart failure)
 - History of previous TIA or stroke
 - Diabetes Mellitus
 - Creatinine level > 2 mg/dL

*Time interval is based on consensus of eviCore executive cardiology panel.

Table-2

Cardiac Risk Stratification List		
High Risk (> 5%)	Intermediate Risk (1-5%)	Low Risk (<1%)
➤ Open aortic and other major open vascular surgery ➤ Open peripheral vascular surgery	➤ Open intraperitoneal and/or intrathoracic surgery ➤ Open carotid endarterectomy ➤ Head and neck surgery ➤ Open orthopedic surgery ➤ Open prostate surgery	➤ Endoscopic procedures ➤ Superficial procedures ➤ Cataract surgery ➤ Breast surgery ➤ Ambulatory surgery ➤ Laparoscopic and endovascular procedures that are unlikely to require further extensive surgical intervention

CD-1.6: Transplant Patients

- Stress Testing in patients for Non-Cardiac Transplant
 - ◆ Individuals who are candidates for any type of organ, bone marrow, or stem cell transplant can undergo imaging stress testing every year (usually stress echo or MPI) prior to transplant.
 - ◆ Individuals who have undergone organ transplant are at increased risk for ischemic heart disease secondary to their medication. Risk of vasculopathy is 7% at one year, 32% at five years and 53% at ten years. An imaging stress test can be repeated annually after transplant for at least two years or within one year of a prior cardiac imaging study if there is evidence of progressive vasculopathy.
 - ◆ After two consecutive normal imaging stress tests, repeated testing is not supported more often than every other year without evidence for progressive vasculopathy or new symptoms.
 - ◆ Stress testing after five years may proceed according to normal patterns of consideration.
- Post-Cardiac transplant assessment of transplant CAD:
 - ◆ One of the following imaging studies may be performed annually:
 - MPI
 - Stress ECHO
 - Stress MRI
 - Cardiac PET perfusion

CD-1.7: Non-imaging Heart Function and Cardiac Shunt Imaging

- Procedures reported with CPT® 78414 and CPT® 78428 are essentially obsolete and should not be performed in lieu of other preferred modalities.
- Echocardiogram is the preferred method for cardiac shunt detection, rather than the cardiac shunt imaging study described by CPT® 78428.
- Ejection fraction can be obtained by echocardiogram, MPI, MUGA study, cardiac MRI, cardiac CT, or cardiac PET depending on the clinical situation, rather than by the non-imaging heart function study described by CPT® 78414.

CD-1.8: Genetic lab testing in the evaluation of CAD

- Corus® CAD genetic expression score – refer to lab management program guidelines

CD-1.9: CAD Risk factor modification

- Risk factor modification
 - ◆ Statins remain the mainstay of medical treatment for cardiovascular risk reduction with an abundance of scientific evidence regarding their efficacy.
 - ◆ PCSK9 drugs are a new addition to the treatment of hyperlipidemia
 - Refer to specialty drug coverage criteria for these drugs.

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CD-2: Echocardiography (ECHO)

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CD-2.1: Transthoracic Echocardiography (TTE) – Coding

TTE CODES		
Transthoracic Echocardiography		CPT®
TTE for congenital cardiac anomalies, complete		93303
TTE for congenital cardiac anomalies, follow-up or limited		93304
TTE with 2-D, M-mode, Doppler and color flow, complete		93306
TTE with 2-D, M-mode, without Doppler or color flow		93307
TTE with 2-D, M-mode, follow-up or limited		93308
Doppler Echocardiography		CPT®
Doppler echo, pulsed wave and/or spectral display		+93320*
Doppler echo, pulsed wave and/or spectral display, follow-up or limited study		+93321*
Doppler echo, color flow velocity mapping		+93325
*CPT® 93320 and CPT® 93321 should not be requested or billed together		
Transthoracic Echocardiography		CPT®
C8921	TTE for congenital cardiac anomalies, complete	93303
C8922	TTE for congenital cardiac anomalies, follow-up or limited	93304
C8929	TTE with 2-D, M-mode, Doppler and color flow, complete	93306
C8923	TTE with 2-D, M-mode, without Doppler or color flow	93307
C8924	TTE with 2-D, M-mode, follow-up or limited	93308
C codes are unique temporary codes established by CMS. C codes were established for contrast echocardiography. Each echocardiography C code corresponds to a standard echo code (Class I CPT code) The C code and the matching CPT code should not both be approved.		
Myocardial strain imaging		
Myocardial strain imaging using speckle tracking-derived assessment of myocardial mechanics (List separately in addition to codes for echocardiography imaging)		+93356
Investigational Codes		
0439T	Myocardial contrast perfusion echocardiography, at rest or with stress, for assessment of myocardial ischemia or viability	Investigational

CD-2.1.1: Transthoracic Echocardiography (TTE) – Coding - General Information

- The most commonly performed study is a complete transthoracic echocardiogram with spectral and color flow Doppler (CPT® 93306).
 - ◆ CPT® 93306 includes the Doppler exams, so CPT® codes 93320-93325 should **not** be assigned together with CPT® 93306.
 - ◆ Doppler codes (CPT® 93320, CPT® 93321, and CPT® 93325) are ‘add-on codes’ (as denoted by the + sign) and are assigned in addition to code for the primary procedure.
- For a 2D transthoracic echocardiogram without Doppler, report CPT® 93307.
- Limited transthoracic echocardiogram should be billed if the report does not “evaluate or document the attempt to evaluate” all of the required structures.
 - ◆ A limited transthoracic echocardiogram is reported with CPT® 93308.

- ◆ CPT® 93321 (not CPT® 93320) should be reported with CPT® 93308 if Doppler is included in the study. CPT® 93325 can be reported with CPT® 93308 if color flow Doppler is included in the study.
- ◆ A limited congenital transthoracic echocardiogram is reported with CPT® 93304.
- Doppler echo may be used for evaluation of the following:
 - ◆ Shortness of breath
 - ◆ Known or suspected valvular disease
 - ◆ Known or suspected hypertrophic obstructive cardiomyopathy
 - ◆ Shunt detection

Practice Notes

- Providers performing echo on a pediatric patient, may not know what procedure codes they will be reporting until the initial study is completed.
- If a congenital issue 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 all 4 codes (CPT® 93303, CPT® 93320, CPT® 93325, and CPT® 93306).
- Depending upon individual health plan payer contracts, post-service audits may be completed to ensure proper claims submission.
- CPT® 76376 and CPT® 76377 are not unique to 3D Echo. These codes also apply to 3D rendering of MRI and CT studies, see **CD-2.8: 3D Echocardiography – Coding**
- CPT® 93325 may also be used with fetal echocardiography.

CD-2.2: Transthoracic Echocardiography (TTE) – Indications

- TTE can be performed for the following:
 - ◆ Initial evaluation of new or worsening cardiac signs or symptoms, including, but not limited to:
 - Dyspnea
 - Chest pain
 - Palpitations
 - Syncope
 - Heart failure
 - Murmur
 - ◆ Hypertension – can be done once with initial evaluation
 - ◆ Initial evaluation of new signs or symptoms of cerebral ischemia or peripheral embolic event
 - ◆ Valve function and structure:

- Initial evaluation if history and/or physical examination suggest significant valvular disorder
- ◆ Ventricular function assessment including, but not limited to the following:
 - Initial evaluation-prior to treatment with (either):
 - Medications that could result in cardiotoxicity/heart failure
 - Radiation that could result in cardiotoxicity/heart failure
 - see also: **CD-12.1: Oncologic Indications for Cancer Therapeutics-Related Cardiac Dysfunction (CTRCD)**
 - Post myocardial infarction can be done once in follow-up. This should not be done less than 6 weeks post MI
- ◆ Evaluation prior to ICD/CRT placement, while establishing 3 months of optimal medical therapy
- ◆ Cardiac structure: an echocardiogram can be done to assess cardiac structure when there are new or worsening cardiac signs or symptoms, suggesting disorders such as, but not limited to:
 - Infiltrative diseases (e.g. sarcoid, amyloid)
 - Ventricular septal defect (VSD)
 - Papillary muscle rupture/dysfunction
 - Hypertrophy including:
 - asymmetric septal hypertrophy
 - spade heart
 - hypertensive concentric hypertrophy
 - infiltrative hypertrophy
 - pacemaker insertion complication
 - pericardial effusion
 - cardiac injury due to blunt chest trauma
- ◆ Cardiac Defects or Masses
 - Embolic source in patients with recent Transient Ischemic Attack (TIA), stroke, or peripheral vascular emboli as an initial study before TEE.
 - ASD repair or VSD repair:
 - Within the first year of surgery
 - Incomplete septal defect repair may be followed yearly
 - Tumor evaluation including myxomas
 - Clot detection
- ◆ Evaluation of adult congenital heart disease see **CD-11: Adult Congenital Heart Disease** and **PEDCD-2: Congenital Heart Disease** in the Pediatric Cardiology imaging guidelines
 - Routine yearly surveillance of adult congenital heart disease is allowed following incomplete or palliative repair, with residual abnormality and without a change in clinical status.
 - Screening of the ascending aorta in known or suspected connective tissue disease that predisposes to an aortic aneurysm or dissection (e.g., Marfan syndrome, hereditary forms of ascending aortopathy) See **PVD-2.2:**

Screening for Vascular related genetic connective tissue Disorders in the Peripheral Vascular Disease imaging guidelines

- ◆ Inflammatory
 - Pericardial effusion/pericardial disease including pericardial cysts
 - Endocarditis including:
 - Fever
 - Positive blood cultures indicating bacteremia or
 - A new murmur
- ◆ Pacemaker insertion complication
- ◆ Screening for the presence of bicuspid aortic valve is recommended for first-degree relatives of patients with bicuspid aortic valve.
- ◆ Screening for first-degree relatives of patients with hypertrophic cardiomyopathy (HCM)
 - First-degree relatives who are 12 to 18 years old should be screened yearly for HCM by 2D- echocardiography, and ECG.
 - First-degree relatives who are older than age 18 should have 2D-echo and ECG every five years to screen for delayed adult-onset LVH.
 - Systematic screening is usually not indicated for first-degree relatives who are younger than age 12 unless there is a high-risk family history or the child is involved in particularly intense competitive sports.
 - Affected individuals identified through family screening or otherwise should be evaluated every 12 to 18 months with 2D-echo, Holter monitor, and blood pressure response during maximal upright exercise.
- ◆ New abnormality, such as RBBB or LBBB, on an EKG that has not been evaluated
- ◆ Thoracic aortic aneurysm/dissection initial evaluation, also see **PVD-6.2: Thoracic Aortic Aneurysm, PVD-6.7: Aortic Dissection and Other Aortic Conditions, PVD-2.3: Screening for TAA in patients with bicuspid aortic valves** in the peripheral vascular disease imaging guideline
- ◆ Initial evaluation prior to solid organ transplant or hematopoietic stem cell transplant (HSCT)

CD-2.3: Frequency of Echocardiography Testing

- Repeat routine echocardiograms are not supported (annually or otherwise) for evaluation of clinically stable syndromes
- A repeat echo is allowed every three years, without a change in clinical status, when there is a history of:
 - ◆ Bicuspid aortic valve
 - ◆ Mild aortic or mitral stenosis
 - ◆ Prosthetic heart valve
 - ◆ Aortic sclerosis without stenosis
- Valve Surgery
 - ◆ If valve surgery is being considered can have TTE twice a year
 - ◆ Post-surgery (repair or prosthetic valve implantation):

- 6 weeks post surgery to establish baseline
- One routine study (surveillance) every 3 years after valve repair or replacement.
- ◆ TAVR follow-up:
 - 1 month post procedure
 - one year post-procedure
 - annually thereafter
 - A baseline post-op TTE is usually performed within one week after surgery. This baseline study may also be approved as an outpatient if not performed in the hospital prior to discharge
 - See: **CD-4.8: Transcatheter Aortic Valve Replacement (TAVR)**
- ◆ Mitral valve clip:
 - 1 month post procedure
 - 6 months post-procedure
 - one year post-procedure
- Pulmonary hypertension
 - ◆ Initially when there is suspected pulmonary hypertension in an individual at high risk for it, such as significant valvular disease, chronic liver disease, connective tissue disease or family history of pulmonary hypertension.
 - ◆ Anytime, without regard for the number or timing of previous ECHO studies
 - To evaluate change in therapy
 - Change in clinical findings or symptoms
 - ◆ Annually-regardless of symptoms if known to be at least moderate in severity
- Once a year (when no change in clinical status), when there a history of:
 - ◆ Significant valve dysfunction for:
 - moderate or severe regurgitation
 - moderate or severe stenosis
 - ◆ Significant valve deformity regardless of extent of regurgitation or stenosis for:
 - Thickened myxomatous valve
 - Bileaflet prolapse
 - ◆ Hypertrophic cardiomyopathy see **CD-2.2: Transthoracic Echocardiography (TTE) – Indications, CD-2.7: Stress Echocardiography – Indications, other than ruling out CAD**
 - ◆ Chronic pericardial effusions
 - ◆ Left ventricular contractility/diastolic function either:
 - prior to planned medical therapy for heart failure
 - to evaluate the effectiveness of on-going therapy
 - ◆ Aortic root dilatation that has not yet been repaired
 - see also **CD-11.2.9: Congenital Valvular Aortic Stenosis**
 - post-repair see **PVD-6.8: Post Aortic Endovascular/Open Surgery Surveillance Studies** in the peripheral vascular disease imaging guideline
 - ◆ Systemic Sclerosis or Scleroderma

- Anytime, without regard for the number or timing of previous ECHO studies, if there is a change in clinical status or new signs or symptoms and a history of:
 - ◆ Cardiac murmurs
 - ◆ Myocardial infarction or acute coronary syndrome
 - ◆ Congestive heart failure (new or worsening)
 - New symptoms of dyspnea
 - Orthopnea
 - Paroxysmal nocturnal dyspnea
 - Dependent Edema
 - Elevated BNP
 - ◆ Pericardial disease
 - ◆ Stroke/transient ischemic attack
 - ◆ Decompression illness
 - ◆ Prosthetic valve dysfunction or thrombosis
 - ◆ A history of prior cardiac transplant
- Anytime, without regard for the number or timing of previous ECHO studies when there is a history of cardiac transplant per transplant center protocol
- Re-evaluation in an individual previously or currently undergoing therapy with cardiotoxic agents see **CD-12.1: Oncologic Indications for Cancer Therapeutics-Related Cardiac Dysfunction (CTRCD)**

Practice note

- Decisions regarding routine echocardiographic follow-up should not be based on the degree of regurgitation alone, but should take into account associated structural valvular and cardiac abnormalities. For example: a structurally normal mitral valve with moderate mitral regurgitation by color flow Doppler and normal left atrial size, does not generally require routine echocardiographic follow-up. However, a thickened, myxomatous appearing mitral valve with bi-leaflet prolapse and only trivial or mild mitral regurgitation, should be followed echocardiographically at routine intervals.

CD-2.4: Transesophageal Echocardiography (TEE) – Coding

Transesophageal Echocardiography		CPT®
TEE with 2-D, M-mode, probe placement, image acquisition, interpretation and report		93312
TEE probe placement only		93313
TEE image acquisition, interpretation, and report only		93314
TEE for congenital anomalies with 2-D, M-mode, probe placement, image acquisition, interpretation and report		93315
TEE for congenital anomalies, probe placement only		93316
TEE for congenital anomalies, image acquisition, interpretation and report only		93317
TEE for monitoring purposes, ongoing assessment of cardiac pumping function on an immediate time basis		93318
Doppler Echocardiography*		CPT®
Doppler echo, pulsed wave and/or spectral display		+93320
Doppler echo, pulsed wave and/or spectral display, follow-up or limited study		+93321
Doppler echo, color flow velocity mapping		+93325
*Doppler echo, if performed, may be reported separately in addition to the primary TEE codes: CPT® 93312, CPT® 93314, CPT® 93315, and CPT® 93317.		
CPT®	Transesophageal Echocardiography	
93312	TEE with 2-D, M-mode, probe placement, image acquisition, interpretation and report	C8925
93315	TEE for congenital anomalies with 2-D, M-mode, probe placement, image acquisition, interpretation and report	C8926
93318	TEE for monitoring purposes, ongoing assessment of cardiac pumping function on an immediate time basis	C8927

- **The complete transesophageal echocardiogram** service, including both (1) probe (transducer) placement and (2) image acquisition/interpretation, is reported with CPT® 93312.
 - ◆ Probe placement only is reported with CPT® 93313.
 - ◆ The image acquisition/interpretation only is reported with CPT® 93314.
- Physicians assign codes CPT® 93312, CPT® 93313, and/or CPT® 93314 to report professional services if the test is performed in a hospital or other facility where the physician cannot bill globally.
 - ◆ Modifier -26 (professional component) is appended to the appropriate code
 - ◆ CPT® 93313 and CPT® 93314 should never be used together. If both services are provided, CPT® 93312 is reported.
- Hospitals should report TEE procedures using CPT® 93312 (the complete service). CPT® 93313 and CPT® 93314 are not used for hospital billing.
- Monitoring of patients undergoing cardiac surgery is CPT® 93318.

CD-2.5: Transesophageal Echocardiography (TEE) – Indications

- Limited transthoracic echo window when further information is needed to guide management (e.g. suspected or confirmed endocarditis, suspected intracardiac mass, etc.)
- Assessing valvular dysfunction, especially mitral regurgitation, when TTE is inadequate and intervention is being considered to repair/replace valve.
- Pre-operative planning for cardiac surgery
- Embolic source or intracardiac shunting when TTE is inconclusive
 - ◆ **Examples:** atrial septal defect, ventricular septal defect, patent foramen ovale, aortic cholesterol plaques, thrombus in cardiac chambers, valve vegetation, tumor
- Embolic events when there is an abnormal TTE or a history of atrial fibrillation
 - ◆ Clarify atria/atrial appendage, aorta, mitral/aortic valve beyond the information that other imaging studies have provided
- Cardiac valve dysfunction
 - ◆ Differentiation of tricuspid from bicuspid aortic valve in setting of aortic enlargement or significant stenosis or significant regurgitation
 - ◆ Congenital abnormalities
- Assessing for left atrial thrombus prior to cardioversion of atrial fibrillation or atrial flutter.
- Prior to planned atrial fibrillation ablation/pulmonary vein isolation procedure.
- Repeat TEE studies are based upon findings in the original study and documentation of the way in which repeat studies will affect patient management, such as the following:
 - ◆ Left atrial appendage (LAA) Closure device (e.g., WATCHMAN®)
 - 45 days post procedure
 - 12 months post procedure
 - ◆ See also **CD-13.5: Percutaneous Mitral Valve Repair (mitral valve clip)**

CD-2.6: Stress Echocardiography (Stress Echo) – Coding

Stress ECHO Procedure Codes		
Stress Echocardiography		CPT®
Echo, transthoracic, with (2D), includes M-mode, during rest and exercise stress test and/or pharmacologically induced stress, with report;*		93350
Echo, transthoracic, with (2D), includes M-mode, during rest and exercise stress test and/or pharmacologically induced stress, with report: <i>including performance of continuous electrocardiographic monitoring, with physician supervision*</i>		93351
Doppler Echocardiography		CPT®
Doppler echo, pulsed wave and/or spectral display**		+93320
Doppler echo, pulsed wave and/or spectral display, follow-up/limited study		+93321
Doppler echo, color flow velocity mapping**		+93325
*CPT® 93350 and CPT® 93351 do not include Doppler studies		
*Doppler echo (CPT® +93320 and CPT® +93325), if performed, may be reported separately in addition to the primary SE codes: CPT® 93350 or CPT® 93351.		
CPT®	Stress Echocardiography	
93350	Echo, transthoracic, with (2D), includes M-mode, during rest and exercise stress test and/or pharmacologically induced stress, with report;*	C8928
93351	Echo, transthoracic, with (2D), includes M-mode, during rest and exercise stress test and/or pharmacologically induced stress, with report: <i>including performance of continuous electrocardiographic monitoring, with physician supervision*</i>	C8930

CD-2.7: Stress Echocardiography–Indications, other than ruling out CAD

- See: **CD-1.4: Stress Testing with Imaging – Indications** . In addition to the evaluation of CAD, stress echo can be used to evaluate the following conditions:
 - ◆ Dyspnea on exertion (specifically to evaluate pulmonary hypertension)
 - ◆ Right heart dysfunction
 - ◆ Valvular heart disease, especially when the outcome would affect a therapeutic or interventional decision
 - ◆ Pulmonary hypertension, when the outcome will measure response to therapy and/or prognostic information
 - ◆ Hypertrophic cardiomyopathy
 - In a patient with a history of hypertrophic cardiomyopathy who has been previously evaluated with a stress echo, another stress echo may be appropriate if there are worsening symptoms or if there has been a therapeutic change (for example: change in medication, surgical procedure performed).
- In general, spectral Doppler (CPT® 93320 or 93321) and color-flow Doppler (CPT® 93325) are necessary in the evaluation of the above conditions and can be added to the stress echo code.

CD-2.8: 3D Echocardiography – Coding

- The procedure codes used to report 3D rendering for echocardiography are not unique to echocardiography and are the same codes used to report the 3D post-processing work for CT, MRI, ultrasound, and other tomographic modalities.
 - ◆ **CPT® 76376**, not requiring image post-processing on an independent workstation, is the most common code used for 3D rendering done with echocardiography
 - ◆ **CPT® 76377** requires the use of an independent workstation

CD-2.9: 3D Echocardiography – Indications

- Echocardiography with 3-dimensional (3D) rendering is becoming universally available, yet its utility remains limited based on the current literature.
- 3D Echo may be indicated when a primary echocardiogram is approved and **one** of the following is needed:
 - ◆ Left ventricular volume and ejection fraction assessment when measurements are needed for treatment decision (e.g. implantation of ICD, alteration in cardiotoxic chemotherapy)
 - ◆ Mitral valve anatomy specifically related to mitral valve stenosis
 - ◆ Guidance of transcatheter procedures such as:
 - Mitral valve clipping
 - TAVR

CD-2.10: Myocardial strain imaging (CPT® 93356)

- See **CD-12.2: Cancer Therapeutics-Myocardial Strain Imaging**

CD-2.11: Myocardial contrast perfusion echocardiography (CPT® 0439T)

- Investigational see **CD-2.1: Transthoracic Echocardiography (TTE) – Coding**

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CD-3: Nuclear Cardiac Imaging

CD-3.1: Myocardial Perfusion Imaging (MPI) – Coding	30
CD-3.2: MPI – Indications	30
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CD-3.6: Myocardial Sympathetic Innervation Imaging in Heart Failure	32
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CD-3.1: Myocardial Perfusion Imaging (MPI) – Coding

Nuclear Cardiac Imaging Procedure Codes	
Myocardial Perfusion Imaging (MPI)	CPT®
MPI, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)	78451
MPI, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	78452

- The most commonly performed myocardial perfusion imaging are single (at rest or stress, CPT® 78451) and multiple (at rest and stress, CPT® 78452) SPECT studies.
 - ◆ Evaluation of the individual's left ventricular wall motion and ejection fraction are routinely performed during MPI and are included in the code's definition.
 - ◆ First pass studies, (CPT® 78481 and CPT® 78483), MUGA, (CPT® 78472 and CPT® 78473) and SPECT MUGA (CPT® 78494) should not be reported in conjunction with MPI codes.
 - ◆ Attenuation correction, when performed, is included in the MPI service by code definition. No additional code should be assigned for the billing of attenuation correction.
- **Multi-day Studies:** In the absence of written payer guidelines to the contrary, it is not appropriate to bill separately for the rest and stress segments of MPI even if performed on separate calendar dates. A single code is assigned to define the entire procedure on the date all portions of the study are completed.
- 3D rendering, (CPT® 76376/CPT® 76377), should not be billed in conjunction with MPI.
- Separate codes for such related services as treadmill testing (CPT® 93015 - CPT® 93018) and radiopharmaceuticals should be assigned in addition to MPI. These services are reimbursed according to each individual payer policy.

CD-3.2: MPI – Indications

- See: **CD-1.4: Stress Testing with Imaging – Indications**

CD-3.3: MUGA – Coding

Cardiac blood pool imaging, or radionuclide ventriculography, can be used to evaluate ventricular function. Cardiac blood pool imaging includes first pass studies (CPT® 78481 and 78483) as well as gated equilibrium studies (CPT® 78472, 78473, 78494, and +78496).

Gated equilibrium studies can also be referred to as multi-gated acquisition (MUGA) scan or equilibrium radionuclide angiography (ERNA). Imaging for gated equilibrium studies can be planar or three-dimensional (single photon emission computed tomography, SPECT).

Of note, all cardiac blood pool imaging is synchronized with electrographic RR interval (EKG-gated); thus, regular rhythm is required for accurate LV assessment.

Nuclear Cardiac Imaging Procedure Codes

First Pass studies	CPT®
Cardiac blood pool imaging (planar), first pass technique; single study, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification	78481
Cardiac blood pool imaging (planar), first pass technique; multiple studies, at rest and with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification	78483
Cardiac blood pool imaging, gated equilibrium, single study , at rest, with right ventricular ejection fraction by first pass technique (List separately in addition to code for primary procedure) This CPT code is an add-on code to 78472.	+78496
Gated Equilibrium Studies – Planar	CPT®
Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress, wall motion study plus ejection fraction, with or without quantitative processing	78472
Cardiac blood pool imaging, gated equilibrium; planar, multiple studies, wall motion study plus ejection fraction, at rest and stress , with or without additional quantification	78473
Gated Equilibrium Studies - SPECT	CPT®
Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing	78494

- The technique employed for a MUGA service guides the code assignment.
 - ◆ CPT® 78472 is used for a planar MUGA scan at rest or stress
 - ◆ CPT® 78473 for planar MUGA scans, multiple studies at rest and stress.
- Planar MUGA studies (CPT® 78472 and CPT® 78473) should not be reported in conjunction with:
 - ◆ MPI (CPT® 78451 - CPT® 78454)
 - ◆ First pass studies (CPT® 78481- CPT® 78483)
 - ◆ SPECT MUGA (CPT® 78494).
- CPT® +78496 is assigned only in conjunction with CPT® 78472.

CD-3.4: MUGA Study – Cardiac Indications

MUGA (Multi Gated Acquisition) – Blood Pool Imaging Indications

- Echocardiography is the preferred method of following left ventricular systolic function.
- MUGA may be appropriate when a recent ECHO, as indicated in **CD 2.2 Transthoracic Echocardiography (TTE) – Indications** and/or **CD 2.3 Frequency of Echocardiography Testing**, was technically limited and prevented accurate assessment of left ventricular function.

- MUGA may be appropriate when there is a significant discrepancy between LVEF assessment by ECHO and another modality (i.e., one study reports normal LVEF and the other, a reduced LVEF) AND there is clear documentation as to how quantitative measurement of LVEF will affect patient management (e.g., implantation of an ICD, alteration in cardiotoxic chemotherapy, etc.).
- MUGA may be performed in place of an ECHO in the following circumstances:
 - ◆ To determine candidacy for ICD/CRT and/or to determine optimal choice of device in individuals who meet criteria for ICD based on ejection fraction and other criteria.
 - ◆ When previously or currently undergoing therapy with potentially cardiotoxic agents, including chemotherapy and radiation, AND a history of previous low LV ejection fraction (LVEF < 50%). See **CD-12.1: Oncologic Indications for Cancer Therapeutics – Related Cardiac Dysfunction (CTRCD)**
- MUGA is **not** indicated when requested simply to compare LVEF by the same modality, a prior MUGA is not a reason to approve another MUGA.

Right ventricular first pass study (CPT® +78496)

- (CPT® 78472 and 78496) may be performed when ECHO is technically limited and prevents accurate assessment of RV function AND when further information about RV function is needed to guide management (e.g. established/diagnosed pulmonary hypertension, suspected or confirmed pulmonary embolus).

First pass studies

- First pass studies (CPT® 78481 and CPT® 78483) may be approved when indications are met for MUGA and/or there is need for information that cannot be obtained by MUGA. First pass studies, (CPT® 78481 and CPT® 78483), MUGA (CPT® 78472 and CPT® 78473) and SPECT MUGA (CPT® 78494) should not be reported in conjunction with MPI codes.

CD-3.5: MUGA Study – Oncologic Indications for Cancer Therapeutics-Related Cardiac Dysfunction (CTRCD)

- See **CD-12.1: Oncologic Indications for Cancer Therapeutics – Related Cardiac Dysfunction (CTRCD)**

CD-3.6: Myocardial Sympathetic Innervation Imaging in Heart Failure

- In heart failure, the sympathetic nervous system is activated in order to compensate for the decreased myocardial function. Initially, this is beneficial, however, long-term this compensatory mechanism is detrimental and causes further damage.
- Markers have been developed, using radioactive iodine, in an attempt to image this increased myocardial sympathetic activity. Currently, AdreView™ (Iodine-123 meta-iodobenzylguanidine), is the only FDA-approved imaging agent available for this purpose. eviCore currently considers AdreView to be experimental and investigational.

- The AMA has established the following set of Category III codes to report these studies:
 - ◆ **0331T** - Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment
 - ◆ **0332T** - Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT.

CD-3.7: Myocardial Tc-99m Pyrophosphate Imaging

Myocardial Tc-99m Pyrophosphate Imaging	
MUGA (Multi Gated Acquisition) – Blood Pool Imaging	CPT®
Myocardial Imaging, infarct avid, planar, qualitative or quantitative	78466
Myocardial Imaging, infarct avid, planar, qualitative or quantitative with ejection fraction by first pass technique	78468
Myocardial Imaging, infarct avid, planar, qualitative or quantitative tomographic SPECT with or without quantification	78469
Radiopharmaceutical Localization Imaging Limited area	78800
Radiopharmaceutical Localization Imaging SPECT Note: When reporting CPT® 78803, planar imaging of a limited area or multiple areas should be included with the SPECT	78803
Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (e.g., head, neck, chest, pelvis), single day imaging	78830

- Historically this method of imaging the myocardium was used to identify recent infarction, hence, the term "infarct-avid scan." Although still available, the sensitivity and specificity for identifying infarcted myocardial tissue are variable and the current use for this indication is limited. See **CD-5: Cardiac MRI**.

CD-3.8: Cardiac Amyloidosis

- Tc-99m pyrophosphate imaging (CPT® 78803 or 78830) may be used to identify cardiac amyloidosis. Chest SPECT and planar imaging may be used, as well as whole-body imaging for identification of systemic ATTR (transthyretin) amyloidosis. See **CD-3.7: Myocardial Tc-99m Pyrophosphate Imaging** for coding information
- For a single planar imaging session alone (without a SPECT study), report CPT® 78800 Radiopharmaceutical Localization Imaging Limited area

- Tc-99m pyrophosphate imaging can be pursued for diagnosis of ATTR amyloidosis when **both** of the following have been assessed to rule out AL amyloidosis and are negative:
 - ◆ serum kappa/lambda free light chain ratio (not SPEP)
 - ◆ immunofixation electrophoresis of serum and urine (SPIE and UPIE)
- Tc-99m pyrophosphate imaging may also be used for the following:
 - ◆ Diagnosis of cardiac ATTR in individuals with cardiac MRI or echocardiography findings consistent with or suggestive of cardiac amyloidosis.
 - ◆ Patients with suspected cardiac ATTR amyloidosis and contraindications to CMR such as renal insufficiency or an implantable cardiac device.

Practice note

- The following conditions would raise high index of suspicion:
 - ◆ Left ventricular hypertrophy but low voltage on ECG
 - ◆ Heart failure with preserved ejection fraction and an increase in left ventricular wall thickness.
 - ◆ Unexplained heart failure with preserved ejection fraction and concomitant right heart failure in an individual over the age of 60
 - ◆ Individuals, especially elderly males, with signs/symptoms of heart failure and any of the following:
 - lumbar spinal stenosis
 - spontaneous biceps tendon rupture
 - bilateral carpal tunnel syndrome or atrial arrhythmias in the absence of usual risk factors
 - ◆ Known or suspected familial amyloidosis.
 - ◆ Low flow, low gradient aortic stenosis

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CD-4: Cardiac CT, Coronary CTA, and CT for Coronary Calcium (CAC)

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CD-4.1: Cardiac CT and CTA – General Information and Coding

Cardiac Imaging Procedure Codes	
Cardiac CT	CPT®
CT, heart, without contrast, with quantitative evaluation of coronary calcium	75571
The code set for Cardiac CT and CCTA (CPT® 75572-CPT® 75574), include quantitative and functional assessment (for example, calcium scoring) if performed	
CPT® 75571 describes a non-contrast CT of the heart with calcium scoring and should be reported only when calcium scoring is performed as a stand-alone procedure.	
➤ Can be used to report a preliminary non-contrast scan which indicates an excessive amount of calcium such that the original scheduled study must be discontinued. ➤ CPT® 75571 should not be reported in conjunction with any of the contrast CT/CTA codes (CPT® 75572- CPT® 75574).	
Cardiac CT and CCTA	CPT®
CT, heart, with contrast, for evaluation of cardiac structure and morphology (including 3D image post-processing, assessment of cardiac function, and evaluation of venous structures, if performed).	75572
CT, heart, with contrast, for evaluation of cardiac structure and morphology <i>in the setting of congenital heart disease</i> (including 3D image post-processing, assessment of cardiac function, and evaluation of venous structures, if performed).	75573
CTA, heart, coronary arteries and bypass grafts (when present), with contrast, including 3D image post-processing (including 3D image post-processing, assessment of cardiac function, and evaluation of venous structures, if performed).	75574
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	0501T
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	0502T
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	0503T
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	0504T

Cardiac Imaging Procedure Codes	
Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission, computerized analysis of data, with review of computerized analysis output to reconcile discordant data, interpretation and report	0623T
Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; data preparation and transmission	0624T
Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; computerized analysis of data from coronary computed tomographic angiography	0625T
Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; review of computerized analysis output to reconcile discordant data, interpretation and report	0626T

- The high negative predictive value (98%-99%) of CCTA in ruling out significant coronary artery disease has been confirmed in multiple studies.
- 3D rendering, (CPT® 76376/CPT® 76377), should not be billed in conjunction with Cardiac CT and CCTA.
- Only one code from the set: CPT® 75572 - CPT® 75574 can be reported per encounter.
- CPT® 75574 includes evaluation of cardiac structure and morphology when performed; therefore, additional code/s should not be assigned.
- Automated quantification and characterization of coronary atherosclerotic plaque (CPT® 0623T, 0624T, 0625T, 0626T) is a service in which coronary computed tomographic angiography (CCTA) data are analyzed using computerized algorithms to assess the extent and severity of coronary artery disease. The use of automated quantification and characterization of coronary atherosclerotic plaque is considered investigational and experimental at this time.

CD-4.2: CT for Coronary Calcium Scoring (CPT® 75571)

CD-4.2.1: CT Calcium Scoring-Asymptomatic and for CAD Screening

- Coronary calcium scoring as a standalone test in asymptomatic patients without any degree of CAD risk is considered screening and is not a covered service.
- Coronary calcium scoring is not indicated in someone with known CAD.

- Medicare policies do not cover certain screening studies including Coronary Calcium Scoring.
- Coronary artery calcium score (CPT® 75571) can be approved when there is documentation of **all** of the following:
 - ◆ The results will impact risk-based decisions for preventive interventions
 - ◆ The individual is an adult age 40-75
 - ◆ The 10-year ASCVD risk including pooled cohort equation is between 5.0% to 19.9%
 - ◆ There is no documented CAD
 - ◆ Individual is not currently on a statin
 - ◆ Individual is not a smoker
 - ◆ There is no history of diabetes
 - ◆ There is no family history of premature CAD
 - ◆ There has been no calcium score performed in the previous 5 years
 - ◆ There has been no prior calcium score > 0

State mandates

- Texas Heart Attack Preventive Screening Law (HR 1290) mandates that insurers in Texas cover either a calcium scoring study (CPT® 75571 or HCPCS S8092) **or** a carotid intima-media thickness study (ultrasound—Category III code 0126T) every five years for certain populations. To qualify, the following must apply:
 - ◆ Must be a Texas resident.
 - ◆ Must be a member of a fully-insured Texas health plan.
 - ◆ Must be a man age 45 to 75 or a woman age 55 to 75.
 - ◆ Must have either diabetes or a Framingham cardiac risk score of intermediate or higher (10% or higher).
 - ◆ Must not have had a calcium scoring study or a carotid intima-media thickness study within the past 5 years.
- New Mexico House Bill 126 Coverage for Health Artery Calcium Scan
 - ◆ Coverage may apply per state mandate as stated in House Bill 126. See <https://www.nmlegis.gov> for guidance on specific application.
 - ◆ Coronary calcium scan can be approved every 5 years to be used as a clinical management tool when all the following apply;
 - Prior CT calcium was > 5 years ago
 - Prior CT calcium scan had a calcium score of zero
 - The individual is between the ages of 45 and 65
 - ◆ The individual has an intermediate risk of developing CAD determined by a health care provider based on a 10 year risk algorithm including pooled cohort equation.

CD-4.2.2: CT Calcium Scoring Indications Symptomatic

- Individuals with new, recurrent or worsening symptoms concerning for cardiac ischemia, who have a 'very low', or 'low' pretest probability of CAD*, see **Table 1** in **CD-1.0: General guidelines**

CD-4.3: CCTA – Indications for CCTA (CPT® 75574)

- New, recurrent or worsening symptoms concerning for cardiac ischemia in individuals who have:
 - ◆ A 'very low, 'low' or 'intermediate' pretest probability of CAD*, see **Table-1** in **CD-1.0: General guidelines**:
 - ◆ Persistent symptoms in individuals with a 'low' or 'intermediate' pre-test probability of coronary disease after a normal stress test
 - ◆ Equivocal, borderline, abnormal or discordant prior noninvasive evaluation where obstructive coronary artery disease remains a concern (<90 days)
 - ◆ Abnormal rest ECG findings, such as a new LBBB, or T-wave inversions, when ischemia is a concern
 - ◆ A prior CABG when **only** graft patency is a concern
- Evaluation of an individual under the age of 40 for suspected anomalous coronary artery(ies) or for treatment planning when there is a history of one or more of the following:
 - ◆ Syncopal episodes during strenuous activities
 - ◆ Persistent chest pain brought on by exertion or emotional stress, and normal stress test
 - ◆ Full sibling(s) with history of sudden death syndrome before age 40 or with documented anomalous coronary artery
 - ◆ Resuscitated sudden death and contraindications for conventional coronary angiography
 - ◆ Prior nondiagnostic coronary angiography in determining the course of the anomalous coronary artery in relation to the great vessels, origin of a coronary artery or bypass graft location (any):
 - Anomalies of origin:
 - LCA or the RCA arising from the pulmonary artery;
 - Interarterial course between the pulmonary artery and the aorta of either the RCA arising from the left sinus of Valsalva or the LCA arising from the right sinus of Valsalva
 - Anomalies of course:
 - myocardial bridging
 - Anomalies of termination:
 - coronary artery fistula

- Initial imaging study in individuals with hypertrophic cardiomyopathy and stable anginal symptoms.
 - ◆ Chest discomfort is common in individuals with hypertrophic cardiomyopathy. The incidence of false positive myocardial perfusion imaging abnormalities is higher in these individuals, whereas the incidence of severe coronary artery stenosis is low.
- Individuals who have recovered from unexplained sudden cardiac arrest in lieu of invasive coronary angiography (both):
 - ◆ to confirm the presence or absence of ischemic heart disease
 - ◆ to exclude the presence of an anomalous coronary artery.

CD-4.4: CCTA – Regardless of symptoms (CPT® 75574):

- Evaluation of newly diagnosed congestive heart failure or cardiomyopathy (all).
 - ◆ No prior history of coronary artery disease, the ejection fraction is less than 50 percent, and low or intermediate risk on the pre-test probability assessment, and
 - ◆ No contraindications to cardiac CT angiography.
 - ◆ No cardiac catheterization, SPECT, cardiac PET, or stress echocardiogram has been performed since the diagnosis of congestive heart failure or cardiomyopathy.
- Unclear coronary artery anatomy despite conventional cardiac catheterization
- Re-do CABG
 - ◆ Assess bypass graft patency
 - ◆ Evaluate the location of the left internal mammary artery (LIMA) and or right internal mammary artery (RIMA) prior to repeat bypass surgery
- Follow-up Left main stent one time at 6-12 months
- Evaluate 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.
 - ◆ To evaluate the great vessels, Chest CTA (CPT® 71275) can be performed instead of CCTA or in addition to CCTA.
 - ◆ For anomalous pulmonary venous return, can add CT abdomen and pelvis with contrast (CPT® 74177).
- When CCTA will replace conventional invasive coronary angiography for any of the following:
 - ◆ Ventricular tachycardia (6 beat runs or greater)
 - ◆ Delayed presentation or retrospective evaluation of suspected Takotsubo syndrome (stress cardiomyopathy)
 - ◆ Preoperative assessment of the coronary arteries in planned surgery for any of the following:
 - Aortic dissection
 - Aortic aneurysm
 - Valvular surgery

- ◆ To assess for coronary involvement in individuals with systemic vasculitis (e.g. Giant Cell Arteritis, Takayasu's, Kawasaki's disease) when there are clinical features suggestive of underlying vasculitis including:
 - Unexplained elevated cardiac markers (erythrocyte sedimentation rate, C-reactive protein)
 - Constitutional symptoms (fever, chills, night sweats, weight loss)
 - Multiple visceral infarcts in the absence of embolic etiology
- **Cardiac Trauma:** Chest CTA (CPT® 71275) and CCTA (CPT® 75574) are useful in detecting aortic and coronary injury and can help in the evaluation of myocardial and pericardial injury see **CD-10.1: Cardiac Trauma – Imaging**

CD-4.5: Fractional Flow Reserve by Computed Tomography

- Fractional flow reserve (FFR) is typically measured using invasive techniques. FFR can be obtained noninvasively from coronary computed tomography angiography data (FFR-CT).
- Indications for FFR-CT
 - ◆ To further assess CAD seen on a recent CCTA that is of uncertain physiologic significance

CD-4.6: CT Heart – Indications (CPT® 75572)

- Cardiac vein identification for lead placement in patients needing left ventricular pacing.
- Pulmonary vein isolation procedure (ablation) for atrial fibrillation
 - ◆ Cardiac MRI (CPT® 75557 or CPT® 75561), chest MRV (CPT® 71555), chest CTV (CPT® 71275), or cardiac CT (CPT® 75572) can be performed to evaluate the anatomy of the pulmonary veins prior to an ablation procedure performed for atrial fibrillation.
 - ◆ Study may be repeated post-procedure between 3-6 months after ablation because of a 1%-2% incidence of asymptomatic pulmonary vein stenosis
 - ◆ See **CD-8.2: Pulmonary Vein Imaging – Indications**
- If echocardiogram is inconclusive for:
 - ◆ Cardiac or pericardial tumor or mass
 - ◆ Cardiac thrombus
 - ◆ Pericarditis/constrictive pericarditis
 - ◆ Complications of cardiac surgery
- In place of MRI when there is clinical suspicion of arrhythmogenic right ventricular dysplasia or arrhythmogenic cardiomyopathy (ARVD/ARVC) if the clinical suspicion is supported by established criteria for ARVD-see **CD-5.2: Cardiac MRI – Indications (excluding Stress MRI)**

- Recurrent laryngeal nerve palsy due to cardiac chamber enlargement.
- Cardiac CT (CPT® 75572) can be performed instead of TEE for assessment of left atrial appendage (LAA) occlusion device or to assess for thrombus, see: **CD-2.5: Transesophageal Echocardiography (TEE) – Indications**
- Coronary imaging is not included in the code definition for CPT® 71275.
 - ◆ The AMA definition for CPT® 71275 reads: “CTA Chest (non-coronary), with contrast material(s), including non-contrast images, if performed, and image post-processing.”

CD-4.7: CT Heart for Congenital Heart Disease (CPT® 75573)

- Coronary artery anomaly evaluation
 - ◆ A cardiac catheterization was performed, and not all coronary arteries were identified.
- Thoracic arteriovenous anomaly evaluation
 - ◆ A cardiac MRI or chest CT angiogram was performed and suggested congenital heart disease.
- Complex adult congenital heart disease evaluation
 - ◆ No cardiac CT or cardiac MRI has been performed, and there is a contraindication to cardiac MRI.
 - ◆ A cardiac CT or cardiac MRI was performed one year ago or more.

CD-4.8: Transcatheter Aortic Valve Replacement (TAVR)

- Once the decision has been made for aortic valve replacement, the following may be used to determine if a patient is a candidate for TAVR:
 - ◆ CTA of chest (CPT® 71275), abdomen and pelvis (combination code CPT® 74174) are considered appropriate, and
 - ◆ Cardiac CT (CPT® 75572) may be considered to measure the aortic annulus or
 - ◆ Coronary CTA (CCTA CPT® 75574) may be considered to both measure the aortic annulus and assess the coronary arteries in lieu of heart catheterization.
- Post TAVR- TTE follow-up is indicated at:
 - ◆ A baseline post-op TTE is indicated within one week after surgery if not performed in the hospital prior to discharge.
 - ◆ 1 month
 - ◆ One year post-procedure
 - ◆ Then annually thereafter.
- A repeat diagnostic left heart catheterization is not medically necessary when the patient is undergoing a transcatheter aortic valve replacement (TAVR).

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CD-5: Cardiac MRI

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CD-5.1: Cardiac MRI – Coding

Cardiac Imaging Procedure Codes	
Cardiac MRI	CPT®/HCPCS
Cardiac magnetic resonance imaging for morphology and function without contrast	75557
Cardiac magnetic resonance imaging for morphology and function without contrast; with stress imaging	75559
Cardiac magnetic resonance imaging for morphology and function without and with contrast and further sequences	75561
Cardiac magnetic resonance imaging for morphology and function without and with contrast and further sequences; with stress imaging	75563
Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure)	+75565
Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging	C9762
Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging	C9763

- Only one procedure code from the set (CPT® 75557- CPT® 75563) should be reported per session.
- Only one flow velocity measurement (CPT® +75565) should be reported per session when indicated.
- C9762--Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging. The use of CMR strain imaging for the quantification of segmental dysfunction is considered investigational and experimental at this time.
- C9763--Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging. The use of stress CMR for the quantification of segmental dysfunction is considered investigational and experimental at this time.

CD-5.2: Cardiac MRI – Indications (excluding Stress MRI)

- Assess myocardial viability (to differentiate hibernating myocardium from scar) when necessary to determine if revascularization should be performed (CPT® 75561)
- Assessment of global ventricular function, myocardial composition, and mass if a specific clinical question is left unanswered by a recent echocardiogram and results will affect patient management (CPT® 75557 or CPT® 75561). Particularly useful in evaluating:
 - ◆ Cardiomyopathy (ischemic, diabetic, hypertrophic, or muscular dystrophy)
 - ◆ Noncompaction
 - ◆ Infiltrative heart disease such as amyloid, iron overload cardiomyopathy (hemosiderosis, hemochromatosis)
 - ◆ Post cardiac transplant
 - ◆ Hypertrophic cardiomyopathy
 - ◆ Suspected acute myocarditis, cardiac aneurysm, trauma, and contusions

- ◆ Monitoring cancer chemotherapy effect on the heart (especially if an accurate assessment of right ventricular function is documented as necessary).
- Pre and postoperative congenital heart disease assessment see **CD-11: Adult Congenital Heart Disease** for defect specific indications (CPT® 75557 or CPT® 75561).
 - ◆ Chest MRA (CPT® 71555) may be added if the aorta or pulmonary artery need to be visualized beyond the root.
 - ◆ Report CPT® +75565 in conjunction with CPT® 75557 or CPT® 75561, only if there is a need to clarify findings on a recent echocardiogram and cardiac Doppler study.
- Chest MRA alone (CPT® 71555) can be performed in certain situations (e.g. suspected dissection, coarctation, known or suspected aortic aneurysm).
- Coarctation of the aorta
 - ◆ Follow-up (surveillance) imaging after repair of coarctation:
 - **Adults:** see **CD-11.3.2: Coarctation of the Aorta**
 - **Infants and children:** see **PEDCD-2.4.11: Aortic Coarctation and IAA (interrupted aortic arch)** in the pediatric cardiac imaging guideline
- Arrhythmogenic right ventricular dysplasia or arrhythmogenic right ventricular cardiomyopathy (ARVD/ARVC) suspicion (CPT® 75557 or CPT® 75561)—must have one of the following:
 - ◆ Nonsustained or sustained VT of LBBB morphology OR >500 PVC's over 24 hours on event recorder or Holter monitor.
 - ◆ ARVD/ARVC confirmed in a first degree relative either by criteria, autopsy, pathogenic genetic mutation or sudden death <35 years of age with suspected ARVD/ARVC.
 - ◆ Inverted T waves in right precordial leads (V1, V2 and V3) or beyond in individuals > 14 years of age in the absence of complete RBBB
 - ◆ Right ventricular akinesis, dyskinesis or aneurysm noted on echo or RV angiography.
- Differentiate constrictive pericarditis from restrictive cardiomyopathy (CPT® 75561).
- Evaluate cardiac tumor or mass when echocardiogram is inconclusive. Evaluate valvular heart disease when echocardiogram is inconclusive. Appropriate procedures include:
 - ◆ CPT® 75557 **or** CPT® 75561 **and**
 - ◆ CPT® 75565
- Pulmonary vein anatomy for planned ablation procedures in patients with atrial fibrillation. Report cardiac MRI (CPT® 75557 or CPT® 75561) *or* chest MRV (CPT® 71555), but not both see **CD-8: Pulmonary Artery and Vein Imaging** for guidelines on follow-up imaging after ablation procedure.
- Suspected cardiac thrombus when echocardiogram is inconclusive (CPT® 75557).

- Right ventricular function evaluation (CPT® 75557 in conjunction with CPT® +75565) if a recent ECHO has been done, and there is documented need to perform cardiac MRI in order to resolve an unanswered question.
- Shunting through a VSD (CPT® 75557 in conjunction with CPT® +75565) if a recent ECHO has been done, including a bubble study, and there is documented need to perform cardiac MRI in order to resolve an unanswered question.
- Conditions that would **not** require an echo prior to an MRI:
 - ◆ Anomalous coronary arteries: Cardiac MRI (CPT® 75561) or CCTA (CPT® 75574) is much better at detecting this than conventional angiography.
 - ◆ Assess coronary arteries in Kawasaki's disease.
 - ◆ Fabry disease
 - Late enhancement MRI may predict the effect of enzyme replacement therapy on myocardial changes that occur with this disease (CPT® 75561).
 - ◆ Initial evaluation for cardiac sarcoidosis.

CD-5.3: Cardiac MRI – Indications for Stress MRI

- For indications for Stress MRI see **CD-1.4: Stress Testing with Imaging – Indications**. Also, if a nuclear perfusion (MPI) stress test was performed and was equivocal, a stress MRI is appropriate.

CD-5.4: Cardiac MRI – Aortic Root and Proximal Ascending Aorta

- See- **PVD-6.2: Thoracic Aortic Aneurysm (TAA)** in the Peripheral Vascular Disease imaging guidelines

CD-5.5: Cardiac MRI – Evaluation of Pericardial Effusion or Diagnosis of Pericardial Tamponade

- Contrast-enhanced cardiac MRI (CPT® 75561) is useful for evaluating pericarditis, neoplastic and other effusion, tamponade or myocardial infiltration if a specific clinical question is left unanswered by echocardiogram or another recent imaging study.

CD-5.6: Cardiac MRI – Myocarditis

Cardiac MRI is indicated for suspected myocarditis even in the absence of an echocardiogram in the presence of **all** of the following:

- New onset or persisting symptoms suggestive of myocarditis (dyspnea, chest pain, palpitations, or effort intolerance), and
- Evidence for recent or ongoing myocardial injury
 - ◆ Ventricular dysfunction noted on any cardiac imaging study, or
 - ◆ New or persisting ECG abnormalities suspicious for myocarditis
 - New ST changes, T wave changes, Q waves, or
 - New conduction abnormalities, such as LBBB or AV block, or
 - VT or VF

- ◆ Elevated troponin
- Strong suspicion for viral etiology of myocardial injury
 - ◆ Recent systemic viral disease or prior myocarditis, and
 - ◆ No evidence of coronary ischemia, such as
 - Lack of risk factors for CAD, or
 - Age under 35 years, or
 - Negative imaging study, such as MPI, CCTA, cath

CD-5.7: Cardiac MRI – Duchenne Muscular Dystrophy (DMD)

Cardiac MRI (CPT® 75557 or 75561-does not include 75565 or 71555 unless otherwise indicated)

- Asymptomatic individual with documented DMD can have annual surveillance cardiac MRI starting at 6 years old (yearly echo is recommended prior to age 6)
- Asymptomatic, documented carrier of DMD can have cardiac MRI every 3 years starting at 18

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CD-6: Cardiac PET

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CD-6.1: Cardiac PET – Coding

Cardiac Imaging Procedure Codes	
Cardiac PET	CPT®
Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study	78459
Myocardial imaging, positron emission tomography (PET), perfusion ;study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study at rest or stress (exercise or pharmacologic)	78491
Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and/or stress (exercise or pharmacologic)	78492
Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study; with concurrently acquired computed tomography transmission scan	78429
Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	78430
Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	78431
Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (e.g., myocardial viability);	78432
Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (e.g., myocardial viability); with concurrently acquired computed tomography transmission scan	78433
Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure)	78434
Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	78815

- 3D rendering, (CPT® 76376/CPT® 76377), should not be billed in conjunction with PET.
- Separate codes for such related services as treadmill testing (CPT® 93015-CPT® 93018) and radiopharmaceuticals should be assigned in addition to perfusion PET. These services are paid according to each individual payer.

CD-6.2: Cardiac PET – Perfusion – Indications

- CPT® 78430, 78431, 78491 and CPT® 78492
- Meets all of the criteria for an imaging stress test in **CD-1.4: Stress Testing with Imaging – Indications** and additionally any one of the following:
 - ◆ Individual is severely obese (for example BMI >40 kg/m²) or
 - ◆ Individual has large breasts or implants
- Equivocal nuclear perfusion (MPI) stress test
- Routine use in post heart transplant assessment of transplant CAD
- CMS (Medicare) does not cover reporting for wall motion and ejection fraction performed in conjunction with cardiac perfusion PET. There is not a separate CPT® or HCPCS code associated with these specific services. eviCore and their partner health plans adhere to the CMS policy unless explicitly stated in the health plan's coverage policy.

CD-6.3: Cardiac PET – Absolute quantitation of myocardial blood flow (AQMBF)

- CPT® 78434
- Performance of quantitation of myocardial blood flow by Cardiac PET is currently non-standardized between different vendor products.
- Absolute quantitation of myocardial blood flow is considered experimental, investigational and/or unproven (EIU).

CD-6.4: Cardiac PET – Metabolic – Indications

- Cardiac PET Metabolic (CPT® 78459 or CPT® 78429)
 - ◆ To determine myocardial viability when a previous study has shown significant left ventricular dysfunction when under consideration for revascularization
 - ◆ To monitor response to therapy for established cardiac sarcoid
- Cardiac PET Metabolic and Perfusion (MPI SPECT CPT® 78451 and CPT® 78459, or CPT® 78432, or CPT® 78433)
 - ◆ To identify established or strongly suspected cardiac sarcoid.

CD-6.5: FDG PET/CT for infections

- FDG PET/CT (CPT® 78815 or 78429) can be approved in the assessment of suspected prosthetic heart valve endocarditis in the following settings, when echocardiography and/or transesophageal echocardiography are equivocal or non-diagnostic and suspicion remains high:
 - ◆ C-reactive protein level of at least 40 mg/L
 - ◆ No evidence of prolonged antibiotic therapy
 - ◆ The implantation was at least 3 months ago and there is no evidence of surgical adhesives used during the valve implantation

- FDG PET/CT for LVAD driveline infection (CPT® 78815 or 78429)
 - ◆ Early infection detection for LVAD drivelines is desirable, since once the infection extends to the cannula and pump pocket, eradication becomes difficult. CT findings are nonspecific and metal device artifacts of the driveline itself affects sensitivity.
 - ◆ FDG PET/CT can be approved for suspected LVAD infection if other studies and examination remain inconclusive.

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CD-7: Diagnostic Heart Catheterization

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CD-7.1: Diagnostic Heart Catheterization – Code Sets

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

- CPT® 93530 to 93533 are appropriate for invasive evaluation of congenital heart disease. See also specific conditions in **CD-11: Adult Congenital Heart Disease**

CD-7.2: Diagnostic Heart Catheterization – Coding Notes

Cardiac catheterization (CPT® 93451-CPT® 93461) includes all “road mapping” angiography necessary to place the catheters, including any injections and imaging supervision, interpretation, and report.
Cardiac catheterization (CPT® 93452-CPT® 93461) (for all conditions other than congenital heart disease) includes contrast injections, imaging supervision, interpretation, and report for imaging typically performed.
Catheter placements in native coronaries or bypass grafts (CPT® 93454-CPT® 93461) include intraprocedural injections for bypass graft angiography, imaging supervision, and interpretation.
Injection codes CPT® 93563-CPT® 93565 should <u>not</u> be used in conjunction with CPT® 93452-CPT® 93461.
Codes CPT® 93451-CPT® 93461 do not include contrast injections and imaging supervision, interpretation, and report for imaging that is separately identified by the following specific procedure codes: CPT® 93566, CPT® 93567 and CPT® 93568.
➤ Separate diagnostic cardiac catheterization codes should only be assigned in conjunction with interventional procedures in the following circumstances: ◆ No prior or recent diagnostic catheterization is available to guide therapy ◆ Individual’s condition has significantly changed since the last diagnostic cath ◆ The treatment plan may be affected ◆ Other vessels may be identified for treatment ◆ Further establishment of a diagnosis from a non-invasive study is necessary

CD-7.3: Diagnostic Left Heart Catheterization (LHC)

CD-7.3.1: LHC – Unstable/Active Coronary Artery Syndromes

- Diagnostic Left Heart Catheterization (LHC) is indicated for individuals in acute settings or with **active** unstable angina and should be handled as medical emergencies.
- These guidelines apply to individuals with **stable** conditions and who are **not** in the acute setting (acute coronary syndrome or unstable angina).
- LHC may be indicated for new onset, accelerating, or worsening ischemic symptoms suggestive of acute coronary syndrome (ACS) occurring at rest, or with minimal exertion resolving with rest, including:
 - ◆ Typical angina with new onset, evolving ischemic EKG changes
 - ◆ Symptoms consistent with the known angina pattern in an individual with a history of CABG or PCI
- Left and right heart cath may be indicated in place of a left heart cath if the above criteria has been met and there is documentation of any of the following:
 - ◆ The major component of the patient symptoms is dyspnea
 - ◆ Newly diagnosed or worsening cardiomyopathy
 - ◆ For surgical planning prior to valve surgery or congenital heart defect repair

CD-7.3.2: LHC – Stable Established Coronary Artery Disease

- Diagnostic Left Heart Catheterization (LHC) is indicated to identify disease for which invasive procedures have been shown to prolong survival:
 - ◆ Left main coronary artery disease plus right coronary artery disease plus left ventricular dysfunction.
 - ◆ Triple vessel coronary artery disease plus left ventricular dysfunction.
- Optimal medical therapy (OMT) includes **all** of the following:
 - ◆ anti-platelet therapy
 - ◆ statin and/or other lipid-lowering therapy
 - ◆ anti-anginal therapy implemented to pursue a goal heart rate of 60 beats per minute or less
 - ◆ anti-hypertensive therapy as may be indicated to pursue a goal systolic blood pressure (SBP) of less than 140 mmHg and a goal diastolic blood pressure (DBP) of less than 90 mmHg
- LHC may be indicated irrespective of OMT for symptomatic individuals who have BOTH established CAD see **CD-1.0: General guidelines, Pre-Test Probability Grid (Table 1)** and high-risk findings on non-invasive stress testing including any of the following:
 - ◆ Typical angina symptoms induced by any modality of recent non-invasive stress testing
 - ◆ Myocardial perfusion imaging with $\geq 10\%$ reversible ischemic burden
 - ◆ Stress echo with at least 3 segments of inducible ischemia
 - ◆ Exercise treadmill testing inducing at least 2.5 mm downsloping ST-depression or 3 mm horizontal ST-depression in at least two contiguous leads
 - ◆ Ventricular tachycardia consisting of at least 3 consecutive beats induced by any modality of non-invasive stress testing
- Left and right heart cath may be indicated in place of a left heart cath if the above criteria has been met and there is documentation of any of the following:
 - ◆ The major component of the patient symptoms is dyspnea
 - ◆ Newly diagnosed or worsening cardiomyopathy
 - ◆ For surgical planning prior to valve surgery or congenital heart defect repair

CD-7.3.3 Stable Symptomatic Suspected or Established Coronary Artery Disease

- Diagnostic left heart catheterization planned for the purpose of screening for coronary artery disease in asymptomatic individuals with or without risk factors for coronary artery disease and not anticipating other cardiac procedures will be considered medically unnecessary
- LHC with coronary arteriography may be indicated when there is new onset, persistent, or worsening of angina symptoms and symptomatic failure of a 12 week trial of OMT (unless there is worsening of symptoms during that time). OMT should include each of the following:
 - ◆ anti-platelet therapy
 - ◆ statin and/or other lipid-lowering therapy

- ◆ anti-anginal therapy implemented to pursue a goal heart rate of 60 beats per minute or less
- ◆ anti-hypertensive therapy as may be indicated to pursue a goal systolic blood pressure (SBP) of less than 140 mmHg and a goal diastolic blood pressure (DBP) of less than 90 mmHg
- LHC may be indicated irrespective of OMT for symptomatic individuals with any pre-test probability for coronary artery disease (CAD) who also have high-risk findings on Coronary CT Angiography (**See CD-4.3: CCTA – Indications for CCTA (CPT® 75574)**), to include any of the following:
 - ◆ Left main coronary artery stenosis $\geq 40\%$
 - ◆ Proximal or mid left anterior descending coronary artery stenosis $\geq 70\%$
 - ◆ Proximal or mid double-vessel coronary artery stenosis $\geq 60\%$
 - ◆ Proximal or mid triple-vessel coronary artery stenosis $\geq 50\%$
 - ◆ CT-FFR measured to be ≤ 0.8 in the proximal or mid segment of any coronary artery irrespective of degree of stenosis
- LHC may be indicated irrespective of OMT for symptomatic individuals who have BOTH high pretest probability of CAD see **CD-1.0: General Issues, Pre-Test Probability Grid (Table 1)** and high-risk findings on non-invasive stress testing including any of the following:
 - ◆ Typical angina symptoms induced by any modality of recent non-invasive stress testing
 - ◆ Myocardial perfusion imaging with $\geq 10\%$ reversible ischemic burden
 - ◆ Stress echo with at least 3 segments of inducible ischemia
 - ◆ Exercise treadmill testing inducing at least 2.5 mm downsloping ST-depression or 3 mm horizontal ST-depression in two leads
 - ◆ Ventricular tachycardia consisting of at least 3 consecutive beats induced by any modality of non-invasive stress testing
- Left and right heart cath may be indicated in place of a left heart cath if the above criteria has been met and there is documentation of any of the following:
 - ◆ The major component of the patient symptoms is dyspnea
 - ◆ Newly diagnosed or worsening cardiomyopathy
 - ◆ For surgical planning prior to valve surgery or congenital heart defect repair

Practice note

- In addition to OMT, physician-guided behavioral modification therapy (BMT) is recommended including all of the following:
 - ◆ Mediterranean diet
 - ◆ Moderate intensity physical activity for at least thirty minutes per day at least five times per week as possible
 - ◆ Attempts at smoking cessation to include at least one of the following:
 - cognitive behavioral therapy
 - nicotine withdrawal replacement therapy
 - varenicline or bupropion therapy

CD-7.3.4: Exclusion of Significant Coronary Artery Disease Involvement in other Cardiac Pathology

- LHC may be indicated when the etiology is unclear for **any** of the following:
 - ◆ New or worsened left ventricular dysfunction or congestive heart failure if coronary artery disease is suspected
 - ◆ Ventricular fibrillation or sustained ventricular tachycardia
 - ◆ Unheralded syncope (not near syncope)
 - ◆ Suspected myocarditis
- Left and right heart cath may be indicated in place of a left heart cath if the above criteria has been met and there is documentation of any of the following:
 - ◆ The major component of the patient symptoms is dyspnea
 - ◆ Newly diagnosed or worsening cardiomyopathy
 - ◆ For surgical planning prior to valve surgery or congenital heart defect repair

CD-7.3.5: Evaluation of structural heart disease

- Evaluation prior to planned surgery
 - ◆ Ruling out coronary artery disease prior to planned non-coronary cardiac or great vessel surgery (i.e. cardiac valve surgery, aortic dissection, aortic aneurysm, congenital disease repair such as atrial septal defect, etc.).
 - ◆ Pre-organ transplant (non-cardiac). Some institutions perform a heart cath as part of their initial evaluation protocol. Others use an imaging stress test for evaluation. Either is appropriate and can be approved but **NOT** both.
- Valvular heart disease when either:
 - ◆ There is a discrepancy between the clinical findings (history, physical exam, and non-invasive test results)
 - ◆ Valvular surgery is being considered.
- Suspected pericardial disease.
- Previous cardiac transplant:
 - ◆ Per transplant center protocol
 - ◆ To assess for accelerated coronary artery disease associated with cardiac transplantation.
- Left and right heart cath may be indicated in place of a left heart cath if the above criteria has been met and there is documentation of any of the following:
 - ◆ The major component of the patient symptoms is dyspnea
 - ◆ Newly diagnosed or worsening cardiomyopathy
 - ◆ For surgical planning prior to valve surgery or congenital heart defect repair

CD-7.4: Right Heart Catheterization (RHC)

CD-7.4.1: General information RHC (CPT® 93451)

- It is performed most commonly from the femoral vein, less often through the subclavian or brachial or internal jugular vein and inter-atrial septal puncture approach.
- It includes a full oximetry for detection and quantification of shunts.
- Pressure measurements are made and are done simultaneously with aortic and left ventricular pressures.
- Cardiac outputs are calculated by several techniques including the Fick thermodilution.

CD-7.4.2: Diagnostic Right Heart Catheterization – Indications

- Diagnostic Right heart cath is indicated when results will impact the diagnosis and management of **any** of the following:
 - ◆ Atrial septal defect (ASD) including shunt detection and quantification
 - ◆ Ventricular septal defect (VSD) including shunt detection and quantification
 - ◆ Patent foramen ovale (PFO)
 - ◆ Anomalous pulmonary venous return
 - ◆ Congenital defects including persistent left vena cava
 - ◆ Pulmonary hypertension
 - ◆ Pericardial diseases (constrictive or restrictive pericarditis)
 - ◆ Valvular disease
 - ◆ Right heart failure
 - ◆ Left heart failure
 - ◆ Newly diagnosed or worsening cardiomyopathy
 - ◆ Preoperative evaluation for valve surgery
 - ◆ During a left heart cath where the etiology of the symptoms remains unclear
 - ◆ Pre-lung transplant to assess pulmonary pressures
 - ◆ Uncertain intravascular volume status with an unclear etiology
 - ◆ Assessment post-cardiac transplant
 - For routine endomyocardial biopsy
 - Assess for rejection
 - Assess pulmonary artery pressure
 - Can be done per the institution protocol or anytime organ rejection is suspected and biopsy is needed for assessment
 - ◆ Evaluation of right ventricular morphology.
 - ◆ Suspected arrhythmogenic right ventricular dysplasia.

CD-7.5: Combined Right and Left Heart Catheterization Indications

- Preoperative evaluation for valve surgery
- The indications for **CD-7.3: Diagnostic Left Heart Catheterization** are met and any of the following are present:
 - ◆ The major component of the patient symptoms is dyspnea
 - ◆ The indications are met according to **CD-7.4: Right Heart Catheterization**
 - ◆ Newly diagnosed or worsening cardiomyopathy

CD-7.6: Planned (Staged) Coronary Interventions

- The CPT® codes for percutaneous coronary interventions (PCI) include the following imaging services necessary for the procedure(s):
 - ◆ Contrast injection, angiography, 'road-mapping', and fluoroscopic guidance
 - ◆ Vessel measurement
 - ◆ Angiography following coronary angioplasty, stent placement, and atherectomy
- Separate codes for these services should not be assigned in addition to the PCI code/s because the services are already included.
- A repeat diagnostic left heart catheterization is not medically necessary when the patient is undergoing a planned staged percutaneous coronary intervention.

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CD-8: Pulmonary Artery and Vein Imaging

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CD-8.2: Pulmonary Vein Imaging – Indications	66

CD-8.1: Pulmonary Artery Hypertension (PAH) – Indications

Pulmonary artery hypertension (PAH) is a complex, chronic disease that requires extensive evaluation, including ECG (right ventricular hypertrophy with/without strain, right atrial dilatation); chest x-ray; arterial blood gas, PFT's, CT angiography or V/Q scan. Imaging is based on suspected etiology.

- Transthoracic echocardiogram (TTE) (CPT® 93306) should be performed initially as it can help determine the probability of pulmonary hypertension. Echo may be accompanied by:
 - ◆ Stress echocardiogram (CPT® 93350 or CPT® 93351), especially in the setting of concomitant valvular disease to assess for treatment
 - ◆ Left and/or right heart catheterization for direct measurement of pressures
 - ◆ High-resolution CT Chest (CPT® 71250) to rule out restrictive lung disorders such as pulmonary fibrosis in the setting of hypoxemia
- For suspected acute and/or chronic pulmonary embolism one of the following:
 - ◆ CTA Chest (CPT® 71275)
 - ◆ MRA Chest (CPT® 71555)
 - ◆ V/Q scan (CPT® 78580-Pulmonary Perfusion Imaging CPT® 78582-Pulmonary Ventilation (e.g., Aerosol or Gas) and Perfusion Imaging). If requested can add to V/Q scan one of the following:
 - SPECT imaging (CPT® 78803)
 - SPECT/CT imaging (CPT® 78830)
- See also in specific subsections:
 - ◆ **CD-2.3: Frequency of Echocardiography Testing, CD-7.4: Right Heart Catheterization (RHC), CD-11.3.12: Severe Pulmonary artery hypertension (PHT) and Eisenmenger syndrome** in the cardiac imaging guidelines
 - ◆ **PEDCD-2.3: Congenital Heart Disease Modality Considerations, PEDCD-7: Pediatric Pulmonary Hypertension - General** in the pediatric cardiac imaging guidelines
 - ◆ **CH-25: Pulmonary Embolism (PE)** in the Chest Imaging Guidelines.

CD-8.2: Pulmonary Vein Imaging – Indications

- Cardiac MRI (CPT® 75557 or CPT® 75561), Chest MRV (CPT® 71555), Chest CTV (CPT® 71275), or Cardiac CT (CPT® 75572) can be performed to evaluate the anatomy of the pulmonary veins:
 - ◆ Prior to an ablation procedure performed for atrial fibrillation.
 - ◆ Post-procedure between 3-6 months after ablation because of a 1% to 2% incidence of asymptomatic pulmonary vein stenosis.
 - If no pulmonary vein stenosis is present, no further follow-up imaging is required.
 - If pulmonary vein stenosis is present on imaging following ablation and symptoms of pulmonary vein stenosis (usually shortness of breath) are present, can be imaged at 1, 3, 6, and 12 months.
 - ◆ The majority (81%) of pulmonary vein stenosis remain stable over 1 year. Progression occurs in 8.8% and regression occurs in a small percentage.

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CD-9: Congestive Heart Failure

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CD-9.1: CHF – Imaging

- Congestive heart failure, including post-cardiac transplant failure:
 - ◆ An echocardiogram is generally the first study to be done after the clinical evaluation of the patient who is suspected of having heart failure.
 - ◆ If the ECHO is limited or does not completely answer the question, then further evaluation with MUGA, cardiac MRI or cardiac CT may be appropriate.
 - ◆ A stress test to assess for CAD may be appropriate. Follow stress testing guideline: **CD-1.4: Stress Testing with Imaging – Indications**
- Arteriovenous fistula with “high output” heart failure:
 - ◆ CT Chest with contrast (CPT® 71260) and/or CT Abdomen and/or CT Pelvis with contrast (CPT® 74160 or CPT® 72193 or CPT® 74177) **OR**
 - ◆ CTA Chest (CPT® 71275) and/or CTA Abdomen and/or CTA Pelvis (CPT® 74175 or CPT® 72191 or CPT® 74174) **OR**
 - ◆ MRI Chest and/or MRI Abdomen and/or MRI Pelvis without and with contrast (CPT® 71552 and/or CPT® 74183 and/or CPT® 72197) **OR**
 - ◆ MRA Chest and/or MRI Abdomen and/or MRI Pelvis (CPT® 71555 and/or CPT® 74185 and/or CPT® 72198)
- Right-sided congestive heart failure can be a manifestation of pulmonary hypertension or serious lung disease.
 - ◆ Chest CT (CPT® 71260) or chest CTA (CPT® 71275) to evaluate for recurrent pulmonary embolism

CD-9.2: Palliative Care in patients with heart failure

- There are currently no widely accepted published guidelines regarding end of life care for end-stage heart failure patients who are not candidates for advanced heart failure treatments such as left ventricular assist devices, heart pumps or heart transplantation. Consideration for palliative care services should be given to such patients.

CD-9.3: Myocardial Sympathetic Innervation Imaging

- In heart failure, the sympathetic nervous system is activated in order to compensate for the decreased myocardial function. Initially, this is beneficial, however, long-term this compensatory mechanism is detrimental and causes further damage.
- Markers have been developed, using radioactive iodine, in an attempt to image this increased myocardial sympathetic activity. Currently, AdreView™ (Iodine-123 meta-iodobenzylguanidine), is the only FDA-approved imaging agent available for this purpose. eviCore currently considers AdreView™ to be experimental and investigational.
- The AMA has established the following set of Category III codes to report these studies:

- ◆ **0331T** - Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment
- ◆ **0332T** - Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment, with tomographic SPECT.

CD-9.4: Left ventricular assist devices (LVAD)

Left ventricular assist devices (LVAD) are implantable devices used in patients with advanced heart failure refractory to medical therapy, often as a bridge to transplantation.

- Echocardiograms (TTE) are obtained frequently for surveillance following implantation:
 - ◆ Post implant-generally at 2 weeks
 - ◆ Then as follows at:
 - One month
 - Three months
 - Six months
 - Twelve months
 - And every 6 months thereafter

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CD-10: Cardiac Trauma

CD-10.1: Cardiac Trauma – Imaging

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CD-10.1: Cardiac Trauma – Imaging

- Any of the following can be used to evaluate cardiac or aortic trauma:
 - ◆ Echocardiogram (TTE, TEE)
 - ◆ Cardiac MRI (CPT® 75557, CPT® 75561, and CPT® 75565)
 - ◆ Cardiac CT (CPT® 75572)
 - ◆ CCTA (CPT® 75574)
 - ◆ Chest CTA (CPT® 71275)
 - ◆ Chest CT (CPT® 71260, CPT® 71270)

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CD-11.1: Congenital heart disease – General Information

- This section covers adult congenital heart disease (CHD), for other associated disorders please see the condition specific sections
 - ◆ Marfan Syndrome
 - ◆ Hypertrophic cardiomyopathy (HCM)
 - ◆ Bicuspid aortic valve (BAV)

CD-11.1.1: Definitions

- Physiological stages (A, B, C, D)
 - ◆ Each congenital heart lesion is divided into 4 physiological stages (A, B, C, D)

Characteristics	Physiological stage			
	A	B	C	D
NYHA functional class	I	II	III	IV
Hemodynamic or anatomic sequelae	None	Mild ventricular enlargement of dysfunction, small shunt	Moderate or greater, ventricular dysfunction. Any venous or arterial stenosis	Moderate or greater, ventricular dysfunction. Any venous or arterial stenosis
Valvular	None	Mild	Moderate or greater	Moderate or greater
Aortic enlargement	None	Mild	Moderate	Severe
Exercise capacity limitation	Normal	Abnormal objective cardiac limitation	Moderate	Severe
Renal hepatic pulmonary dysfunction	None		Mild but responsive to medication	Refractory to treatment
Cyanosis/ hypoxemia	None		Mild	Severe
Arrhythmias	None	Arrhythmia not requiring treatment	Needs rx	Refractory to rx
Pulmonary hypertension	None		Mild to moderate	Severe or Eisenmenger

- CHD Anatomic classification
 - ◆ Class I-Simple
 - Native disease
 - Isolated small ASD
 - Isolated small VSD
 - Mild isolated pulmonic stenosis
 - Repaired conditions
 - Previously ligated or occluded ductus arteriosus
 - Repaired secundum ASD or sinus venosus defect without significant residual shunt or chamber enlargement

- Repaired VSD without significant residual shunt or chamber enlargement
- ◆ Class II-Moderate Complexity
 - Repaired or unrepaired conditions
 - Aorto-left ventricular fistula
 - Anomalous pulmonary venous connection, partial or total
 - Anomalous coronary artery arising from the pulmonary artery
 - Anomalous aortic origin of a coronary artery from the opposite sinus
 - AVSD (partial or complete, including primum ASD)
 - Congenital aortic valve disease
 - Congenital mitral valve disease
 - Coarctation of the aorta
 - Ebstein anomaly (disease spectrum includes mild, moderate, and severe variations)
 - Infundibular right ventricular outflow obstruction
 - Ostium primum ASD
 - Moderate and large unrepaired secundum ASD
 - Moderate and large persistently patent ductus arteriosus
 - Pulmonary valve regurgitation (moderate or greater)
 - Pulmonary valve stenosis (moderate or greater)
 - Peripheral pulmonary stenosis
 - Sinus of Valsalva fistula/aneurysm
 - Sinus venosus defect
 - Subvalvular aortic stenosis (excluding HCM; HCM not addressed in these guidelines)
 - Supravalvular aortic stenosis
 - Straddling atrioventricular valve
 - Repaired tetralogy of Fallot
 - VSD with associated abnormality and/or moderate or greater shunt
- ◆ Class III- Great Complexity (or Complex)
 - Cyanotic congenital heart defect (unrepaired or palliated, all forms)
 - Double-outlet ventricle
 - Fontan procedure
 - Interrupted aortic arch
 - Mitral atresia
 - Single ventricle (including double inlet left ventricle, tricuspid atresia, hypoplastic left heart, any other anatomic abnormality with a functionally single ventricle)
 - Pulmonary atresia (all forms)
 - TGA (classic or d-TGA; CCTGA or l-TGA)
 - Truncus arteriosus
 - Other abnormalities of atrioventricular and ventriculoarterial connection (i.e., crisscross heart, isomerism, heterotaxy syndromes, ventricular inversion)

CD-11.1.2: Modalities

- Echocardiogram- transthoracic (TTE) or transesophageal (TEE)
 - ◆ Transthoracic echocardiography (TTE) is an indispensable tool in the initial and serial follow-up evaluation to identify abnormalities and changes that commonly influence management decisions.
- Cardiac MRI (CMR)
 - ◆ CMR plays a valuable role in assessment of RV size and function, because it provides data that are reproducible and more reliable than data obtained with alternative imaging techniques
 - ◆ For intracardiac congenital heart disease, CMR will typically include flow velocity mapping for shunts and flow assessment.
 - ◆ Imaging that only requires aortic arch imaging, does not require intracardiac CMR, only chest MRA.
- Cardiac Computed Tomography (CCT) and Cardiac Computed Tomography Angiography (CCTA)
 - ◆ The most important disadvantage of CCT (including CT angiography) as an imaging technique is the associated exposure to ionizing radiation.
- Cardiac catheterization
 - ◆ (hemodynamic and/or angiographic) in patients with adult CHD AP classification II and III, or interventional cardiac catheterization in patients with adult CHD AP classification I to III should be performed by, or in collaboration with, cardiologists with expertise in adult CHD
- Exercise Testing
 - ◆ Exercise test does not imply stress imaging
- Stress Imaging
 - ◆ Includes-MPI, stress echo, stress MRI
 - ◆ PET stress may be included as per **CD-6: Cardiac PET**
- Circumstances where CMR, CCT, TEE, and/or Cardiac Catheterization may be Superior to TTE
 - ◆ Assessment of RV size and function in repaired Tetralogy of Fallot (TOF), systemic right ventricles, and other conditions associated with right ventricular (RV) volume and pressure overload
 - ◆ Identification of anomalous pulmonary venous connections
 - ◆ Serial assessment of thoracic aortic aneurysms, especially when the dilation might extend beyond the echocardiographic windows
 - ◆ Accurate assessment of pulmonary artery (PA) pressure and pulmonary vascular resistance
 - ◆ Assessment for re-coarctation of the aorta
 - ◆ Sinus venosus defects
 - ◆ Vascular rings
 - ◆ Evaluation of coronary anomalies
 - ◆ Quantification of valvular regurgitation

CD-11.1.3: Coding

Modality	CPT®
Echocardiogram	
Transthoracic echocardiogram (TTE)	
TTE for congenital cardiac anomalies; complete	93303
TTE for congenital cardiac anomalies; limited study	93304
TTE (2D) m-mode recording, complete, with spectral and color flow doppler echocardiography	93306
TTE (2D) with or without m-mode recording; complete	93307
TTE (2D) with or without m-mode recording; limited study	93308
Transesophageal echocardiogram (TEE)	
TEE (2D) including probe placement, imaging, interpretation, and report	93312
TEE for congenital cardiac anomalies; including probe placement, imaging, interpretation, and report	93315
MRI	
cardiac (CMR)	
Cardiac MRI for morphology and function without contrast	75557
Cardiac MRI for morphology and function without and with contrast	75561
Chest MRI	
MRI chest without contrast	71550
MRI chest with contrast	71551
MRI chest with & without contrast	71552
MRI Angiography (MRA) Chest MRA	
MRA chest (excluding myocardium) with or without contrast	71555
CT	
cardiac (CCT)	
CT, heart, with contrast material, for evaluation of cardiac structure and morphology	75572
CT, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease	75573
CT Angiography-cardiac (CCTA)	
CTA heart, coronary arteries and bypass grafts (when present), with contrast, including 3D image post processing	75574
CT-chest	
CT Thorax without contrast	71250
CT Thorax with contrast	71260
CT Thorax without & with contrast	71270
CT Angiography-chest (chest CTA)	
CTA Chest without and with contrast	71275
Stress Imaging (echo, MRI, MPI)	
Stress echo	
Echocardiography (TTE), (2D), with or without m-mode, during rest and cardiovascular stress, with interpretation and report	93350
Echocardiography (TTE), (2D), m-mode, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation	93351

Modality	CPT®
Stress MRI	
Cardiac MRI for morphology and function without contrast, with stress imaging	75559
Cardiac MRI for morphology and function without and with contrast, with stress imaging	75563
Myocardial perfusion imaging (MPI)	
MPI, tomographic (SPECT) including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed; single study, at rest or stress (exercise or pharmacologic)	78451
MPI, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	78452
Pulmonary perfusion imaging	
Pulmonary perfusion imaging (e.g., particulate)	78580
Pulmonary ventilation (e.g., aerosol or gas) and perfusion imaging	78582
Quantitative differential pulmonary perfusion, including imaging when performed	78597
Quantitative differential pulmonary perfusion and ventilation (e.g., aerosol or gas), including imaging when performed	78598

CD-11.2: Congenital Heart Disease Imaging Indications

- The following sections are based on the congenital heart lesion. Requests for imaging based on other cardiac conditions, such as CAD, HCM, acquired valvular lesions, should follow the adult cardiac guidelines for those conditions.

CD-11.2.1: ASD-Atrial septal defects

- This section does not include patent foramen ovale (PFO) or PFO occluders.
- Initial studies-Diagnosis, clinical changes, consideration of surgery
 - ◆ Echocardiogram at time of diagnosis
 - CMR, CCT (CPT® 75573), and/or TEE are useful if echo (TTE) is suboptimal and either:
 - ASD is suspected
 - To evaluate pulmonary venous connections in known ASD
 - Chest MRA or chest CTA may be indicated if echo shows pulmonary venous anomalies
 - If normal, repeat pulmonary vein imaging is not required.
 - ◆ Transesophageal echocardiogram (TEE) is recommended to guide percutaneous ASD closure
 - ◆ Diagnostic cath is indicated when there is either:
 - Evidence of pulmonary hypertension
 - Unanswered questions on CMR/CCT for venous drainage.
- TTE is indicated post ASD device placement:
 - ◆ 6 months to evaluate for erosion

- ◆ 1 week (if amplatzer)
 - ◆ 1 month
 - ◆ 6 months
 - ◆ 12 months
 - ◆ then every 1-2 years
- Due to low risk of erosion in PFO devices- PFO device closure requires follow-up at 6-12 months. No additional evaluation unless PFO not closed
- Stress imaging and coronary artery imaging would be based on **CD-1.4: Stress Testing with Imaging – Indications**

Follow-up ASD if surgically closed or if no interventions

Modality	Physiological stage / intervals for routine imaging (months)			
Physiological stage	A	B	C	D
TTE	36	24	12	12

CD-11.2.2: Anomalous Pulmonary Venous Connections

- Initial studies-Diagnosis, clinical changes, consideration of surgery
- ◆ Echocardiogram at time of diagnosis
 - CMR and/or Chest MRA, or cardiac CT and/or chest CTA at time of diagnosis if any issues with pulmonary veins or RV volume.
 - Cardiac Cath at time of diagnosis for hemodynamic data and issues not answered on other imaging
 - ◆ Routine stress imaging or coronary artery imaging not required.
 - ◆ Echo, CMR, CT, per cardiology request for clinical changes
 - Diagnostic heart catheterization if questions unanswered on imaging

Follow-up Anomalous Pulmonary Venous Connections

Modality	Physiological stage / intervals for routine imaging (months)			
Physiological stage	A	B	C	D
Echo (TTE)	36	24	12	12

CD-11.2.3: Ventricular Septal Defect (VSD)

- Initial studies-Diagnosis, clinical changes, consideration of surgery
- ◆ Echo (TTE) at time of diagnosis
 - CMR or CCT can be performed if questions are unanswered on echo
 - Catheterization at time of diagnosis for hemodynamics if pulmonary hypertension (PHT) or shunt size is a question

Long term follow-up VSD

Modality	Physiological stage / intervals for routine imaging (months)			
Physiological stage	A	B	C	D
Echo (TTE)	36	24	12	12

CD-11.2.4: Atrioventricular Septal Defect (AV Canal, AVSD, endocardial cushion defect)

- Initial studies-Diagnosis, clinical changes, consideration of surgery
 - ◆ Echo (TTE) at time of diagnosis
 - CMR or cardiac CT at time of diagnosis if there are unanswered questions on echo
 - Cardiac cath at time of diagnosis when CMR and TTE leave questions unanswered that affect patient management
 - ◆ Stress imaging per **CD-1.4: Stress Testing with Imaging – Indications**

Long term follow-up -AVSD

Modality	Physiological stage / intervals for routine imaging (months)			
Physiological stage	A	B	C	D
Echo (TTE)	24	24	12	12

CD-11.2.5: Patent Ductus Arteriosus (PDA)

- Initial studies-Diagnosis, clinical changes, consideration of surgery
 - ◆ Echo at time of diagnosis
 - Chest MR or Chest CT if there are questions left unanswered by echo
 - Cardiac Cath for hemodynamics (if planned device closure, diagnostic cardiac cath is not indicated as it is included in the procedure code)
 - ◆ Stress imaging per **CD-1.4: Stress Testing with Imaging – Indications**

Long term follow-up PDA

Modality	Physiological stage / intervals for routine imaging (months)			
Physiological stage	A	B	C	D
Echo (TTE)	36	24	12	12

CD-11.2.6: Cor Triatriatum

- Initial studies-Diagnosis, clinical changes, consideration of surgery
 - ◆ Echocardiogram (TTE) at time of diagnosis
 - CMR and/or Chest MRA or cardiac CT and/or chest CTA may be approved
 - Diagnostic cath may be approved if additional information is required for medical management
 - ◆ Long term follow-up
 - Stress imaging per **CD-1.4: Stress Testing with Imaging – Indications**

CD-11.2.7: Congenital Mitral Stenosis

- Initial studies-Diagnosis, clinical changes, consideration of surgery
 - ◆ Echocardiogram (TTE) at time of diagnosis

Long term follow-up congenital mitral stenosis

Modality	Physiological stage / intervals for routine imaging (months)			
Physiological stage	A	B	C	D
Echo (TTE)	24	24	12	12

CD-11.2.8: Subaortic Stenosis (SAS)

- Initial studies-Diagnosis, clinical changes, consideration of surgery
 - ◆ Echocardiogram (TTE) at time of diagnosis
 - ◆ Stress imaging (stress echo or stress MRI) for any of the following:
 - Once at the time of diagnosis
 - New or changed signs or symptoms of ischemia
 - Changes in cardiac function
 - If cardiac intervention is being considered
 - Any signs or symptoms allowed in **CD-1.4: Stress Testing with Imaging – Indications**

Long term follow-up SAS

Modality	Physiological stage / intervals for routine imaging (months)			
Physiological stage	A	B	C	D
Echo (TTE)	24	24	12	12
Stress imaging		24	24	12

CD-11.2.9: Congenital Valvular Aortic Stenosis

- Initial studies-Diagnosis, clinical changes, consideration of surgery
 - ◆ Echocardiogram (TTE) at time of diagnosis
 - ◆ TEE may be required if TTE limited or equivocal
 - ◆ Chest MRA or chest CTA if one of the following:
 - Suspicion of Coarctation based on exam and echocardiogram
 - Proximal ascending aorta not well visualized on TTE

Routine follow-up Congenital Valvular Aortic Stenosis

Modality	Physiological stage / intervals for routine imaging			
Stage (valvular AS)	Progressive (stage B) Mild Vmax 2.0-2.9 m/s	Progressive (stage B) Moderate Vmax 3.0-3.9 m/s	Severe (stage C) ≥ 4.0 m/s	Aortic root dilation >4.5 cm
echo (TTE)	3 years	1 years	6 months	12 months
Chest MRA or CTA				if ascending allowed yearly

Degree of aortic stenosis (AS) severity			
	Mild AS	Moderate AS	Severe AS
Vmax (m/s) ^a maximum Doppler velocity	2.0-2.9	3.0-3.9	≥ 4.0
Mean gradient (mmHg) ^a	<30	30-49	≥ 50
AVA (cm ²) aortic valve area	>1.5	1.0-1.5	<1.0
AVAi (cm ² /m ² BSA) indexed aortic valve area	≥ 1.0	0.6-0.9	<0.6
^a At normal transvalvular flow, BSA= body surface area			

Adapted from: ESC Guidelines for the management of grown-up congenital heart disease (new version 2010): The Task Force on the Management of Grown-up Congenital Heart Disease of the European Society of Cardiology (ESC).

CD-11.2.10: Aortic disease in Turner Syndrome

- Dissection more common for a given aortic diameter. Mid-ascending aortic disease more common and may not be reliably seen on echocardiogram
- Initial studies-Diagnosis, clinical changes, consideration of surgery
 - ◆ Echocardiogram (TTE) at time of diagnosis
 - ◆ Chest MRA or chest CTA to rule out mid ascending aortic aneurysm if mid aorta was not seen on echocardiogram.
- Surveillance
 - ◆ Echocardiogram (TTE) yearly
 - Chest MRA or CTA if mid ascending aorta not visualized
 - ◆ For documented thoracic aortic aneurysm (TAA) ≤ 4 cm
 - Routine Chest MRA or CTA yearly
 - ◆ For documented thoracic aortic aneurysm (TAA) > 4 cm
 - Chest MRA or CTA every 6 months.

CD-11.3: Aortopathies with CHD

- Dilated aortic arches are not uncommon with several congenital heart disease and postoperative procedures including- Aortic stenosis, Ross repair, Tetralogy of Fallot, Transposition of the great arteries (TGA), Pulmonary atresia, hypoplastic left heart syndrome (HLHS), Truncus Arteriosus, single ventricle patients.

CD-11.3.1: Supravalvular Aortic Stenosis

- Supravalvular aortic stenosis is a relatively rare condition overall but is seen commonly in patients with Williams syndrome or homozygous familial hypercholesterolemia.
- Initial studies-Diagnosis, clinical changes, consideration of surgery
 - ◆ Echocardiogram (TTE) at time of diagnosis
 - ◆ Chest MRA or chest CTA
 - ◆ Cardiac MRI or cardiac CTA to assess coronary ostia
 - ◆ Cardiac cath for any patients pre cardiac intervention for coronary arteries
- New cardiac symptoms-any of the following:
 - ◆ Cardiac CT or cardiac MR
 - ◆ Chest CTA or chest MRA
 - ◆ Stress imaging as per **CD-1.4: Stress Testing with Imaging – Indications**

Routine follow-up supravalvular AS

Modality	Physiological stage / intervals for routine imaging (months)			
Physiological stage	A	B	C	D
TTE	24	24	12	12
CMR or CCT	36	36	36	36

CD-11.3.2: Coarctation of the Aorta

- Coarctation is suspected based on clinical findings:
 - ◆ BP higher in upper extremities than in the lower extremities
 - ◆ Absent femoral pulses
 - ◆ Continuous murmur
 - ◆ Abdominal bruit
 - ◆ Berry aneurysm with hemorrhage
 - ◆ Rib notching on x-ray
 - ◆ Abnormal thoracic aortic imaging and blood pressures
- Initial studies-Diagnosis, clinical changes, consideration of surgery
 - ◆ Echocardiogram (TTE) at time of diagnosis
 - No further imaging is required if echocardiogram (TTE), blood pressure, and exam rule out Coarctation.
 - Echo and exam are equivocal or positive one of the following is indicated:
 - Chest CTA
 - Chest MRA

- Patients with Coarctation of the aorta do not require intracardiac MR unless issue cannot be resolved on echocardiogram.
- Screening for intracranial aneurysm by MRA or CTA of head is allowed
- ◆ ETT for diagnosis of exercise induced hypertension does not require imaging
- ◆ Cardiac MR not required unless issues unresolved by echo for intracardiac anatomy
- ◆ Diagnostic cath can be approved prior to stenting of the coarctation
- ◆ Stress imaging, TEE, Cardiac MR or CT, Coronary imaging not routinely
- Symptomatic
 - ◆ Patients with Coarctation are at risk for dissection. When patient has new or worsening symptoms any of the following:
 - Echocardiogram (TTE)
 - Chest MRA or CTA.
 - ◆ For exertional symptoms, one of the following:
 - Stress imaging-per **CD-1.4: Stress Testing with Imaging – Indications**
 - Cardiac MRI or cardiac CT

Routine follow-up Coarctation of the Aorta

Modality	Physiological stage / intervals for routine imaging (months)			
Physiological stage	A	B	C	D
TTE	24	24	12	12
Chest MRA or Chest CTA	36	36	12	12

CD-11.3.3: Valvular Pulmonary Stenosis

- Overview Initial studies-Diagnosis, clinical changes, consideration of surgery
 - ◆ Echocardiogram (TTE) at time of diagnosis
 - ◆ For issues affecting management not well visualized on TTE
 - Cardiac MRI or cardiac CT
 - Chest MRA or chest CTA
- Valvular PS routine follow-up and testing.
 - ◆ Echocardiogram-stages
 - Mild PS – peak gradient <36 mmHg (peak velocity < 3m/s)
 - Moderate PS- peak gradient 36-64 mmHg (peak velocity 3-4 m/s)
 - Severe PS- peak gradient >64 mmHg (peak velocity > 4 m/s); or mean gradient >35 mmHg.
 - ◆ Routine stress imaging is not required
 - ◆ Routine chest or cardiac or ischemia workup not required.

Valvular PS routine imaging

Modality	Physiological stage / intervals for routine imaging (months)			
Physiological stage	A	B	C	D
TTE	36	24	12	12

Isolated Pulmonary regurgitation after PS repair-Echo and CMR at same interval as TOF

Modality	Physiological stage / intervals for routine imaging (months)			
Physiological stage	A	B	C	D
TTE	24	12	12	12
CMR	36	24	12	12

CD-11.3.4: Branch and Peripheral pulmonary stenosis

- Overview
 - ◆ Can be seen in newborns as a normal variant in the first 6 months of life
 - ◆ Can be seen in surgeries of right ventricular outflow (TOF)
 - Noonan
 - Alagille
 - Williams
 - Maternal rubella exposure
 - Keutel syndrome
- Initial studies-Diagnosis, clinical changes, consideration of surgery
 - ◆ Echocardiogram (TTE) at time of diagnosis
 - ◆ Baseline chest MRA or chest CTA
 - ◆ Cath may be considered if other advanced imaging is not adequate for management
 - ◆ VQ scan or chest MRA for differential blood flow

Routine follow-up branch and peripheral pulmonary stenosis

Modality	Physiological stage / intervals for routine imaging (months)			
Physiological stage	A	B	C	D
TTE	24	24	12	12
Cardiac MRI or cardiac CT	36	36	24	24
Chest MRA or chest CTA	36	36	24	24

CD-11.3.5: Double chambered RV

- Initial studies-Diagnosis, clinical changes, consideration of surgery
 - ◆ Echocardiogram (TTE) at time of diagnosis

Routine follow-up double chambered right ventricle (RV)

Modality	Physiological stage / intervals for routine imaging (months)			
Physiological stage	A	B	C	D
Echo (TTE)	24	24	12	12

CD-11.3.6: Ebstein Anomaly

- Overview Initial studies-Diagnosis, clinical changes, consideration of surgery
 - ◆ Echocardiogram (TTE) at time of diagnosis
 - ◆ TEE if either:
 - TTE is not adequate
 - If surgery/intervention planned
 - ◆ Cardiac MRI or cardiac CT at time of Diagnosis

Routine follow-up Ebstein Anomaly

Modality	Physiological stage / intervals for routine imaging (months)			
Physiological stage	A	B	C	D
Echo (TTE)	12	12	12	12
Cardiac MRI or cardiac CT	60	36	24	12

CD-11.3.7: Tetralogy of Fallot (TOF, VSD with PS)

- Includes TOF with pulmonary atresia, VSD PA
- Initial studies-Diagnosis, clinical changes, consideration of surgery
 - ◆ Echocardiogram (TTE) at time of diagnosis
 - ◆ Cardiac MR or Cardiac CTA at time of diagnosis
 - ◆ Chest MRA or Chest CTA at time of diagnosis
 - ◆ Cardiac catheterization if other advanced imaging leaves unanswered questions
- Prior to cardiac intervention or surgery
 - ◆ Repeat imaging Echo/MR/CT
 - ◆ Cath prior to surgery or intervention
 - If planned Catheter Pulmonary Valve replacement, procedure includes diagnostic cath and hemodynamics and diagnostic cath is not billed separately
- New or worsening symptoms
 - ◆ Repeat advanced imaging
 - New or worsening symptoms
 - New EKG changes

- ◆ Stress imaging (stress echo, stress MRI, or MPI) allowed for typical chest pain, even if intermediate pretest probability at atypical symptoms in patients with known or undefined coronary artery (CA) anatomy or CA pathology
- ◆ VQ scan or MRA chest for left/right perfusion abnormality

Routine Follow-up Tetralogy of Fallot (TOF)

Modality	Physiological stage / intervals for routine imaging (months)			
Physiological stage	A	B	C	D
TTE	24	12	12	12
Cardiac MRI or CCTA	36	24	12	12
Chest CTA or MRA	36	24	12	12

CD-11.3.8: Right Ventricle-to-Pulmonary Artery Conduit

- Initial studies-Diagnosis, clinical changes, consideration of surgery. Surgical repair for many lesions such as TOF/ Truncus /Pulmonary atresia
 - ◆ Echocardiogram (TTE) at time of diagnosis
 - ◆ Cardiac MRI or Cardiac CTA
 - ◆ Chest MRA or Chest CTA
 - ◆ Prior to interventions or surgery may repeat any of the above imaging
 - ◆ Cath allowed for new symptoms or with new imaging findings as needed for management
 - ◆ Stress imaging (stress echo, stress MRI or MPI) as requested for symptoms

Routine follow-up Right Ventricle-to-Pulmonary Artery Conduit

Modality	Physiological stage / intervals for routine imaging (months)			
Physiological stage	A	B	C	D
TTE	12	12	12	12
CMR or CCTA	36	36	12	12
Chest MRA or chest CTA	36	36	12	12

CD-11.3.9: Transposition of the great arteries (TGA)

- Initial studies-Diagnosis, clinical changes, consideration of surgery
 - ◆ Echocardiogram (TTE) at time of diagnosis
 - ◆ Baseline Cardiac MRI or CCTA
 - ◆ Baseline Chest MRA or CTA
 - ◆ Stress imaging as requested for symptoms or signs of ischemia
 - ◆ V/Q scan for left to right PA perfusion or chest MRA
 - ◆ Symptomatic patients should be offered stress physiological imaging and repeat anatomic imaging considered if symptoms are suggestive of coronary ischemia (regardless of diamond forester pretest probability category)
 - ◆ Cath right and left heart when issues not elucidated on advanced imaging

Routine follow-up TGA

Modality	Physiological stage / intervals for routine imaging (months)			
Physiological stage	A	B	C	D
TTE	12	12	12	12
CMR or CCTA	36	24	12	12
Chest MRA or Chest CTA	36	24	12	12

CD-11.3.10: Congenitally corrected TGA

- Initial studies-Diagnosis, clinical changes, consideration of surgery
 - ◆ Echocardiogram (TTE) at time of diagnosis
 - ◆ Baseline CMR and Chest MRA
 - ◆ CMR and/or Echo for changes in clinical status

Routine follow-up congenitally corrected TGA

Modality	Physiological stage / intervals for routine imaging (months)			
Physiological stage	A	B	C	D
Echo (TTE)	12	12	12	12
CMR or CCTA	36	36	12	12
Chest CTA or chest MRA	36	36	12	12

CD-11.3.11: Fontan Palliation of Single Ventricle Physiology

- Including Tricuspid Atresia and Double Inlet Left Ventricle, HLHS, HRHS, PA, Mitral atresia, AVC unbalanced, single ventricle, DIRV, pulmonary atresia, HLHS, Glen procedure, TA, double outlet right ventricle (DORV), and single ventricle physiology
- Initial studies-Diagnosis, clinical changes, consideration of surgery
 - ◆ Echocardiogram (TTE) at time of diagnosis and with any new Symptoms
 - ◆ CMR or CCTA can be done annually (vs. based on below chart) on patients who have prior issues that were equivocal on echo, and the data is required (i.e. very poor windows)
 - Cardiac catheterization prior to surgical interventions
 - ◆ Echo/CMR or CCTA/chest MRA or chest CTA/cath with any new signs or symptoms
 - ◆ V/Q scan or MRA for lung perfusion left vs. right

Routine follow-up Fontan Palliation of Single Ventricle Physiology

Modality	Physiological stage / intervals for routine imaging (months)			
Physiological stage	A	B	C	D
Echo (TTE)	12	12	12	12
CMR or cardiac CT	36	24	24	24
Chest CTA or MRA	36	24	24	24

CD-11.3.12: Severe Pulmonary artery hypertension (PHT) and Eisenmenger syndrome

- Initial studies-Diagnosis, clinical changes, consideration of surgery
 - ◆ Echo (TTE)
 - Initial diagnosis
 - With new signs or symptoms
 - ◆ Cardiac cath
 - Echo (TTE) results suggest PHT
 - New signs or symptoms with PHT

Long term follow-up Severe Pulmonary artery hypertension (PHT) and Eisenmenger syndrome

Modality	Physiological stage / intervals for routine imaging (months)			
Physiological stage	A	B	C	D
TTE			12	12
CMR or CCT			As needed	As needed
Chest MRA or chest CTA			As needed	As needed
Cath			As needed	As needed

CD-11.3.13: Coronary artery anomalies

- Initial studies-Diagnosis, clinical changes, consideration of surgery
 - ◆ Echocardiogram (TTE)
 - At baseline
 - Any signs or symptoms
 - ◆ Coronary CT/MR/Cath for initial evaluation
 - ◆ CA from wrong sinus-baseline stress imaging regardless of symptoms
 - ◆ Stress imaging for any cardiac signs or symptoms
 - ◆ For Kawasaki GL regarding echo, Stress imaging, coronary imaging, see pediatric GL: **PEDCD-6: Kawasaki Disease**

CD-11.4: Pregnancy – Maternal Imaging

➤ Overview

- ◆ World Health Organization (WHO) classification:
 - WHO classification I: no detectable increased risk of maternal mortality and no/mild increase in morbidity.
 - Uncomplicated small or mild pulmonary stenosis
 - Patent Ductus Arteriosus (PDA)
 - Mitral valve prolapse
 - Successfully repaired simple lesions (atrial or ventricular septal defect, patent ductus arteriosus, anomalous pulmonary venous connection)
 - WHO classification II: small increase in maternal risk mortality or moderate increase in morbidity.
 - Unrepaired atrial or ventricular septal defect
 - Repaired tetralogy of Fallot
 - WHO classification II–III (depending on individual)
 - Mild left ventricular impairment
 - Native or tissue valvular heart disease not considered WHO I or IV
 - Marfan syndrome without aortic dilation
 - Aorta <45 mm in association with bicuspid aortic valve disease
 - Repaired coarctation
 - WHO classification III: significantly increased risk of maternal mortality or severe morbidity. Expert counseling required. If pregnancy is decided upon, intensive specialist cardiac and obstetric monitoring needed throughout pregnancy, childbirth and the puerperium.
 - Mechanical valve
 - Systemic right ventricle
 - Fontan circulation
 - Unrepaired cyanotic heart disease
 - Other complex congenital heart disease
 - Aortic dilation 40–45 mm in Marfan syndrome
 - Aortic dilation 45–50 mm in bicuspid aortic valve disease
 - WHO classification IV: extremely high risk of maternal mortality or severe morbidity; pregnancy contraindicated. If pregnancy occurs, termination should be discussed. If pregnancy continues, care as for WHO class III.
 - Pulmonary arterial hypertension from any cause
 - Severe systemic ventricular dysfunction (LVEF <30%, NYHA functional class III–IV)
 - Severe mitral stenosis; severe symptomatic aortic stenosis
 - Marfan syndrome with aorta dilated >45 mm
 - Aortic dilation >50 mm in aortic disease associated with bicuspid aortic valve
 - Native severe coarctation of the aorta

Adapted from: Elkayam U, Goland S, Pieper PG, Silversides CK. High-Risk Cardiac Disease in Pregnancy. Journal of the American College of Cardiology..

- Congenital heart disease imaging in pregnancy
 - ◆ Echocardiogram (TTE) when planning pregnancy
 - ◆ TEE if TTE equivocal
 - ◆ CMR can be performed prior to planning pregnancy in those lesions where CMR would be routinely performed at some later date
 - ◆ Chest CTA or chest MRA of arch if known disease with aortic involvement or if known dilation
 - ◆ Repeat echocardiogram and MR (can be without gad) can be performed based on the II, III, IV, or other risk factors
 - ◆ Severe complex CHD, may require echo monthly, or even weekly (every two weeks) (major physiological changes)-may be best as often as needed (Pulmonary hypertension, changes in function, can guide delivery after 24 weeks)
 - ◆ Echo can be performed if new signs or Symptoms during pregnancy
 - ◆ Post-partum first year can have more frequent imaging
 - ◆ Stress imaging pre/during pregnancy for patients with known Coronary artery anomaly, pulmonary hypertension, LVOT obstruction, cardiac dysfunction, single ventricle.
 - ◆ WHO II, III, IV, can have echo MR CT stress imaging prior to pregnancy
 - ◆ WHO I- one echocardiogram during pregnancy
 - ◆ WHO II- one echocardiogram per trimester during pregnancy
 - ◆ WHO II/III- echocardiogram every 2 months during pregnancy
 - ◆ WHO III/IV- echocardiogram monthly during pregnancy
 - Patients may require more (even weekly) if treatment decision, delivery is considered.
- Syndromes that allow cardiac imaging at the time of diagnosis if not previously done. This list is not exhaustive
 - ◆ DiGeorge (velocardiofacial)
 - ◆ (22q11.2)
 - ◆ Down syndrome (trisomy 21)
 - ◆ Holt Oram (TBX5)
 - ◆ Klinefelter syndrome (47 XXY)
 - ◆ Noonan (PTPN11, KRAS, SOS1 RAF1, NRAS, BRAF, MAP2K1)
 - ◆ Turner (45X)
 - ◆ Williams (7q11.23 deletion)
 - ◆ Any syndrome associated with congenital heart disease.
- Echocardiogram at time of Diagnosis (either genetic testing or clinical features)
- CMR or CCTA if arch involved in disease.

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CD-12: Cancer Therapeutics-Related Cardiac Dysfunction (CTRCD)

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CD-12.1: Oncologic Indications for Cancer Therapeutics – Related Cardiac Dysfunction (CTRCD)

- Echocardiogram evaluation of LV ejection fraction and wall motion analysis is appropriate to determine LV function in individuals on cardiotoxic chemotherapeutic drugs:
 - ◆ The time frame should be determined by the provider, but no more often than baseline and at every 6 weeks.
 - ◆ May repeat every 4 weeks if cardiotoxic chemotherapeutic drug is withheld for significant left ventricular cardiac dysfunction
 - ◆ If the LVEF is < 50% on echocardiogram follow up can be done with MUGA at appropriate intervals.
- Echocardiography vs. MUGA for Determining Left Ventricular Ejection Fraction (LVEF) in Patients on Cardiotoxic Chemotherapy Drugs:
 - ◆ eviCore guidelines support using **echocardiography rather than MUGA** for the determination of LVEF and/or wall motion EXCEPT in one of the circumstances described previously in **CD-3.4: MUGA Study – Cardiac Indications**.
- Echocardiogram is recommended for cancer survivors with a history of chest radiotherapy or anthracycline exposure who are pregnant or planning to become pregnant as follows:
 - ◆ a baseline exam
 - ◆ once in the first trimester
 - ◆ once in the third trimester
 - ◆ study can be repeated for any symptoms at any other time as needed during or immediately following pregnancy
- For adults who received anthracyclines in childhood see **PEDONC-19.2**

Practice Note

- Advantages of Echocardiography in comparison to MUGA in patients on cardiotoxic chemotherapy:
 - ◆ No ionizing radiation
 - ◆ No IV access required when echo contrast is not used
 - ◆ Allows view of the pericardium to look for effusion
 - ◆ Allows estimate of pulmonary pressure
 - ◆ May allow visualization of a clot or tumor in the Inferior Vena Cava (IVC) and/or the right heart

CD-12.2: Cancer Therapeutics-Myocardial Strain Imaging

- Myocardial strain imaging (CPT® 93356) can be approved in addition to the primary echocardiogram in individuals receiving therapy with cardiotoxic agents for **any** of the following:
 - ◆ Initial evaluation-prior to treatment with (either):
 - Medications that could result in cardiotoxicity/heart failure
 - Radiation that could result in cardiotoxicity/heart failure

- ◆ Re-evaluation in an individual previously or currently undergoing therapy with cardiotoxic agents as per echocardiogram parameters. See **CD-12.1: Oncologic Indications for Cancer Therapeutics – Related Cardiac Dysfunction (CTRCD)**
- ◆ Periodic re-evaluation in a patient undergoing therapy with cardiotoxic agents and worsening symptoms

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CD-13: Pre-Surgical Cardiac Testing

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CD-13.1: Pre-Surgical Cardiac Testing – General Information

- It is important to differentiate requests for preoperative CT imaging before cardiac surgery according to type of procedure planned:
 - ◆ Primary cardiac operation—individuals who have not had prior heart surgery
 - ◆ Redo procedures—individuals who have had a prior procedure (it is important to determine the type of procedure as this may impact which modality is most appropriate for the pre-operative assessment)
 - ◆ Minimally invasive procedures, such as minimally invasive aortic valve operations, minimally invasive or robotic mitral operations, TAVR, MitraClip™ or other percutaneous valve procedures (such as valve in valve aortic or mitral, percutaneous tricuspid and TMVR which will be increasing in the future)
- In re-operative cardiac surgery, the benefit of preoperative CT is to assess for aortic calcifications, to evaluate the anatomic relationships in the mediastinum, such as the location of the various cardiac chambers and great vessels and proximity to the sternum, and to assess for the location of prior bypass grafts. Information can then be used to change the operative strategy including non-midline approach, peripheral vascular exposure, and alternative cannulation sites and for establishing cardiopulmonary bypass before re-sternotomy. These techniques can result in decreased incidence of intraoperative injury to heart, great vessels and prior bypass grafts and lower rates of postoperative stroke. IV contrast is necessary with these studies to delineate the anatomic structures. However, in patients with renal insufficiency, the provider might choose to forgo the contrast if does not want to contrast load the patient prior to placing them on the heart-lung machine.
- Aortic atherosclerosis is recognized as the single most important determinant of postoperative stroke. There is evidence to support that preoperative CT is associated with lower postoperative stroke rates and mortality after primary cardiac surgery.
 - ◆ CT chest without contrast (CPT® 71250) can be performed pre-operatively to allow the surgeon to:
 - Visualize the extent and location of aortic atherosclerosis
 - Change the operative strategy such as those problematic areas are avoided

CD-13.2: Primary Cardiac Surgery – No Previous Cardiac Surgery

- CT Chest without contrast (CPT® 71250) to evaluate for the presence of ascending aortic calcifications may be indicated prior to primary cardiac surgery when there is documented high risk for aortic calcification including any of the following:
 - ◆ Aortic calcification on chest x-ray or other diagnostic test (TEE, fluoroscopy, etc.)
 - ◆ Calcific aortic stenosis
 - ◆ End stage renal disease (dialysis)

CD-13.3: Re-operative cardiac surgery

- Patients undergoing re-operative cardiac surgery may undergo **one** of the following tests for preoperative assessment:
 - ◆ CT chest with IV contrast
 - ◆ CTA chest
 - ◆ CCTA only if prior CABG (this might be in addition to CT with IV contrast as CCTA will not show the extent of the thoracic aorta that needs to be visualized)
 - ◆ CT heart usually does not provide the necessary information, and should not be approved routinely.

CD-13.4: Minimally Invasive Valve Surgery

- See **CD-4.8: Transcatheter Aortic Valve Replacement (TAVR)**
- For patient undergoing minimally invasive aortic valve surgery and minimally invasive or robotic mitral valve surgery, one of the following can be approved for preoperative assessment of patient suitability for the approach and for subsequent procedure planning.
- CTA chest, CTA abdomen and pelvis
- CT chest and CT abdomen and pelvis with contrast

CD-13.5: Percutaneous Mitral Valve Repair (mitral valve clip)

- Percutaneous treatment of mitral regurgitation can be accomplished using venous access to apply a clip device (e.g., MitraClip™ currently FDA approved) to provide edge-to-edge mitral leaflet coaptation, approximating opposing sections of the anterior and posterior mitral valve leaflets. FDA approved indications include treatment for patients with symptomatic, moderate to severe or severe primary mitral regurgitation whose surgical risks are prohibitive, as well as symptomatic moderate to severe or severe secondary mitral regurgitation who have failed optimal medical therapy. This therapy should include, if indicated, cardiac resynchronization therapy.
- The following imaging may be used to determine if a patient is eligible for the procedure:
 - ◆ Transthoracic echo with or without 3D rendering
 - ◆ Transesophageal echo with or without 3D rendering
 - ◆ Heart catheterization, including right heart cath if requested
- Because this is a venous approach, CTA of abdomen, chest, and/or pelvis **is not** indicated.
- Post procedure transthoracic echo (TTE) can be performed at the following intervals:
 - ◆ One month
 - ◆ Six months
 - ◆ One year

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