

## Medical Policy



### Title: **Contrast-Enhanced Coronary Computed Tomography Angiography (CCTA) for Coronary Artery Evaluation**

<i>Related Policies:</i>	<ul style="list-style-type: none"> <li>▪ <i>Computed Tomography to Detect Coronary Artery Calcification</i></li> <li>▪ <i>Coronary Computed Tomography Angiography with Selective Noninvasive Fractional Flow Reserve</i></li> </ul>
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<b>Professional / Institutional</b>
Original Effective Date: November 1, 2001 / June 3, 2004
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Populations	Interventions	Comparators	Outcomes
Individuals: <ul style="list-style-type: none"> <li>• With acute chest pain and suspected coronary artery disease in the emergency setting, at intermediate to low risk</li> </ul>	Interventions of interest are: <ul style="list-style-type: none"> <li>• Coronary computed tomography angiography</li> </ul>	Comparators of interest are: <ul style="list-style-type: none"> <li>• Standard emergency department care</li> <li>• Alternative noninvasive testing and standard emergency department care</li> </ul>	Relevant outcomes include: <ul style="list-style-type: none"> <li>• Overall survival</li> <li>• Morbid events</li> <li>• Resource utilization</li> </ul>
Individuals: <ul style="list-style-type: none"> <li>• With stable chest pain, intermediate risk of coronary artery disease,</li> </ul>	Interventions of interest are: <ul style="list-style-type: none"> <li>• Coronary computed tomography angiography</li> </ul>	Comparators of interest are: <ul style="list-style-type: none"> <li>• Alternative noninvasive testing and standard care</li> </ul>	Relevant outcomes include: <ul style="list-style-type: none"> <li>• Overall survival</li> <li>• Test accuracy</li> <li>• Morbid events</li> </ul>

Populations	Interventions	Comparators	Outcomes
meeting guideline criteria for noninvasive testing			<ul style="list-style-type: none"> <li>Resource utilization</li> </ul>
Individuals: <ul style="list-style-type: none"> <li>With suspected anomalous coronary arteries</li> </ul>	Interventions of interest are: <ul style="list-style-type: none"> <li>Coronary computed tomography angiography</li> </ul>	Comparators of interest are: <ul style="list-style-type: none"> <li>Standard of care</li> </ul>	Relevant outcomes include: <ul style="list-style-type: none"> <li>Overall survival</li> <li>Test accuracy</li> <li>Morbid events</li> <li>Resource utilization</li> </ul>

## DESCRIPTION

Contrast-enhanced coronary computed tomography angiography (CCTA) is a noninvasive imaging test that requires the use of intravenously administered contrast material and high-resolution, high-speed computed tomography machinery to obtain detailed volumetric images of blood vessels. It is a potential diagnostic alternative to current tests for cardiac ischemia (i.e., noninvasive stress testing and/or coronary angiography).

## OBJECTIVE

The objective of this evidence review is to evaluate whether coronary computed tomography angiography (CCTA) improves health outcomes compared with alternative testing strategies and/or standard of care. Three major indications for cardiac or CCTA are considered: (1) evaluation of patients with acute chest pain without known coronary disease presenting in the emergency department setting, (2) evaluation of stable patients with signs and symptoms of coronary artery disease in the non-emergency department setting, and (3) evaluation of anomalous coronary arteries.

## BACKGROUND

### Coronary Artery Disease

Various noninvasive tests are used to diagnose coronary artery disease (CAD). These tests can be broadly classified as those that detect functional or hemodynamic consequences of obstruction and ischemia (exercise treadmill testing, myocardial perfusion imaging, stress echocardiography with or without contrast), and others that identify the anatomic obstruction itself (coronary computed tomography angiography [CCTA], coronary magnetic resonance imaging).<sup>1</sup> Functional testing involves inducing ischemia by exercise or pharmacologic stress and detecting its consequences. However, not all patients are candidates. For example, obesity or obstructive lung disease can make obtaining echocardiographic images of sufficient quality difficult. Conversely, the presence of coronary calcifications can impede the detection of coronary anatomy with CCTA.

### Diagnostic Testing

Some tests will be unsuitable for particular patients. The presence of dense arterial calcification or an intracoronary stent can produce significant beam-hardening artifacts and may preclude satisfactory imaging. The presence of an uncontrolled rapid heart rate or arrhythmia hinders the ability to obtain diagnostically satisfactory images. Evaluation of the distal coronary arteries is

more difficult than the visualization of the proximal and mid-segment coronary arteries due to greater cardiac motion and the smaller caliber of coronary vessels in distal locations.

Evaluation of obstructive CAD involves quantifying arterial stenoses to determine whether significant narrowing is present. Lesions with stenosis more than 50% to 70% in diameter accompanied by symptoms are considered significant.

Contrast-enhanced CCTA is a noninvasive imaging test that requires the use of intravenously administered contrast material and high-resolution, high-speed computed tomography machinery to obtain detailed volumetric images of blood vessels. It has been suggested that CCTA may help rule out CAD and avoid invasive coronary angiography in patients with a low clinical likelihood of significant CAD. Also of interest is the potentially important role of nonobstructive plaques (i.e., those associated with <50% stenosis) because their presence is associated with increased cardiac event rates.<sup>2</sup> Coronary computed tomographic angiography also can visualize the presence and composition of these plaques and quantify plaque burden better than conventional angiography, which only visualizes the vascular lumen. Plaque presence has been shown to have prognostic importance.

The use of electron-beam computed tomography or helical computed tomography to detect coronary artery calcification and the use of fractional flow reserve computed tomography to support the functional evaluation of CAD are not addressed in this evidence review.

### **Coronary Arterial Anomalies**

Congenital coronary arterial anomalies (i.e., abnormal origin or course of a coronary artery) that lead to clinically significant problems are relatively rare.<sup>3</sup> Symptomatic manifestations may include ischemia or syncope. Clinical presentation of anomalous coronary arteries is difficult to distinguish from other more common causes of cardiac disease; however, an anomalous coronary artery is an important diagnosis to exclude, particularly in young patients who present with unexplained symptoms (e.g., syncope). There is no specific clinical presentation to suggest a coronary artery anomaly.

### **Radiation Exposure**

Exposure to ionizing radiation increases lifetime cancer risk.<sup>4</sup> Three studies have estimated excess cancer risks due to radiation exposure from CCTA. Assuming a 16-mSv dose, Berrington de Gonzalez et al (2009) estimated the 2.6 million CCTAs performed in 2007 would result in 2700 cancers or approximately 1 per 1000.<sup>5</sup> Smith-Bindman et al (2009) estimated that cancer would develop in 1 of 270 women and 1 of 600 men age 40 undergoing CCTA with a 22-mSv dose.<sup>6</sup> Einstein et al (2007) employed a standardized phantom to estimate organ dose from 64-slice CCTA.<sup>7</sup> With modulation and exposures of 15 mSv in men and 19 mSv in women, calculated lifetime cancer risk at age 40 was 7 per 1000 men (1/143) and 23 per 1000 women (1/43). However, estimated radiation exposure used in these studies was considerably higher than received with current scanners - now typically under 10 mSv and often less than 5 mSv with contemporary machines and radiation reduction techniques. For example, in the 47-center Prospective Multicenter Study on Radiation Dose Estimates of Cardiac CT Angiography I (PROTECTION I) study enrolling 685 patients, the mean radiation dose was 3.6 mSv, using a sequential scanning technique.<sup>8</sup> In a study of patients undergoing an axial scanning protocol, Hausleiter et al (2012) reported on a mean radiation dose of 3.5 mSv and produced equivalent

ratings of image quality compared with helical scan protocols, which had much higher mean radiation doses of 11.2 mSv.<sup>9</sup>

Levels of radiation delivered with the current generation scanners using reduction techniques (prospective gating and spiral acquisition) have declined substantially - typically to under 10 mSv. For example, an international registry developed to monitor CCTA radiation exposure has reported a median of 2.4 mSv (interquartile range, 1.3 to 5.5).<sup>10</sup> By comparison, radiation exposure accompanying rest-stress perfusion imaging varies by isotope used - approximately 5 mSv for rubidium 82 (positron emission tomography), 14 mSv for fluorine 18 fluorodeoxyglucose, 9 mSv for sestamibi (single-photon emission computed tomography), and 41 mSv for thallium; during diagnostic invasive coronary angiography, approximately 7 mSv is delivered.<sup>11</sup> Electron-beam computed tomography using electrocardiogram triggering delivers the lowest dose (0.7 to 1.1 mSv with 3-mm sections). Any cancer risk due to radiation exposure from a single cardiac imaging test depends on age (higher with younger age at exposure) and sex (greater for women).<sup>12,7,6</sup> Empirical data have suggested that every 10 mSv of exposure is associated with a 3% increase in cancer incidence over 5 years.<sup>13</sup>

### **Incidental Findings**

A number of studies using scanners with 64 or more detector rows were identified.<sup>14,15,16,17,18,19,20,21,22</sup> Incidental findings were frequent (26.6% to 68.7%) with pulmonary nodules typically the most common and cancers typically more rare (5/1000 or less). Aglan et al (2010) compared the prevalence of incidental findings when the field of view was narrowly confined to the cardiac structures with that when the entire thorax was imaged.<sup>14</sup> As expected, incidental findings were less frequent in the restricted field (clinically significant findings in 14% versus 24% when the entire field was imaged).

### **REGULATORY STATUS**

Coronary computed tomographic angiography is performed using multidetector-row computed tomography, and multiple devices have been cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process. Current machines are equipped with at least 64 detector rows. Intravenous iodinated contrast agents used for CCTA also have received FDA approval.

**POLICY**

- A. Contrast-enhanced coronary computed tomography angiography for evaluation of individuals without known coronary artery disease and acute chest pain in the emergency department setting is considered **medically necessary**.
- B. Contrast-enhanced coronary computed tomography angiography for evaluation of individuals with stable chest pain and meeting guideline criteria for a noninvasive test in the outpatient setting (see Policy Guidelines) is considered **medically necessary**.
- C. Contrast-enhanced coronary computed tomography angiography for evaluation of individuals with suspected anomalous (native) coronary arteries is considered **medically necessary**.
- D. Contrast-enhanced coronary computed tomography angiography for coronary artery evaluation is considered **experimental / investigational** for all other indications.

**POLICY GUIDELINES**

The 2012 collaborative medical association guidelines for the diagnosis and management of individuals with stable heart disease list several class I recommendations on the use of noninvasive testing in individuals with suspected stable ischemic heart disease. A class I recommendation indicates that a test should be performed. In general, individuals with at least intermediate risk (10% to 90% risk by standard risk prediction instruments) are recommended to have some type of test, the choice depending on interpretability of the electrocardiogram, capacity to exercise, and presence of comorbidity.

**Pretest Probability of CAD by age, gender, and symptoms\***

Age (yrs.)	Gender	Typical / Definite Angina Pectoris	Atypical / Probable Angina Pectoris	Nonanginal Chest Pain	Asymptomatic
< 39	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	Men	High	Intermediate	Intermediate	Low
	Women	High	Intermediate	Intermediate	Low

High: >90% pretest probability. Intermediate: between 10% and 90% pretest probability. Low: between 5% and 10% pretest probability. Very low: <5% pretest probability. CAD: coronary artery disease. \*Modified from the ACC/AHA Exercise Testing Guidelines to reflect all age ranges.<sup>65</sup>

**Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.**

## **RATIONALE**

This evidence review has been updated regularly with searches of the PubMed database. The most recent literature update was performed through July 24, 2023.

Evidence reviews assess whether a medical test is clinically useful. A useful test provides information to make a clinical management decision that improves the net health outcome. That is, the balance of benefits and harms is better when the test is used to manage the condition than when another test or no test is used to manage the condition.

The first step in assessing a medical test is to formulate the clinical context and purpose of the test. The test must be technically reliable, clinically valid, and clinically useful for that purpose. Evidence reviews assess the evidence on whether a test is clinically valid and clinically useful. Technical reliability is outside the scope of these reviews, and credible information on technical reliability is available from other sources.

Promotion of greater diversity and inclusion in clinical research of historically marginalized groups (e.g., People of Color [African-American, Asian, Black, Latino and Native American]; LGBTQIA (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual); Women; and People with Disabilities [Physical and Invisible]) allows policy populations to be more reflective of and findings more applicable to our diverse members. While we also strive to use inclusive language related to these groups in our policies, use of gender-specific nouns (e.g., women, men, sisters, etc.) will continue when reflective of language used in publications describing study populations.

## **PATIENTS WITH ACUTE CHEST PAIN PRESENTING IN THE EMERGENCY SETTING**

### **Clinical Context and Test Purpose**

The purpose of coronary computed tomography angiography (CCTA) imaging in individuals with acute chest pain is to diagnose coronary artery obstruction and guide treatment decisions.

The following PICO was used to select literature to inform this review.

### ***Populations***

The relevant population of interest is individuals with acute chest pain and suspected coronary artery disease (CAD) who are at an intermediate- to low-risk presenting in the emergency setting.

### ***Interventions***

The intervention of interest is CCTA.

### ***Comparators***

The following tests and practices are currently being used to make decisions about managing acute chest pain and suspected CAD: standard emergency department (ED) care and alternative noninvasive testing including stress tests.

### **Outcomes**

The outcomes of interest are mortality, diagnostic accuracy, and utilization of invasive coronary artery angiography (ICA). The time of interest is in the first few days after admission to an ED and several years or more after CCTA to evaluate event rates.

### **Study Selection Criteria**

For the evaluation of clinical validity of the CCTA for acute chest pain, studies that meet the following eligibility criteria were considered:

- Reported on the accuracy of the marketed version of the technology (including any algorithms used to calculate scores)
- Included a suitable reference standard
- Patient/sample clinical characteristics were described
- Patient/sample selection criteria were described.

### **Clinically Valid**

A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

The diagnostic characteristics of CCTA have not been directly assessed in patients in the ED setting. Because patients who test negative on CCTA are discharged from care and their disease status is unknown, there is verification bias, and diagnostic characteristics of CCTA cannot be determined. The diagnostic characteristics of CCTA, previously established in other studies, were assumed to apply to patients in the ED setting and were tested in randomized trials to establish clinical utility.

### **Clinically Useful**

A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, more effective therapy, or avoid unnecessary therapy or testing.

### **Direct Evidence**

Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from randomized controlled trials (RCTs).

### **Systematic Reviews**

Gongora et al (2018) published a meta-analysis of 10 RCTs (N=6285 ) comparing CCTA with the standard of care (SOC) in patients with acute chest pain in an ED or inpatient setting.<sup>23</sup> Pooled results suggested that CCTA is associated with more frequent revascularization and ICA, without reducing the risk of adverse cardiac events. Among the limitations of the review was the heterogeneity of SOC across assessed studies, the possibility of publication bias due to the small number of trials available, and the presence of only a few studies that prespecified downstream testing criteria following CCTA results. Tables 1 and 2 summarize review characteristics and results.

**Table 1. Characteristics of Systematic Reviews Assessing CCTA in ED Settings**

Study	Dates	Trials	Participants	N (Range)	Design	Duration, months
Gongora et al (2018) <sup>23</sup> ,	2007-2016	10	Acute chest pain in an ED or inpatient setting	6285	RCT	1 to 19

CCTA: coronary computed tomography angiography; ED: emergency department; RCT: randomized controlled trial.

**Table 2. Results of Systematic Reviews Comparing CCTA With SOC in ED Settings**

Study	ICA (CCTA vs SOC)	Revascularization (CCTA vs SOC)	All-Cause Mortality (CCTA vs SOC)	All-Cause MI (CCTA vs SOC)	All-Cause MACE (CCTA vs SOC)
Gongora et al (2018) <sup>23</sup> ,					
	Higher incidence in CCTA	Higher incidence in CCTA	No significant between-group difference	No significant between-group difference	No significant between-group difference
RR (95% CI)	1.32 (1.07 to 1.63)	1.77 (1.35 to 2.31)	0.48 (0.17 to 1.36)	0.82 (0.49 to 1.39)	0.98 (0.67 to 1.43)
p	.01	<.001	.17	.47	.92

CCTA: coronary computed tomography angiography; CI: confidence interval; ED: emergency department; ICA: invasive coronary angiography; MACE: major adverse cardiac event; MI: myocardial infarction; RR: relative risk; SOC: standard of care.

Skelly et al (2016) conducted a comparative effectiveness review for the Agency for Healthcare Research and Quality (AHRQ) that assessed noninvasive testing for CAD.<sup>24</sup> Reviewers found that:

- After CCTA, clinical outcomes for patients with an intermediate pretest risk
  - were similar when compared with usual care or functional testing (low to moderate strength of evidence).
  - were similar when compared with single-photon emission computed tomography (low strength of evidence).
- After CCTA, referral for ICA and revascularization
  - was more common than after functional testing (high strength of evidence).
  - was similar compared with single-photon emission computed tomography and usual care (low strength of evidence).
- After CCTA, additional testing in the ED setting
  - was less common compared with usual care (moderate strength of evidence).
  - was more common than after single-photon emission computed tomography (high strength of evidence).
- After CCTA, hospitalization
  - was less common compared with usual care in the ED setting (moderate to low strength of evidence).
  - was similar to functional testing in the outpatient setting (moderate strength of evidence).

Overall, reviewers found no clear differences between strategies for clinical or management outcomes, although CCTA could lead to a higher frequency of referral for ICA and revascularization. Of note, AHRQ archived this report since it is greater than 3 years old. The findings of the report may be used for research purposes, but should not be considered current.

### Randomized Controlled Trials

Tables 3 and 4 summarize the characteristics and results of RCTs assessing CCTA procedures conducted in ED settings.

**Table 3. Characteristics of RCTs Assessing CCTA in ED Settings**

Study; Trial	Countries	Sites	Dates	Participants	Interventions	
					Active	Comparator(s)
Gray et al (2021) <sup>25</sup> ; RAPID-CTCA	UK	37	2015-2019	Adults with suspected ACS and at least 1 of: previous CHD, raised cardiac troponin levels, or abnormal ECG	877 to early CCTA + SOC	871 to SOC
Smulders et al (2019) <sup>26</sup> ; CARMENTA	Netherlands	1	2012-2016	Patients with acute chest pain, normal or inconclusive ECG, and elevated cardiac troponin levels presenting to the ED	70 to CCTA	68 to CMR; 69 to routine clinical care
Levsky et al (2018) <sup>27</sup>	U.S.	1	2011-2016	Patients with acute chest pain or pressure for whom noninvasive testing is requested	201 to CCTA	199 to SE
Hamilton-Craig et al (2014) <sup>28</sup> ; CT-COMPARE	Australia	1	2010-2011	Men ≥30 y or women ≥40 y presenting to the ED with acute undifferentiated chest pain	322 to CCTA	240 to SOC (exercise treadmill testing)
Linde et al (2013) <sup>29</sup> ; CATCH	Denmark	1	2010-2013	Patients with suspected NSTEMI-ACS but normal ECG and troponins; discharged within 24 h needing further risk stratification	299 to CCTA (285 had FU available)	301 to SOC (291 had FU available)
Litt et al (2012) <sup>30</sup> ; AC RIN-PA	U.S.	5	2009-2011	Symptoms consistent with possible ACS; >30 y; low risk of MI	908 to CCTA	462 to traditional care
Hoffmann et al (2012) <sup>31</sup> ; ROMICAT II	U.S.	9	2010-2012	Chest pain or angina equivalent <24 h before ED presentation; 40-74 y; sinus rhythm; warranting further risk stratification	50 to CCTA	499 to SOC
Goldstein et al (2011) <sup>32</sup> ; CT-STAT	U.S.	16	2007-2008	Chest pain <12 h; ≥25 y; low risk of complications; no sign of ischemia at enrollment	361 to CCTA	338 to MPI

Study; Trial	Countries	Sites	Dates	Participants	Interventions	
					Active	Comparator(s)
Goldstein et al (2007) <sup>33</sup> ,	U.S.	1	2005	Chest pain or angina-like symptoms <12 h; ≥25 y; low risk of complications	99 to MSCT	98 to SOC

ACS: acute coronary syndrome; CCTA: coronary computed tomography angiography; CHD: coronary heart disease; CMR: cardiovascular magnetic resonance imaging; ECG: electrocardiogram; ED: emergency department; FU: follow-up; MI: myocardial infarction; MPI: myocardial perfusion imaging; MSCT: multislice computed tomography; NSTEMI: non-ST-elevation acute coronary syndrome; RCT: randomized controlled trial; SE: stress echocardiography; SOC: standard of care.

Gray et al (2021) published an open-label RCT comparing CCTA with SOC in intermediate-risk patients with suspected acute coronary syndrome (ACS).<sup>25</sup> Overall, the mean age was 61.6 years with 64% male patients. The primary endpoint was all cause death or subsequent type 1 or 4b myocardial infarction (MI) at 1 year, and it occurred in 51 (5.8%) patients in the early CCTA group compared with 53 (6.1%) patients in the SOC group (hazard ratio [HR] 0.91; 95% confidence interval [CI], 0.62 to 1.35; p=.65). However, clinicians reported greater diagnostic certainty with CCTA (mean increase of 1.4), and fewer patients in the CCTA group underwent ICA (Table 4).

Smulders et al (2020) published a 3-arm, prospective, open-label RCT that compared a diagnostic strategy incorporating cardiovascular magnetic resonance imaging (CMR) or CCTA as a gatekeeper for ICA with a control strategy (i.e., routine clinical care) in patients with non-ST-segment elevation myocardial infarction (NSTEMI).<sup>26</sup> Results revealed that CMR or CCTA as an initial test was associated with a reduced proportion of patients referred to ICA during initial hospitalization (87% CMR [p=.001] and 66% CCTA [p<.001] as compared to routine clinical care [100%]). Significantly fewer ICAs were performed in the CCTA- than CMR-first strategy (p=.004). The reduction in ICA in the CMR- or CCTA-first strategy compared with routine clinical care was persistent after 1 year (88% CMR [p=.003], 70% CCTA [p<.001] and 100% routine clinical care). Similar clinical outcomes were seen: CMR versus routine (HR 0.78; 95% CI, 0.37 to 1.61); CCTA versus routine (HR 0.66; 95% CI, 0.31 to 1.42); and CMR versus CCTA (HR 1.19; 95% CI, 0.53 to 2.66). In the non-CMR and non-CCTA arms, follow-up CMR and CCTA were performed in 67% and 13% of patients and led to a new diagnosis in 33% and 3%, respectively (p<.001). A follow-up CMR led to a new MI diagnosis in 7 patients.

Levsky et al (2018) published an RCT comparing CCTA (n=201) to stress echocardiography (n=199) in low- to intermediate-risk patients presenting to the ED with acute chest pain. In the CCTA arm, 39 (19%) patients were hospitalized, compared with 22 (11%) patients in the stress echocardiography arm, resulting in a difference of 8% (95% CI, 1% to 15%; p=.026).<sup>27</sup> Median length of stay in the hospital was longer for the CCTA arm (58 hours vs. 34 hours; p=.002). There was no significant difference between the CCTA and stress echocardiography arms in terms of major adverse cardiac events (MACE, including death); MACE occurred in 11 CCTA patients and 7 stress echocardiography patients, respectively (p=.47) over a median follow-up of 24 months. The median complete initial work-up radiation exposure for the CCTA arm was 6.4 mSv (interquartile range, 5.3 to 7.8 mSv), significantly more than that of stress echocardiography (0 mSv; p<.001). The trial had a number of limitations, including the single-center design and omission of high sensitivity troponin assays.

Hamilton-Craig et al (2014) reported on the diagnostic performance and cost of CT angiography versus stress electrocardiogram (ECG) (CT-COMPARE) trial, which assessed the length of stay and patient costs in 562 patients presenting to the ED with low-to-intermediate risk chest pain who received CCTA or exercise stress testing.<sup>28</sup> Length of stay was significantly reduced in CCTA patients compared with exercise testing patients. Clinical outcomes at 30 days and 12 months did not differ.

Linde et al (2013) reported on the CARdiac cT in the treatment of acute Chest pain (CATCH) trial, which randomized 600 patients to a CCTA-guided strategy or to SOC.<sup>29</sup> For the CCTA-guided strategy, referral for ICA required coronary stenosis greater than 70%. This trial differed in design from the others because patients had been discharged from the ED, and if there was intermediate stenosis (50% to 70%) on CCTA, a stress test was performed.

Litt et al (2012) reported on the American College of Radiology Imaging Network of Pennsylvania (AC RIN-PA) trial, which also evaluated the safety of CCTA in patients in the ED.<sup>30</sup> Although the trial was a randomized comparison with traditional care, the principal outcome was safety after negative CCTA examinations. No patients who had negative CCTA examinations (n=460) died or had a MI within 30 days. Compared with traditional care, patients in the CCTA group had higher rates of discharge from the ED (49.6% versus 22.7%) and higher rates of detection of coronary disease.

Hoffmann et al (2012) reported on the Rule Out Myocardial Ischemia/Infarction by Computer Assisted Tomography (ROMICAT II) trial, which compared the length of stay with outcomes in 549 patients evaluated using CCTA or usual care.<sup>31</sup> For the 50 patients in the CCTA arm, the mean hospital length of stay was reduced by 7.6 hours, and more patients were discharged directly from the ED (47% versus 12%). There were no undetected coronary syndromes or differences in adverse events at 28 days. However, in the CCTA arm, there was more subsequent diagnostic testing and higher cumulative radiation exposure.

Goldstein et al (2011) reported on the Coronary Computed Tomography for Systematic Triage of Acute Chest Pain Patients to Treatment (CT-STAT) trial, which evaluated a similar sample of 699 patients.<sup>32</sup> Over a 6-month follow-up, there were no deaths in either arm; there were 2 cardiac events in the CCTA arm and 1 in the perfusion imaging arm. A second noninvasive test was obtained more often after CCTA (10.2% vs 2.1%), but cumulative radiation exposure in the CCTA arm (using retrospective gating) was significantly lower (mean, 11.5 mSv vs 12.8 mSv).

Goldstein et al (2007) randomized 197 patients without evidence of ACS to CCTA (n=99) or usual care (n=98).<sup>33</sup> Over a 6-month follow-up, no cardiac events occurred in either arm. Diagnosis was achieved more quickly after CCTA.

**Table 4. Summary of Results of RCTs Assessing CCTA in ED Settings**

Study	ICA (CCTA vs Control), %	Diagnostic Accuracy (CCTA vs Control), % <sup>a</sup>	MI in Negative CCTA Arm	Median Diagnostic Time (CCTA vs Control), hr <sup>b</sup>	FU, mo
Gray et al (2021) <sup>25</sup> ,	54 vs. 60.8	NR	NR	2.2 vs. 2.0 <sup>d</sup>	12
Smulders et al (2019) <sup>26</sup> ,	66 vs. 100	NR	7	NR	1 and 12
Levsky et al (2018) <sup>27</sup> ,	NR	NR	NR	5.4 vs. 4.7 <sup>c</sup>	1 and 12
Hamilton-Craig et al (2014) <sup>28</sup> ,	9.0 vs. 4.2	94%/99% vs. 83%/91% <sup>d</sup>	0	13.5 vs. 20.7 <sup>c</sup>	1 and 12
Linde et al (2013) <sup>29</sup> ,	17 vs. 12	71 vs 36 <sup>e</sup>	0	NR	4
Litt et al (2012) <sup>30</sup> ,	5.1 vs. 4.2	NR	0	18.0 vs. 24.8	1
Hoffmann et al (2012) <sup>31</sup> ,	12.0 vs. 21.0	NR	0	5.8 vs. 21.0	1
Goldstein et al (2011) <sup>32</sup> ,	6.6 vs. 6.2	76.9 vs. 54.5	0	2.9 vs. 6.2	6
Goldstein et al (2007) <sup>33</sup> ,	12.1 vs. 7.1	88.9 vs. 98.0	0	3.4 vs. 15.0	6

CCTA: coronary computed tomography angiography; ED: emergency department; FU: follow-up; ICA: invasive coronary angiography; MI: myocardial infarction; NR: not reported; RCT: randomized controlled trial.

<sup>a</sup> Confirmed with angiographic and clinical results.

<sup>b</sup> Time from randomization to definitive diagnosis.

<sup>c</sup> Refers to length of stay rather than time to diagnosis.

<sup>d</sup> Reporting the sensitivity/specificity for CCTA versus exercise stress electrocardiogram for acute coronary syndrome with stenosis >70%.

<sup>e</sup> Positive predictive value for CCTA versus standard of care.

The purpose of the limitations tables (Tables 5 and 6) is to display notable limitations identified in each study. This information is synthesized as a summary of the body of evidence following each table and provides the conclusions on the sufficiency of the evidence supporting the position statement.

**Table 5. Study Relevance Limitations for RCTs Assessing CCTA in ED Settings**

Study	Population <sup>a</sup>	Intervention <sup>b</sup>	Comparator <sup>c</sup>	Outcomes <sup>d</sup>	Duration of Follow-Up <sup>e</sup>
Gray et al (2021) <sup>25</sup> ,					
Smulders et al (2019) <sup>26</sup> ,	2. Patients with a history of myocardial disease and/or				

<b>Study</b>	<b>Population<sup>a</sup></b>	<b>Intervention<sup>b</sup></b>	<b>Comparator<sup>c</sup></b>	<b>Outcomes<sup>d</sup></b>	<b>Duration of Follow-Up<sup>e</sup></b>
	severe noncardiac comorbidities were excluded				
Levsky et al (2018) <sup>27,</sup>					
Hamilton-Craig et al (2014) <sup>28,</sup>	4. Limited applicability to men <30 y and women <40 y				
Linde et al (2013) <sup>29,</sup>					
Litt et al (2012) <sup>30,</sup>	4. Limited to patients 40 to 74 y; may not be relevant for younger or older individuals				
Hoffmann et al (2012) <sup>31,</sup>					
Goldstein et al (2011) <sup>32,</sup>					
Goldstein et al (2007) <sup>33,</sup>		3. Unequal rates of ICA/revascularization	3. Unequal rates of ICA/revascularization		

CCTA: coronary computed tomography angiography; ED: emergency department; ICA: invasive coronary angiography; RCT: randomized controlled trial.

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

<sup>a</sup> Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.

<sup>b</sup> Intervention key: 1. Classification thresholds not defined; 2. Version used unclear; 3. Not intervention of interest.

<sup>c</sup> Comparator key: 1. Classification thresholds not defined; 2. Not compared to credible reference standard; 3. Not compared to other tests in use for same purpose.

<sup>d</sup> Outcomes key: 1. Study does not directly assess a key health outcome; 2. Evidence chain or decision model not explicated; 3. Key clinical validity outcomes not reported (sensitivity, specificity, and predictive values); 4. Reclassification of diagnostic or risk categories not reported; 5. Adverse events of the test not described (excluding minor discomforts and inconvenience of venipuncture or noninvasive tests).

<sup>e</sup> Follow-Up key: 1. Follow-up duration not sufficient with respect to natural history of disease (true-positives, true-negatives, false-positives, false-negatives cannot be determined).

**Table 6. Study Design and Conduct Limitations of RCTs Assessing CCTA in ED Settings**

Study	Allocation <sup>a</sup>	Blinding <sup>b</sup>	Selective Reporting <sup>c</sup>	Data Completeness <sup>d</sup>	Power <sup>e</sup>	Statistical <sup>f</sup>
Gray et al (2021) <sup>25</sup> ,		1,2. Patients and clinicians were not blinded				
Smulders et al (2019) <sup>26</sup> ,		1, 2.			3. Sample size calculation based on an estimated 75% ICA referral rate; however, all patients (100%) in the routine clinical care arm eventually underwent ICA	
Levsky et al (2018) <sup>27</sup> ,					2. Not powered to detect differences in MACE	
Hamilton-Craig et al (2014) <sup>28</sup> ,					2. Not powered to compare outcomes	
Linde et al (2013) <sup>29</sup> ,		1. Only patients and clinicians blinded to treatment allocation			2. Not powered to detect differences in secondary outcomes (intermediate cardiac events)	
Litt et al (2012) <sup>30</sup> ,					2. Due to low incidence of events, not powered for primary outcome (safety)	
Hoffmann et al (2012) <sup>31</sup> ,		1. No blinding to treatment				
Goldstein et al (2011) <sup>32</sup> ,				1. 10.3% of patients lost to follow-up	2. Not powered for secondary outcome (safety)	

Study	Allocation <sup>a</sup>	Blinding <sup>b</sup>	Selective Reporting <sup>c</sup>	Data Completeness <sup>d</sup>	Power <sup>e</sup>	Statistical <sup>f</sup>
Goldstein et al (2007) <sup>33</sup> ,					1. Power calculations not reported	4. No assessment of alternative noninvasive tests

CCTA: coronary computed tomography angiography; ED: emergency department; ICA: invasive coronary angiography; MACE: major adverse cardiac event; RCT: randomized controlled trial:

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

<sup>a</sup> Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.

<sup>b</sup> Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.

<sup>c</sup> Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.

<sup>d</sup> Data Completeness key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).

<sup>e</sup> Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.

<sup>f</sup> Statistical key: 1. Analysis is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Analysis is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated.

### Long-Term Follow-Up Studies

Results from long-term follow-up studies are tabulated in Table 7.

**Table 7. Results of Follow-Up Studies of RCTs**

Study	Initial Study Design (Trial)	Follow-Up Duration	Results
Linde et al (2015) <sup>34</sup> ,	RCT (CATCH)	18.7 mo (IQR, 16.8 to 20.1)	In the CCTA group (n=285), there were 5 MACE vs. 14 MACE in the SOC group (n=291) (HR=0.36; 95% CI, 0.16 to 0.95; p=.04)
Schlett et al (2011) <sup>35</sup> ,	RCT (ROMICAT)	2 y	Of 333 patients without CAD detected by CCTA, none had a MACE event during follow-up

CAD: coronary artery disease; CCTA: coronary computed tomography angiography; CI: confidence interval; HR: hazard ratio; IQR: interquartile range; MACE: major adverse cardiac event; RCT: randomized controlled trial; SOC: standard of care.

### Nonrandomized Studies

Durand et al (2017) compared the diagnostic performance of dobutamine-stress echocardiography (DSE) with CCTA in 217 adults.<sup>36</sup> Patients had normal measurements of troponin I or T, and electrocardiography results. All patients received DSE and CCTA, with only 75 (34.6%) patients receiving ICA, which served as the reference test. The primary endpoint was the diagnostic accuracy of the tests for detecting coronary stenosis greater than 50%. Forty-nine (22.6%) patients had a positive CCTA while 33 (15.2%) patients had a positive DSE. A negative CCTA result was reported in 144 (66.4%) patients, and 146 (67.3%) had a negative DSE result. Overall, CCTA was more sensitive than DSE in detecting CAD, while specificity was similar between tests. At 6 months, no patients had died or received a diagnosis of MI, but 1 patient

presented with ACS whose diagnosis was initially missed. No limitations were identified. Tables 8 and 9 summarize the trial characteristics and results.

**Table 8. Key Nonrandomized Trials Assessing CCTA in ED Settings**

Study	Study Type	Country	Dates	Participants	Treatment	Comparator	Follow-Up, mo
Durand et al (2017) <sup>36</sup> ,	Prospective head-to-head multicenter	France	NR	Adults treated at the ED for chest pain <24 h after symptom onset	CCTA	DSE	6

CCTA: coronary computed tomography angiography; DSE: dobutamine-stress echocardiography; ED: emergency department; NR: not reported.

**Table 9. Results of Key Nonrandomized Trials Assessing CCTA in ED Settings**

Study	Diagnostic Accuracy		Incidence of MI	ICA, n (%) <sup>a</sup>
	CCTA <sup>b</sup>	DSE <sup>b</sup>		
Durand et al (2017) <sup>36</sup> ,				
N	217	217	None during FU	75 (34.6)
Sensitivity, %	96.9	51.6		
Specificity, %	48.3	46.7		
PLR (95% CI)	2.09 (1.36 to 3.11)	1.03 (0.62 to 1.72)		
NLR (95% CI)	0.07 (0.01 to 0.52)	1.10 (0.63 to 1.96)		

CCTA: coronary computed tomography angiography; CI: confidence interval; DSE: dobutamine-stress echocardiography; ED: emergency department; FU: follow-up; ICA: invasive coronary angiography; MI: myocardial infarction; NLR: negative likelihood ratio; PLR: positive likelihood ratio.

<sup>a</sup> Number of patients who received ICA.

<sup>b</sup> Of detected coronary stenosis >50%.

### Section Summary: Acute Chest Pain Presenting in the Emergency Setting

The high negative predictive value of CCTA in patients presenting to the ED with chest pain permits ruling out coronary disease with high accuracy. The efficiency of the workup is improved because patients are safely and quickly discharged from the ED with no adverse outcomes among patients with negative CCTA examinations.

Other important outcomes that require consideration when comparing technologies include ICA rates, use of a second noninvasive test, radiation exposure, and follow-up of any incidental findings. Some studies have shown that subsequent invasive testing is more frequent in patients who received CCTA. Studies have differed over which treatment strategies result in higher overall radiation exposure. Incidental findings after CCTA are common and lead to further testing, but the impact of these findings on subsequent health outcomes is uncertain.

### **Patients With Stable Chest Pain and Suspected Coronary Artery Disease**

Before the use of CCTA, the initial noninvasive test in a diagnostic strategy was always a functional test. Current practice guidelines recommend a noninvasive test be performed in patients with an intermediate risk of CAD. The choice of the functional test is based on clinical factors such as the predicted risk of disease, ECG interpretability, and ability to exercise. When the disease is detected, treatment alternatives include medical therapy or revascularization (percutaneous coronary intervention or coronary artery bypass graft surgery). If revascularization is indicated, patients undergo ICA to confirm the presence of stenosis. Which approach to adopt is based on the extent of anatomic disease, symptom severity, evidence of ischemia from functional testing, and, more recently, fractional flow reserve obtained during angiography. Many studies have shown that only a subset of anatomically defined coronary lesions are clinically significant and benefit from revascularization. Other studies have shown only limited benefits for treating coronary stenoses in stable patients. Thus an assessment of the diagnostic characteristics of CCTA alone is insufficient to establish clinical utility. A difficulty in evaluating a noninvasive diagnostic test for CAD is that patient outcomes depend not only on test results but also on the management and treatment strategy. The most convincing evidence of clinical utility compares outcomes after anatomic-first (CCTA) and functional-first (e.g., perfusion imaging, stress echocardiography) strategies.

Relevant studies reviewed here include those comparing the diagnostic performance of CCTA with angiography, studies of outcomes of patients undergoing CCTA versus alternative tests, and studies of incidental findings and radiation exposure.

### **Clinical Context and Test Purpose**

The purpose of CCTA in individuals with stable chest pain and suspected CAD is to diagnose coronary artery obstruction and guide treatment decisions.

The following PICO was used to select literature to inform this review.

#### ***Populations***

The relevant population of interest is individuals with stable chest pain and suspected CAD who are at an intermediate-risk and meet guideline criteria for noninvasive testing.

#### ***Interventions***

The intervention of interest is CCTA.

#### ***Comparators***

The following tests and practices are currently being used to make decisions about managing stable chest pain: noninvasive testing including exercise electrocardiography, myocardial perfusion imaging (MPI), stress echocardiography, and standard care.

#### ***Outcomes***

The outcomes of interest are mortality, sensitivity and specificity, MI, hospitalization, and utilization of ICA. The time of interest is in the short-term to evaluate follow-up procedures after imaging and for several years or more after CCTA to determine event rates.

### Study Selection Criteria

For the evaluation of clinical validity of the CCTA for stable chest pain, studies that meet the following eligibility criteria were considered:

- Reported on the accuracy of the marketed version of the technology (including any algorithms used to calculate scores)
- Included a suitable reference standard
- Patient/sample clinical characteristics were described
- Patient/sample selection criteria were described.

### Clinically Valid

A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

### Review of Evidence

There is a large body of evidence evaluating the diagnostic characteristics of CCTA for identifying coronary lesions. The best estimate of the diagnostic characteristics of CCTA can be obtained from recent meta-analyses, systematic reviews, and guideline reports. Table 10 shows ranges of sensitivity and specificity for functional noninvasive tests as summarized in collaborative medical association guidelines for the diagnosis and management of stable angina by Fihn et al (2012).<sup>37</sup> Sensitivities tended to range between 70% and 97%, depending on the test and study, and specificities ranged between 70% and 90%.

Characteristics and results of reviews are summarized in Tables 11 and 12. For CCTA, estimates of sensitivity from various systematic reviews are considerably higher (Table 12).

**Table 10. Sensitivity and Specificity Estimates for Functional Noninvasive Tests From Guidelines**

Noninvasive Test	Sensitivity (Range or Single Estimates), %	Specificity (Range or Single Estimates), %
Exercise electrocardiography	61	70 to 77
Pharmacologic stress echocardiography	85 to 90	79 to 90
Exercise stress echocardiography	70 to 85	77 to 89
Exercise myocardial perfusion imaging	82 to 88	70 to 88
Pharmacologic stress myocardial perfusion imaging	88 to 91	75 to 90
Coronary computed tomography angiography	93 to 97	80 to 90

Adapted from Fihn et al (2012).<sup>37</sup>

**Table 11. SR & MA Characteristics of Clinical Validity for CCTA in Stable Chest Pain and Suspected CAD**

Study	Study Population	Reference Standard	Threshold for Positive Index Test	Timing of Reference and Index Tests	Blinding of Assessors	Comment
Haase et al (2019) <sup>38</sup> ,	Individuals with a clinical indication for coronary angiography due to suspected CAD because of stable chest pain.  Individual patient data sufficient to calculate pre-test clinical risk.  N = 5332 in 65 prospective diagnostic accuracy studies	ICA	CCTA: <ul style="list-style-type: none"> <li>Obstructive CAD: <math>\geq 50\%</math> stenosis</li> </ul> Pre-test Clinical Risk: <ul style="list-style-type: none"> <li>CAD Consortium prediction tool</li> </ul>	NR	NR	Acceptable thresholds for index and reference tests were unclear. Calculation of pre-test clinical risk assessment not clearly described. Timing of tests not reported.
Nielsen et al (2014) <sup>39</sup> ,	Studies examining the diagnostic accuracy of CCTA vs functional testing in patients suspected of stable CAD.  N = 1575 in 11 diagnostic accuracy studies	ICA	CCTA: NR	NR	NR	Details on blinding and timing were limited. Quality assessment results for bias risk in diagnostic accuracy studies was predominantly low.
Ollendorf et al (2011) <sup>40</sup> ,	42 diagnostic accuracy studies	ICA	CCTA: NR	NR	Blinded review of CCTA and ICA	
Health Quality Ontario (2010) <sup>41</sup> ,	Individuals with intermediate	ICA	CCTA: <ul style="list-style-type: none"> <li>CAD: <math>\geq 50\%</math> stenosis</li> </ul>	NR	NR	Analysis is limited by significant heterogeneity

Study	Study Population	Reference Standard	Threshold for Positive Index Test	Timing of Reference and Index Tests	Blinding of Assessors	Comment
	pre-test probability of CAD.					between studies.

CAD: coronary artery disease; CCTA: coronary computed tomography angiography; ICA: invasive coronary angiography; MA: meta-analysis; NR: not reported; SR: systematic review.

**Table 12. SR & MA Results for CCTA in Stable Chest Pain and Suspected CAD**

Study; Subgroup	Clinical Validity, % (95% CI)			
	Sensitivity	Specificity	PPV	NPV
Haase et al (2019) (COME-CCT); Overall <sup>38</sup> ,	95.2 (92.6 to 96.9)	79.2 (74.9 to 82.9)	75.6 (NR)	86.3 (NR)
Haase et al (2019) (COME-CCT); Pre-test Clinical Risk Subgroup <sup>38</sup> , 7%	NR	NR	50.9 (43.3 to 57.7)	97.8 (96.4 to 98.7)
15%	NR	NR	55.8 (48.6 to 62.3)	97.1 (95.4 to 98.2)
50%	NR	NR	75.4 (70.5 to 79.5)	90.9 (87.5 to 93.4)
67%	NR	NR	82.7 (78.3 to 86.2)	85.0 (80.2 to 88.9)
Nielsen et al (2014) <sup>39</sup> ,	98 (93 to 99)	82 (63 to 93)	85 (71 to 93.5)	97.5 (87 to 99)
Ollendorf et al (2011) <sup>40</sup> ,	98 (96 to 99)	85 (81 to 89)	NR	NR
Health Quality Ontario (2010) <sup>41</sup> ,	96.1 (94 to 98.3)	81.5 (73.0 to 89.9)	NR	NR

CCTA: coronary computed tomography angiography; CI: confidence interval; MA: meta-analysis; NPV: negative predictive value; NR: not reported; PPV: positive predictive value; SR: systematic review.

### Clinically Useful

A test is clinically useful if the use of the results inform management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, more effective therapy, or avoid unnecessary therapy or testing.

### Direct Evidence

Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

### Systematic Reviews

De Campos et al (2022) conducted a meta-analysis of long-term outcomes in patients receiving CCTA or functional testing for stable CAD.<sup>42</sup> The composite primary outcome included the rate of death from any cause and nonfatal ACS. Follow-up ranged from 1 to 5 years; only 3 trials had follow-up periods longer than 1 year. The primary outcome occurred in 378 patients (2.6%) assigned to the CCTA group and in 397 (2.7%) of patients in the functional testing group (relative risk 0.97; 95% CI, 0.76 to 1.22;  $p=.77$ ;  $I^2=43\%$ ). Tables 13 and 14 summarize review characteristics and results.

Foy et al (2017) conducted a systematic review comparing CCTA with functional stress testing for patients with suspected CAD and stable or acute chest pain.<sup>43</sup> In the CCTA arm, there were 10,315 patients, and in the functional stress testing arm, there were 9777 patients; both CCTA and functional stress testing strategies varied among the 13 trials. Overall mortality and cardiac hospitalization did not differ between CCTA and functional stress testing groups. There were fewer cases of MI in the CCTA group than in the functional stress testing group; however, the incidence of ICA and revascularization were higher in the CCTA group. Coronary computed tomographic angiography was associated with an increase in new diagnoses of CAD as well as increased prescription of aspirin and statin therapy. All trials reported a lack of blinding, both of patients and personnel, and the overall quality of evidence was moderate, despite a high-risk of bias in several studies included. Additional limitations included the lack of available patient-level data, the absence of assessment of time to hospital discharge, and differences in radiation exposure. Tables 13 and 14 summarize review characteristics and results.

**Table 13. Characteristics of SR & MA Assessing CCTA for Stable Chest Pain**

Study	Dates	Trials	Participants	N (Range)	Design	Duration
De Campos et al (2022) <sup>42</sup> ,	2009-2019	8	Patients with stable CAD	29,579 (303 to 9102)	RCT	≥ 12 months follow-up
Foy et al (2017) <sup>43</sup> ,	2000-2016	13	Patients with suspected CAD	20,092 (CCTA arm: n=10,315; functional stress testing arm: n=9,777)	RCT	NR

CAD: coronary artery disease; CCTA: coronary computed tomography angiography; MA: meta-analysis; NR: not reported; RCT: randomized controlled trial; SR: systematic review.

**Table 14. Results of SR & MA Assessing CCTA for Stable Chest Pain**

Study	Incidence of ICA, %	Revascularization, %	Adverse Events, %	New Diagnoses of CAD, %	Medication Use, % <sup>a</sup>
De Campos et al (2022) <sup>42</sup> ,					
CCTA vs. Functional stress testing	14.86 vs 19.43 <sup>b</sup>	NR	NR	NR	NR

Study	Incidence of ICA, %	Revascularization, %	Adverse Events, %	New Diagnoses of CAD, %	Medication Use, % <sup>a</sup>
OR (95% CI)	0.75 (0.6 to 0.96)	1.63 (0.97 to 2.74)			
Foy et al (2017) <sup>43</sup> ,					
CCTA vs. Functional stress testing	11.7 vs 9.1	7.2 vs 9.1	<ul style="list-style-type: none"> <li>Mortality: 1.0 vs 1.1</li> <li>Hospitalization: 2.7 vs 2.7</li> <li>MI: 0.7 vs 1.1</li> </ul>	18.3 vs 8.3	Aspirin: 21.6 vs 8.2  Statins: 20.0 vs 7.3
RR (95% CI)	1.33 (1.12 to 1.59)	1.86 (1.43 to 2.43)	<ul style="list-style-type: none"> <li>Mortality: 0.93 (0.71 to 1.21)</li> <li>Hospitalization: 0.98 (0.79 to 1.21)</li> <li>MI: 0.71 (0.53 to 0.96)</li> </ul>	2.80 (2.03 to 3.87)	Aspirin: 2.21 (1.21 to 4.04)  Statins: 2.03 (1.09 to 3.76)

CAD: coronary artery disease; CCTA: coronary computed tomography angiography; CI: confidence interval; ICA: invasive coronary angiography; MA: meta-analysis; MI: myocardial infarction; NR: not reported; OR: odds ratio; RR: relative risk; SR: systematic review.

<sup>a</sup> Proportion of patients who experienced a significant increase in medication use.

<sup>b</sup> This analysis excludes 1 study with a population deemed low-risk and another considered the main source of heterogeneity.

### Randomized Controlled Trials

For patients at intermediate risk of CAD, 7 major RCTs were identified by comparing outcomes after a CCTA strategy with outcomes after other noninvasive testing strategies. Tables 15 and 16 summarize trial characteristics and results.

**Table 15. Characteristics of Key RCTs Assessing CCTA in Stable Chest Pain**

Study; Trial	Countries	Sites	Dates	Participants	Interventions	
					Active	Comparator
Maurovich-Horvat et al (2022) <sup>44</sup> ; DISCHARGE	16 European countries	26	2015-2019	Patients with stable chest pain referred for ICA	1808 to CCTA	1753 to ICA
Stillman et al (2020) <sup>45</sup> ; RESCUE	U.S.	44	2011-2013	Patients with stable angina and suspected CAD	518 to CCTA	532 to SPECT-MPI
Newby et al (2019) <sup>46</sup> ; SCOT-HEART	U.K.	12	2010-2014	Patients referred for assessment of angina due to suspected CHD	2073 to standard of care plus CCTA	2073 to standard of care

Study; Trial	Countries	Sites	Dates	Participants	Interventions	
					Active	Comparator
Chang et al (2019) <sup>47</sup> ; CONSERVE	Various	22	2012-2016	Patients with suspected CAD referred to nonemergent ICA	823 to selective referral strategy with initial CCTA	808 to direct referral strategy with initial ICA
Rudzinski et al (2018) <sup>48</sup> ; CAT-CAD	Poland	1	2015-2016	Patients with stable angina and suspected CAD	60 to CCTA	60 to ICA
Douglas et al (2015) <sup>49</sup> ; PROMISE	U.S.	193	2010-2013	Symptomatic outpatients without diagnosed CAD	4996 to anatomic testing strategy with CCTA	5007 to functional testing strategy
SCOT-HEART Investigators (2015) <sup>50</sup> ; SCOT-HEART	U.K.	12	2010-2014	Patients referred for assessment of angina due to suspected CHD	2073 to standard of care plus CCTA	2073 to standard of care
McKavanagh et al (2015) <sup>51</sup> ; CAPP	U.K.	NR	2010-2011	Patients with symptoms of stable chest pain	250 to EST	250 to cardiac CT

CAD: coronary artery disease; CHD: coronary heart disease; CT: computed tomography; CCTA: coronary computed tomography angiography; EST: exercise stress electrocardiogram test; ICA: invasive coronary angiography; NR: not reported; RCT: randomized controlled trial; SPECT-MPI: single photon emission computed tomography myocardial perfusion imaging.

Maurovich-Horvat et al (2022) reported results from the Diagnostic Imaging Strategies for Patients with Stable Chest Pain and Intermediate Risk of Coronary Artery Disease (DISCHARGE) trial.<sup>44</sup> Patients were at least 30 years of age and randomized to CCTA or ICA. The primary outcome was a composite of cardiovascular death, nonfatal MI, or nonfatal stroke. After a median of 3.5 years of follow-up there was no difference in the primary outcome between the CCTA and ICA groups (HR 0.70; 95% CI, 0.46 to 1.07; p=.1).

Stillman et al (2020) reported results from the Randomized Evaluation of Patients with Stable Angina Comparing Utilization of Noninvasive Examinations (RESCUE) trial, which randomized 1050 patients with stable angina and suspected CAD to CCTA or single photon emission CT myocardial perfusion imaging (SPECT-MPI) to direct patients to optimal medical therapy alone or optimal medical therapy with revascularization.<sup>45</sup> The primary endpoint was first MACE (cardiac death or MI), or revascularization. Over a mean follow-up period of 16.2 months, there was a similar rate of MACE or revascularization in patients with CCTA compared to SPECT-MPI (p=.19). The authors did not report separate rates of MACE and revascularization.

Newby et al (2019) published updated 5-year outcomes from the CT coronary angiography in patients with suspected angina due to coronary heart disease (SCOT-HEART) trial. A significantly lower rate of death or nonfatal MI was found for patients undergoing CCTA with the SOC. Coronary computed tomographic angiography was not found to increase rates of

revascularization or subsequent utilization of ICA at this time point.<sup>46</sup> The authors of a post-hoc analysis of the 5 year SCOT-HEART data concluded that "the beneficial effect of CCTA on outcomes is consistent across subgroups with plausible underlying mechanisms" and that CCTA "improves CHD [coronary heart disease] outcomes by enabling better targeting of preventative treatments to those with CAD."<sup>52</sup>

Chang et al (2019) randomized 1611 patients to different referral strategies, where initial assessment for CAD was performed by CCTA or ICA. Downstream clinical decision-making and testing were left to the discretion of treating physicians. The primary outcome measure was noninferiority of CCTA in regard to MACE.<sup>47</sup>

Rudzinski et al (2018) reported on results from the Coronary Artery Computed Tomography as the First-Choice Imaging Diagnostic in Patients With High Pre-Test Probability of Coronary Artery Disease (CAT-CAD) trial, which randomized 120 patients with suspected CAD to undergo CCTA versus direct ICA. Outcomes were evaluated during the diagnostic and therapeutic periods. Evaluation with CCTA was found to reduce the total number of ICAs performed.<sup>48</sup>

Douglas et al (2015) reported on the PROspective Multicenter Imaging Study for Evaluation of Chest Pain (PROMISE) trial, which randomized 10,003 patients to CCTA or exercise electrocardiography, nuclear stress testing, or stress echocardiography (as determined by physician preference) as the initial diagnostic evaluation.<sup>49</sup> Coronary computed tomographic angiography also did not meet prespecified noninferiority criteria compared with alternative testing. Some clinical outcomes assessed at 12 months favored CCTA, but the differences were nonsignificant. Coronary catheterization and revascularization rates were higher in the CCTA group. In a further prespecified analysis of PROMISE trial data, Hoffmann et al (2017) found that there was no difference in event rates (death, MI, or angina) between the groups at a median of 26 months follow-up.<sup>53</sup> However, CCTA had better discriminatory ability than functional testing to predict events (e.g., in categories of normal, mildly abnormal, moderately abnormal, and severely abnormal) in patients who had nonobstructive CAD ( $p=.04$ ). When the Framingham Risk Score was added to functional testing results, there was no significant difference in prognostic capability between the approaches ( $p=.29$ ).

In the SCOT-HEART trial (2015), investigators randomized 4146 patients to CCTA plus SOC or SOC alone. The primary endpoint was the change in the proportion of patients with a more certain diagnosis (presence or absence) of angina pectoris.<sup>50</sup> Secondary outcomes included death, MI, revascularization procedures, and hospitalizations for chest pain. Analysis of the primary outcome showed that patients who underwent CCTA had an increase in the certainty of their diagnosis relative to those in usual care (relative risk, 1.79; 95% CI, 1.62 to 1.96). Williams et al (2017) reported on symptoms and quality of life for participants in the SCOT-HEART trial.<sup>54</sup> Symptoms improved in both groups; however, improvements in symptoms and quality of life at 6 months were lower in patients in the CCTA arm than the functional testing arm. This outcome was due primarily to patients who were diagnosed with moderate CAD or had a new prescription of preventative therapy compared with patients diagnosed with normal coronary arteries or who had their preventative therapy discontinued.

In the comparison of cardiac computerized tomography and exercise stress electrocardiogram test for the investigation of stable chest pain (CAPP) trial, McKavanagh et al (2015) randomized 500 patients with stable chest pain to CCTA or exercise stress testing.<sup>51</sup> The primary outcome

was the change difference in scores of Seattle Angina Questionnaire domains at 3 months. Patients were also followed for further diagnostic tests and management. In the CCTA arm, 15.2% of subjects underwent revascularization. In the exercise stress testing arm, 7.7% underwent revascularization. For the primary outcome, angina stability and quality of life showed significantly greater improvement in the CCTA arm than in the exercise stress testing arm.

**Table 16. Results of Key RCTs Assessing CCTA in Stable Chest Pain**

Study	Death or Nonfatal Myocardial Infarction	Incidence of ICA	Revascularization	Normal Findings on ICA	Angina Stability	Hospitalization
Maurovich-Horvat et al (2022) <sup>44</sup>		NR		NR	NR	NR
CCTA, %	1.5		14.2			
ICA, %	1.7		18			
HR	0.87 (0.52 to 1.46)		0.76 (0.65 to 0.90)			
p	NR		NR			
Stillman et al (2020) <sup>45</sup>		NR	NR	NR	NR	NR
CCTA, %	Negative test (1.2%); Positive test (20.5%)*					
SPECT-MPI, %	Negative test (3.2%); Positive test (34.8%)*					
HR	1.03 (0.61 to 1.75)*					
p	.19*					
Newby et al (2019) <sup>46</sup>				NR	NR	NR
CCTA + standard care, n (%)	48 (2.3)	491 (23.7)	279 (13.5)			
Standard care, n (%)	81 (3.9)	502 (24.2)	267 (12.9)			
HR at 5 yr (95% CI)	0.59 (0.41 to 0.84)	1.00 (0.88 to 1.13)	1.07 (0.91 to 1.27)			
p	.004	NR	NR			

<b>Study</b>	<b>Death or Nonfatal Myocardial Infarction</b>	<b>Incidence of ICA</b>	<b>Revascularization</b>	<b>Normal Findings on ICA</b>	<b>Angina Stability</b>	<b>Hospitalization</b>
Chang et al (2019) <sup>47</sup> ,					NR	
Selective Referral to CCTA, n (%)	36 (4.6)	179 (23%)	98 (13%)	24.6%		33 (4.2%)
Direct Referral to ICA, n (%)	33 (4.6)	719 (89%)	127 (18%)	61.1%		31 (4.3%)
HR (95% CI)	0.99 (0.66 to 1.47)	NR	NR			NR
p	.026 (1-sided noninferiority)	<.001	.007	<.001		NR
Rudzinski et al (2018) <sup>48</sup> ,			NR		NR	
CCTA, n	0	21		5		25
ICA, n	0	59		42		73
p		<.0001		<.0001		<.0001
Douglas et al (2015) <sup>49</sup> ,		NR	NR	NR	NR	
CCTA group	104					61
Functional testing group	112					41
HR (95% CI)	0.88 (0.67 to 1.15)					
p	.35					
SCOT-HEART Investigators (2015) <sup>50</sup> ,		NR	NR	NR	NR	
CCTA, n (%)	26					511 (12.3)
Standard care, n (%)	42					247 (11.9)
HR (95% CI)	0.616 (0.378 to 1.006)					0.928 (0.780 to 1.104)
p	.527					.399
McKavanagh et al (2015) <sup>51</sup> ,	NR	NR	NR	NR		NR

Study	Death or Nonfatal Myocardial Infarction	Incidence of ICA	Revascularization	Normal Findings on ICA	Angina Stability	Hospitalization
MD at 3 mo (95% CI)					-11.1 (-17.4 to -.48)	
p						
MD at 12 mo (95% CI)					-6.8 (-12.8 to -0.7)	
p					.028	

CI: confidence interval; CCTA: coronary computed tomography angiography; HR: hazard ratio; ICA: invasive coronary angiography; MD: mean difference; NR: not reported; RCT: randomized controlled trial; SPECT-MPI: single photon emission computed tomography myocardial perfusion imaging.

\*In the Stillman et al (2020) study, the primary endpoint included cardiovascular death, nonfatal myocardial infarction, or revascularization.

Tables 17 and 18 display notable relevance, design, and conduct limitations identified in each trial.

**Table 17. Study Relevance Limitations of RCTs Assessing CCTA in Stable Chest Pain**

Study	Population <sup>a</sup>	Intervention <sup>b</sup>	Comparator <sup>c</sup>	Outcomes <sup>d</sup>	Duration of Follow-Up <sup>e</sup>
Maurovich-Horvat et al (2022) <sup>44</sup> ,	4. Conducted only in European population				
Stillman et al (2020) <sup>45</sup> ,				1. Key health outcomes not addressed	2. Not sufficient duration for harms
Newby et al (2019) <sup>46</sup> ,	4. Patients >75 y excluded				
Chang et al (2019) <sup>47</sup> ,	4. Population included >84% Asian patients in each treatment arm				
Rudzinski et al (2018) <sup>48</sup> ,					2. Not sufficient duration for harms
Douglas et al (2015) <sup>49</sup> ,				1. Test performance and utility not addressed	

Study	Population <sup>a</sup>	Intervention <sup>b</sup>	Comparator <sup>c</sup>	Outcomes <sup>d</sup>	Duration of Follow-Up <sup>e</sup>
SCOT-HEART Investigators (2015) <sup>50</sup> ,	4. Patients >75 y excluded				
McKavanagh et al (2015) <sup>51</sup> ,	4. Low number of diabetics included due to exclusion criteria		1, 2. Noted difficulty in contrasting the results of anatomic and functional tests		

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

CCTA: coronary computed tomography angiography; RCT: randomized controlled trial.

<sup>a</sup> Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.

<sup>b</sup> Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest.

<sup>c</sup> Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively.

<sup>d</sup> Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not establish and validated measurements; 5. Clinical significant difference not prespecified; 6. Clinical significant difference not supported.

<sup>e</sup> Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms.

**Table 18. Study Design and Conduct Limitations of RCTs Assessing CCTA for Stable Chest Pain**

Study	Allocation <sup>a</sup>	Blinding <sup>b</sup>	Selective Reporting <sup>c</sup>	Data Completeness <sup>d</sup>	Power <sup>e</sup>	Statistical <sup>f</sup>
Maurovich-Horvat et al (2022) <sup>44</sup> ,		1. Not blinded to treatment assignment.				
Stillman et al (2020) <sup>45</sup> ,		1. Not blinded to treatment assignment.		1. High loss to follow-up or missing data (i.e., low adherence).		
Newby et al (2019) <sup>46</sup> ,		1-3. Treatments and outcomes not blinded and potential bias among attending clinicians was present.				
Chang et al (2019) <sup>47</sup> ,	2. Allocation not concealed.	1. Not blinded to treatment assignment.		1. High loss to follow-up or missing data.		

Study	Allocation <sup>a</sup>	Blinding <sup>b</sup>	Selective Reporting <sup>c</sup>	Data Completeness <sup>d</sup>	Power <sup>e</sup>	Statistical <sup>f</sup>
Rudzinski et al (2018) <sup>48</sup> ,	2. Allocation not concealed.			2. Unclear handling of missing data.	1. Power calculation not reported.	3. Confidence intervals not reported.
Douglas et al (2015) <sup>49</sup> ,						
SCOT-HEART Investigators (2015) <sup>50</sup> ,		1-3. Treatments and outcomes not blinded and potential bias among attending clinicians was present.				
McKavanagh et al (2015) <sup>51</sup> ,					3. Study not powered to evaluate prognosis or adverse CAD events.	

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

CAD: coronary artery disease; CCTA: coronary computed tomography angiography; RCT: randomized controlled trial.

<sup>a</sup> Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.

<sup>b</sup> Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.

<sup>c</sup> Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.

<sup>d</sup> Data Completeness key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).

<sup>e</sup> Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.

<sup>f</sup> Statistical key: 1. Analysis is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Analysis is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated.

### Section Summary: Stable Angina and Suspected Coronary Artery Disease

A number of studies have evaluated the diagnostic accuracy of CCTA for diagnosing CAD in an outpatient population. In general, these studies have reported high sensitivity and specificity, although there is some variability in these parameters across studies. Meta-analyses of these studies have shown that, for the detection of anatomic disease, CCTA has a sensitivity greater than 95%, which is superior to all other functional noninvasive tests. Specificity is at least as good as other noninvasive tests. However, the link between improved diagnosis and health outcomes is not as clear, and thus outcome studies are necessary to demonstrate the clinical utility of CCTA.

Direct clinical trial evidence comparing CCTA and other strategies in the diagnostic management of stable patients with suspected CAD has not demonstrated the superiority of CCTA in any of the single clinical trials. Recent clinical trials have demonstrated similar or lower rates of ICA and subsequent revascularization procedures with CCTA versus standard care or ICA, respectively. An important problem when interpreting the clinical trials is that the comparator strategies differ: in the PROMISE and CAPP trials, CCTA was compared with an alternative noninvasive test; in other studies, CCTA supplemented usual care (which may or may not have included a noninvasive test). These trial design differences are likely to reflect how CCTA is used in clinical practice—either as a substitute for another noninvasive test or as an adjunct to other noninvasive tests. The PROMISE trial explicitly compared CCTA with an alternative functional test as the initial diagnostic test. Although the trial did not show the superiority of CCTA and did not meet prespecified criteria for noninferiority, an examination of some secondary clinical outcomes supports a conclusion of noninferiority. The results of the other randomized trials are consistent with the noninferiority of CCTA compared with other established noninvasive tests and ICA. Thus, the randomized studies suggest that outcomes of patients are likely to be similar to CCTA versus other noninvasive tests.

### **Suspected Anomalous Coronary Arteries**

Anomalous coronary arteries are an uncommon finding during angiography, occurring in approximately 1% of coronary angiograms completed for evaluation of chest pain. However, these congenital anomalies can be clinically important depending on the course of the anomalous arteries.

### **Clinical Context and Test Purpose**

The purpose of CCTA in individuals who have suspected anomalous coronary arteries is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The following PICO was used to select literature to inform this review.

#### ***Populations***

The relevant population of interest is individuals with suspected anomalous coronary arteries.

#### ***Interventions***

The therapy being considered is CCTA.

#### ***Comparators***

The following practice is currently being used to make decisions about managing suspected anomalous coronary arteries: SOC without CCTA.

### **Outcomes**

The general outcomes of interest are overall survival, test accuracy, morbid events, and resource utilization. The time of interest is in the short-term to evaluate follow-up procedures after imaging and for several years or more after CCTA to determine event rates.

### **Study Selection Criteria**

For the evaluation of clinical validity of the CCTA for anomalous coronary arteries, studies that meet the following eligibility criteria were considered:

- Reported on the accuracy of the marketed version of the technology (including any algorithms used to calculate scores)
- Included a suitable reference standard
- Patient/sample clinical characteristics were described
- Patient/sample selection criteria were described.

### **Clinically Valid**

A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

### **Clinically Useful**

A test is clinically useful if the use of the results inform management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, more effective therapy, or avoid unnecessary therapy or testing.

### **Direct Evidence**

Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs. No RCTs were identified assessing the clinical utility of CCTA for suspected anomalous coronary arteries; however, case series exist.

### **Case Series**

A number of case series have consistently reported that CCTA can delineate the course of these anomalous arteries, even when conventional angiography cannot.<sup>55,56,57,58,</sup>

### **Section Summary: Suspected Anomalous Coronary Arteries**

Results from case series have shown that CCTA delineates the course of anomalous coronary arteries, even when conventional angiography cannot. However, none of the studies reported results when the initial reason for the study was to identify these anomalies, nor did any of the studies discuss the impact on therapeutic decisions. Given the uncommon occurrence of these symptomatic anomalies, it is unlikely that a prospective trial of CCTA could be completed.

### **Other Diagnostic Uses of Coronary Computed Tomography Angiography**

Given its ability to define coronary artery anatomy, there are many potential diagnostic uses of CCTA, including patency of coronary artery bypass grafts, in-stent restenosis, screening, and preoperative evaluation.

### **Patency**

Evaluating patency of vein grafts is less technically challenging due to vein size and lesser motion during imaging. In contrast, internal mammary grafts may be more difficult to image due to their small size and presence of surgical clips. Finally, assessing native vessels distal to grafts presents difficulties, especially when calcifications are present, due to their small size. In a systematic review, including results from 64-slice scanners, Stein et al (2008) reported high sensitivity (98%; 95% CI, 95% to 99%; 740 segments) and specificity (97%; 95% CI, 94% to 97%).<sup>59</sup> Other small studies have reported high sensitivity and specificity.<sup>60,61</sup> Lacking are multicenter studies demonstrating likely clinical benefit, particularly given the reasonably high disease prevalence in patients evaluated.

### **In-Stent Restenosis**

Use of CCTA for evaluating in-stent restenosis presents other technical challenges: motion, beam-hardening, and partial volume averaging. Whether these challenges can be overcome to obtain sufficient accuracy and impact outcomes has not been demonstrated.

### **Screening**

Use for screening a low-risk population was evaluated by McEvoy et al (2011) in patients undergoing CCTA (n=1000) or a control intervention (n=1000).<sup>62</sup> Findings reported in this study were abnormal in 215 screened patients. Over 18 months of follow-up, screening was associated with more invasive testing and statin use but no difference in cardiac event rates.

### **Preoperative Evaluation**

Use for screening in a high-risk population was evaluated in the Screening For Asymptomatic Obstructive Coronary Artery Disease Among High-Risk Diabetic Patients Using CT Angiography (FACTOR-64) trial, which randomized 900 subjects with diabetes to screening with CCTA or SOC.<sup>63</sup> Patients in this trial were asymptomatic but considered to be at high-risk for CAD due to long-standing diabetes. The primary outcome was a composite of mortality, nonfatal MI, or unstable angina requiring hospitalization. At a median follow-up of 4 years, there was no significant difference between the groups for the primary outcome (CCTA, 6.2% vs. control, 7.6%; HR=0.80; p=.38).

The utility of CCTA for the pre-operative screening of patients undergoing noncardiac surgery with an intermediate- to high-risk of CAD was assessed by Koshy et al (2019).<sup>64</sup> While current guidelines recommend stress testing in individuals at intermediate- to high-risk, over one-third of perioperative MACE occur among those with negative test results. Occurrence of MACE was reported in 7.2% of 3480 patients. Risk of perioperative MACE was found to increase with the severity of CAD on CCTA findings (no CAD, 2.0%; non-obstructive CAD, 4.1%; obstructive single-vessel, 7.1%; obstructive multivessel, 23.1%; p<.001). Obstructive multivessel CAD predicted the highest risk of MACE (odds ratio 8.9, 95% CI, 5.1 to 15.3; p<.001). In a high-risk subgroup, absence of multivessel disease demonstrated a high negative predictive value of 96% (95% CI, 92.8 to 98.4). The investigators acknowledge that the prognostic value of these findings has unclear clinical utility, as it is not known how non-obstructive or single-vessel CAD findings would change the clinical management of patients. Additionally, prior studies have not demonstrated a benefit of preoperative medical therapy or revascularization in lowering the incidence of MACE.

**SUPPLEMENTAL INFORMATION**

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

**Practice Guidelines and Position Statements**

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

**American College of Cardiology Foundation et al**

The American College of Cardiology along with several other organizations (2021) published guidelines for evaluation and diagnosis of chest pain that include recommendations for coronary computed tomography angiography (CCTA).<sup>65</sup>

For intermediate-risk patients with no known coronary artery disease (CAD) the guidelines pertinent to CCTA state:

- "For intermediate-risk patients with acute chest pain and no known CAD eligible for diagnostic testing after a negative or inconclusive evaluation for ACS [acute coronary syndrome], CCTA is useful for exclusion of atherosclerotic plaque and obstructive CAD."
- "For intermediate-risk patients with acute chest pain with evidence of previous mildly abnormal stress test results (≤1 year), CCTA is reasonable for diagnosing obstructive CAD."
- "For intermediate-risk patients with acute chest pain and no known CAD, as well as an inconclusive prior stress test, CCTA can be useful for excluding the presence of atherosclerotic plaque and obstructive CAD."

For intermediate-risk patients with known CAD the guidelines pertinent to CCTA state:

- "For intermediate-risk patients with acute chest pain and known nonobstructive CAD, CCTA can be useful to determine progression of atherosclerotic plaque and obstructive CAD."

The American College of Cardiology Foundation and several other medical societies (2012) issued joint guidelines for the management of patients with stable ischemic heart disease (Table 19).<sup>37</sup>

**Table 19. Guidelines on Management of Stable IHD**

Diagnosis	Recommendation	Class	LOE
Unknown			
	Able to exercise		
	"CCTA might be reasonable for patients with an intermediate pretest probability of IHD who have at least moderate physical functioning or no disabling comorbidity."	I Ib	B
	Unable to exercise		
	"CCTA is reasonable for patients with a low-to-intermediate pretest probability of IHD who are incapable of at least moderate physical functioning or have a disabling comorbidity."	IIa	B

Diagnosis	Recommendation	Class	LOE
	"CCTA is reasonable for patients with an intermediate pretest probability of IHD who a) have continued symptoms with prior normal test findings, or b) have inconclusive results from prior exercise or pharmacological stress testing, or c) are unable to undergo stress with nuclear MPI or echocardiography."	IIa	C
Known coronary disease			
	Able to exercise		
	"CCTA may be reasonable for risk assessment in patients with SIHD who are able to exercise to an adequate workload but have an uninterpretable ECG."	IIb	B
	"Pharmacological stress imaging (nuclear MPI, echocardiography, or CMR) or CCTA is not recommended for risk assessment in patients with SIHD who are able to exercise to an adequate workload and have an interpretable ECG."	III	C
	Unable to exercise		
	"Pharmacological stress CMR is reasonable for risk assessment in patients with SIHD who are unable to exercise to an adequate workload regardless of interpretability of ECG."	IIa	B
	"CCTA can be useful as a first-line test for risk assessment in patients with SIHD who are unable to exercise to an adequate workload regardless of interpretability of ECG."	IIa	C
	"A request to perform either a) more than 1 stress imaging study or b) a stress imaging study and a CCTA at the same time is not recommended for risk assessment in patients with SIHD."	III	C
	Regardless of patients' ability to exercise		
	"CCTA might be considered for risk assessment in patients with SIHD unable to undergo stress imaging or as an alternative to invasive coronary angiography when functional testing indicates a moderate- to high-risk result and knowledge of angiographic coronary anatomy is unknown."	IIb	C

CCTA: coronary computed tomography angiography; CMR: cardiac magnetic resonance; ECG: electrocardiography; IHD: ischemic heart disease; LOE: level of evidence; MPI: myocardial perfusion imaging; SIHD: stable ischemic heart disease.

The American College of Cardiology Foundation and other medical societies (2013) published appropriate use criteria for detection and risk assessment of stable ischemic heart disease.<sup>66</sup> Coronary computed tomography angiography (CCTA) was considered appropriate for:

- Symptomatic patients with intermediate (10% to 90%) pretest probability of coronary artery disease (CAD) and uninterpretable electrocardiogram (ECG) or inability to exercise
- Patients with newly diagnosed systolic heart failure
- Patients who have had a prior exercise ECG or stress imaging study with abnormal or unknown results

- Patients with new or worsening symptoms and normal exercise ECG.

**National Institute for Health and Care Excellence**

The National Institute for Health and Care Excellence (2016) has recommended CCTA as first-line testing for patients with stable angina if the clinical assessment indicates typical or atypical angina, or if the clinical assessment indicates non anginal chest pain but 12-lead resting electrocardiography (ECG) has been done and indicates ST-T changes or Q waves.<sup>67</sup>

**Society of Cardiovascular Computed Tomography**

The Society of Cardiovascular Computed Tomography (SCCT, 2021) published an expert consensus document on CCTA.<sup>68</sup> Recommendations on use of CCTA in select patients are included in Table 20. In addition to the recommendations listed below, the expert consensus included additional recommendations in several patient populations, including patients with known CAD.

**Table 20. Society of Cardiovascular Computed Tomography Guidelines on Coronary Computed Tomography Angiography**

Diagnosis	Recommendation
Stable chest pain with no known CAD	It is appropriate to perform CTA as the first line test for evaluating patients with no known CAD who present with stable typical or atypical chest pain, or other symptoms which are thought to represent a possible anginal equivalent (e.g., dyspnea on exertion, jaw pain).
	It is appropriate to perform coronary CTA following a nonconclusive functional test, in order to obtain more precision regarding diagnosis and prognosis, if such information will influence subsequent patient management.
	Coronary CTA is rarely appropriate in very low risk symptomatic patients, such as those <40 years of age who have noncardiac symptoms (e.g., chest wall pain, pleuritic chest pain).
Noncardiac surgery	It is appropriate to perform CTA as an alternative to other noninvasive tests for evaluation of selected patients prior to noncardiac surgery.
Coronary anomalies	It is appropriate to perform CTA for the evaluation of coronary anomalies.

CAD: coronary artery disease; CTA: cardiac computed tomography angiography.

In 2022, SCCT published an expert consensus document on use of CCTA for patients presenting to the emergency department with acute chest pain.<sup>69</sup> Relevant recommendations from the consensus document are listed in Table 21.

**Table 21. Society of Cardiovascular Computed Tomography Guidelines on Coronary Computed Tomography Angiography for Acute Chest Pain in the Emergency Department**

Scenario	Recommendation
Patient with no known CAD	
ECG diagnostic for STEMI	CCTA is usually not appropriate (door-to-balloon time <90 minutes should be prioritized).
NSTEMI-ACS is leading diagnosis (evidence of myocardial ischemia on ECG without ST-segment elevation, elevated troponin)	CCTA may be appropriate (e.g., to determine if invasive evaluation is appropriate).
High risk for ACS (no definite evidence of myocardial ischemia on ECG, normal or equivocal troponin)	CCTA may be appropriate as an alternative to functional testing or invasive evaluation.
Low to intermediate risk for ACS (no definite evidence of myocardial ischemia on ECG, normal or equivocal troponin, and/or inadequate or mildly abnormal functional testing during index ED visit or within previous year)	CCTA is appropriate and is most effective to rule out ACS.
Very low risk for ACS (no definite evidence of myocardial ischemia on ECG, normal or equivocal troponin, and/or non-cardiac chest pain is leading diagnosis)	CCTA may be appropriate (e.g., to confidently exclude CAD and provide risk stratification).
Patient with documented CAD, post-revascularization	
Prior PCI with stent $\geq 3$ mm within a proximal coronary segment (no definite evidence of myocardial ischemia on ECG, normal or equivocal troponin)	CCTA is appropriate for early triage.
Prior CABG (no definite evidence of myocardial ischemia on ECG, normal or equivocal troponin)	CCTA is appropriate, particularly for evaluating graft patency.

ACS: acute coronary syndrome; CABG: coronary artery bypass grafting; CAD: coronary artery disease; CCTA: coronary computed tomography angiography; ECG: electrocardiography; ED: emergency department; NSTEMI: non-ST-segment-elevation myocardial infarction; ST-segment-elevation myocardial infarction.

### U.S. Preventive Services Task Force Recommendations

No U.S. Preventive Services Task Force recommendations for CCTA have been identified.

### Ongoing and Unpublished Clinical Trials

Some currently ongoing trials that might influence this review are listed in Table 22.

**Table 22. Summary of Key Trials**

<b>NCT Number</b>	<b>Title</b>	<b>Enrollment</b>	<b>Completion Date</b>
<b><i>Ongoing</i></b>			
NCT04748237	Randomized Evaluation of Coronary Computed Tomographic Angiography in Intermediate-risk Patients Presenting to the Emergency Department With Chest Pain	3500	Dec 2025
NCT02099019	Usefulness of Coronary Computed Tomography Angiography for Therapeutic Decision-Making; Revascularization	3000	Feb 2025
NCT05677386	Prevention of Heart Disease in Adult Danes Using Computed Tomography Coronary Angiography - The DANE-HEART Trial	6000	Dec 2026
<b><i>Unpublished</i></b>			
NCT03129659	Coronary CT Angiography for Improved Assessment of Suspected Acute Coronary Syndrome With Inconclusive Diagnostic Work-up	230	Sep 2022

NCT: national clinical trial.

**CODING**

**The following codes for treatment and procedures applicable to this policy are included below for informational purposes. This may not be a comprehensive list of procedure codes applicable to this policy.**

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

**The code(s) listed below are medically necessary ONLY if the procedure is performed according to the "Policy" section of this document.**

<b>CPT/HCPCS</b>	
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image post processing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)

**Revisions**

01-10-2006	<p>In "Policy" section, deleted old policy and added "Computed tomographic angiography (CTA) is considered experimental/investigational for the evaluation of coronary arteries including but not limited to the following:</p> <ol style="list-style-type: none"> <li>1. Screening for coronary artery disease (CAD), either in asymptomatic subjects or as part of a preoperative evaluation</li> <li>2. Diagnosis of CAD, in patients with acute or non-acute symptoms, or after a coronary intervention</li> <li>3. Delineation of a coronary artery anatomy or anomaly</li> </ol> <p>Computed tomographic angiography (CTA) of other arteries may be indicated when medically necessity is properly documented."</p> <p>In "Coding", Covered Diagnosis section added "Note: The use of any diagnosis code does not guarantee reimbursement. Medical necessity will be based on documentation in the medical record."</p> <p>In "Reference" Government Agency; Medical Society; and Other Authoritative Publications section added #3 – BCBSA, #4 - BCBSKS Medical Consultant (401) and #5 – BCBSKS Medical Consultant (MCMC).</p>
Effective 09-01-2006	<p>In "Policy" section added "Note: As of June 14, 2006, per updated review by consultant, coronary CT angiography remains experimental / investigational because of lack of adequate repeated studies. Further investigation is needed. Consultant (MCMC – S087, Board certified in Internal Medicine, Cardiovascular Disease and Clinical Cardiac Electrophysiology) stated "There are, however, rare, highly specialized cases where a patient is at high risk of complications from coronary angiography, a properly performed SPECT nuclear stress imaging study has been somewhat positive but not definitive, where the noninvasive detection of a significant coronary lesion would lead to an invasive evaluation, in which case multislice CT angiography procedure is medically appropriate and necessary in order to exclude a lesion and prevent a high risk invasive procedure."</p> <p>In "Coding" CPT section added CPT codes 0145T, 0150T, and 0151T as directed by the Medical Director.</p>

<b>Revisions</b>	
	In "Reference" Government Agency; Medical Society; and Other Authoritative Publications section added #6, MCMC, Medical Care Ombudsman Program (MCOP), June 14, 2006, MCOP ID 1070-1753.
Effective 01-01-2007	In "Coding" CPT section, CPT code 72175 revised for 2007, the term 'noncoronary' has been added.
Effective 04-01-2007	In "Policy" section, deleted "Consultant (MCMC – S087, Board certified in Internal Medicine, Cardiovascular Disease and Clinical Cardiac Electrophysiology) stated "There are, however, rare, highly specialized cases where a patient is at high risk of complications from coronary angiography, a properly performed SPECT nuclear stress imaging study has been somewhat positive but not definitive, where the noninvasive detection of a significant coronary lesion would lead to an invasive evaluation, in which case multislice CT angiography procedure is medically appropriate and necessary in order to exclude a lesion and prevent a high risk invasive procedure" per Medical Director.
	In "Coding" CPT section, deleted CPT codes 0145T, 0150T, and 0151T per Medical Director.
	In "Coding" section, Covered Diagnosis, deleted "Note: The use of any diagnosis code does not guarantee reimbursement. Medical necessity will be based on documentation in the medical record. Services performed for any other diagnosis requires review with medical records" per Medical Director.
Effective 07-30-2007	<ul style="list-style-type: none"> <li>• Description section was updated to provide more detail about CTA technology.</li> <li>• Policy was liberalized to consider CTA medically necessary for evaluation of anomalous (native) coronary arteries in symptomatic patients when conventional angiography is unsuccessful or equivocal and when results will impact treatment. CTA remains experimental / investigational for all other indications.</li> <li>• Policy section was revised deleting: "Computed tomographic angiography (CTA) is considered experimental/investigational for the evaluation of coronary arteries including but not limited to the following:               <ol style="list-style-type: none"> <li>1. Screening for coronary artery disease (CAD), either in asymptomatic subjects or as part of a preoperative evaluation</li> <li>2. Diagnosis of CAD, in patients with acute or non-acute symptoms, or after a coronary intervention</li> <li>3. Delineation of a coronary artery anatomy or anomaly"</li> </ol> </li> </ul>
	AND "Note: As of June 14, 2006, per updated review by consultant, coronary CT angiography remains experimental / investigational because of lack of adequate repeated studies. Further investigation is needed."
	<ul style="list-style-type: none"> <li>• Policy section was revised adding the first two paragraphs.</li> <li>• Documentation section was added.</li> </ul>
	<ul style="list-style-type: none"> <li>• CPT codes 0146T, 0147T, 0148T, and 0149T were added for coronary anomalies.</li> <li>• Diagnosis codes 746.85 and 746.87 were added for coronary anomalies. Codes 747, 747.10, 747.11, 747.21, 747.22, and 747.3 were deleted.</li> </ul>
	<ul style="list-style-type: none"> <li>• References were updated.</li> </ul>
Effective 01-25-2008	<ul style="list-style-type: none"> <li>• Changed the name of the Policy to "Coronary CT Angiography and Calcium Scoring" from "Computed Tomographic Angiography (CTA)"</li> </ul>
	In Description section: <ul style="list-style-type: none"> <li>• Added "coronary" to the second paragraph, fifth sentence, "...suggested that coronary CTA may be..."</li> <li>• Added "coronary" to the third paragraph, first sentence, "Coronary CTA has several..."</li> </ul>
	In Policy section:

<b>Revisions</b>	
	<ul style="list-style-type: none"> <li>Removed the third paragraph, "Computed tomographic angiography (CTA) of other arteries may be indicated when medical necessity is properly documented."</li> <li>Under "Documentation" added "coronary", "All coronary CTA studies will be..."</li> <li>Under "Utilization" added "coronary", "Coronary CTA studies will be..."</li> </ul>
	<p>In Coding section:</p> <ul style="list-style-type: none"> <li>Removed CPT codes 70496, 70498, 71275, 72191 73206, 73706, 74175.</li> <li>Removed Diagnosis codes 093.0, 414.10, 415.0, 415.11, 417.0, 417.1, 417.8, 441.02, 444.1, 447.0, 447.2, 453.2, 745.0, 745.10, 745.11, 745.12, 745.19, 745.2, 745.3, 746.87, 747.20, 747.29, 747.40, 794.2, 996.1, 996.74, V12.59</li> <li>Removed Revenue Codes 32X, 34X, 35X, 40X.</li> </ul>
Effective 01-30-2008	<p>In Description section:</p> <ul style="list-style-type: none"> <li>Added "The available evidence does not provide sufficient information to permit conclusions on the effect of coronary CT angiography on health outcomes."</li> <li>"Electron beam computed tomography (EBCT) and multi detector computed tomography (MDCT) are methods used for measurement of coronary artery calcification. Calcium scores have been investigated both as a diagnostic technique in symptomatic patients to determine the necessity of coronary angiography or in asymptomatic patients as a screening technique for coronary artery disease. Published studies do not establish a clear role for detection of coronary artery calcification by computed tomography in coronary disease risk stratification in asymptomatic or symptomatic patients, nor have any studies shown that clinical outcomes can be favorably altered by the use of computed tomography based determination of coronary artery calcification in screening for coronary artery disease"</li> </ul> <p>In Policy section:</p> <ul style="list-style-type: none"> <li>Added "The use of computed tomography to detect coronary artery calcification is considered investigational."</li> </ul> <p>In Coding section added:</p> <ul style="list-style-type: none"> <li>Added CPT/HCPCS codes 0144T S8092.</li> <li>Added Diagnosis codes 414.01, V81.1</li> </ul>
Effective 12-15-2008	<p>In Heading:</p> <ul style="list-style-type: none"> <li>Revised title from Coronary CT Angiography and Calcium Scoring to Contrast-Enhanced Computed Tomography Angiography (CTA) for Coronary Artery Evaluation.</li> <li>Added a "See also" reference to other pertinent policies.</li> </ul> <p>In Description section:</p> <ul style="list-style-type: none"> <li>Updated terminology and discussion.</li> </ul> <p>In Policy section:</p> <ul style="list-style-type: none"> <li>Removed "The use of computed tomography to detect coronary artery calcification is considered investigational." See Computed Tomography to Detect Coronary Artery Calcification policy.</li> </ul> <p>Added Rationale section.</p> <p>In Coding section:</p> <ul style="list-style-type: none"> <li>Removed CPT / HCPCS codes: 0144T, S8092.</li> <li>Removed Diagnosis codes: 414.11, 414.19, 441.01, 441.03, 441.1, 441.2, 441.5, 441.3, 441.7, 441.9, 442.82, 446.7, 746.85, V81.0.</li> <li>Added Diagnosis codes: 414.02, 414.03, 414.04, 414.05.</li> </ul> <p>Updated Revisions and References sections.</p>
Effective 08-11-2009	<p>In Header:</p> <ul style="list-style-type: none"> <li>Added policy reference of Cardiac Computed Tomography (CT)</li> </ul> <p>In Rationale section:</p>

<b>Revisions</b>	
	<ul style="list-style-type: none"> <li>Added 2009 Update</li> </ul>
01-01-2010	<p>In Coding Section:</p> <ul style="list-style-type: none"> <li>Added CPT Code: 75574</li> <li>Removed CPT Codes: 0146T, 0147T, 0148T, 0149T</li> </ul>
08-19-2011	<p>In the Policy Language section:</p> <ul style="list-style-type: none"> <li>In Item #1, added "using 64 slices or greater may be considered medically necessary for the following inductions:               <ol style="list-style-type: none"> <li>For the evaluation of chest pain syndrome in patients with intermediate pre-test probability of CAD by Framingham risk scoring (10-20%)* or by American College of Cardiology criteria ** (see policy guidelines) and ECG is uninterpretable of patient is unable to exercise or have contraindications to exercise and pharmacologic stress testing.</li> <li>For the evaluation of acute chest pain in patients with intermediate pre-test probability of CAD by Framingham risk scoring (10-20%)* or by American College of Cardiology criteria** (see policy guidelines) and no ECG changes and serial enzymes are negative.</li> <li>For the evaluation of chest pain syndrome in patients with uninterpretable or equivocal stress test (exercise, perfusion, or stress echo).</li> <li>For the assessment of complex congenital heart disease including anomalies of coronary circulation, great vessels, and cardiac chambers and valves."</li> </ol> </li> <li>Added Item #3, "Contrast-enhanced computed tomographic angiography is considered experimental / investigational for any of the following Body mass index (BMI) greater than 40.               <ol style="list-style-type: none"> <li>Inability to image at desired heart rate (under 80 beats per minute).</li> <li>Persons in atrial fibrillation or with other significant arrhythmia.</li> <li>Persons with extensive coronary calcification by plain film or with prior contraindications to the procedure:</li> <li>Angston score greater than 1700."</li> </ol> </li> </ul> <p>Added Policy Guidelines.</p> <p>Updated Other References.</p>
12-09-2011	<p>Updated Description section.</p> <p>In the Policy section:</p> <ul style="list-style-type: none"> <li>Added "Contrast-enhanced computed tomographic angiography for the emergency evaluation of patients without known coronary artery disease and acute chest pain is considered medically necessary."</li> </ul> <p>Updated Rationale section.</p> <p>Updated Reference section.</p>
02-26-2013	<p>Updated Description section.</p> <p>Updated Rationale section.</p> <p>Updated Reference section.</p>
12-31-2013	<p>In Coding section:</p> <ul style="list-style-type: none"> <li>Added ICD-10 Diagnosis (<i>Effective October 1, 2014</i>)</li> </ul>
02-04-2015	<p>Updated Description section.</p> <p>Updated Rationale section.</p> <p>Updated Coding section:</p> <ul style="list-style-type: none"> <li>Changed effective date for ICD-10 Diagnoses to <i>October 1, 2015</i>.</li> </ul> <p>Updated References section.</p>
03-02-2016	<p>Updated Description section.</p> <p>In Policy section:</p> <ul style="list-style-type: none"> <li>Removed Item 1, "Contrast-enhanced computed tomographic angiography using 64 slices or greater may be considered medically necessary for the following</li> </ul>

<b>Revisions</b>	
	<p>indications: a. For the evaluation of chest pain syndrome in patients with intermediate pre-test probability of CAD by Framingham risk scoring (10-20%)* or by American College of Cardiology criteria**(see Policy Guidelines) and ECG is uninterpretable or patient is unable to exercise or have contraindications to exercise and pharmacologic stress testing.</p> <p>b. For the evaluation of acute chest pain in patients with intermediate pre-test probability of CAD by Framingham risk scoring (10-20%)* or by American College of Cardiology criteria**(see Policy Guidelines) and no ECG changes and serial enzymes are negative.</p> <p>c. for the evaluation of chest pain syndrome in patients with uninterpretable or equivocal stress test (exercise, perfusion, or stress echo).</p> <p>d. For the assessment of complex congenital heart disease including anomalies of coronary circulation, great vessels, and cardiac chambers and valves" and revised to read, "Contrast-enhanced computed tomography angiography for evaluation of patients with stable chest pain and meet guideline criteria (see Policy Guidelines) for requiring a noninvasive test in the outpatient setting is considered medically necessary."</p> <ul style="list-style-type: none"> <li>▪ In Item 2, removed "emergency" and added "in the emergency room/emergency department setting" to read, "Contrast-enhanced computed tomographic angiography for the evaluation of patients without known coronary artery disease and acute chest pain in the emergency room/emergency department setting is considered medically necessary.</li> <li>▪ Added Item 3.</li> <li>▪ Removed previous Item 4, "Contrast-enhanced computed tomographic angiography is considered experimental / investigational for any of the following contraindications to the procedure: <ul style="list-style-type: none"> <li>a. Body mass index (BMI) greater than 40.</li> <li>b. Inability to image at desired heart rate (under 80 beats per minute).</li> <li>c. Persons in atrial fibrillation or with other significant arrhythmia.</li> <li>d. Persons with extensive coronary calcification by plain film or with prior Angston score greater than 1700."</li> </ul> </li> <li>▪ In Policy Guidelines, replaced all previous verbiage with 2012 ACCF/AHA/ACP/AATS/PCNA, SCAI/STS guidelines.</li> </ul> <p>Updated Rationale section.</p> <p>Updated References section.</p> <p>Added Appendix section.</p>
05-25-2016	<p>In Policy section:</p> <ul style="list-style-type: none"> <li>▪ In Policy Guidelines, added Pretest Probability table.</li> </ul> <p>Updated References section.</p>
12-21-2016	<p>Policy title changed from "Contrast-Enhanced Computed Tomography Angiography (CTA) for Coronary Artery Evaluation."</p> <p>Updated Description section.</p> <p>In Policy section:</p> <ul style="list-style-type: none"> <li>▪ In Item A, added "coronary", "symptoms of", "ischemic heart disease", "ing", and removed "chest pain" and "requiring" to read, "Contrast-enhanced coronary computed tomography angiography for evaluation of patients with symptoms of stable ischemic heart disease and meeting guideline criteria (see Policy Guidelines) for a noninvasive test in the outpatient setting is considered medically necessary."</li> <li>▪ In Item B, added "coronary" and removed "the" to read, "Contrast-enhanced coronary computed tomography angiography for evaluation of patients without</li> </ul>

<b>Revisions</b>	
	<p>known coronary artery disease and acute chest pain in the emergency room/emergency department setting is considered medically necessary."</p> <ul style="list-style-type: none"> <li>▪ In Item C, added "coronary" and removed "[when conventional angiography is unsuccessful or equivocal and when the results will impact treatment]" to read, "Contrast-enhanced coronary computed tomography angiography for the evaluation of anomalous (native) coronary arteries in patients in whom they are suspected may be considered medically necessary."</li> <li>▪ In Item D, added "coronary" to read, "Contrast-enhanced coronary computed tomography angiography for coronary artery evaluation is considered experimental / investigational for all other indications."</li> </ul>
	Updated Rationale section.
	Updated References section.
	Removed Appendix.
10-25-2017	Updated Description section.
	Updated Rationale section.
	Updated References section.
04-25-2018	Updated Description section.
	In Policy section: <ul style="list-style-type: none"> <li>▪ <u>In Item B, removed "emergency room/" to read, "Contrast-enhanced coronary computed tomography angiography for evaluation of patients without known coronary artery disease and acute chest pain in the emergency room/emergency department setting is considered medically necessary."</u></li> </ul>
	Updated References section.
November 5, 2019	Updated Description section.
	Updated Rationale section.
	In Coding section: <ul style="list-style-type: none"> <li>• Added ICD-10 code: I20.8.</li> </ul>
	Updated References section.
05-22-2020	Updated Policy Guidelines: <ul style="list-style-type: none"> <li>• Replaced chart in policy guidelines that was omitted in error- Pretest Probability of CAD by age, gender, and symptoms</li> </ul>
11-05-2021	In related policies the following policies are archived Deleted: <i>CTA and MRA of the Head, Neck, Abdomen, Pelvis, and Lower Extremities Cardiac Computed Tomography (CT)</i>
	Updated Description section
	Updated Rationale section
	Updated Reference section
11-09-2022	Updated Description Section
	Updated Policy Section <ul style="list-style-type: none"> <li>▪ Section C: Re-worded statement to read " Contrast-enhanced coronary computed tomography angiography for evaluation of individuals with suspected anomalous (native) coronary arteries is considered medically necessary."</li> </ul>
	Updated Rationale Section
	Updated References Section
10-24-2023	Updated Description Section
	Updated Rationale Section
	Updated Coding Section <ul style="list-style-type: none"> <li>▪ Removed ICD-10 Codes</li> </ul>
	Updated References Section

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