LifeWise
Health Plan of Washington

MEDICAL POLICY – 2.02.507

Coronary Angiography for Known or Suspected Coronary Artery Disease in Adults

Effective Date:	Sep. 1, 2026	RELATED MEDICAL POLICIES:
Last Revised:	Aug. 11, 2026	N/A
Replaces:	N/A	

The Site of Service Medical Necessity criteria within this policy DO NOT apply to Indian Health Services (IHS) facilities.
Please refer to the medical necessity criteria for the procedure only

Select a hyperlink below to be directed to that section.

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Introduction

An angiogram is a test that uses a special dye, and a type of x-ray called fluoroscopy. A coronary angiogram is specifically for the heart. After injecting the dye, a series of x-rays are taken to look at how the blood is flowing through the arteries within the heart. The goal is to find out if these arteries are narrowed or blocked. Information about the locations and extent of narrowing or blockage helps determine whether treatment is needed and what type it should be. This policy discusses when coronary angiography may be medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

We will review for medical necessity this elective surgical procedure.

We also will review the site of service for medical necessity. Site of service is defined as the location where the surgical procedure is performed, such as an off campus-outpatient hospital or medical center, an on campus-outpatient hospital or medical center, an ambulatory surgical center, or an inpatient hospital or medical center.

Site of Service for Elective Surgical Procedures	Medical Necessity
Medically necessary sites of service: • **Off campus-outpatient hospital/medical center** • **On campus-outpatient hospital/medical center** • **Ambulatory Surgical Center**	**Certain elective surgical procedures will be covered in the most appropriate, safe, and cost-effective site. These are the preferred medically necessary sites of service for certain elective surgical procedures**

Inpatient hospital/medical center	**Certain elective surgical procedures will be covered in the most appropriate, safe, and cost-effective site. This site is considered medically necessary only when the individual has a clinical condition which puts him or her at increased risk for complications including any of the following (this list may not be all inclusive):**
	• Anesthesia Risk
	  ○ ASA classification III or higher (see **definition**)
	  ○ Personal history of complication of anesthesia
	  ○ Documentation of alcohol dependence or history of cocaine use
	  ○ Prolonged surgery (greater than 3 hours)
	• Cardiovascular Risk
	  ○ Uncompensated chronic heart failure (**NYHA class** III or IV)
	  ○ Recent history of myocardial infarction (MI) (less than 3 months)
	  ○ Poorly controlled, resistant hypertension*
	  ○ Recent history of cerebrovascular accident (less than 3 months)
	  ○ Increased risk for cardiac ischemia (drug eluting stent placed less than 1 year or angioplasty less than 90 days)

Site of Service for Elective Surgical Procedures	Medical Necessity
	○ Symptomatic cardiac arrhythmia despite medication ○ Significant valvular heart disease • Liver Risk ○ Advanced liver disease (MELD Score greater than 8)** • Pulmonary Risk ○ Chronic obstructive pulmonary disease (COPD) (FEV1 less than 50%) ○ Poorly controlled asthma (FEV1 less than 80% despite treatment) ○ Moderate to severe obstructive sleep apnea (OSA)*** • Renal Risk ○ End stage renal disease (on dialysis) • Other ○ Morbid obesity (BMI greater than or equal to 50) ○ Pregnancy ○ Bleeding disorder (requiring replacement factor, blood products, or special infusion product [DDAVP**** does not meet this criterion]) ○ Anticipated need for transfusion(s) * 3 or more drugs to control blood pressure ** https://reference.medscape.com/calculator/meld-score-end-stage-liver-disease *** Moderate-AHI greater than or equal to 15 and less than or equal to 30, Severe-AHI greater than or equal to 30 ****DDAVP-Deamino-Delta-D-Arginine Vasopressin (Desmopressin)
Inpatient hospital/medical center	**This site of service is considered NOT medically necessary for certain elective surgical procedures when the site of service criteria listed above in this policy are not met.**

This policy only applies to adults aged 19 and older

Condition	Medical Necessity
Conditions that do not require medical review	**Coronary angiography may be considered medically necessary for the following conditions that do not require medical review:** • Congenital heart disease • Heart failure • Hypertrophic cardiomyopathy • Kawasaki disease • Pulmonary artery extrinsic compressions of left main coronary artery • Valvular disease • Post cardiac transplant ○ Individual has not undergone coronary angiography in the preceding six months • The individual is 19 years of age or younger

Coronary artery disease, known or suspected	**Coronary angiography for known or suspected coronary artery disease (CAD) may be considered medically necessary when criteria for any one of the following conditions are met:**
	Angina
	• **Stable angina** in any of the following situations:
	  ○ Recurrent angina within 9 months of percutaneous coronary intervention (PCI)
	  ○ Canadian Cardiovascular Society (CCS) class I or II classification of angina (see **Table**) with intolerance of or failure to respond to optimal medical treatment (OMT)
	  ○ CCS class III or IV classification of angina that improves to class I or II on optimal medical treatment
	  ○ CCS class III or IV classification of angina despite optimal medical treatment
	  ▪ OMT is use of two or more anti-anginal medications from different therapeutic classes, including either a beta-blocker or calcium channel blocker or both unless contraindicated
	• **Unstable angina** or non-ST-elevation myocardial infarction, and high or intermediate risk for adverse outcome, as indicated by any of the following:
	  ○ Elevated troponin levels

Condition	Medical Necessity
	○ Ischemia related heart failure ○ Persistent hemodynamic or electrical instability ○ Left ventricular ejection fraction (LVEF) less than 40% ○ Prior PCI* in past 6 months or prior CABG** in past 12 months ○ Suspected or confirmed new ST segment depression ○ Sustained ventricular arrhythmia (ventricular tachycardia or sustained ventricular fibrillation lasting greater than or equal to 30 seconds) ○ Recurrent angina or ischemia at rest or low activity for greater than 20 minutes despite optimal medical treatment • Suspected Prinzmetal's angina (also known as variant angina) **OR** **High risk for CAD based on non-invasive findings** • High risk for CAD is suspected based on findings from non-invasive testing, as indicated by any of the following: ○ Echocardiographic wall motion abnormality involving greater than 2 segments ○ High-risk Duke Treadmill Score (less than or equal to -11) (see **Table**) ○ Left ventricular ejection fraction (LVEF) of 35% or less at rest ○ Stress electrocardiogram findings of ST-segment elevation, or ventricular arrhythmia, or at least 2 mm of ST-segment depression ○ Stress-induced large perfusion defect (particularly if anterior) or multiple moderate size perfusion defects ○ Stress-induced left ventricular dysfunction (exercise LVEF less than 35%) ○ Significant stenosis (greater than or equal to 50%) in an unprotected left main coronary artery on recent coronary CT angiography (CCTA) (see **Related Information**). **OR** **High Risk for CAD as evidenced on myocardial perfusion imaging** • Other evidence of high risk on myocardial perfusion imaging, as indicated by any of the following:

Condition	Medical Necessity
	○ A large, fixed perfusion defect with left ventricular dilatation or increased lung uptake of radioisotope ○ A stress-induced moderate perfusion defect with left ventricular dilatation or increased lung uptake of radioisotope ○ Left ventricular enlargement or transient ischemic dilation (TID) ratio is greater than 1.2 **OR** **After acute myocardial infarction** • After acute myocardial infarction, for risk-stratification when any of the following are present: ○ Clinically significant heart failure during hospital course ○ Ischemia provoked by minimal exercise on noninvasive testing ○ Left ventricular ejection fraction of 45% or less, and the individual is unable to undergo noninvasive testing **OR** **Other high-risk factors** • Ischemia that recurs (verified by clinical or noninvasive testing) within 12 months of coronary artery bypass graft (CABG) • Suspected pericarditis (acute) when signs and symptoms, troponin levels, and pattern of ST elevation cannot definitively rule out acute infarction • The individual survived sudden cardiac arrest or has a sustained ventricular tachycardia • Cardiac risk assessment needed prior to high-risk non-cardiac surgery, for an individual with disability, illness, or physical challenge that precludes non-invasive testing • Suspected stent thrombosis, either abrupt closure or subacute, following percutaneous coronary intervention • Reevaluation of a specific area or structure with same imaging modality, as indicated by 1 or more of the following: ○ Change in clinical status (e.g., worsening symptoms or new associated symptoms) ○ Need for re-imaging either prior to or after performance of invasive procedure

Condition	Medical Necessity
	○ Need for interval reassessment that may impact treatment plan **Coronary angiography for known or suspected coronary artery disease is considered NOT medically necessary in the absence of the above criteria.** * PCI: Percutaneous Coronary Intervention ** CABG: Coronary Artery Bypass Graft

Documentation Requirements
The individual's medical records submitted for review should document that medical necessity criteria are met. The record should include clinical documentation of: • Diagnosis/condition • History and physical examination documenting the severity of the condition • Results and/or reports from prior imaging or testing completed • Any prior procedures • Other high-risk factors

Coding

Code	Description
CPT	
93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;
93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography
93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization

Code	Description
93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization
93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed
93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography
93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed
93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography
HCPCS	
C7516	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report
C7517	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, with iliac and/or femoral artery angiography, nonselective, bilateral or ipsilateral to catheter insertion, performed at the same time as cardiac catheterization and/or coronary angiography, includes positioning or placement of the catheter in the distal aorta or ipsilateral femoral or iliac artery, injection of dye, production of permanent images, and radiologic supervision and interpretation
C7518	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography with endoluminal imaging of initial coronary vessel or graft using

Code	Description
	intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging, supervision, interpretation and report
C7519	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary angiography including pharmacologically induced stress
C7520	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) includes intraprocedural injection(s) for bypass graft angiography with iliac and/or femoral artery angiography, nonselective, bilateral or ipsilateral to catheter insertion, performed at the same time as cardiac catheterization and/or coronary angiography, includes positioning or placement of the catheter in the distal aorta or ipsilateral femoral or iliac artery, injection of dye, production of permanent images, and radiologic supervision and interpretation
C7521	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography with right heart catheterization with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report
C7522	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation with right heart catheterization, with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary angiography including pharmacologically induced stress
C7523	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report
C7524	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, with intravascular doppler velocity and/or

Code	Description
	pressure derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary angiography including pharmacologically induced stress
C7525	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report
C7526	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary angiography including pharmacologically induced stress
C7527	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report
C7528	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary angiography including pharmacologically induced stress
C7529	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary angiography including pharmacologically induced stress
C7552	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and

Code	Description
	interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress, initial vessel
C7553	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography with pharmacologic agent administration (e.g., inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed
C7557	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed and intraprocedural coronary fractional flow reserve (FFR) with 3D functional mapping of color-coded FFR values for the coronary tree, derived from coronary angiogram data, for real-time review and interpretation of possible atherosclerotic stenosis(es) intervention
C7562	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed with intraprocedural coronary fractional flow reserve (ffr) with 3d functional mapping of color-coded ffr values for the coronary tree, derived from coronary angiogram data, for real-time review and interpretation of possible atherosclerotic stenosis(es) intervention
C7568	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary angiography including pharmacologically induced stress (new code effective 01/01/26)
C7569	Percutaneous transluminal coronary angioplasty, single major coronary artery or branch with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report (new code effective 01/01/26)
C7570	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation with intraprocedural coronary fractional flow reserve (FFR) with 3D functional mapping of color-coded FFR values for the coronary tree, derived from

Code	Description
	coronary angiogram data, for real-time review and interpretation of possible atherosclerotic stenosis(ies) intervention (List separately in addition to code for primary procedure) (new code effective 01/01/26)

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Related Information

Definition of Terms

American Society of Anesthesiologists (ASA) Physical Status Classification

ASA PS Classification	Definition	Adult Examples including, but not limited to
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Current smoker, social alcohol drinker, pregnancy, obesity (30<BMI<40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, history (>3 months) of MI, CVA, TIA, or CAD/stents.
ASA IV	A patient with severe systemic disease that is a constant threat to life	Recent (<3 months) MI, CVA, TIA or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, shock, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are	

ASA PS Classification	Definition	Adult Examples including, but not limited to
	being removed for donor purposes	

DM-diabetes mellitus, HTN-hypertension, COPD-chronic obstructive pulmonary disease, ESRD-end stage renal disease, MI-myocardial infarction, CVA-cerebral vascular accident, TIA-transient ischemic attack, CAD-coronary artery disease, DIC-disseminated intravascular coagulation, ARD-acute respiratory distress

Source: **Statement on ASA Physical Status Classification System**. Accessed July 15, 2026.

Coronary artery bypass graft (CABG): A surgical procedure that restores blood flow to the heart by bypassing blocked or narrowed coronary arteries using arterial or venous grafts obtained from another part of the body.

Coronary computed tomography angiography (CCTA): A noninvasive imaging study that uses computed tomography and intravenous contrast material to visualize the coronary arteries and evaluate for coronary artery stenosis or obstruction.

Left ventricular ejection fraction (LVEF): The percentage of blood ejected from the left ventricle during each cardiac contraction. LVEF is commonly used to assess left ventricular systolic function.

Invasive coronary angiography (ICA): A minimally invasive procedure that uses a catheter and contrast dye to visualize the coronary arteries and detect blockages or narrowing. It is considered invasive because it involves inserting a thin, flexible tube (catheter) into a major blood vessel, usually in the groin (femoral artery) or wrist (radial artery), and guiding it to the heart.

Non-ST-elevation myocardial infarction (NSTEMI): A type of acute myocardial infarction characterized by elevated cardiac biomarkers without persistent ST-segment elevation on electrocardiography.

Percutaneous coronary intervention (PCI): A catheter-based procedure used to open narrowed or blocked coronary arteries, typically through balloon angioplasty, stent placement, or both.

Unprotected left main coronary artery (ULMCA) disease: Refers to significant narrowing or obstruction of the left main coronary artery (LCMA) that is not bypassed by a CABG. No prior surgical bypass to the left anterior descending (LAD) or circumflex arteries, which are the major branches of the LMCA.

Angina and Heart Failure Classification Tools

Canadian Cardiovascular Society (CCS) Functional Classification of Angina: A standardized classification system used to describe the severity of angina symptoms and the degree to which symptoms limit physical activity, is commonly used for classifying the severity of angina.

CCS Functional Classification of Angina
Class I. Ordinary physical activity does not cause angina, such as walking and climbing stairs. Angina with strenuous or rapid or prolonged exertion at work or recreation
Class II. Slight limitation of ordinary activity. Walking or climbing stairs rapidly, walking uphill, walking or stair climbing after meals, or in cold, or in wind, or under emotional stress or only during the few hours after awakening. Walking more than two blocks on the level and climbing more than one flight of ordinary stairs at a normal pace and in normal conditions.
Class III. Marked limitation of ordinary physical activity. Walking one or two blocks on the level and climbing one flight of stairs in normal conditions and at normal pace.
Class IV. Inability to carry on any physical activity without discomfort – anginal syndrome may be present at rest.

Source: **Canadian Cardiovascular Society grading of angina pectoris**. Accessed July 16, 2026

Duke Treadmill Score (DTS): DTS is a point system that incorporates the results from exercise duration on the treadmill, the magnitude of ST segment deviation on EKG, and exercise-induced angina. The test identifies patients with a high probability of severe coronary artery disease (triple vessel or left main coronary artery disease) that may be found at angiography and who have a higher mortality risk.

The Duke Treadmill Score is calculated as:

DTS = Exercise time (minutes) - (5 x ST deviation in mm) - (4 x angina index)

Risk level	Score	5-year mortality
Low risk	score ≥ to +5	3%
Intermediate risk	score between +5 and -11	10%
High risk	score ≤ -11	35%

New York Heart Association (NYHA) Classification:

Class I No symptoms and no limitation in ordinary physical activity, e.g., shortness of breath when walking, climbing stairs etc.
Class II Mild symptoms (mild shortness of breath and/or angina) and slight limitation during ordinary activity.
Class III Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g., walking short distances (20–100 m). Comfortable only at rest.
Class IV Severe limitations. Experiences symptoms even while at rest. Mostly bedbound patients

Place of Service (Professional Claims Codes):

Off-Campus-Outpatient Hospital A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Code 19)

Inpatient Hospital A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions. (Code 21)

On Campus-Outpatient Hospital A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Code 22)

Ambulatory Surgical Center A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis. (Code 24)

Evidence Review

Description

Cardiac angiography is an invasive procedure that includes fluoroscopy after injection of contrast material via catheter into the great vessels, chambers, and coronary vessels of the heart, as well as venous and arterial bypass grafts or other arterial conduits such as the mammary

arteries. In addition to demonstrating areas of impeded, regurgitant, or otherwise abnormal blood flow, cardiac angiography with right heart catheterization or left ventriculography enables quantitative assessment of myocardial function, such as left ventricular ejection fraction, cardiac output, or degree of shunting. It also enables quantitative assessment of coronary blood flow.

If a blockage is found, a percutaneous coronary intervention (PCI) such as angioplasty may be done to open the blockage. This may be done during the same procedure or at a later time. If there are many blockages or blockages in certain areas, a coronary artery bypass may be indicated.

Risks of coronary angiography include cardiac tamponade, arrhythmias, injury to a catheterized artery, low blood pressure, allergic reaction to contrast dye, excessive bleeding, kidney damage, stroke, or heart attack.

Coronary angiography refers specifically to the imaging of the coronary arteries to investigate coronary artery disease.

Background

Coronary artery disease is the most common form of heart disease in the United States and a leading cause of death. In 2022, it was responsible for 371,506 deaths, and approximately 5% of the adult population were living with the condition. Each year, around 805,000 individuals experience a heart attack, with 605,000 being first-time events and 200,000 occurring in those with a prior history. These figures underscore the importance of timely and accurate diagnosis to prevent progression and reduce the burden of cardiovascular morbidity.[1]

Clinical guidelines from the American College of Cardiology (ACC), American Heart Association (AHA), and European Society of Cardiology (ESC) support the use of coronary angiography in specific scenarios, including acute coronary syndromes, high-risk stress test results, and preoperative evaluation for cardiac surgery. The decision to proceed with angiography is typically based on a combination of clinical presentation, risk stratification tools, and results from prior imaging or functional testing. As a diagnostic modality, it provides critical information that can guide therapeutic interventions and long-term management strategies.

Summary of Evidence

For coronary artery disease, cardiac angiography may be indicated for evaluation of stable angina when symptoms cannot be medically controlled, are disabling, and when interventional treatment has been proposed as the next form of therapy. Qayyum (2008) and colleagues performed a systematic review to evaluate whether routine invasive strategy improves cardiovascular outcomes more than selective invasive strategies for acute coronary syndrome[2]. They evaluated 10 trials with a total of 10,648 individuals and found that a routine invasive strategy cannot be proven to reduce deaths or nonfatal myocardial infarction.

Mills et al. (2025) conducted data meta-analysis of six randomized controlled trials including 2,257 female individuals with non-ST-elevation acute coronary syndrome (NSTE-ACS).[29] Females have a greater risk of adverse events after NSTE-ACS due to lower frequency of receiving guideline-recommended coronary angiography and revascularization. Early invasive management (N=1141, 5 hours to angiography) was not associated with a statistically significant reduction in the composite outcome of all-cause mortality or myocardial infarction compared with delayed invasive management (N=1116, 49 hours to angiography) among female subjects with an average age of 69 years. However, early invasive management was associated with reduced recurrent ischemia. A subgroup analyses of high-risk female subjects with a Global Registry of Acute Coronary Events (GRACE) score greater than 140 or elevated cardiac biomarkers was associated with a lower incidence of all-cause mortality or myocardial infarction at 6 months post early coronary angiography (2.8%) vs. late coronary angiography (4.6%).

Cardiac angiography use is discouraged in individuals who have mild angina that is responsive to medication, with no evidence of ischemia on noninvasive testing. One major study is the Clinical Outcomes Utilizing Revascularization and Aggressive Drug Evaluation (COURAGE) trial.[7] This study looked at 2,287 individuals with stable coronary artery disease who were randomized to optimal medical therapy (OMT) with or without percutaneous coronary intervention (PCI). During a median 4.6-year follow-up, the study revealed no significant differences in the primary end point of all-cause mortality or nonfatal myocardial infarction [MI] or major secondary end points (composites of death/MI/stroke; hospitalization for acute coronary syndromes [ACSs]). There were no significant differences between treatment arms for the composite of cardiac death or MI or in any of the major pre-specified composite cardiovascular events during long-term follow-up, even after excluding peri-procedural MI as an outcome of interest. Overall, cause-specific cardiovascular outcomes paralleled closely the primary and secondary composite outcomes of the trial as a whole. Compared with an initial management strategy of OMT alone, addition of PCI did not decrease the incidence of major cardiovascular outcomes including cardiac death or the composite of cardiac death/MI/ACS/stroke in individuals with stable coronary artery disease.

A systematic review and meta-analysis of 20 trials (N=27,753) initial diagnostic strategies for the assessment of suspected stable coronary artery disease (CAD) by Zito et al. (2023) showed invasive coronary angiography (ICA) compared to coronary computed tomography angiography (CCTA) had similar health effects, including rates of major adverse cardiac events (MACE), symptom improvement, and downstream testing.[11] Both invasive coronary angiography (ICA) and CCTA demonstrated comparable clinical outcomes and diagnostic effectiveness and generally outperformed exercise electrocardiography and SPECT-MPI in identifying obstructive CAD. The systematic review supports a stepwise diagnostic approach for suspected stable CAD: starting with non-invasive testing, preferably CCTA when available, followed by selective ICA based on test results. This strategy balances patient safety, diagnostic accuracy, and resource utilization, reducing unnecessary invasive procedures while maintaining favorable cardiovascular outcomes.

Similar findings were reported by a systematic review and meta-analysis of three trials by Corballis et al. (2023), who found no significant differences in MACE, myocardial infarction, stroke, or death between computational tomography coronary angiography (CTCA) and ICA strategies among individuals (N=5,662) with stable coronary disease, although CTCA was associated with lower rates of revascularization and fewer invasive angiograms demonstrating no obstructive coronary artery disease.[30] The findings support a shift toward anatomical imaging, including ICA or CCTA, over traditional functional testing in evaluating stable CAD. The authors conclude CTCA is both a safe and appropriate first testing strategy for individuals under investigation for stable coronary disease.

Similarly, Machado et al. (2023) conducted a meta-analysis of five randomized controlled trials involving 5,727 individuals with stable chest pain referred for invasive coronary angiography. A CCTA-first strategy resulted in a 77% decrease in ICA with lower rates of coronary revascularization and stroke without significant differences in cardiovascular mortality, nonfatal myocardial infarction, major adverse cardiovascular events, or cardiovascular hospitalizations. The authors concluded that CCTA may be considered as an initial diagnostic strategy in selected individuals with stable chest pain.[31]

Specialty society guidelines recommend cardiac angiography for risk assessment in individuals with stable ischemic heart disease when clinical characteristics and the results of noninvasive testing suggest a high likelihood of severe disease. For example, cardiac angiography is indicated when noninvasive imaging suggests the possibility of left main coronary artery stenosis or severe multi-vessel disease, or to guide percutaneous interventions.

Practice Guidelines and Position Statements

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

Guidelines or position statements will be considered for inclusion 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, American Heart Association, American College of Physicians, American Association for Thoracic Surgery, Preventive Cardiovascular Nurses Association, Society for Cardiovascular Angiography and Interventions, Society of Thoracic Surgeons Guideline

In 2012, the American College of Cardiology Foundation (ACCF), American Heart Association (AHA) task force on practice guidelines, and the American College of Physicians (ACCP), American Association for Thoracic Surgery (AATS), the Preventive Cardiovascular Nurses Association (PCNA), Society for Cardiovascular Angiography and Interventions (SCAI), and the Society of Thoracic Surgeons (STS) guideline for the diagnosis and management of patients with stable ischemic heart disease (SIHD) detailed indications for coronary angiography.[15]

3.2.1. Coronary Angiography as an Initial Testing Strategy to Assess Risk: Recommendations

Class I (Should be performed)

- Individuals with SIHD who have survived sudden cardiac death or potentially life-threatening ventricular arrhythmia should undergo coronary angiography to assess cardiac risk. (Level of Evidence: B – Single RCT or nonrandomized studies)
- Individuals with SIHD who develop symptoms and signs of heart failure should be evaluated to determine whether coronary angiography should be performed for risk assessment. (Level of Evidence: B – Single RCT or nonrandomized studies)

3.2.2. Coronary Angiography to Assess Risk After Initial Workup With Noninvasive Testing: Recommendations

Class I (Should be performed)

- Coronary arteriography is recommended for individuals with SIHD whose clinical characteristics and results of noninvasive testing indicate a high likelihood of severe IHD and when the benefits are deemed to exceed risk. (Level of Evidence: C – Consensus opinion, case studies or standard of care)

Class IIa (It is reasonable to perform)

- Coronary angiography is reasonable to further assess risk in individuals with SIHD who have depressed LV function (EF <50%) and moderate risk criteria on noninvasive testing with demonstrable ischemia (Level of Evidence: C - Consensus opinion, case studies or standard of care)
- Coronary angiography is reasonable to further assess risk in individuals with SIHD and inconclusive prognostic information after noninvasive testing or in individuals for whom noninvasive testing is contraindicated or inadequate. (Level of Evidence: C - Consensus opinion, case studies or standard of care)
- Coronary angiography for risk assessment is reasonable for individuals with SIHD who have unsatisfactory quality of life due to angina, have preserved LV function (EF >50%), and have intermediate risk criteria on noninvasive testing. (Level of Evidence: C - Consensus opinion, case studies or standard of care)

Class III: (No benefit)

- Coronary angiography for risk assessment is not recommended in individuals with SIHD who elect not to undergo revascularization or who are not candidates for revascularization because of comorbidities or individual preferences. (Level of Evidence: B – Single RCT or nonrandomized studies)
- Coronary angiography is not recommended to further assess risk in individuals with SIHD who have preserved LV function (EF >50%) and low-risk criteria on noninvasive testing. (Level of Evidence: B – single RCT or nonrandomized studies)

- Coronary angiography is not recommended to assess risk in individuals who are at low risk according to clinical criteria and who have not undergone noninvasive risk testing. (Level of Evidence: C - Consensus opinion, case studies or standard of care)
- Coronary angiography is not recommended to assess risk in asymptomatic individuals with no evidence of ischemia on noninvasive testing. (Level of Evidence: C - Consensus opinion, case studies or standard of care)

In 2014, the ACC/AHA/AATS/PCNA/SCAI/STS Focused Update of the Guideline for the Diagnosis and Management of Patients With Stable Ischemic Heart Disease[16] specified a Class I recommendation for coronary angiography as useful in individuals with presumed stable ischemic heart disease who have unacceptable ischemic symptoms despite guideline-directed medical treatment and who are amenable to, and candidates for, coronary revascularization.

American Heart Association, American College of Cardiology, American Society for Preventive Cardiology, National Lipid Association, and Preventive Cardiovascular Nurses Association Guideline– Chronic Coronary Disease

In 2023, the American Heart Association (AHA), American College of Cardiology (ACC), American College of Clinical Pharmacy (ACCP), American Society for Preventive Cardiology (ASPC), National Lipid Association (NLA), and Preventive Cardiovascular Nurses Association (PCNA) published a guideline for the management of patients with chronic coronary disease (CCD).[32] The guideline notes that evidence from the COURAGE, BARI 2D, and ISCHEMIA trials did not demonstrate improvement in major clinical outcomes with a routine revascularization strategy compared with guideline-directed medical therapy alone in many individuals with chronic coronary disease. The guideline recommends invasive coronary angiography in individuals with chronic coronary disease who have a change in symptoms or functional capacity that persists despite guideline-directed medical therapy when the findings will guide therapeutic decision-making and improve anginal symptoms. The guideline also supports use of stress imaging and other noninvasive testing for risk stratification and evaluation of persistent symptoms prior to consideration of revascularization.

- In individuals "with chronic coronary disease and a change in symptoms or functional capacity that persists despite guideline-directed medical therapy, invasive coronary angiography is recommended for guiding therapeutic decision-making with the goal of improving anginal symptoms." (Class I, Level of Evidence B-R).

- In individuals "with chronic coronary disease and a change in symptoms or functional capacity that persists despite guideline-directed medical therapy, positron emission tomography/single photon emission CT myocardial perfusion imaging (PET/SPECTMPI), cardiovascular magnetic resonance (CMR) imaging, or stress echocardiography is recommended to detect the presence and extent of myocardial ischemia, estimate risk of major adverse cardiovascular events (MACE), and guide therapeutic decision".-(Class I, Level of Evidence B-NR).
- In individuals "with chronic coronary disease and a change in symptoms or functional capacity that persists despite guideline-directed medical therapy who have had previous coronary revascularization, coronary CT angiography (CCTA) is reasonable to evaluate bypass graft or stent patency (for stents less than or equal to 3 mm)". (Class IIa, Level of Evidence B-NR).

American College of Cardiology, American Heart Association, American College of Emergency Physicians, National Association of EMS Physicians, Society of Cardiovascular Angiography and Interventions Acute Coronary Syndromes Guideline

In 2025, the American College of Cardiology (ACC), American Heart Association (AHA), American College of Emergency Physicians (ACEP), National Association of EMS Physicians (NAEMSP), and Society for Cardiovascular Angiography and Interventions (SCAI) published a guideline for the management of patients with acute coronary syndromes (ACS).[33] The guideline incorporates updated evidence regarding the evaluation and management of unstable angina, non-ST-elevation myocardial infarction (NSTEMI), and ST-elevation myocardial infarction (STEMI), and emphasizes risk-based selection of invasive and noninvasive management strategies. The guideline supports the use of coronary angiography in individuals with ACS who are at elevated risk for adverse cardiovascular outcomes and in whom findings would guide revascularization or other therapeutic decision-making.

Selected recommendations supporting coronary angiography include:

- Coronary angiography is recommended as part of an invasive management strategy for individuals with acute coronary syndromes who have high-risk clinical features or objective evidence of ischemia.

- Risk stratification should be used to identify individuals who may benefit from an early invasive approach, including those with elevated cardiac biomarkers, hemodynamic instability, recurrent ischemia, or significant arrhythmias.
- Coronary angiography provides important diagnostic and prognostic information that may guide decisions regarding percutaneous coronary intervention (PCI), coronary artery bypass grafting (CABG), or optimal medical therapy.
- Selection of invasive versus conservative management should incorporate clinical presentation, risk assessment, comorbidities, and patient-specific factors.

American College of Cardiology, American Heart Association, American Society for Echocardiography, American Society of Nuclear Cardiology, American Society for Preventive Cardiology, Heart Failure Society of America, Heart Rhythm Society, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Computed Tomography, Society for Cardiovascular Magnetic Resonance, Society of Thoracic Surgeons Criteria for the Detection and Risk Assessment of Chronic Coronary Disease

In 2023, the American College of Cardiology (ACC), American Heart Association (AHA), American Society of Echocardiography (ASE), American Society of Nuclear Cardiology (ASNC), American Society for Preventive Cardiology (ASPC), Heart Failure Society of America (HFSA), Heart Rhythm Society (HRS), Society for Cardiovascular Angiography and Interventions (SCAI), Society of Cardiovascular Computed Tomography (SCCT), Society for Cardiovascular Magnetic Resonance (SCMR), and Society of Thoracic Surgeons (STS) published updated *Multimodality Appropriate Use Criteria for the Detection and Risk Assessment of Chronic Coronary Disease*.[34] The document provides appropriateness ratings for invasive and noninvasive diagnostic testing in individuals with suspected or known chronic coronary disease. Invasive coronary angiography was rated as an appropriate diagnostic testing option in symptomatic individuals with likely anginal symptoms and cardiovascular risk factors, in individuals with moderate-to-severe ischemia identified on stress imaging, in individuals with severe coronary stenosis identified on coronary computed tomography angiography (CCTA), and in individuals with newly diagnosed heart failure with reduced ejection fraction and no prior coronary artery disease evaluation. The

document also notes that invasive coronary angiography is rarely appropriate in individuals with symptoms that are less likely anginal and have a clear noncardiac explanation. The criteria emphasize that selection of diagnostic testing should be guided by symptoms, cardiovascular risk factors, prior testing results, and overall clinical risk assessment.

Selected appropriate use criteria supporting invasive coronary angiography include:

• Symptomatic individuals with likely anginal symptoms who are age 50 years or older and/or have two or more cardiovascular risk factors.

• Symptomatic individuals with moderate-to-severe ischemia identified on stress imaging.

• Symptomatic individuals with severe coronary stenosis identified on coronary CT angiography (CAD-RADS 4–5).

• Individuals with newly diagnosed heart failure with reduced ejection fraction and no prior coronary artery disease evaluation.

• Invasive coronary angiography is rarely appropriate in individuals with symptoms that are less likely anginal and have a clear noncardiac explanation.

American College of Cardiology, American Heart Association, European Society of Cardiology Guidelines for Ventricular Arrhythmias and Prevention of Sudden Cardiac Death

In 2006, the American College of Cardiology (ACC), American Heart Association (AHA), European Society of Cardiology (ESC) Guidelines for Ventricular Arrhythmias and Prevention of Sudden Cardiac Death for management of individuals with ventricular arrhythmias and the prevention of sudden cardiac death suggested it may be the only diagnostic tool available for an individual unable to have exercise treadmill testing or stress imaging due to intolerance to pharmacologic stress or other technical reasons (e.g., obesity, severe pulmonary disease).[14] It also is indicated in individuals resuscitated from cardiac arrest or premonitory death rhythms, such as polymorphic ventricular tachycardia or sustained ventricular tachycardia.

The National Institute for Health and Care Excellence (NICE)

In 2016 the National Institute for Health and Care Excellence (NICE) recommended coronary angiography for individuals with stable angina only when symptoms are not satisfactorily controlled with optimal medical treatment.[21]

Several different risk scoring systems and clinical prediction tools (such as SYNTAX and ACUITY) have been created to help differentiate individuals who are likely to have significant obstructive disease on coronary angiography from those who are not, as well as to help determine optimal revascularization strategy and clinical outcomes. Specialty society guidelines state that calculation of the Society of Thoracic Surgeons (STS) and SYNTAX scores is reasonable in individuals who have unprotected left main coronary artery lesions and complex coronary artery disease.

Occupation of Patient that Involves Safety of Others

Abnormal results on noninvasive testing help determine cardiac risk regardless of occupation. Indications for proceeding directly to coronary angiography, without non-invasive risk stratifying studies, do not change based on occupation. Factors such as age or sedentary lifestyle alone, in absence of other diagnoses listed in the policy statement; do not convey risk sufficient to proceed directly with coronary angiography. Thus, the occupation of an individual, coupled with a factor such as sedentary lifestyle, does not, by itself, convey risk and coronary angiography would be considered not medically necessary.

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History

Date	Comments
06/10/13	New policy. Add to Cardiology section. This policy is approved with a 90-day hold for provider notification and will be effective on October 1, 2013.
08/15/13	Update Related Policies. Change title to policy 2.02.508.
10/17/13	Update Related Policies. Change title to policy 2.02.508
10/13/14	Annual Review. Policy extensively re-written. Policy statements reorganized but intent is unchanged. Policy updated with literature search. Reference to using MCG as a tool to guide determinations is removed. References added. Diagnosis codes (both ICD-9 and ICD-10) removed from the policy.
12/22/14	Interim Review. Reference #1 removed. Related Policies 6.01.03 and 6.01.43 archived and removed.
08/11/15	Annual Review. Policy updated with literature search. Reference added. Investigational statement on Coronary Artery Calcium Scoring deleted because this technology is reviewed by AIM and the policy has been archived. Remainder of policy statement unchanged.
01/12/16	Annual Review. Policy reviewed. Literature search did not prompt adding new references. Policy statements unchanged.
03/01/17	Annual Review, approved February 14, 2017. Policy reviewed with literature search, no references added. Policy statements unchanged.
04/11/17	Policy moved into new format; no change to policy statements. Evidence Review section reformatted.
03/01/18	Annual Review, approved February 27, 2018. Minor edits for clarity. Otherwise, no change to policy statements. Reference added. Note added that this policy has been revised. Added Surgery Site of Service criteria, which becomes effective June 1, 2018.
06/01/18	Minor update; removed note and link to updated policy. Surgery Site of Service criteria becomes effective.
03/01/19	Annual Review, approved February 5, 2019. Reference added. Added indication of post cardiac transplant when criteria are met.
05/01/19	Minor update, clarified Site of Service requirements.

Date	Comments
04/01/20	Delete policy, approved March 10, 2020. This policy will be deleted effective July 2, 2020, and replaced with InterQual criteria for dates of service on or after July 2, 2020.
07/02/20	Delete policy.
11/01/20	Policy reinstated effective February 5, 2021, approved October 13, 2020. Policy update with literature review. Reference added. Policy statements unchanged.
10/01/21	Annual Review, approved September 2, 2021. Policy updated with literature review. No references added. Policy statements unchanged.
05/01/22	Annual Review, approved April 25, 2022. Policy updated with literature review. No references added. Policy statements unchanged except for minor edits only.
01/01/23	Coding update. Added new HCPC codes Add C7516, C7517, C7518, C7519, C7520, C7521, C7522, C7523, C7524, C7525, C7526, C7527, C7528, C7529, C7552, and C7553.
04/01/23	Annual Review, approved March 20, 2023. Policy reviewed. No references added. Policy statements unchanged. Changed the wording from "patient" to "individual" throughout the policy for standardization.
08/01/23	Interim Review, approved July 11, 2023. Added medically necessary policy statement for high-risk CAD based on noninvasive findings of CCTA. Reference added.
01/01/24	Coding update. Added new HCPCS codes C7557 and C7558.
11/01/24	Annual Review, approved October 21, 2024. Policy reviewed. References added. Policy statements unchanged.
01/01/25	Coding update. Added new HCPCS code C7562. Termed HCPCS code C7558.
08/01/25	Minor update. Removed Related Policy 11.01.524 Site of Service Surgical Procedures. Professional Claims codes placed in Related Information.
10/01/25	Annual Review, approved September 8, 2025. Policy reviewed. References added. Policy statements unchanged.
01/01/26	Coding update. Added new HCPCS codes C7569 and C7570 effective January 1, 2026.
06/01/26	Minor update. Added header to indicate that site of service review does not apply to Indian Health Services (IHS) facilities.
07/01/26	Coding update. Policy/table correction. HCPCS C7569 added to table after missed from previous update. No additional changes.
09/01/26	Annual Review, approved August 11, 2026. Policy reviewed with literature search completed July 10, 2026, references added. Policy statements updated to add optimal medical treatment (OMT) requirement for stable angina for each Canadian Cardiovascular Society Class with OMT defined as “OMT is use of two or more anti-anginal medications from different therapeutic classes, including either a beta-blocker or calcium channel blocker or both unless contraindicated”; updated for unstable angina criteria sustained ventricular arrhythmia “(ventricular tachycardia or sustained ventricular fibrillation lasting greater than or equal to 30 seconds)”, updated “Left

Date	Comments
	ventricular enlargement or transient ischemic dilation (TID) ratio is greater than 1.2". Added additional terms to Related Information Section, Expanded Practice Guidelines and Position Statements to include: 2023 American Heart Association (AHA), American College of Cardiology (ACC), American College of Clinical Pharmacy (ACCP), American Society for Preventive Cardiology (ASPC), National Lipid Association (NLA), and Preventive Cardiovascular Nurses Association (PCNA) guideline on chronic coronary disease (CCD) management, 2025 ACC, AHA, American College of Emergency Physicians (ACEP), National Association of EMS Physicians (NAEMSP), and Society for Cardiovascular Angiography and Interventions (SCAI) guideline acute coronary syndromes (ACS) management. 2023 ACC, AHA, American Society of Echocardiography (ASE), American Society of Nuclear Cardiology (ASNC), ASPC, Heart Failure Society of America (HFSA), Heart Rhythm Society (HRS), SCAI, Society of Cardiovascular Computed Tomography (SCCT), Society for Cardiovascular Magnetic Resonance (SCMR), and Society of Thoracic Surgeons (STS) multimodality appropriate use criteria for the detection and risk assessment of CCD.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2026 Premera All Rights Reserved.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.