

# Medical Policy



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**\*Current Policy Effective Date: 11/1/26**  
(See policy history boxes for previous effective dates)

## **Title: Computed Tomography to Detect Coronary Artery Calcification**

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### **Description**

Several types of fast computed tomography (CT) imaging, including electron-beam CT and spiral CT, allow the quantification of calcium in coronary arteries. Coronary artery calcium (CAC) is associated with coronary artery disease (CAD). The use of CAC scores has been studied in the prediction of future risk of CAD and in the diagnosis of CAD in symptomatic individuals

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### **Medical Policy Statement**

Computed tomography for the detection of coronary artery calcification is **established** when criteria are met.

Algorithmic detection and quantification of coronary artery calcium and/or aortic valve calcification from computed tomography of the chest, with report, is **experimental/investigational**. There is insufficient evidence to determine that the technology results in an improvement in net health outcomes.

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### **Inclusionary and Exclusionary Guidelines**

Benefits must be verified. Employer groups may decline coverage of this test.

#### **Inclusions:**

Coronary artery calcium (CAC) testing is established to assist with decisions regarding management of hypercholesterolemia when ALL of the following apply:

- CAC testing has not been performed within the preceding 5 years
- No known atheromatous vascular disease

- Not diabetic
- Age  $\geq 40$  years and  $\leq 75$  years
- Low-density lipoprotein (LDL) cholesterol  $\geq 70$  mg/dL and  $\leq 190$  mg/dL
- 10-year risk (using atherosclerotic cardiovascular disease [ASCVD] Pooled Cohort Equations)  $\geq 5\%$  and  $\leq 20\%$

**Exclusions:**

ANY of the following:

- Family history of premature atherosclerotic cardiovascular disease
- Persistently elevated low-density lipoprotein ( $\geq 160$  mg/dL)
- Persistently elevated triglyceride ( $> 175$ mg/dL)
- Metabolic syndrome
- Chronic kidney disease (eGFR 15-59 mL/min/1.73 m<sup>2</sup>)
- Chronic inflammatory condition
- History of menopause before age 40 years
- History of preeclampsia
- High risk race/ethnicity (e.g., South Asian ancestry)
- Markers associated with increased risk of atherosclerotic cardiovascular disease (if measured):
  - Elevated high-sensitivity C-reactive protein ( $\geq 2.0$  mg/L)
  - Elevated lipoprotein(a) ( $> 50$ mg/dL)
  - Apolipoprotein B  $> 130$ mg/dL
  - Ankle-brachial index less than 0.9

Algorithmic detection and quantification of coronary artery calcium and/or aortic valve calcification from computed tomography of the chest, with report, is experimental/investigational.

## CPT/HCPCS Level II Codes

**Established codes:**

75571                      S8092

**Other codes (investigational, not medically necessary, etc.):**

G0680

**Notes:**

- *Code(s) may not be covered by all contracts or certificates. Please consult customer or provider inquiry resources at BCBSM or BCN to verify coverage.*
- *Individual policy criteria determine the coverage status of the CPT/HCPCS code(s) on this policy. Codes listed in this policy may have different coverage positions (such as established or experimental/investigational) in other medical policies.*

## Background

### CORONARY ARTERY CALCIUM

Coronary artery calcium (CAC) is associated with coronary artery disease (CAD). The development of fast computed tomography (CT) scanners has allowed the measurement of CAC in clinical practice. Coronary artery calcium has been evaluated in several clinical settings. The most widely studied indication is for the use of CAC in the prediction of future risk of CAD in individuals with subclinical disease, with the goal of instituting appropriate risk-reducing therapy (e.g., statin treatment, lifestyle modifications) to improve outcomes. Also, CAC has been evaluated in individuals with symptoms potentially consistent with CAD, but in whom a diagnosis is unclear.

### Detection

Electron-beam computed tomography (EBCT; also known as ultrafast CT) and spiral CT (or helical CT) may be used as an alternative to conventional CT scanning due to faster throughput. In both methods, the speed of image acquisition gives them unique value for imaging a moving heart. The rapid image acquisition time virtually eliminates motion artifact related to cardiac contraction, permitting visualization of the calcium in the epicardial coronary arteries. Electron-beam computed tomography software permits quantification of calcium area and density, which are translated into calcium scores. Calcium scores have been investigated as a technique for detecting CAC, both as a diagnostic technique in symptomatic individuals to rule out an atherosclerotic etiology of symptoms or, in asymptomatic individuals, as an adjunctive method for risk stratification for CAD.

Electron-beam computed tomography and multidetector CT were initially the primary fast CT methods for measurement of CAC. A fast CT study for CAC measurement takes 10 to 15 minutes and requires only a few seconds of scanning time. More recently, computed tomography angiography has been used to assess coronary calcium. Because of the basic similarity between EBCT and computed tomography angiography in measuring coronary calcium, it is expected that computed tomography angiography provides information on coronary calcium that is similar to EBCT.

Computed tomography scan-derived coronary calcium measures have been used to evaluate coronary atherosclerosis. Coronary calcium is present in coronary atherosclerosis, but atherosclerosis detected may or may not be causing ischemia or symptoms. Coronary calcium measures may be correlated with the presence of critical coronary stenoses or serve as a measure of the patient's proclivity toward atherosclerosis and future coronary disease. Thus, coronary calcium could serve as a variable to be used in a risk assessment calculation to determine appropriate preventive treatment in asymptomatic individuals. Alternatively, in other clinical scenarios, coronary calcium scores might help determine whether there is an atherosclerotic etiology or component to the presenting clinical problem in symptomatic individuals, thus helping to direct further workup for the clinical problem. In this second scenario, a calcium score of 0 usually indicates that the patient's clinical problem is unlikely to be due to atherosclerosis and that other etiologies should be more strongly considered. In neither case does the test determine a specific diagnosis. Most clinical studies have examined coronary calcium for its potential use in estimating the risk of future coronary heart disease events.

### Risk Assessment Tool

The ASCVD (atherosclerotic cardiovascular disease) pooled cohort risk score is based on national guidelines developed by the American College of Cardiology. It is a calculation of an individual's 10-year risk of having a cardiovascular problem, such as a heart attack or stroke. This risk estimate considers age, sex, race, cholesterol levels, blood pressure, medication use, diabetes status, and smoking status. Risk assessment is a critical step in the current approach to primary prevention of atherosclerotic cardiovascular disease (myocardial infarction, heart failure, atherosclerosis and stroke). The pooled cohort equation has been widely validated and is broadly useful for the general US clinical population. But the risk assessment tool may systematically underestimate risk in certain patient groups, and overestimate risk in others. Therefore when uncertainty remains, as for individuals at borderline (ASCVD risk score of 5 to 7.5) or intermediate risk (ASCVD risk score of 7.6 to 19.9), or if the patient is undecided after a patient–clinician discussion with consideration of risk enhancing factors (e.g., family history), additional testing with measurement of coronary artery calcium can be useful to reclassify risk estimates and improve selection of individuals for use or avoidance of statin therapy.<sup>6</sup>

### **Nomenclature**

Coronary calcium levels can be expressed in many ways. The most common method is the Agatston score, which is a weighted summed total of calcified coronary artery area observed on CT. This value can be expressed as an absolute number, commonly ranging from 0 (low risk) to 400 (high risk). These values can be translated into age- and sex-specific percentile values. Different imaging methods and protocols will produce different values based on the specific algorithm used to create the score, but the correlation between any 2 methods appears to be high, and scores from 1 method can be translated into scores from a different method.

### **Algorithmic Analysis of Chest Computed Tomography**

Algorithmic detection and quantification of coronary artery calcium and/or aortic valve calcification is a computer-assisted analysis of chest computed tomography imaging that identifies and measures calcium buildup in the coronary arteries and/or aortic valve and generates a report of the findings.

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## **Summary of Evidence**

For individuals who are asymptomatic with the risk of coronary artery disease (CAD) who receive coronary artery calcium (CAC) scoring, the evidence includes one prospective study and feedback from Michigan College of Cardiology. Evidence from the prospective study concluded that adding coronary artery calcium (CAC) to traditional risk factors enables accurate 10-year CHD risk estimation. Michigan College of Cardiology recommends CAC is indicated for the population identified in our policy. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are asymptomatic with the risk of coronary artery disease (CAD) who receive coronary artery calcium (CAC) scoring, the available evidence suggests that algorithmic detection and quantification of coronary artery calcium and/or aortic valve calcification from chest CT is technically feasible and may correlate with dedicated coronary artery calcium scoring. However, the evidence is primarily limited to validation studies, observational associations, and reviews of algorithm performance. Current evidence does not

demonstrate that this technology consistently matches established coronary artery calcium risk categories, changes clinical management, or improves net health outcomes. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

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## Rationale

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function including benefits and harms. Every clinical condition has specific outcomes that are important to individuals and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms. The following is a summary of the key literature to date.

McClelland et al (2015) sought to derive and validate a novel risk score to estimate 10-year coronary heart disease risk using coronary artery calcium and traditional risk factors.<sup>1</sup> Algorithm development was conducted in the MESA (Multi-Ethnic Study of Atherosclerosis), a prospective community-based cohort study of 6,814 participants age 45 years to 84 years, who were free of clinical heart disease at baseline and were followed for 10 years. The MESA study is sex balanced and included 39% non-Hispanic whites, 12% Chinese Americans, 28% African Americans, and 22% Hispanic Americans. External validation was conducted in the Heinz Nixdorf Recall Study (HNR) and the Dallas Heart Study (DHS). The authors found that inclusion of coronary artery calcium, in the MESA risk score offered significant improvements in risk prediction (C-statistic 0.80 vs. 0.75;  $p < 0.0001$ ). External validation in both the HNR and DHS studies provided evidence of very good discrimination and calibration. The difference in estimated 10-year risk between events and nonevents was approximately 8% to 9%, indicating excellent discrimination. Mean calibration, or calibration-in-the-large, was excellent for both studies, with average predicted 10-year risk within one-half of a percent of the observed event rate. The authors concluded that an accurate estimate of 10-year coronary heart disease risk can be obtained using traditional risk factors and coronary artery calcium.

Van Assen et al (2021) evaluated the use of a deep neural network to automatically quantify coronary artery calcium on chest CT and compared the results with standard Agatston scoring from dedicated noncontrast cardiac CT. The study found a high correlation between the automated calcium measurements and reference standard calcium scoring, suggesting that artificial intelligence-based assessment of coronary artery calcium from chest CT is technically feasible.<sup>9</sup> However, classification into standard coronary artery calcium risk categories was not fully reliable, with correct classification reported in approximately 70% of cases in one cohort and 82% in a second cohort using qualitative risk categories. These findings indicate that while automated calcium scoring from non-gated chest CT may identify and estimate coronary artery calcium, it may not consistently match established calcium scoring categories used for clinical decision-making. The study primarily supports technical validation and does not demonstrate that use of the algorithm improves patient management, cardiovascular risk stratification, or net health outcomes. Therefore, the evidence supports that automated coronary artery calcium scoring from chest CT remains investigational pending additional studies demonstrating clinical utility and outcome benefit.

Xu et al (2022) evaluated whether a deep learning algorithm could automatically identify and quantify coronary artery calcium on routine non-gated chest CT scans and compared the results with dedicated coronary calcium scoring CT, which served as the reference standard. The study demonstrated that automated calcium scoring from routine chest CT was technically feasible and showed strong correlation with dedicated calcium scoring CT.<sup>10</sup> However, the algorithm did not perfectly classify patients into standard coronary artery calcium risk categories, with correct classification varying by CT slice thickness. These findings suggest that automated analysis of routine chest CT may help identify coronary artery calcium, but the evidence primarily supports technical validation rather than improved clinical outcomes. The study does not establish that use of the algorithm changes clinical management, improves cardiovascular risk stratification compared with established testing, or improves net health outcomes. Therefore, the findings support that algorithmic coronary artery calcium scoring from routine chest CT remains investigational pending additional evidence demonstrating clinical utility and outcome benefit.

O'Toole et al (2025) conducted a scoping review evaluating the use of artificial intelligence for coronary artery calcium scoring on non-ECG-gated chest CT examinations. The review found that AI-based approaches may provide efficient and reproducible methods for identifying and estimating coronary artery calcium on routine chest CT scans, suggesting technical feasibility and potential workflow advantages.<sup>11</sup> However, the authors noted important limitations across the available literature, including variability in study design, imaging protocols, datasets, evaluation methods, reporting standards, and real-world implementation settings. In addition, the reviewed evidence primarily focused on algorithm performance and diagnostic agreement rather than whether AI-based calcium scoring changes clinical management or improves cardiovascular outcomes. Therefore, while the technology may be promising as an opportunistic screening or risk-assessment tool, the available evidence is insufficient to determine that AI-based coronary artery calcium scoring from non-gated chest CT improves net health outcomes. Additional prospective studies and real-world clinical utility data are needed before this technology can be considered established.

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## Supplemental Information

### Practice Guideline - American Heart Association/American College of Cardiology

The American College of Cardiology and American Heart Association (2018)<sup>3</sup> Clinical Practice Guidelines on the Management of Blood Cholesterol state, A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines  
“Top 10 Take-Home Messages to Reduce Risk of Atherosclerotic Cardiovascular Disease Through Cholesterol Management”

In discussion of the scope of the guideline:<sup>3</sup>

“...when risk status is uncertain, a coronary artery calcium (CAC) score is an option to facilitate decision-making in adults  $\geq 40$  years of age”.

Guideline 9:<sup>3</sup>

In adults 40 to 75 years of age without diabetes mellitus and with LDL-C levels  $\geq 70$  mg/dL to 189 mg/dL ( $\geq 1.8$ -4.9 mmol/L), at a 10-year ASCVD risk of  $\geq 7.5\%$  to 19.9%, if a decision about statin therapy is uncertain, consider measuring coronary artery calcium (CAC). If CAC is zero,

treatment with statin therapy may be withheld or delayed, except in cigarette smokers, those with diabetes mellitus, and those with a strong family history of premature ASCVD. A CAC score of 1 to 99 favors statin therapy, especially in those  $\geq 55$  years of age. For any patient, if the CAC score is  $\geq 100$  Agatston units or  $\geq 75$ th percentile, statin therapy is indicated unless otherwise deferred by the outcome of clinician–patient risk discussion.

The American College of Cardiology and American Heart Association (2019) Guideline on the Primary Prevention of Cardiovascular Disease is in line with the blood cholesterol guideline stating that adults (40 to 75 years of age) who are being evaluated for cardiovascular disease prevention should initially undergo 10-year atherosclerotic cardiovascular disease (ASCVD) risk estimation with a clinician-patient risk discussion before starting pharmacological therapy.<sup>4</sup> The guideline also notes that assessing for other risk-enhancing factors can help guide decision making "about preventive interventions in select individuals, as can CAC scanning." The guideline specifically states the following recommendation regarding assessment of cardiovascular risk and CAC:

- In adults at intermediate risk ( $\geq 7.5\%$  to  $< 20\%$  10-year ASCVD risk) or selected adults at borderline risk ( $5\%$  to  $< 7.5\%$  10-year ASCVD risk), if risk-based decisions for preventive interventions remain uncertain, it is reasonable to measure a CAC score to guide clinician-patient risk discussion [Class (Strength) of Recommendation: IIa; Level (Quality) of Evidence: B-NR]. A IIa class of recommendation is of moderate strength based on moderate quality nonrandomized studies.

**2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: A Report of the American College of Cardiology/American Heart Association Task Force <sup>4</sup>**

- Prevention strategies occur at the population level but must also engage individual adults to slow the development of ASCVD. The most important way to prevent ASCVD is to promote a healthy lifestyle throughout life. Prevention strategies must include a strong focus on lifestyle optimization (improvements in diet, physical activity, and avoidance of tobacco use and exposure to secondhand smoke) to minimize the risk of future ASCVD events.

The American Heart Association, American College of Cardiology (2021) Guideline on Evaluation and Diagnosis of Chest Pain includes a recommendation for CAC as first-line testing in patients with stable chest pain with no known coronary artery disease and low likelihood of obstruction.<sup>6</sup> The guidelines recommend the addition of CAC may also be useful for intermediate-high risk patients with stable chest pain and no known coronary artery disease undergoing stress testing.

## Special Report - American Heart Association/American College of Cardiology

The American Heart Association and the American College of Cardiology (2019) issued a special report on the use of risk assessment tools to guide decision-making in the primary prevention of ASCVD.<sup>5</sup> This report includes an algorithm of clinical approaches to incorporate CAC measurement in risk assessment for borderline- and intermediate-risk patients:

"For borderline-risk (10-year risk 5% to <7.5%) and intermediate-risk (7.5% to <20%) patients who are undecided regarding statin therapy, or when there is clinical uncertainty regarding the net benefit, consider the value of additional testing with measurement of CAC. If CAC is measured, interpret results as follows:

- a. CAC score of 0 indicates that a borderline- or intermediate-risk individual is reclassified to a 10-y event rate lower than predicted, and below the threshold for benefit from a statin. Consider avoiding or postponing statin therapy unless there is a strong family history of premature ASCVD, history of diabetes mellitus, or heavy cigarette smoking. Consider repeat CAC measurement in 5 years if patient remains at borderline or intermediate risk.
- b. CAC score 1 to 99 and <75th percentile for age/sex/race/ethnicity indicates that there is subclinical atherosclerosis present. This may be sufficient information to consider initiating statin therapy, especially in younger individuals, but does not indicate substantial reclassification of the 10-y risk estimate. Consider patient preferences and, if statin decision is postponed, consider repeat CAC scoring in 5 years.
- c. CAC score 100 or ≥75th percentile for age/sex/race/ethnicity indicates that the individual is reclassified to a higher event rate than predicted, that is above the threshold for statin benefit. Statin therapy is more likely to provide benefit for such patients."

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### Regulatory Status:

Many models of CT devices, including EBCT and other ultrafast CT devices, have been cleared for marketing by the U.S. Food and Drug Administration through the 510(k) process. U.S. FDA product code: JAK.

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### Government Regulations

#### National:

There is no national coverage determination addressing this procedure.

#### Local:

**Wisconsin Physicians Service Insurance Corporation (WPS)**

**Local Coverage Determination (LCD): Coronary Computed Tomography Angiography (CCTA) (L35121)**

**Original Effective Date 10/01/2015**

**Revision Effective Date 10/30/2025**

**Limitations:**

1. The test is never covered for screening, i.e., in the absence of signs, symptoms or disease.
2. The test will be considered not medically necessary if the anticipated results are not expected to provide new, additional information to that already previously obtained from other tests (such as stress myocardial perfusion images or cardiac ultrasound). New or additional information should facilitate the management decision, not merely add a new layer of testing.
3. The test will be considered not medically necessary if pretest evaluation indicates that the patient would require invasive cardiac angiography for further diagnosis or for therapeutic intervention.
4. The test may be denied, on post-pay review, as not medically necessary when used for cardiac evaluation if there were pre-test knowledge of sufficiently extensive calcification of the suspect coronary segment that would diminish the interpretive value. (e.g., angina decubitus, unstable angina, Prinzmetal angina, etc.)
5. Coverage is limited to devices that process thin, high-resolution slices (1mm or less). The multi-detector scanners must have at least 64 slices per rotation capability.
6. The administration of beta blockers and the monitoring of the patient during MDCT/CCTA by a physician experienced in the use of cardiovascular drugs is included as part of the test and is not a separately payable service.
7. All studies must be ordered by the physician/qualified non-physician practitioner treating the patient and who will use the results of the test in the management of the patient.
8. The test must be performed under the direct supervision of a physician, similar to the stress myocardial perfusion imaging.
9. This LCD does not address electron beam tomography (EBT) technology or Ultrafast CT for coronary artery examination. There is no extension of coverage of EBT based on this policy.
10. Quantitative calcium scoring is not a covered service and will be denied as not medically necessary. Calcium scoring reported in isolation is considered a screening service. When performed in association with CT angiography, there is neither separate nor additional included reimbursement for the calcium scoring.
11. Atrial fibrillation or atrial flutter alone is not an indication; atrial fibrillation or atrial flutter with planned ablation therapy is allowed.

**Wisconsin Physicians Service Insurance Corporation (WPS)**

**Local Coverage Article: Billing and Coding: Coronary Computed Tomography**

**Angiography (CCTA) (A57552)**

**Original Effective Date 11/28/2019**

**Revision Effective Date 10/04/2024**

75571 is listed in the Group 2 Non-covered codes table.

*(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicaid Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)*

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## Related Policies

Contrast-Enhanced Computed Tomography Angiography (CTA, CCTA, MDCT, MSCT) of the Heart and/or Coronary Arteries

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## References

1. McClelland RL, Jorgensen NW, Budoff M, et al. 10-Year coronary heart disease risk prediction using coronary artery calcium and traditional risk factors: derivation in the MESA (Multi-Ethnic Study of Atherosclerosis) with validation in the HNR (Heinz Nixdorf Recall) Study and the DHS (Dallas Heart Study) J Am Coll Cardiol. 2015;66:1643–53. PMID 26449133
2. Taylor AJ, Cerqueira M, Hodgson JM, et al. ACCF/SCCT/ACR/AHA/ASE/ASNC/SCAI/SCMR 2010 appropriate use criteria for cardiac computed tomography. J Am Coll Cardiol. 2010;56(22):1864-1894. <https://www.ahajournals.org/doi/10.1161/cir.0b013e3181fcae66> Accessed 4/8/26.
3. Grundy SM, Stone NJ, Bailey AL, et al. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Circulation. June 18 2019;139(25):e1082-e1143 PMID 30586774 <https://www.ahajournals.org/doi/10.1161/cir.0000000000000625> Accessed 4/8/26.
4. Arnett DK, Blumenthal RS, Albert MA, et al. 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Circulation. Sep 10 2019; 140(11): e596-e646. PMID 30879355 <https://www.ahajournals.org/doi/10.1161/CIR.0000000000000678#:~:text=Adults%20should%20engage%20in%20at,achieving%20exercise%20recommendations%2C%20are%20crucial>. Accessed 4/8/26.
5. Lloyd-Jones DM, Braun LT, Ndumele CE, et al. Use of Risk Assessment Tools to Guide Decision-Making in the Primary Prevention of Atherosclerotic Cardiovascular Disease: A Special Report From the American Heart Association and American College of Cardiology. Circulation. Jun 18 2019;139(25):e1162-e1177 PMID 30586766 <https://www.ahajournals.org/doi/full/10.1161/CIR.0000000000000638> Accessed 4/8/26.
6. Gulati M, Levy PD, Mukherjee D, et al. 2021 AHA/ACC/ASE/CHEST/SAEM/SCCT/SCMR Guideline for the Evaluation and Diagnosis of Chest Pain: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Circulation. Nov 30 2021; 144(22): e368-e454. PMID 34709879
7. Wisconsin Physicians Service Insurance Corporation. Local Coverage Determination: Coronary Computed Tomography Angiography (CCTA). Original effective date 10/01/2015. Revision effective date 11/30/23. [LCD - Coronary Computed Tomography Angiography \(CCTA\) \(L35121\) \(cms.gov\)](https://www.cms.gov/medicare/coverage/determinations/lcds/l35121) Accessed 4/8/26.
8. Wisconsin Physicians Service Insurance Corporation. Local Coverage Article Billing and Coding: Coronary Computed Tomography Angiography (CCTA). A57552 Original effective date 11/28/2019. Revision effective date 10/01/2024. [Article - Billing and Coding: Coronary Computed Tomography Angiography \(CCTA\) \(A57552\)](https://www.cms.gov/medicare/coverage/determinations/lcds/a57552) Accessed 4/8/26.

9. Xu C, Guo H, Xu M, Duan M, Wang M, Liu P, Luo X, Jin Z, Liu H, Wang Y. Automatic coronary artery calcium scoring on routine chest computed tomography (CT): comparison of a deep learning algorithm and a dedicated calcium scoring CT. *Quant Imaging Med Surg.* 2022 May;12(5):2684-2695. doi: 10.21037/qims-21-1017. PMID: 35502379; PMCID: PMC9014138.
10. van Assen M, Martin SS, Varga-Szemes A, Rapaka S, Cimen S, Sharma P, Sahbaee P, De Cecco CN, Vliegenthart R, Leonard TJ, Burt JR, Schoepf UJ. Automatic coronary calcium scoring in chest CT using a deep neural network in direct comparison with non-contrast cardiac CT: A validation study. *Eur J Radiol.* 2021 Jan;134:109428. doi: 10.1016/j.ejrad.2020.109428. Epub 2020 Nov 21. PMID: 33285350.
11. O'Toole FE, Zaffer M, Cohen J, Allard M, Kingsbury CM, Muralidhar R, Jacobs RJ. Advances in Artificial Intelligence for Non-ECG-Gated Coronary Artery Calcium Scoring: A Scoping Review. *Cureus.* 2025 Oct 7;17(10):e94019. doi: 10.7759/cureus.94019. PMID: 41209904; PMCID: PMC12590512.

*The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through April, 2026, the date the research was completed.*

### Joint BCBSM/BCN Medical Policy History

| <b>Policy Effective Date</b> | <b>BCBSM Signature Date</b> | <b>BCN Signature Date</b> | <b>Comments</b>                                                                                                                                                                                                |
|------------------------------|-----------------------------|---------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 6/3/02                       | 6/3/02                      | 7/2/02                    | Joint policy established                                                                                                                                                                                       |
| 2/16/04                      | 2/16/04                     | 3/1/04                    | Routine maintenance                                                                                                                                                                                            |
| 6/15/05                      | 6/15/05                     | 5/20/05                   | Routine maintenance                                                                                                                                                                                            |
| 1/10/06                      | 1/10/06                     | 3/10/06                   | Routine maintenance                                                                                                                                                                                            |
| 3/1/08                       | 12/11/07                    | 11/18/07                  | Routine maintenance                                                                                                                                                                                            |
| 9/1/10                       | 6/15/10                     | 6/29/10                   | Routine maintenance                                                                                                                                                                                            |
| 9/1/11                       | 6/21/11                     | 6/21/11                   | Routine maintenance                                                                                                                                                                                            |
| 11/1/11                      | 8/16/11                     | 8/16/11                   | Routine maintenance; title changed from Electron Beam Computed Tomography (EBCT) for Coronary Artery Disease to Computed Tomography to Detect Coronary Artery Calcification.<br>Added CPT code 75571 to policy |
| 5/1/13                       | 2/19/13                     | 3/4/13                    | Routine maintenance                                                                                                                                                                                            |
| 3/1/15                       | 12/12/14                    | 12/29/14                  | Routine maintenance                                                                                                                                                                                            |
| 7/1/16                       | 4/19/16                     | 4/19/16                   | Routine maintenance                                                                                                                                                                                            |
| 1/1/17                       | 10/11/16                    | 10/11/16                  | Routine maintenance                                                                                                                                                                                            |
| 1/1/18                       | 10/19/17                    | 10/19/17                  | Routine maintenance                                                                                                                                                                                            |
| 1/1/19                       | 10/16/18                    | 10/16/18                  | Routine maintenance                                                                                                                                                                                            |
| 1/1/20                       | 10/15/19                    |                           | Routine maintenance                                                                                                                                                                                            |
| 1/1/21                       | 10/20/20                    |                           | Routine maintenance<br>Ref added: 8,11,12,13,29                                                                                                                                                                |
| 5/1/21                       | 2/16/21                     |                           | Routine maintenance                                                                                                                                                                                            |
| 3/1/22                       | 12/14/21                    |                           | Routine maintenance<br>Ref added: 4, 5                                                                                                                                                                         |
| 9/1/22                       | 6/21/22                     |                           | Routine maintenance<br>Position change to covered, with criteria. Ref 1-5 added.<br>Risk score section added to Background.                                                                                    |
| 9/1/23                       | 6/13/23                     |                           | Routine maintenance (jf)<br>Ref 7 added from BCBSA                                                                                                                                                             |

|         |         |  |                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------|---------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|         |         |  | Vendor Managed NA                                                                                                                                                                                                                                                                                                                                                                                                 |
| 9/1/24  | 6/11/24 |  | Routine maintenance (jf)<br>Vendor Managed: Carelton                                                                                                                                                                                                                                                                                                                                                              |
| 9/1/25  | 6/17/25 |  | Routine maintenance (jf)<br>Vendor Managed: Carelton                                                                                                                                                                                                                                                                                                                                                              |
| 9/1/26  | 6/16/26 |  | Routine maintenance (jf/no)<br>Vendor Managed: Carelton<br><ul style="list-style-type: none"> <li>• <b>Formatting changes made:</b> <ul style="list-style-type: none"> <li>○ Sections rearranged for better flow</li> <li>○ Added Description and Background separated</li> <li>○ MPS edited</li> <li>○ Notes edited in code section</li> </ul> </li> </ul>                                                       |
| 11/1/26 | 8/18/26 |  | Routine maintenance (jf/no)<br>Vendor Managed: Carelton<br><ul style="list-style-type: none"> <li>• Policy coming for code update: New code G0680 E/I EFD 4/1/26</li> <li>• Edit to background, exclusion, rationale and summary of evidence</li> <li>• Added new MPS, making policy to Mixed status</li> <li>• Edit to inclusions based on update to Turning Point criteria</li> </ul> <p>Added Ref: 9,10,11</p> |

Next Review Date: 2nd Qtr, 2027

**BLUE CARE NETWORK BENEFIT COVERAGE**  
**POLICY: COMPUTED TOMOGRAPHY TO DETECT CORONARY ARTERY CALCIFICATION**

**I. Coverage Determination:**

|                                                                                            |                                                             |
|--------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <b>Commercial HMO<br/>(includes Self-Funded<br/>groups unless otherwise<br/>specified)</b> | covered                                                     |
| <b>BCNA (Medicare<br/>Advantage)</b>                                                       | See Government Regulations section.                         |
| <b>BCN65 (Medicare<br/>Complementary)</b>                                                  | Coinsurance covered if primary Medicare covers the service. |