National Imaging Associates, Inc.	
Clinical guidelines **MUGA (Multiple Gated Acquisition) Scan**	**Original Date: September 1997**
CPT Codes: 78472, 78473, 78494, +78496	**Last Revised Date: April ~~February~~ 2023~~22~~**
Guideline Number: NIA_CG_027	**Implementation Date: January 2024~~3~~**

GENERAL INFORMATION

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *Where a specific clinical indication is not directly addressed in this guideline, medical necessity determination will be made based on widely accepted standard of care criteria. These criteria are supported by evidence-based or peer-reviewed sources such as medical literature, societal guidelines and state/national recommendations.*

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Indications for Multiple Gated Acquisition (MUGA) Scan[1]

- To evaluate left ventricular function in a patient with coronary artery disease, valvular heart disease, myocardial disease, or congenital heart disease, in any of the following scenarios:
  - When ventricular function is required for management, and transthoracic echocardiography (TTE) or other imaging has proven inadequate[2, 3]
  - When there are conflicting results between other testing (i.e., Myocardial Perfusion Imaging and TTE) in the measurement of ejection fraction (EF), and the results of the MUGA will help in the management of the patient

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- Prior TTE has demonstrated systolic dysfunction (EF < 50%) and management will change based on the results of the MUGA scan

- In the course of treatment with cardiotoxic medication ~~chemotherapy~~ when TTE images are inadequate to evaluate left ventricular systolic function[2-6]:
  - Baseline assessment prior to initiation of therapy
  - Monitoring during therapy. -The frequency of testing should be left to the discretion of the ordering provider but in the absence of new abnormal findings, generally no more often than every 6 weeks while on active therapy
  - Long term surveillance after completion of therapy may be required, especially for those who have been exposed to anthracycline medication. -The frequency of testing is generally every 6-12 months, or at the discretion of the provider
  - ~~Previous low LV ejection fraction was < 50% and receiving potentially cardiotoxic chemotherapy~~
  - ~~Prior to cardiotoxic chemotherapy, and subsequently for monitoring and follow up. The frequency of testing should be left to the discretion of the ordering physician, but generally no more often than at baseline and every 6 weeks thereafter~~
  -

~~Where a specific clinical indication is not directly addressed in this guideline, medical necessity determination will be made based on widely accepted standard of care criteria. These criteria are supported by evidence-based or peer-reviewed sources such as medical literature, societal guidelines, and state/national recommendations.~~

BACKGROUND[2, 7-9]

Multiple-gated acquisition (MUGA) scanning uses radiolabeled red blood cells to scan right and left ventricular images in a cine loop format that is synchronized with the electrocardiogram.

A prior MUGA scan is not an indication for repeat MUGA (if another modality would be suitable, i.e., TTE).

Abbreviations

EF	Ejection Fraction
MUGA	Multiple Gated Acquisition (nuclear scan of ventricular function)
TTE	Transthoracic echocardiography

POLICY HISTORY

Date	Summary
March 2023	Added statement on clinical indications not addressed in this guideline
February 2022	No significant changes
March 2021	Added the following statement: Previous low LV ejection fraction was < 50% and receiving potentially cardiotoxic chemotherapy
March 2020	• Added general information section as Introduction which outlines requirements for documentation of pertinent office notes by a licensed clinician, and inclusion of laboratory testing and relevant imaging results for case review • Added statement to Background that a prior MUGA scan is not an indication for repeat MUGA (if another modality would be suitable. i.e., TTE) • Removed statements from Background that CMR is recommended when TTE is inadequate and/or candidacy for cardiotoxic chemotherapy based upon LVEF is questionable and that MUGA can also be considered when CMR is not available.
July 23, 2019	• Removed chart on individual dosing for specific chemotherapeutic agents • Added indication for when there are conflicting results between other testing (i.e., MPI and TTE) in the measurement of ejection fraction, and the results of the MUGA will help in the management of the patient • Removed section on Radionuclide Angiography, Combination of Other Studies with MUGA, section on TTE and strain • Removed CAD indication • Added indication for cardiotoxicity as follows: ○ In the course of cardiotoxic chemotherapy when TTE images are inadequate to evaluate left ventricular systolic function (Patel 2013, Plana 2014, Yancy 2013, Zamorano 2016): ▪ Prior to cardiotoxic chemotherapy, and subsequently for monitoring and follow up. The frequency of testing should be left to the discretion of the ordering physician, but generally no more often than at baseline and every 6 weeks thereafter ▪ In patients with EF < 50% on TTE receiving potentially cardiotoxic chemotherapy, more frequent monitoring (every 4 weeks) may be appropriate

	~~Removed section on Radionuclide Angiography, Combination of Other Studies with MUGA, section on TTE and strain~~

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POLICY HISTORY

Date	Summary
April 2023	• Added statement on clinical indications not addressed in this guideline
February 2022	No significant changes

Reviewed / Approved by NIA Clinical Guideline Committee

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