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Cardiovascular Services**Invasive Coronary Angiography and Percutaneous Coronary Intervention**

Louisiana Medicaid covers elective invasive coronary angiography (ICA) and percutaneous coronary intervention (PCI) as treatment for cardiovascular conditions under specific circumstances.

The policy only applies to beneficiaries age 18 and older and does not apply to the following beneficiaries:

- Beneficiaries under the age of 18;
- Pregnant beneficiaries;
- Cardiac transplant beneficiaries;
- Solid organ transplant candidates; and
- Survivors of sudden cardiac arrest.

Eligibility Criteria**Elective ICA**

Elective ICA is covered and considered medically necessary in beneficiaries with one or more of the following:

- Congenital heart disease that cannot be characterized by non-invasive modalities such as cardiac ultrasound, CT, or MRI;
- Heart failure with reduced ejection fraction for the purposes of diagnosing ischemic cardiomyopathy;
- Hypertrophic cardiomyopathy prior to septal ablation or myomectomy;
- Severe valvular disease or valvular disease with plans for surgery or percutaneous valve replacement;

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- Type 1 myocardial infarction within the past three months defined by detection of a rise and/or fall of cardiac troponin values with at least 1 value above the 99th percentile upper reference limit and with at least 1 of the following:
 - Symptoms of acute myocardial ischemia;
 - New ischemic electrocardiogram (ECG) changes;
 - Development of pathological Q waves;
 - Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality in a pattern consistent with an ischemic etiology; and
 - Identification of a coronary thrombus;

- History of ventricular tachycardia requiring therapy for termination or sustained ventricular tachycardia not due to a transient reversible cause, within the past year;

- History of ventricular fibrillation;

- Return of angina within 9 months of prior PCI;

- Patients without chronic kidney disease who have Canadian Cardiovascular Society class I-IV classification of angina with intolerance of or failure to respond to at least two target dose anti-anginal medications (beta blocker, dihydropyridine or non-dihydropyridine calcium channel blocker, nitrates, and/or ranolazine); and

- High risk imaging findings, defined one or more of the below:
 - Severe resting left ventricular dysfunction (LVEF \leq 35%) not readily explained by noncoronary causes;
 - Resting perfusion abnormalities \geq 10% of the myocardium in patients without prior history or evidence of myocardial infarction;
 - Stress electrocardiogram findings including \geq 2 mm of ST-segment depression at low workload or persisting into recovery, exercise-induced ST-segment elevation, or exercise-induced ventricular tachycardia/ventricular fibrillation;
 - Severe stress-induced left ventricular dysfunction (peak exercise LVEF $<$ 45% or drop in LVEF with stress \geq 10%);
 - Stress-induced perfusion abnormalities affecting \geq 10% myocardium or stress segmental scores indicating multiple vascular territories with abnormalities;
 - Stress-induced left ventricular dilation;

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- Inducible wall motion abnormality (involving >2 segments or 2 coronary beds);
- Wall motion abnormality developing at low dose of dobutamine (≥ 10 mg/kg/min) or at a low heart rate (<120 beats/min); and
- Left main stenosis ($\geq 50\%$ stenosis) on coronary computed tomography angiography.

ICA for non-acute, stable coronary artery disease is not considered medically necessary, including for patients with stable angina who are not interested in revascularization or who are not candidates for PCI or coronary artery bypass graft surgery.

Elective PCI

Elective PCI for angina with stable coronary artery disease is considered medically necessary in:

- Beneficiaries without chronic kidney disease who have Canadian Cardiovascular Society class I-IV classification of angina with intolerance of or failure to respond to at least two target dose anti-anginal medications (beta blocker, dihydropyridine or non-dihydropyridine calcium channel blocker, nitrates, and/or ranolazine).

Elective PCI for other cardiac conditions is considered medically necessary in beneficiaries with one or more of the following:

- Heart failure with reduced ejection fraction for the purposes of treating ischemic cardiomyopathy;
- Left main stenosis $\geq 50\%$ as determined on prior cardiac catheterization or coronary computed tomography angiography, if the patient has documentation indicating they were declined for a coronary artery bypass graft surgery; and
- Type 1 myocardial infarction within the past three months as defined by detection of a rise and/or fall of cardiac troponin values with at least 1 value above the 99th percentile upper reference limit and with at least 1 of the following:
 - Symptoms of acute myocardial ischemia;
 - New ischemic electrocardiogram changes;
 - Development of pathological Q waves;
 - Imaging evidence of new loss of viable myocardium, or new regional wall motion abnormality in a pattern consistent with an ischemic etiology; and
 - Identification of a coronary thrombus.

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Elective PCI for non-acute, stable coronary artery disease is not considered medically necessary in all other patient populations, including if the patient is unwilling to adhere with recommended medical therapy, or if the patient is unlikely to benefit from the proposed procedure (e.g. life expectancy less than 6 months due to a terminal illness).