POLICY GUIDANCE

American Heart Association.

Expanding Coverage of Cardiac Computed Tomography for Calcium Scoring

December 2025

Background

Cardiac computed tomography, commonly known as a cardiac CT scan, is utilized to take images of a patient's beating heart to visualize their cardiac anatomy, coronary circulation and great vessels. Cardiac CT scans are commonly used by clinicians to evaluate the state of a patient's heart muscle, coronary arteries, pulmonary veins, pericardium, and thoracic and abdominal aorta.[1] The reason for use of cardiac CT is that many cardiac events occur among those considered to be borderline or intermediate risk and coronary artery calcium (CAC) testing can help reclassify risk for a cardiac event, guide preventive therapy decisions, and help avoid unnecessary imaging or invasive procedures. [2,3,4]

While the clinical indications for ordering a cardiac CT vary, and there are many diagnostic imaging modalities to consider in practice, one potential application of the technology involves non-invasive, cross-sectional scanning of the vessels that supply blood to the heart muscle to measure the presence and amount of calcium-containing plaque. The scan produces a patient-specific "score" that is designed to estimate, on a scale of 0 to over 400, the risk or extent of coronary artery disease based on the number, size and density of calcified plaque deposits in the coronary arteries and can guide whether statins should be prescribed or further testing or intervention is required. The higher the score, the greater the risk for having a heart attack, experiencing a stroke or dying from one of these adverse events in the next 10 years.

Statement of the Problem

While numerous studies have indicated that CAC tests, with an approximate cost of between $100-$400[5], are a reliable measure of certain patients' relative risks for adverse cardiac (e.g., heart attacks) and neurological (e.g., strokes) events, most public and private payors heavily restrict coverage of the procedure and require a majority of patients, despite the procedure's proven benefits and relatively low

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[1] https://my.clevelandclinic.org/health/diagnostics/16834-cardiac-computed-tomography

[2] Yeboah J, McClelland RL, Polonsky TS, Burke GL, Sibley CT, O'Leary D, Carr JJ, Goff DC, Greenland P, Herrington DM. Comparison of novel risk markers for improvement in cardiovascular risk assessment in intermediate-risk individuals. *JAMA*. 2012;308:788–795. doi: 10.1001/jama.2012.9624.

[3] Gulati M, Levy PD, Mukherjee D, et al . *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*. 2021; doi:10.1161/CIR.0000000000001029; *J Am Coll Cardiol*. 2021; doi:10.1016/j.jacc.2021.07.053.

[4] Foraker R, Sperling L, Bratzke L, Budoff M, Leppert M, Razavi AC, Rodriguez F, Shapiro MD, Whelton S, Wong ND, Yang E; on behalf of the American Heart Association Prevention Science Committee of the Council on Epidemiology and Prevention and Council on Cardiovascular and Stroke Nursing; Council on Clinical Cardiology; and Council on Cardiovascular Radiology and Intervention. Opportunistic detection of coronary artery calcium on noncardiac chest computed tomography: an emerging tool for cardiovascular disease prevention: a scientific statement from the American Heart Association. *Circulation.* Published online October 16, 2025. doi: 10.1161/CIR.0000000000001382.

[5] 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. 2018. 139(25).*

risk profile, to pay for it on an elective, out-of-pocket basis. CAC scoring can play a valuable role when risk status is unclear after considering traditional risk factors and risk enhancers and the latest guidelines support CAC as a gate-keeper in low-risk chest pain evaluation, reducing unnecessary, often more expensive downstream testing.[6]

Impetus for Action

In November 2018, the joint American College of Cardiology (ACC)/American Heart Association (AHA) Task Force on Clinical Practice Guidelines issued new cholesterol-related recommendations supporting the use of cardiac CT scans to produce CAC scores for certain at-risk patients.[7] The guideline recommended "considering CAC scoring for adults at borderline (5–7.5%) or intermediate (7.5–20%) 10-year ASCVD risk when uncertainty remains about statin therapy after formal risk estimation and evaluation of risk-enhancing factors. CAC scoring can help refine risk and guide clinician–patient discussions about preventive strategies, including statin initiation or deferral."[68] The guideline leads clinicians through a process, using a calculated formula and taking into account known risk factors, to place a patient in one of four classifications of risk: low, borderline, intermediate or high. Subsequent updates and the 2025 AHA Scientific Statement have expanded its role, advocating opportunistic CAC detection on routine chest CTs and integration of AI-based scoring to improve access and preventive care.[9]

Policy Position

Given the existing body of evidence on the procedure's cost- and clinical-effectiveness in certain situations, the AHA support efforts to expand coverage of and appropriate payment for CAC tests across the payor continuum, especially for patients who might benefit from knowing their score and having it considered in care decisions made by their physician or team of healthcare providers, including[7,8]:

- Adults aged 40–75 years without diabetes, LDL-C 70–189 mg/dL, and 10-year ASCVD risk of 7.5%–19.9% (intermediate risk):
- If the decision about statin therapy is uncertain, CAC measurement can help refine risk assessment.
- Borderline risk (5%–7.5%): CAC may also be considered if risk-enhancing factors are present.

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[6] Gulati M, Levy PD, Mukherjee D, et al. *Circulation*. 2021; doi:10.1161/CIR.0000000000001029; *J Am Coll Cardiol*. 2021; doi:10.1016/j.jacc.2021.07.053. *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*.

[7] 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. 2018. 139(25).*

[8] *Leandro Slipczuk, MD, PhD, Vice Chair, Ron Blankstein, MD, Chiara Bucciarelli-Ducci, MD, PhD, Lynne T. Braun, NP, PhD, FAHA, Lawrence M. Phillips, MD, FAHA, Pamela Piña, MD, Leslee J. Shaw, PhD, FAHA, Jacqueline Tamis-Holland, MD, FAHA, Eric Williamson, MD, and Salim S. Virani, MD, PhDState of the Art: Evaluation and Medical Management of Nonobstructive Coronary Artery Disease in Patients With Chest Pain: A Scientific Statement From the American Heart Association.*. *https://www.ahajournals.org/doi/10.1161/CIR.0000000000001394*. Nov 2025.

[9] Foraker R, Sperling L, Bratzke L, Budoff M, Leppert M, Razavi AC, Rodriguez F, Shapiro MD, Whelton S, Wong ND, Yang E; on behalf of the American Heart Association Prevention Science Committee of the Council on Epidemiology and Prevention and Council on Cardiovascular and Stroke Nursing; Council on Clinical Cardiology; and Council on Cardiovascular Radiology and Intervention. Opportunistic detection of coronary artery calcium on noncardiac chest computed tomography: an emerging tool for cardiovascular disease prevention: a scientific statement from the American Heart Association. *Circulation.* Published online October 16, 2025. doi: 10.1161/CIR.0000000000001382.

Current ACC/AHA guidelines do not recommend routine CAC testing for asymptomatic patients at very low (<5%) or high (>20%) 10-year ASCVD risk, as the score is unlikely to alter management.[7,8] CAC scoring is primarily intended for adults at borderline or intermediate risk when preventive therapy decisions remain uncertain. In select cases, CAC may be considered for low- or high-risk individuals if treatment decisions are unclear or patient preference warrants further risk clarification

Stakeholders

Public and private payors often have significant authority to decide which tests to cover under the terms of their respective health benefit plans. Of paramount importance in weighing any coverage-related decisions are the cost-and clinical-effectiveness of a specific test. No National Coverage Determination (NCD) for CAC scoring exists. State Medicaid programs have internal coverage criteria for CAC scoring when medically necessary, requiring prior authorization and documentation of risk factors. With publication of the latest ACC/AHA guidelines, space may exist within the policy arena to advocate for the inclusion of CAC tests under beneficiaries' benefit plans and the appropriate payment of providers and facilities performing these tests. In approaching payors, absent a mandate on the federal level that applies to all coverage arrangements, the following stakeholders must be targeted in a market-specific fashion:

Stakeholder	Impact / Scope	Oversight Control	Policy Mechanism(s)
Federal legislative and regulatory bodies (e.g., U.S. Congress, U.S. Department of Health & Human Services, Department of Labor)	• Medicare • Medicaid • Private Insurance	• Plans regulated in part or in full by federal laws and/or regulations (e.g., Public Health Service Act (PHSA), Employee Retirement Income Security Act (ERISA), Internal Revenue Code (IRC), Social Security Act (SSA))	• Legislative mandates • Regulatory fixes • Technical changes via sub-regulatory means
State legislative and regulatory bodies	• Medicaid • Private insurance	• Plans regulated in part or in full by state laws and/or regulations	• Legislative mandates • Regulatory fixes • Technical changes via sub-regulatory means • Requests to the federal government via waivers to • Selection of benchmark plans with existing cardiac

			CT coverage standards
Employers sponsoring and/or offering insurance to employees	• Employer-sponsored plans, including self-funded or fully-insured options that allow for customization	• Individual employers' plans	• Working directly with several large employers to pilot the inclusion of CAC testing into their plans

Policy Approaches for Consideration

Mechanism	*Impacted Market(s)*	*Explanation / Notes*
Formal submission of a National Coverage Determination (NCD) request to the Centers for Medicare & Medicaid Services (CMS)	Medicare	On the federal level, the Centers for Medicare and Medicaid Services (CMS) periodically issues or reviews Medicare coverage decisions through federal directives known as NCDs. Reviews of petitioners' requests undergo an extensive review, with opportunities for public participation, involving a close examination of any supporting evidentiary documentation provided as a component of the request and information provided that addresses the relevance, usefulness, and/or benefits of the item or service to the Medicare population. The Society for Heart Attack Prevention & Eradication (SHAPE) submitted an NCD request (i.e.., "A Formal Request for a National Coverage Determination for Coronary Artery Calcium Testing") to CMS on January 7, 2019. 8aecaa_f2e1cb7f1b3640f08ba990335f5c23b8.pdf CMS commenced the customary in-depth clinical evidence review and considered the universe of the evidence as well as the positions of the Agency for Healthcare Research and Quality, and the United States Preventive Services Task Force (USPSTF) which consistently characterized CAC testing as screening or preventive. Because of this characterization of the evidence and the limits of CMSauthority under the Medicare statute, which does not allow for coverage of screening or

		preventive services except for under certain circumstances (i.e., expressly mentioned in the statute or given a USPSTF grade A or B recommendation), CMS did not open an NCD on CAC testing. They mentioned that there may be the opportunity to pursue opportunities for coverage at the local Medicare Administrative Contactor level. If the updated review by USPSTF changes the level of recommendation to A or B, there may be the opportunity to reengage with the Coverage Analysis Group for an NCD.
Formal submission of a Local Coverage Determination (LCD) request to regional Medicare contractor with jurisdictional authority over an assigned region	Medicare; regional in scope.	In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare contractors based on an LCD. The processes and mechanism by which interested parties within a contractor's jurisdiction may request a new LCD or reconsideration request for an active LCD differs slightly from one contractor to the next. With that said, petitioners must adhere to the submission requirements and criteria established by both CMS and the contractor being petitioned. Several contractors have existing LCDs in effect pertaining to CAC scoring. Model Local Coverage Determination* MEDICAL POLICY - COMPUTED TOMOGRAPHY TO DETECT CORONARY ARTERY CALCIFICATION LCD - Cardiac Computed Tomography & Angiography (CCTA) (L33423)
U.S. Preventive Services Task Force (USPSTF) Review of CAC Scoring	Medicaid Medicare Private health plans	The USPSTF is an independent panel of experts in primary care and prevention who systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services. A key provision of the Affordable Care Act (ACA) is the requirement that private insurance plans cover services for adults that have a USPSTF rating of "A" or "B" without any patient cost-sharing. With the exception of "grandfathered" or "grandmothered' health plans, the preventive services rules apply to all private plans (i.e., individual, small group, large group and self-insured plans). Further, individuals

		participating in Medicare and the Medicaid expansion population (i.e., the new adult group) are required to be provided with access to preventive services without cost-sharing. The USPSTF concluded in 2018 that the current evidence was insufficient to assess the balance of benefits and harms of CAC scoring to traditional risk assessment for cardiovascular disease (CVD) in asymptomatic adults to prevent CVD events.[10] As of November 2025, the USPSTF is updating its review of evidence for Enhanced Risk Assessment for Cardiovascular Disease: Coronary Artery Calcium Scoring.[11]
Supporting the introduction and passage of state-specific benefit mandates	Variable; depends on the text of a bill, statute and/or regulations	As it currently stands, only Texas has an existing mandate related to the coverage of and payment for CAC tests. SHAPE is leading efforts for legislative mandates in several other states, including California and South Carolina, but none have yet succeeded to the point of legislative passage, being signed into law, and being codified into state statutes and implementing regulations. The primary limitation to state-specific benefit mandates is that the requirements apply only to plans subject to state statutes and regulations. While any bill signed into law in a specific state would likely apply to a large swath of fully insured coverage arrangements, self-funded plans would remain free to deny coverage/payment given longstanding ERISA pre-emption protections. Thus, state mandates would leave the largest source of insurance coverage (i.e., ERISA plans offered through self-funded employer arrangements) free to decide to what extent, if at all, CAC scoring would be covered and paid for.
Working directly with payors to advocate for inclusion in their benefits packages and/or groups that are contracted with or represent	Variable; depends on the payor's scope of control and level of	The option exists to approach large employers with interests similar to the AHA to pilot the inclusion of CAC testing into their own health plans (e.g., health systems that offer the test to

[10] Cardiovascular Disease: Risk Assessment With Nontraditional Risk Factors. July 10, 2018. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/cardiovascular-disease-screening-using-nontraditional-risk-assessment

[11] Enhanced Risk Assessment for Cardiovascular Disease: Coronary Artery Calcium Scoring . Sept. 26, 2024. Final Research Plan: Enhanced Risk Assessment for Cardiovascular Disease: Coronary Artery Calcium Scoring | United States Preventive Services Taskforce

large cohorts of payors to encourage more widespread adoption	interest (e.g., single employer plan, all of an insurance company's individual market plans, blanket coverage across a payor's full suite of off-the-shelf, insured products)	patients, but don't include it in their own employer-sponsored plans). Further, the AHA could work directly with technology assessment firms or organizations that are designed to speed the uptake of new guidelines or evidence into clinical practice (e.g., Evidence Street at the BlueCross BlueShield Association, National Guideline Clearinghouse (NGC) at the Agency on Healthcare Research and Quality (AHRQ)) to encourage a review of the new guidelines and explore ways for the recommended interventions considered in the ACC/AHA to be incorporated into payors' clinical and payment policies.