2.02.16 Ultrasonographic Measurement of Carotid Intima-Medial Thickness as an Assessment of Subclinical Atherosclerosis

<table>
<thead>
<tr>
<th><strong>Policy Statement</strong></th>
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</thead>
<tbody>
<tr>
<td>Ultrasonographic measurement of carotid intima-media thickness (CIMT) as a technique for identifying subclinical atherosclerosis is considered <strong>investigational</strong> for use in the screening, diagnosis, or management of atherosclerotic disease.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Policy Guidelines</strong></th>
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<tbody>
<tr>
<td>The following CPT category I code specific to the combination of carotid intima-media thickness (CIMT) and carotid atheroma evaluation:</td>
</tr>
<tr>
<td>- <strong>93895</strong>: Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral</td>
</tr>
<tr>
<td>The following CPT category III code specific to this test:</td>
</tr>
<tr>
<td>- <strong>0126T</strong>: Common carotid intima-media thickness (IMT) study for evaluation of atherosclerotic burden or coronary heart disease risk factor assessment</td>
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<table>
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<tr>
<th><strong>Description</strong></th>
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<tr>
<td>Ultrasonographic measurement of carotid intima-media (or intimal-medial) thickness (CIMT) refers to the use of B-mode ultrasound to determine the thickness of the 2 innermost layers of the carotid artery wall, the intima and the media. Detection and monitoring of intima-medial thickening, which is a surrogate marker for atherosclerosis, may provide an opportunity to intervene earlier in atherogenic disease and/or monitor disease progression.</td>
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<table>
<thead>
<tr>
<th><strong>Related Policies</strong></th>
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<tbody>
<tr>
<td>- Computed Tomography to Detect Coronary Artery Calcification</td>
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<tr>
<td>- Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease</td>
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</tbody>
</table>

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<tr>
<th><strong>Benefit Application</strong></th>
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<tr>
<td>Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.</td>
</tr>
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</table>

Some state or federal mandates [e.g., Federal Employee Program (FEP)] prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

<table>
<thead>
<tr>
<th><strong>Regulatory Status</strong></th>
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<tr>
<td>In 2003, SonoCalc® (SonoSite) was cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process. The FDA determined that this software was substantially equivalent to existing image display products for use in the automatic measurement of the IMT of the carotid artery from images obtained from ultrasound systems.</td>
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</tbody>
</table>
Subsequently, other devices have been cleared for marketing by the FDA through the 510(k) process. FDA product code: LLZ

**Rationale**

**Background**

**Coronary Heart Disease**

Coronary heart disease (CHD) accounts for 30.8% of all deaths in the United States. Established major risk factors for CHD have been identified by the National Cholesterol Education Program Expert Panel. These risk factors include elevated serum levels of low-density lipoprotein cholesterol, and total cholesterol, and reduced levels of high-density lipoprotein cholesterol. Other risk factors include a history of cigarette smoking, hypertension, family history of premature CHD, and age.

**Diagnosis**

The third report of the National Cholesterol Education Program Adult Treatment Panel established various treatment strategies to modify the risk of CHD, with emphasis on target goals of low-density lipoprotein cholesterol. Pathology studies have demonstrated that levels of traditional risk factors are associated with the extent and severity of atherosclerosis. The third report of the National Cholesterol Education Program Adult Treatment Panel recommended use of the Framingham criteria to further stratify those patients with 2 or more risk factors for more intensive lipid management. However, at every level of risk factor exposure, there is substantial variation in the amount of atherosclerosis, presumably related to genetic susceptibility and the influence of other risk factors. Thus, there has been interest in identifying a technique that can improve the ability to diagnose those at risk of developing CHD, as well as to measure disease progression, particularly for those at intermediate risk.

The carotid arteries can be well-visualized by ultrasonography, and ultrasonographic measurement of the carotid intima-media thickness has been investigated as a technique to identify and monitor subclinical atherosclerosis. B-mode ultrasound is most commonly used to measure the carotid intima-media thickness. The intima-media thickness (IMT) is measured and averaged over several sites in each carotid artery. Imaging of the far wall of each common carotid artery yields more accurate and reproducible IMT measurements than imaging of the near wall. Two echogenic lines are produced, representing the lumen-intima interface and the media-adventitia interface. The distance between these 2 lines constitutes the IMT.

**Literature Review**

Evidence reviews assess whether a medical test is clinically useful. A useful test provides information to make a clinical management decision that improves the net health outcome. That is, the balance of benefits and harms is better when the test is used to manage the condition than when another test or no test is used to manage the condition.

The first step in assessing a medical test is to formulate the clinical context and purpose of the test. The test must be technically reliable, clinically valid, and clinically useful for that purpose. Evidence reviews assess the evidence on whether a test is clinically valid and clinically useful. Technical reliability is outside the scope of these reviews, and credible information on technical reliability is available from other sources.

The literature on the use of carotid intima-media thickness (CIMT) for cardiac risk stratification consists of numerous cohort studies and systematic reviews of these cohort studies. The following review includes the largest prospective cohort studies and the most important systematic reviews of these studies.
Ultrasonographic Measurement of CIMT

Clinical Context and Test Purpose

The purpose of CIMT testing in patients who are undergoing cardiac risk assessment is to inform a decision whether to monitor and/or intervene to treat those at increased cardiac risk.

The question addressed in this evidence review is: Does CIMT improve risk categorization in individuals who are undergoing a cardiac risk assessment?

The following PICOTS were used to select literature to inform this review.

**Patients**
The relevant population of interest is individuals undergoing cardiac risk assessment.

**Interventions**
The test being considered is an ultrasonographic measurement of CIMT.

**Comparators**
Individual risk for cardiac events may be determined from multivariate risk models, such as the Framingham Risk Score.

**Outcomes**
The general outcomes of interest in CIMT measurement are to characterize the disease activity accurately and predict major adverse cardiac events, including stroke, myocardial infarction, and heart failure.

**Timing**
Five- to 10-year studies are of particular interest due to the prolonged natural history of cardiovascular disease.

**Setting**
The primary setting for CIMT measurement is an outpatient clinic.

**Technically Reliable**
Assessment of technical reliability focuses on specific tests and operators and requires review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review, and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

**Clinically Valid**
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

**Systematic Reviews**
Mookadam et al (2010) conducted a systematic review of the role of CIMT in predicting individual cardiovascular event risk, and as a tool for assessing therapeutic interventions. Reviewers concluded that CIMT is an independent risk factor for cardiovascular events and may be useful in determining treatment when there is uncertainty regarding the approach or patient reluctance. However, they recommended further study to identify the best approaches to screening and interventions to prevent progression of atherosclerosis.

In meta-analysis, the USE Intima-Media Thickness collaboration investigators sought to determine whether common CIMT measurements can assist in estimating the 10-year risk of first-time myocardial infarction (MI) or first-time stroke when added to the Framingham Risk Score. Using individual data for 45,828 patients from 14 population-based cohort studies, Den Ruijter et al (2012) found risk of first-time MI or stroke was related positively to both the Framingham Risk...
Score and the adjusted common CIMT. The mean common CIMT was 0.73 mm, and it increased in every cohort with patient age during a median follow-up of 11 years. For every 0.1-mm difference in common CIMT, the hazard ratio (HR) for risk of MI or stroke, which occurred in 4007 patients, was 1.12 (95% confidence interval [CI], 1.09 to 1.14) for women and 1.08 (95% CI, 1.05 to 1.11) for men. However, adding common CIMT measurements to the Framingham Risk Score did not improve risk prediction and resulted in the reclassification of risk in only 6.6% of patients. The added value of mean common CIMT in reclassifying risk was only 0.8% (95% CI, 0.1% to 1.6%) and did not differ between men and women. The C statistic of the Framingham Risk Score model with and without CIMT was similar for men (0.759; 95% CI, 0.752 to 0.766) and women (0.757; 95% CI, 0.749 to 0.764), suggesting the addition of CIMT in risk assessment offered limited benefit.

In another meta-analysis of individual participant data pooled from 16 studies (total N=36,984 patients), Lorenz et al (2012) examined CIMT progression from 2 ultrasound screenings taken 2 to 7 years apart (median, 4 years).5 Patients were followed for a mean of 7 years, during which time 1339 strokes, 1519 MI, and 2028 combined end points (MI, stroke, vascular death) occurred. Mean CIMT of the 2 ultrasound results was predictive of cardiovascular risk using the combined end point (adjusted HR=1.16; 95% CI 1.10 to 1.22). In sensitivity analyses, no associations were found between cardiovascular risk and individual CIMT progression regardless of CIMT definition, end point, and adjustments. As an example, for the combined end points, an increase of 1 standard deviation in mean common CIMT progression resulted in an overall estimated HR of 0.97 (95% CI, 0.94 to 1.00) when adjusted for age, sex, and mean common CIMT; the HR was 0.98 (95% CI, 0.95 to 1.01) when adjusted for vascular risk factors. These data confirmed that CIMT is a predictor of cardiovascular risk but did not demonstrate that changes in CIMT over time are predictive of future events.

A meta-analysis of 15 articles by van den Oord et al (2013) found similar results on the added value of CIMT.6 Six cohort studies (total N=32,299 patients) were evaluated to examine the predictive value of CIMT when added to traditional cardiovascular risk factors. While a CIMT increase of 0.1 mm was predictive for MI (HR=1.15; 95% CI, 1.12 to 1.18) and stroke (HR=1.17; 95% CI, 1.15 to 1.21), the addition of CIMT did not statistically improve risk prediction over traditional cardiovascular risk factors (p=0.8).

Studies have found that including carotid plaques in CIMT measurements improved the predictive value of cardiovascular risk over CIMT assessed only in plaque-free sites.7-10 However, the meta-analysis by Lorenz found no difference in the main results between studies that included CIMT with carotid plaque and plaque-free CIMT.5 The systematic review by Peters et al (2012) found adding carotid plaque to the traditional CIMT model increased the C statistic from 0.01 to 0.06.11

**Prospective Cohort Studies**
Numerous prospective cohort studies have evaluated the association between CIMT and future cardiovascular events. Some of the larger trials are discussed below. For example, in the Atherosclerosis Risk in Communities study, trialists evaluated risk factors associated with increased CIMT in 15,800 subjects.12 CIMT had a graded relation with increasing quartiles of plasma total cholesterol, low-density lipoprotein cholesterol, and triglycerides. CIMT also correlated with the incidence of coronary heart disease (CHD) in a subgroup of patients enrolled in the trial after 4 to 7 years of follow-up.13 Among the 12,841 subjects studied, there were 290 incident events. The HR rates for women and men, adjusted for age and sex, comparing extreme CIMT (i.e., ≥1 mm) with nonextreme CIMT (i.e., <1 mm), were 5.07 for women and 1.85 for men. The strength of the relation was reduced by including major CHD risk factors but remained elevated for higher measurements of CIMT. Authors concluded that mean CIMT was a noninvasive predictor of future CHD incidence.
The Rotterdam cohort study started in 1989 and recruited 7983 men and women ages 55 years and older. Its main objective was to investigate the prevalence and incidence of risk factors for chronic diseases, including cardiovascular disease (CVD), in older adults. One aspect of the study sought to determine whether progression of atherosclerosis in asymptomatic elderly subjects is a prelude to cardiovascular events. Measurements of CIMT were used to assess the progression of atherosclerosis. Increasing CIMT was associated with increased risks of stroke and MI.\textsuperscript{14}

OLeary et al (1999) performed CIMT measurement on 4476 asymptomatic subjects ages 65 years or older without clinical CVD in the Cardiovascular Health Study.\textsuperscript{15} The incidence of cardiovascular events correlated with measurements of CIMT; this association remained significant after adjusting for traditional risk factors. Authors concluded that increases in CIMT were directly associated with an increased risk of MI and stroke in older adults without a history of CVD.

The longitudinal Carotid Atherosclerosis Progression Study included 4904 subjects. All subjects received a baseline CIMT measurement as well as traditional risk factor analysis and were followed for 10 years (mean follow-up, 8.5 years; range, 7.1-10.0 years). Adverse events were MI in 73 (1.5%) patients, angina or MI in 271 (5.5%) patients, and death in 72 (1.5%) subjects. Lorenz et al (2010) retrospectively reviewed Carotid Atherosclerosis Progression Study data.\textsuperscript{16} They modeled the predictive value of CIMT on the cardiovascular adverse events within that decade. Because the thresholds of CIMT measurements that would lead to reclassification of risk are unknown, the authors used 24 models of reclassification and 5 statistical tests. Each model compared the predictive value of traditional risk factors alone with those risk factors plus CIMT. None of the reclassification models improved with the addition of CIMT measurements. Trialists concluded that their retrospective analysis did not support the use of CIMT as a clinically useful risk classification tool when used with traditional risk factor analysis.

In the Multi-Ethnic Study of Atherosclerosis (MESA) trial, an ongoing cohort study of atherosclerosis, CIMT was found to be a modestly better predictor of stroke, but a worse predictor of CHD than coronary artery calcium (CAC) score at a median follow-up of 3.9 years among 6698 adults asymptomatic at baseline.\textsuperscript{17} In a report from the MESA trial by Paramsothy et al (2010), CIMT results in 4792 healthy, nondiabetic adults who were not on lipid-lowering medications were compared across 6 different lipid groups, including normolipemia and several types of common dyslipidemias.\textsuperscript{18} Mean CIMT values were increased only for the combined hyperlipidemia (defined as any high-density lipoprotein cholesterol level, low-density lipoprotein cholesterol \( \geq \) 160 mg/dL, and triglyceride \( \geq \) 150 mg/dL) and simple hypercholesterolemia (defined as any high-density lipoprotein cholesterol level, low-density lipoprotein cholesterol \( \geq \) 160 mg/dL, and triglyceride < 150 mg/dL) groups. In another MESA report, assessing 6760 patients with elevated high-sensitivity C-reactive protein as defined by the JUPITER study, Blaha et al (2011) found CIMT increases correlated with obesity but only mildly with high-sensitivity C-reactive protein. A report from MESA trial by Patel et al (2015), which evaluated 6125 individuals with a family history of premature CHD, identified 382 atherosclerotic CVD events at a mean follow-up of 10.2 years. The study found that CAC data improved the risk estimation of atherosclerotic CVD events, but CIMT did not.

In the Bogalusa Heart Study (N=991 subjects), obesity along with overweight and elevated metabolic risk were associated with increased CIMT.\textsuperscript{21} In this study population, Camhi et al (2011) found that 41% of patients had increased CHD risk. In the CARDIA study, clotting factor VII was associated with increases in CIMT in 1254 subjects.\textsuperscript{22} CIMT has also been used as a surrogate outcome measure in atherosclerosis treatment research studies.\textsuperscript{23}

Raiko et al (2010) compared CAD risk scoring tools for identification of CHD risk with CIMT results in 2204 healthy adults, ages 24 to 39 years, from the Cardiovascular Risk in Young Finns study.\textsuperscript{24} The CVD risk scoring tools evaluated included the Framingham Risk Score, Reynolds Risk Score,
Systematic Coronary Risk Evaluation (SCORE), PROCAM, and FINRISK. In this population-based follow-up study, the authors found all CVD risk scores performed equally well in predicting subclinical atherosclerosis, as measured by high CIMT 6 years later.

The Biolmage study, reported by Baber et al (2015), enrolled 5808 asymptomatic individuals from the United States. All patients were evaluated by 3-dimensional carotid ultrasound and by CAC score and followed for a mean of 2.7 years. The primary end point was major cardiovascular events, defined as cardiovascular death, MI, and ischemic stroke. Carotid plaque burden was an independent predictor of outcomes, with an HR of 2.36 (95% CI, 1.13 to 4.92) for individuals in the highest tertile. The CAC score was also an independent predictor of outcomes, with HRs similar to carotid plaque. Both carotid plaque and CAC score led to significant net reclassification, with a net reclassification index of 0.23.

Geisel et al (2017) conducted a prospective cohort study of 3108 patients without CVD on entrance to the study. All patients were evaluated for traditional risk factors of CVD; they were also assessed to calculate the CIMT, CAC score, and Ankle-Brachial Index score. During a mean follow-up of 10 years, 223 individuals suffered a major cardiovascular event (coronary event, stroke, CV death). All 3 methods helped predict adverse cardiovascular events. While CIMT was found to be higher in those who experienced an adverse cardiovascular event (0.76) than those who did not (0.69), CIMT did not significantly improve the prediction of cardiac risk for patients with an intermediate Framingham Risk Score.

Villines et al (2017) prospectively assessed a cohort of 3801 African American patients free of CVD at baseline. Over a median follow-up of 9 years, there were 171 new cases of CVD and 339 deaths. The incidence of cardiovascular events correlated with changes in CIMT and participants in the highest CIMT quartile had the largest unadjusted incident rates of CVD for both men and women. However, risk reclassification improved only slightly when adding CIMT to a model that included only traditional risk factors for CVD.

Section Summary: Clinically Valid
Evidence from large, prospective cohort studies has established that CIMT is an independent risk factor for CAD. However, systematic reviews have shown that use of CIMT data to reclassify patients into clinically relevant categories is modest and may not be clinically important. The uncertainty concerning the ability to reclassify patients into clinically relevant categories limits the potential for CIMT to improve health outcomes.

Clinically Useful
A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

Direct Evidence
Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from randomized controlled trials.

In a study by Johnson et al (2011), 355 patients, ages 40 years with 1 or more CAD risk factors, received carotid ultrasound screenings to determine prospectively whether abnormal results would change physician and patient behaviors. Results were considered abnormal (when CIMT was >75th percentile or with the presence of carotid plaque) in 266 patients. Self-reported questionnaires were completed before the carotid ultrasound, immediately after the ultrasound, and 30 days later to assess behavioral changes. Physician behavior in prescribing aspirin (p<0.001) and cholesterol medication (p<0.001) changed significantly after identification of abnormal carotid ultrasound results. Abnormal ultrasound results predicted reduced dietary...
sodium (odds ratio, 1.45; p=0.002) and increased fiber intake (odds ratio, 1.55, p=0.022) in patients, but no other significant changes. Health outcomes were not evaluated in this study, and the short-term follow-up limits interpretation of results.

Chain of Evidence
Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

The evidence on the reclassification of cardiovascular risk offers a potential chain of evidence to improve outcomes. If a measure helps reclassify patients into risk categories that have different treatment approaches, then clinical management changes may occur that lead to improved outcomes. Because the ability to reclassify patients into clinically relevant categories with CIMT is modest at best, the clinical utility of this measure for reclassification is uncertain.

Section Summary: Clinically Useful
There is no direct evidence on the clinical utility of measuring CIMT for cardiac risk stratification. The available evidence on reclassification into clinically relevant categories does not indicate that use of CIMT will improve health outcomes.

Summary of Evidence
For individuals who are undergoing cardiac risk assessment who receive ultrasonic measurement of CIMT, the evidence includes large cohort studies, case-control studies, and systematic reviews. Relevant outcomes are test accuracy and morbid events. Some studies have correlated increased CIMT with other commonly used markers for risk of CHD and with risk for future cardiovascular events. A meta-analysis of individual patient data by Lorenz et al (2012) found that CIMT was associated with increased cardiovascular events although CIMT progression over time was not associated with increased cardiovascular event risk. In a systematic review by Peters et al (2012), the added predictive value of CIMT was modest, and the ability to reclassify patients into clinically relevant categories was not demonstrated. The results from these reviews and other studies have demonstrated the predictive value of CIMT is uncertain, and that the predictive ability for any level of population risk cannot be determined with precision. Also, available studies do not define how the use of CIMT in clinical practice improves outcomes. There is no scientific literature that directly tests the hypothesis that measurement of CIMT results in improved patient outcomes and no specific guidance on how measurements of CIMT should be incorporated into risk assessment and risk management. The evidence is insufficient to determine the effects of the technology on health outcomes.

Supplemental Information
Practice Guidelines and Position Statements

American College of Cardiology and American Heart Association
The 2013 guidelines on the assessment of cardiovascular risk from the American College of Cardiology and the American Heart Association did not recommend carotid intimal-medial thickness (CIMT) measurement in routine risk assessment of a first atherosclerotic cardiovascular disease event (class III: no benefit; level of evidence: B). This differs from their 2010 joint guidelines for assessment of cardiovascular risk, which indicated CIMT might be reasonable for assessing cardiovascular risk in intermediate-risk asymptomatic adults.

American Association of Clinical Endocrinologists et al
The American Association of Clinical Endocrinologists and American College of Endocrinology published guidelines (2017) stating that CIMT could be applied as a risk stratification tool in determining the need for more aggressive preventive strategies against cardiovascular disease (grade B; best evidence level 2)—but not routinely.
American Society of Echocardiography
The American Society of Echocardiography (2008) consensus statement, endorsed by the Society for Vascular Medicine, stated that CIMT is a feature of arterial wall aging “that is not synonymous with atherosclerosis, particularly in the absence of plaque.” The statement recommended measurement of both CIMT and carotid plaque by ultrasound “for refining CVD [cardiovascular disease] risk assessment in patients at intermediate cardiovascular disease risk (Framingham Risk Score 6–20%) without established CHD [coronary heart disease], peripheral arterial disease, cerebrovascular disease, diabetes mellitus, or abdominal aortic aneurysm.” However, Society acknowledged that “More research is needed to determine whether improved risk prediction observed with CIMT or carotid plaque imaging translates into improved patient outcomes.”

U.S. Preventive Services Task Force Recommendations
The U.S. Preventive Services Task Force (2009; USPSTF) published a systematic review of CIMT within the scope of a larger recommendation on the use of nontraditional risk factors in coronary heart disease risk assessment. USPSTF could not draw conclusions on the applicability of CIMT to the intermediate-risk population at large outside the research setting. The USPSTF summary of recommendation specific to CIMT stated that: “... the current evidence is insufficient to assess the balance of benefits and harms of using ... [CIMT] ... to screen asymptomatic men and women with no history of CHD to prevent CHD events.” USPSTF identified the following research need: “The predictive value ... of carotid IMT... should be examined in conjunction with traditional Framingham risk factors for predicting CHD events and death.”

Medicare National Coverage
There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials
Some currently unpublished trials that might influence this review are listed in Table 1.

Table 1. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
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<tr>
<td>NCT01849575</td>
<td>Direct VisualizAtion of Asymptomatic Atherosclerotic Disease for Optimum Cardiovascular Prevention. A Population Based Pragmatic Randomised Controlled Trial Within Västerbotten Intervention Programme (VIP) and Ordinary Care</td>
<td>3200</td>
<td>Jun 2021</td>
</tr>
</tbody>
</table>

NCT: National Clinical Trial.

References
5. Lorenz MW, Polak JF, Kavousi M, et al. Carotid intima-media thickness progression to predict cardiovascular events in the general population (the PROG-IMT collaborative...


**Documentation for Clinical Review**

- No records required

**Coding**

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms.
of the Policy. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.

IE

The following services may be considered investigational.

<table>
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<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
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<tr>
<td>CPT®</td>
<td>0126T</td>
<td>Common carotid intima-media thickness (IMT) study for evaluation of atherosclerotic burden or coronary heart disease risk factor assessment</td>
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<tr>
<td></td>
<td>93895</td>
<td>Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral</td>
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<td>HCPCS</td>
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<td>ICD-10</td>
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Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Action</th>
<th>Reason</th>
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<tbody>
<tr>
<td>12/07/2006</td>
<td>New Policy Adoption</td>
<td>Medical Policy Committee</td>
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<tr>
<td>04/02/2010</td>
<td>Policy revision without position change Coding update</td>
<td>Medical Policy Committee</td>
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<tr>
<td>08/06/2013</td>
<td>Policy revision without position change. Policy placed on No Further Routine Literature Review and Update status.</td>
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<td>09/30/2014</td>
<td>Policy title change from Carotid Intima-Media Thickness Measurement Policy revision without position change</td>
<td>Medical Policy Committee</td>
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<td>01/01/2015</td>
<td>Coding update</td>
<td>Administrative Review</td>
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<td>01/01/2017</td>
<td>Policy revision without position change</td>
<td>Medical Policy Committee</td>
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<td>03/01/2017</td>
<td>Policy revision without position change</td>
<td>Medical Policy Committee</td>
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<tr>
<td>07/01/2018</td>
<td>Policy revision without position change</td>
<td>Medical Policy Committee</td>
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Definitions of Decision Determinations

Medically Necessary: A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.
**Prior Authorization Requirements (as applicable to your plan)**

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department. Please call (800) 541-6652 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.