Policy Number	**RAD605.001**
Policy Effective Date	**12/15/2025**

Cardiac Applications of Positron Emission Tomography Scanning

Table of Contents

Related Policies (if applicable)
None

Disclaimer

Carefully check state regulations and/or the member contract.
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Coverage

Myocardial Perfusion

Cardiac positron emission tomography (PET) scanning **may be considered medically necessary** to assess myocardial perfusion and thus diagnose coronary artery disease (CAD) in individuals with at least intermediate-risk (see Policy Guidelines) for CAD when the following criteria are met:

- Indeterminate noninvasive imaging tests (e.g., single-photon emission computed tomography [SPECT] scan, myocardial perfusion imaging, stress echocardiogram); OR
- Individuals for whom SPECT could be reasonably expected to be suboptimal in quality due to either body habitus (e.g., moderate to severe obesity [i.e., body mass index (BMI) > 35 kg/m^2], large breasts and/or implants, left mastectomy; or chest wall deformity) or any other technical problems (e.g., indeterminant prior SPECT, extensive prior myocardial infarction [MI], etc.).

Myocardial Viability

Cardiac PET scanning **may be considered medically necessary** to assess the myocardial viability in individuals with severe left ventricular dysfunction as a technique to determine candidacy for a revascularization procedure. (See the Background section regarding the relative effectiveness of PET and SPECT scanning.)

Quantification of Myocardial Blood Flow

Cardiac PET scanning **is considered experimental, investigational and/or unproven** for quantification of myocardial blood flow for cardiac event risk stratification in individuals diagnosed with coronary artery disease (CAD).

Cardiac Sarcoidosis

Cardiac PET scanning **may be considered medically necessary** for diagnosing cardiac sarcoidosis in individuals who are unable to undergo magnetic resonance imaging (MRI). Examples of individuals who are unable to undergo MRI include, but are not limited to, individuals with pacemakers, automatic implanted cardioverter-defibrillators (AICDs), or other metal implants.

Policy Guidelines

Positron emission tomography (PET) scans are considered most appropriate in patients with an intermediate-risk of coronary artery disease (CAD), typically defined as a 25% to 75% probability of having CAD. Clinically, this group of patients typically includes those with chest pain but without a history of myocardial infarction or stroke. Patients at either low- or high-risk of CAD may not require a myocardial perfusion study at all.

Description

Positron emission tomography (PET) scans use positron-emitting radionuclide tracers, which simultaneously emit 2 high-energy photons in opposite directions. These photons can be simultaneously detected (referred to as coincidence detection) by a PET scanner, comprising multiple stationary detectors that encircle the thorax. Compared with single photon emission computed tomography (SPECT) scans, coincidence detection offers a greater spatial resolution. PET has been investigated as an option to diagnose and evaluate patients with cardiac conditions such as coronary artery disease, left ventricular dysfunction, and cardiac sarcoidosis.

Background

Coronary Artery Disease

Heart disease is the leading cause of death for men and women in the United States (U.S.). (1) Heart disease is also the leading cause of death for people of most racial and ethnic groups in the U.S., including Black, American Indian, Alaska Native, Hispanic, and White men. For women from the Pacific Islands and Asian American, American Indian, Alaska Native, and Hispanic women, heart disease is second only to cancer. Coronary artery disease is the most common type of heart disease in the U.S., killing more than 371,000 people per year. Angina is the most common symptom of CAD. Risk factors for CAD include being overweight, physical inactivity,

poor diet, and smoking. A family history of heart disease also increases the risk for CAD, especially in cases where there is a family history of early onset heart disease (i.e., age 50 years or younger).

Positron Emission Tomography

Positron emission tomography scans use positron-emitting radionuclide tracers, which simultaneously emit 2 high-energy photons in opposite directions. These photons can be simultaneously detected (referred to as coincidence detection) by a PET scanner, comprising multiple stationary detectors that encircle the thorax. Compared with single-photon emission computed tomography (SPECT) scans, coincidence detection offers a greater spatial resolution.

Myocardial Perfusion Imaging

For myocardial perfusion studies, patient selection criteria for PET includes an individual assessment of the pretest probability of CAD, based both on patient symptoms and risk factors. Patients at low-risk for CAD may be adequately evaluated with exercise electrocardiography. Patients at high-risk for CAD typically will not benefit from noninvasive assessment of myocardial perfusion; a negative test will not alter disease probability sufficiently to avoid invasive angiography. Accordingly, myocardial perfusion imaging is potentially beneficial for patients at intermediate risk of CAD (variably defined as 25% to 75% or 10% to 90% disease probability).[a] Risk can be estimated using the patient's age, sex, and chest pain quality. Table 1 summarizes patient populations at intermediate risk for CAD. (2)

[a] Intermediate-risk ranges used in different studies may differ from the range used here. The American College of Cardiology guidelines have defined low risk as less than 10%, intermediate risk as 10% to 90%, and high risk as greater than 90%.

Table 1. Individuals at Intermediate Risk for Coronary Artery Disease According to Chest Pain Quality

Populations	Typical Angina[a]	Atypical Angina[b]	Nonanginal Chest Pain[c]
Men	30-39	30-70	≥50
Women	30-60	≥50	≥60

Values are age or age range in years.

[a] Chest pain with all of the following characteristics: 1) substernal chest discomfort with characteristic quality and duration, 2) provoked by exertion or emotional stress, and 3) relieved by rest or nitroglycerin.

[b] Chest pain that lacks 1 of the characteristics of typical angina.

[c] Chest pain that has 1 or none of the typical angina characteristics.

Body habitus can limit SPECT; particularly moderate-to-severe obesity, which can attenuate tissue tracer leading to inaccurate images. In patients for whom body habitus is expected to lead to suboptimal SPECT scans, PET scanning is preferred.

Among patients with CAD, myocardial perfusion imaging can be used to quantify myocardial blood flow and myocardial flow reserve (MFR). (3) Quantitative assessment of myocardial

perfusion is sensitive for detection of ischemic tissue within the myocardium and can allow for accurate determination of risk for cardiovascular events. These quantitative measurements can also be predictive of adverse cardiovascular outcomes. For example, the presence of an abnormally low MFR can identify patients at higher risk of cardiovascular death.

Myocardial perfusion studies with PET are also useful in the diagnosis of cardiac sarcoidosis. (4) Perfusion studies performed in patients with sarcoidosis and suspected cardiac involvement can detect presence of inflammation, fibrosis of the myocardial tissue, and function and involvement of the left and right ventricles.

Myocardial Viability
Patients selected to undergo PET scanning for myocardial viability are typically those with severe left ventricular dysfunction who are being considered for revascularization. A PET scan may determine whether the left ventricular dysfunction is related to the viable or nonviable myocardium. Patients with viable myocardium may benefit from revascularization but those with nonviable myocardium will not. As an example, PET scanning is commonly performed in potential heart transplant candidates to rule out the presence of viable myocardium.

Radionuclide Tracers
A variety of radionuclide tracers are used for PET scanning, including fluorine 18, rubidium 82, oxygen 15, nitrogen 13, and carbon 11. Most tracers have a short half-life and must be manufactured with an on-site cyclotron. Rubidium 82 is produced by a strontium 82/rubidium 82 generator. The half-life of fluorine 18 is long enough that it can be manufactured commercially offsite and shipped to imaging centers. Radionuclides may be coupled with a variety of physiologically active molecules, such as oxygen, water, or ammonia. Fluorine 18 is often coupled with fluorodeoxyglucose to detect glucose metabolism, which in turn reflects metabolic activity, and thus viability, of the target tissue. Tracers that target the mitochondrial complex also are being developed.

Regulatory Status
A number of PET platforms have been cleared by the U.S. Food and Drug Administration (FDA) through the 510(k) process since the Penn-PET scanner was approved in 1989. These systems are intended to aid in detecting, localizing, diagnosing, staging, and restaging of lesions, tumors, disease, and organ function for the evaluation of diseases and disorders such as, but not limited to, cardiovascular disease, neurologic disorders, and cancer. The images produced by the system can aid in radiotherapy treatment planning and interventional radiology procedures.

PET radiopharmaceuticals have been evaluated and approved by the FDA for use as diagnostic imaging agents. These radiopharmaceuticals are approved for specific conditions.

In December 2009, the FDA issued guidance for Current Good Manufacturing Practice for PET drug manufacturers, (5) and in August 2011, the FDA issued similar Current Good Manufacturing Practice guidance for small businesses. (6) An additional final guidance document issued in December 2012 required all PET drug manufacturers and compounders to

operate under an approved new drug application (NDA) or abbreviated NDA, or investigational new drug application, by December 2015. (7)

To avoid interruption of the use of PET radiotracers already in use in clinical practice, before the issuance of specific guidance documents, the FDA made determinations of safety and effectiveness for certain uses of PET radiotracers. The following radiopharmaceuticals used with PET for cardiac-related indications were reviewed in this manner and subsequently had approved NDAs as summarized in Table 2.

Table 2. Radiopharmaceuticals Approved for Use Prior to 2012 With Positron Emission Tomography for Cardiac Indication[a]

Radiopharmaceutical	Manufacturer	NDA	Approved	Cardiac-Related Indication with PET
Fluorine 18 fluorodeoxyglucose (F-18-FDG)	Various	20306	2000	CAD and left ventricular dysfunction, when used with myocardial perfusion imaging, to identify left ventricular myocardium with residual glucose metabolism and reversible loss of systolic function
Ammonia N 13	Zevacor Pharma	22119	2000	Imaging of the myocardium under rest or pharmacologic stress conditions to evaluate myocardial perfusion in patients with suspected or existing CAD
Rubidium 82 chloride	Bracco Diagnostics	19414	1989	Assessing regional myocardial perfusion in the diagnosis and localization of myocardial infarction

CAD: coronary artery disease; NDA: new drug application; PET: positron emission tomography.
[a] This table only lists products that received an approved NDA prior to the final guidance for Current Good Manufacturing Practice for PET drug manufacturers issued by the Food and Drug Administration in December 2012.

Rationale

Medical policies 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. Medical policies assess the evidence on whether a test is clinically valid and clinically useful. Technical reliability is outside the scope of these policies, and credible information on technical reliability is available from other sources.

Suspected Coronary Artery Disease

Clinical Context and Test Purpose

The purpose of positron emission tomography (PET) scanning in individuals who have suspected coronary artery disease (CAD) is to evaluate perfusion to the heart. Positron emission tomography can assess relative perfusion, coronary flow reserve, absolute myocardial blood flow (MBF) at stress and rest, left ventricular ejection fraction (LVEF), possible ischemic dilatation, and coronary artery calcium levels. These parameters can be used to diagnose CAD.

The following PICO was used to select literature to inform this policy.

Populations

The population of interest is individuals with suspected CAD who have indeterminate single photon emission computed tomography (SPECT) scans.

Interventions

The intervention of interest is cardiac PET perfusion imaging.

Comparators

The following tests are currently being used to make decisions about managing suspected CAD: coronary angiography or noninvasive tests for CAD (e.g., stress echocardiography, exercise electrocardiography).

Outcomes

For individuals with suspected CAD, the outcomes of interest are the avoidance of unnecessary invasive procedures, cardiac events, and mortality. Additional outcomes of interest, including PET sensitivity, specificity, positive likelihood ratio, negative likelihood ratio, and test accuracy are measured from time to diagnosis.

Study Selection Criteria

For the evaluation of the clinical validity of cardiac PET perfusion imaging, studies that met the following eligibility criteria were considered:

- Reported on the accuracy of the marketed version of the technology (including any algorithms used to calculate scores);
- Included a suitable reference standard (describe the reference standard);
- Patient/sample clinical characteristics were described;
- Patient/sample selection criteria were described.

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).

The sensitivity and specificity of PET may be slightly better than those for SPECT. Performance characteristics for PET and SPECT based on a 2007 Canadian joint position statement are shown in Table 3. (8)

Table 3. Performance Characteristics of Positron Emission Tomography and Single Photon Emission Computed Tomography

Outcome Measures	PET	SPECT
Sensitivity, %	91	88
Specificity, %	89	77
Estimated positive likelihood ratio[a]	8.27	3.83
Estimated negative likelihood ratio[b]	0.10	0.16

Adapted from Beanlands et al. (2007). (8)
PET: positron emission tomography; SPECT: single-photon emission computed tomography.
[a] Estimated positive likelihood ratio = sensitivity/(1 - specificity).
[b] Estimated negative likelihood ratio = (1 - sensitivity)/specificity.

Diagnostic Performance

Systematic Reviews

Xu et al. (2021) conducted a meta-analysis that compared cardiac magnetic resonance imaging (MRI), SPECT, and PET for the diagnosis of CAD. (9) Diagnostic studies were eligible for inclusion if either coronary angiography or fractional flow reserve (FFR) was used as the reference standard. The literature search, conducted through July 2020, identified 203 articles (N=23,942) that assessed the diagnostic performance of cardiac MRI (56 articles), SPECT (134 articles), and PET (25 articles). There were no statistically significant differences in sensitivities between cardiac MRI, SPECT, and PET (86% [95% confidence interval (CI), 84% to 88%], 83% [95% CI, 81% to 85%], 85% [95% CI, 80% to 89%], respectively; p=.109). For specificity, cardiac MRI (83% [95% CI, 81% to 86%]) and PET (86% [95% CI, 81% to 89%]) performed significantly better than SPECT (77% [95% CI, 74% to 80%]; p<.01 for both comparisons); there was no statistically significant difference between cardiac MRI and PET. Similarly, the area under the curve values of cardiac MRI (0.92 [95% CI, 0.89 to 0.94]), SPECT (0.87 [95% CI, 0.84 to 0.90]), and PET (0.92 [95% CI, 0.89 to 0.94]) indicated that cardiac MRI and PET had better diagnostic performance for the detection of CAD compared with SPECT (p<.01 for both comparisons).

Knuuti et al. (2018) reported on the results of a meta-analysis of the performance of noninvasive tests to rule-in and rule-out significant coronary artery stenosis in patients with stable angina including publications through April 2017 that included at least 100 patients with stable CAD and either invasive coronary angiography or invasive coronary angiography with FFR measurement as reference standard. (10) A total of 132 studies (N=28,664) using invasive coronary angiography as the reference standard and 23 studies (N=4131) using FFR as the reference standard were included. The pooled analysis for the outcome of anatomically

significant CAD included 418 patients for PET and the sensitivity, specificity, positive likelihood ratio, and negative likelihood ratio were as follows: 90% (95% CI, 78% to 96%); 85% (95% CI, 78% to 90%); 5.87 (95% CI, 3.40 to 10.15); and 0.12 (95% CI, 0.05 to 0.29), respectively. The pooled analysis for outcome of functionally significant CAD included 709 patients for PET and the sensitivity, specificity, positive likelihood ratio, and negative likelihood ratio were as follows: 89% (95% CI, 82% to 93%); 85% (95% CI, 81% to 88%); 6.04 (95% CI, 4.29 to 8.51); and 0.13 (95% CI, 0.08 to 0.22), respectively.

Dai et al. (2016) conducted a meta-analysis comparing the abilities of the following cardiac imaging modalities to diagnose CAD: SPECT, PET, dobutamine stress echocardiography, cardiac MRI, and computed tomography (CT) perfusion imaging. (11) The reference standard was FFR derived from CT. The literature search, conducted through June 2015, identified 74 studies for inclusion, 5 of which used PET. Study quality was assessed using Standards for Reporting Diagnostic Accuracy and Quality Assessment of Diagnostic Accuracy Studies tools. Pooled sensitivity and specificity for PET were 90% (95% CI, 80% to 95%) and 84% (95% CI, 81% to 90%), respectively. These rates were similar to FFR, the reference standard (sensitivity, 90% [95% CI, 85% to 93%]; specificity, 75% [95% CI, 62% to 85%]).

Takx et al. (2015) reported a meta-analysis of studies that compared noninvasive myocardial perfusion imaging modalities (MRI, CT, PET, SPECT, echocardiography) with coronary angiography plus FFR. (12) Literature was searched to May 2014, and 37 studies met inclusion criteria (N=4698 vessels). Three PET studies of moderate-to-high quality were included (n=870 vessels); pretest probability of CAD was intermediate to intermediate-high in these studies. Negative likelihood ratio was chosen as the primary outcome of interest because ruling out hemodynamically significant CAD is a primary purpose of noninvasive imaging. At the vessel level, pooled negative likelihood ratios for PET, MRI, and CT were similar and were lower (better) than the pooled negative likelihood ratio for SPECT (PET pooled negative likelihood ratio, 0.15 [95% CI, 0.05 to 0.44]; SPECT pooled negative likelihood ratio, 0.47 [95% CI, 0.37 to 0.59]). Similarly, at the patient-level, pooled negative likelihood ratios for PET, MRI, and CT were better than the pooled negative likelihood ratios for SPECT and echocardiography (PET pooled negative likelihood ratio, 0.14 [95% CI, 0.02 to 0.87]; SPECT pooled negative likelihood ratio, 0.39 [95% CI, 0.27 to 0.55]). The area under the receiver operating characteristic analyses was similar at both the vessel level (PET, 0.95 vs. SPECT, 0.83) and the patient-level (PET, 0.93 vs. SPECT, 0.82).

Retrospective Studies

Another consideration is that there are fewer indeterminate results with PET than SPECT. Bateman et al. (2006) retrospectively matched 112 SPECT and 112 PET studies by sex, body mass index (BMI), and presence and extent of CAD, and compared diagnostic accuracy and degree of interpretative certainty (age, 65 years; 52% male; mean BMI, 32 kg/m^2; 76% with CAD diagnosed on angiography). (13) Eighteen (16%) of 112 SPECT studies were classified as indeterminate compared with 4 (4%) of 112 PET studies. Liver and bowel uptake were believed to affect 46 (41%) of 112 SPECT studies, compared with 6 (5%) of 112 PET studies. In obese

patients (BMI, >30 kg/m^2), the accuracy of SPECT was 67% and 85% for PET; accuracy in non-obese patients was 70% for SPECT and 87% for PET.

Prognostic Performance

Systematic Reviews

Chen et al. (2017) published a meta-analysis assessing the prognostic value of PET myocardial perfusion imaging in patients with known or suspected CAD. (14) For inclusion, studies had to have at least one of the following outcomes: mortality, cardiac infarction, or major adverse cardiac event (MACE). The literature search, conducted through June 2016, identified 11 studies for inclusion. Quality assessment was based on: 1) cohort follow-up of 90% or more; 2) blinded outcome assessors; and 3) corroboration of outcomes with hospital records or death certificates. Nine of the studies were of good quality, and 2 were fair. All 11 studies included cardiac death as the primary or secondary outcome, with a pooled negative predictive value (NPV) of 99% (95% CI, 98% to 99%). Seven studies included all-cause death as an outcome, with a pooled NPV of 95% (95% CI, 93% to 96%). Four studies included MACE as an outcome, with a pooled NPV of 90% (95% CI, 78% to 96%).

Smulders et al. (2017) published a meta-analysis comparing the prognostic value of the following negative noninvasive cardiac tests: coronary CT angiography, cardiovascular MRI, exercise electrocardiographic testing, PET, stress echocardiography, and SPECT. (15) Outcomes of interest were annual event rates of myocardial infarction and cardiac death. The literature search, conducted through April 2015, identified 165 studies for inclusion, 4 of which involved PET. Study quality was assessed using the Newcastle-Ottawa Scale for observational studies. Pooled annual event rates for cardiac death and myocardial infarction for PET were low (0.41; 95% CI, 0.15 to 0.80), indicating that a patient with a negative PET test has a good prognosis.

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, more effective therapy, or avoid unnecessary therapy or 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 (RCTs).

No RCTs comparing outcomes for patients undergoing PET perfusion imaging to patients who did not undergo PET perfusion imaging were identified.

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.

Meta-analyses have shown that PET is a useful prognostic tool that can be performed successfully in some patients in whom SPECT may be indeterminate due to body habitus or other anatomic factors. Therefore, PET results can be useful in informing clinical decisions in these intermediate-risk patients.

Section Summary: Suspected Coronary Artery Disease

Evidence on the diagnostic accuracy of PET for CAD consists of several systematic reviews and meta-analyses. Meta-analyses comparing PET with reference standards such as invasive coronary angiography and FFR have shown that PET is comparable in diagnostic accuracy. Additionally, some of these meta-analyses found PET to have significantly greater sensitivity or specificity compared to SPECT, which further validates its use among patients with indeterminate SPECT results. Meta-analyses evaluating the clinical utility of PET have looked at outcomes such as mortality and adverse cardiac events. These meta-analyses have shown that PET is a useful prognostic tool.

Severe Left Ventricular Dysfunction Considering Revascularization

Clinical Context and Test Purpose

The purpose of PET scanning in individuals with severe left ventricular (LV) dysfunction is to determine myocardial viability to assist with revascularization.

The following PICO was used to select literature to inform this policy.

Populations

The population of interest is individuals with severe LV dysfunction who are potential candidates for revascularization.

Interventions

The intervention of interest is PET scanning.

Comparators

The following tests are currently being used to make decisions about managing severe LV dysfunction: cardiac MRI or cardiac SPECT scanning.

Outcomes

For individuals with severe LV dysfunction who are potential candidates for revascularization, the intermediate outcome is a viability assessment. If there is sufficient viable myocardium detected, the individual would be a candidate for revascularization. For severe LV dysfunction, the outcome of interest would be the time to cardiac events.

Study Selection Criteria

For the evaluation of the clinical validity of cardiac PET perfusion imaging, studies that met the following eligibility criteria were considered:

- Reported on the accuracy of the marketed version of the technology (including any algorithms used to calculate scores);

- Included a suitable reference standard (describe the reference standard);
- Patient/sample clinical characteristics were described;
- Patient/sample selection criteria were described.

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).

Diagnostic Performance

PET has perhaps been most thoroughly researched as a technique to assess myocardial viability to determine candidacy for a coronary revascularization procedure. A fixed perfusion defect, as imaged on SPECT scanning or stress thallium echocardiography, may suggest nonviable myocardium. However, a PET scan may reveal metabolically active myocardium, suggesting areas of "hibernating" myocardium that would benefit from revascularization. The most common PET technique for this application consists of N 13 ammonia as a perfusion tracer and fluorine 18-labeled fluorodeoxyglucose (18F-FDG) as a metabolic marker of glucose utilization. FDG uptake in areas of hypoperfusion (referred to as FDG/blood flow mismatch) suggests viable but hibernating myocardium. The ultimate clinical validation of this diagnostic test is the proportion of patients who experience improvement in LV dysfunction after revascularization of hibernating myocardium, as identified by PET scanning.

SPECT scanning also may be used to assess myocardial viability. Initial myocardial uptake of thallium 201 reflects myocardial perfusion, and redistribution after prolonged periods can be a marker of myocardial viability. Initial protocols required redistribution imaging after 24 to 72 hours. Although this technique was associated with a strong positive predictive value, there was a low NPV; i.e., 40% of patients without redistribution nevertheless showed clinical improvement after revascularization. NPVs have improved with the practice of thallium reinjection. Twenty-four to 72 hours after initial imaging, patients receive a reinjection of thallium and undergo redistribution imaging.

Studies identified in the literature have shown the equivalence of SPECT and PET in their ability to assess myocardium viability.

Using a thorax-cardiac phantom with different sized inserts that simulated infarcts, Knesaurek and Machac (2006) tested SPECT and PET images. (16) The investigators concluded that PET was better at detecting smaller defects than SPECT. In this study, a 1-cm insert, not detected by SPECT, was detected by PET.

Slart et al. (2005) compared dual-isotope simultaneous acquisition SPECT and PET in the detection of myocardial viability in 58 patients with CAD and dysfunctional LV myocardium. (17) Tracer uptake for PET and SPECT was compared by linear regression and correlation analysis, which showed there was an overall good agreement between SPECT and PET for the assessment of myocardial viability in patients with severe LV dysfunction.

Prognostic Performance

Randomized Controlled Trials

Mielniczuk et al. (2025) conducted an international pragmatic trial (15 sites) that randomized patients with ischemic heart failure who needed additional assessment of ischemia to advanced imaging (PET or cardiac magnetic resonance, n=64) or SPECT (n=56). (18) The primary endpoint was a composite of cardiac death, myocardial infarction, resuscitated cardiac arrest, and cardiac hospitalization (worsening heart failure, acute coronary syndrome, arrhythmia). After 4 years of follow-up, the cumulative incidence rate of the primary outcome was 33.1% among patients who received advanced imaging and 33.0% among patients who received SPECT (hazard ratio [HR], 0.94; 95% CI, 0.49 to 1.80; p=.853). The authors also enrolled a cohort of patients who met the inclusion criteria but both imaging modalities were not available at their site (N=552); these patients served as a registry cohort. A combined analysis of randomized and registry patients found that there was a benefit of advanced imaging compared to SPECT on cardiac death (HR, 0.56; 95% CI, 0.33 to 0.96; p=.04).

The Positron Emission Tomography and Recovery Following Revascularization study evaluated the impact of FDG-PET viability imaging on patients with severe LV dysfunction. Patients from 9 sites were randomized to FDG-PET-assisted physician management (n=218) or standard care management by a physician without PET imaging available (n=212). Physicians in the standard care management group could order a different test to determine viability; however, the study did not indicate what specific tests were ordered or in what frequency. Management decision options were: revascularization, revascularization workup, or neither. The primary outcome was a composite of cardiac death, myocardial infarction, or recurrent hospital stay for a cardiac cause. Beanlands et al. (2007) reported on results after 1 year of follow-up. (19) The intention-to-treat HR of a composite event occurring at 1 year was not significant (0.78; 95% CI, 0.58 to 1.1; p=.15) for PET-assisted management of care compared with standard care. However, among patients in the PET-assisted management of care group who had high or medium myocardium viability and who therefore were recommended to receive revascularization or a revascularization workup, 26% did not ultimately receive the recommended care. Reasons given included symptoms stabilizing, renal failure, multiple comorbidities, and patient refusal. When subgroup analysis included only those patients who received the treatment as recommended based on PET images, the HR for a composite event was significant (0.62; 95% CI, 0.42 to 0.93).

Mc Ardle et al. (2016) published long-term follow-up results for the Positron Emission Tomography and Recovery Following Revascularization trial. (20) Six of the 9 original sites participated in the long-term follow-up study (197 patients in the PET-assisted arm, 195 patients in the standard care arm). Long-term results were similar to the 1-year results. The HR for time to composite event for the whole study population did not differ significantly between the PET-assisted group and the standard care group (0.82; 95% CI, 0.62 to 1.1); however, when the analysis was conducted using only the subgroup of patients who adhered to the PET imaging-based recommendations, the HR was statistically significant (0.73; 95% CI, 0.54 to 0.99).

Siebelink et al. (2001) performed a prospective randomized study comparing management decisions with outcomes based on PET imaging (n=49) or SPECT imaging (n=54) in patients who had chronic CAD and LV dysfunction and were being evaluated for myocardial viability. (21) Management decisions based on readings of the PET or SPECT images included either drug therapy for patients without viable myocardium or revascularization with either angioplasty or coronary artery bypass grafting (CABG) for patients with viable myocardium. This study is unique in that the diagnostic performance of PET and SPECT was tied to actual patient outcomes. No difference in patient management or cardiac event-free survival was demonstrated between management based on the 2 imaging techniques. The authors concluded that either technique could be used to manage patients considered for revascularization. However, the sample size for the study was determined based on the assumption that patients randomized to SPECT would have a 20% higher cardiac event rate. Therefore, the study may have been underpowered to detect a difference in cardiac outcomes between groups.

Nonrandomized Studies

Srivatsava et al. (2016) published a study of 120 patients with LV dysfunction who underwent both SPECT-CT and FDG-PET/CT to determine myocardial viability. (22) If both tests showed defects (i.e., matched defects), the tissue was considered nonviable. If a defect was seen in the SPECT-CT test but uptake of 18F-FDG was seen with the FDG-PET test (i.e., mismatched defects), the tissue was considered hibernating but viable. If more than 7% of the myocardium was considered viable, patients underwent revascularization by either stenting or CABG (78 patients). Patients assessed as having less than 7% viable myocardium were medically managed (42 patients). Among 786 segments of myocardium with evidence of reduced perfusion, 432 segments (55%) were matched defects and 354 segments (45%) were mismatched defects. The primary outcome was global LVEF. Change in LVEF after 3 months was significantly larger in the surgically managed group (3.5; 95% CI, 2.5 to 4.5) than in the medically managed group (0.7; 95% CI, -0.8 to 2.2). All patients with observed viability of the myocardium on PET were managed surgically. A decline in LVEF was seen in 5 patients (6.4%) who received surgical management compared with 9 patients (21.4%) who were managed medically.

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, more effective therapy, or avoid unnecessary therapy or 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 RCTs.

Section Summary: Severe Left Ventricular Dysfunction Considering Revascularization

Evidence for the use of PET to assess myocardial viability consists of 2 randomized trials. A large controlled trial that randomized patients with LV dysfunction into 2 groups: 1 was managed by

physicians receiving PET images to inform care decisions, and the other was managed by physicians who did not receive PET images. Follow-up at 1 year and 5 years showed that when patients received care as indicated by the PET images, they were at a decreased risk for cardiac death, myocardial infarction, or recurrent hospital stay compared with patients who did not. Although the study did not define what standard care consisted of, physicians were permitted to order non-PET viability tests for patients in the standard care group. However, it is unclear how many patients received other tests for viability, and what tests were administered. A smaller RCT did not find a difference in a composite outcome of cardiac events between PET and SPECT, likely due to small sample size/lack of power. A small prospective study has suggested that the accuracy of PET and SPECT are roughly similar for this purpose; however, this study may have been underpowered to detect a difference between groups. A small, nonrandomized study also showed that PET may be useful for detecting viable myocardium when SPECT shows nonviable tissue.

Myocardial Blood Flow Quantification

Clinical Context and Test Purpose

The purpose of PET scanning in individuals who have CAD is to quantify MBF for cardiac event risk stratification.

The following PICO was used to select literature to inform this policy.

Populations

The population of interest is individuals with CAD in need of quantifying MBF for cardiac event risk stratification.

Interventions

The intervention of interest is quantitative cardiac PET perfusion imaging. Both MBF and myocardial flow reserve (MFR; defined as stress MBF/rest MBF) can be quantified. Generally, a MFR ≥2 is indicative of normal perfusion and is associated with a good prognosis. (23) Lower values of MFR may require further invasive testing to rule out epicardial CAD. As MFR decreases, the likelihood of multivessel obstructive CAD increases with a corresponding worsening prognosis.

Comparators

The following tests are currently being used to make decisions about quantifying MBF in individuals with CAD: coronary angiography with FFR and clinical risk models.

Outcomes

For individuals with CAD who require MBF quantification, the intermediate outcome is accurate quantification. The relevant follow-up would be the time to cardiac events.

Study Selection Criteria

For the evaluation of the clinical validity of cardiac PET perfusion imaging, studies that met the following eligibility criteria were considered:

- Reported on the accuracy of the marketed version of the technology (including any algorithms used to calculate scores);
- Included a suitable reference standard (describe the reference standard);
- Patient/sample clinical characteristics were described;
- Patient/sample selection criteria were described.

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).

Diagnostic Performance

Cohort Studies

Several publications have described the use of PET imaging to quantify both MBF and MFR. (24, 25) However, as noted in an accompanying editorial (26) and by subsequent reviewers, (27) larger prospective clinical trials are needed to understand the clinical utility of these approaches. Diagnostic accuracy of PET myocardial perfusion imaging, as compared to FFR as a reference standard, is limited to 15-oxygen (O)-water PET imaging, which is not available in the US. (12) Most PET examinations are performed with 82-Rubidium (Rb) chloride instead, which has less favorable flow-extraction characteristics. Therefore, it is not possible to extrapolate the findings from 15-O-water PET studies to clinical settings in which 82-Rb-chloride is used.

Prognostic Performance

Systematic Reviews

Ahmed et al. (2023) conducted a meta-analysis of 21 studies (N=46,815) on the prognostic value of MFR, as assessed by PET, for predicting adverse cardiovascular events in patients with suspected or known CAD. (28) Among the analyzed patients, 32% had known CAD. The results for the overall population of patients with suspected or known CAD demonstrated that impaired MFR was associated with a significantly increased risk of adverse outcomes (not specified) (relative risk [RR], 2.94; 95% CI, 2.42 to 3.56; p<.001). Similar results were found in the subgroup of patients with suspected CAD, but a subgroup analysis of patients with known CAD was not reported.

Jensen et al. (2023) conducted a meta-analysis of 19 studies on the prognostic value of MFR (called coronary flow reserve [CFR] in this analysis) in patients with non-obstructive CAD and coronary microvascular disease. (29) The analysis assessed CFR using PET, transthoracic echocardiography (TTE), and invasive coronary assessment for predicting adverse cardiovascular events. The results showed that the risk of death and MACE was significantly higher in patients with low CFR compared to those with normal CFR (odds ratio [OR], 3.23; 95% CI, 2.13 to 4.88; p<.001). For PET, the ORs) for the risk of death and MACE were 2.51 (95% CI, 1.40 to 4.49; p=.002) and 2.87 (95% CI, 2.16 to 3.81; p<.001), respectively. For TTE, the ORs for the risk of death and MACE were 4.25 (95% CI, 2.94 to 6.15; p<.001) and 6.98 (95% CI, 2.56 to 19.01; p<0.001), respectively. Lastly, for invasive intracoronary assessment, the ORs for the risk of death and MACE were 2.23 (95% CI, 1.15 to 4.34; p=.018) and 4.61 (95% CI, 2.51 to 8.48; p<.001), respectively.

Green et al. (2021) conducted a meta-analysis on the prognostic value of MFR (called CFR in this analysis), as assessed by PET, for predicting adverse cardiovascular events in patients with suspected or known CAD. (30) The prognostic value of MFR was analyzed as a dichotomous variable (i.e., impaired vs. preserved MFR); cut-off values used were as reported by the individual study. Thirteen studies (N=12,334) were identified. Four of the studies included patients with suspected CAD only; the remainder of the studies included a mixed population (suspected or known CAD). Eleven studies reported MACE outcomes, and the pooled HR for patients with impaired versus preserved MFR was 1.93 (95% CI, 1.65 to 2.27; I^2=11%). Only 5 studies reported on hard events (i.e., cardiac death, myocardial infarction) and there was significant heterogeneity (I^2=72.8%); the pooled HR was 3.11 (95% CI, 1.88 to 5.14). Six studies included data useful to calculate separately the incidence rate of MACE events. The pooled incidence rate ratio for patients with impaired versus preserved MFR was 2.26 (95% CI, 1.79 to 2.85; I^2=20.3%). Funnel plots for the MACE, but not hard events, indicated significant bias towards positive results. Publication bias may result in overstating the benefits of MFR prognostic value. Heterogeneity between studies and small sample sizes of some of the included studies further complicate interpretation. For instance, the cut-off value for designating an impaired MFR was not consistent across trials, stemming from differences in tracers, imaging protocols, and stress agents used in the studies. The authors note that due to the large heterogeneity in the study population, there is a need for further investigations to maximize the prognostic role of MFR.

Juarez-Orozco et al. (2017) reported on the results of a systematic review of prognostic studies of quantitative myocardial perfusion evaluation with PET in patients with suspected or known CAD. (31) Eight studies (N=6804 patients) were included. Risk of bias was assessed using the Quality in Prognostic Studies tool. The risk of bias was rated as low overall with the exception of 1 domain (prognostic factor measurement) with the uncertain risk of bias due to the differences in population characteristics and tracer used. The mean follow-up range was 12 to 117 months for the MACE outcome, 66 to 88 months for the cardiac death outcome, and 43 to 117 months for the all-cause mortality outcome. MFR was independently associated with MACE in all 8 studies with the range of adjusted HRs from 1.19 to 2.93. Pooled analyses for MACE included only 2 studies due to the differences in populations and cutoff values for MFR; the pooled HR was 1.92 (95% CI, 1.29 to 2.84) for the 2 studies, which included patients with a previous myocardial infarction and a MFR cutoff of 2.0. There was not enough evidence to pool reported HRs to establish the prognostic value of MFR for cardiac death or all-cause mortality.

Cohort Studies

Since available meta-analyses have identified the need for larger, and preferably prospective, cohort investigations to more precisely identify the prognostic value of MFR measurements, cohort studies not included in the previously summarized meta-analyses that included at least 1000 participants are included below. Meta-analyses by Green et al. (2021) and Juarez-Orozco et al. (2017) incorporated 16 studies, which evaluated diverse populations that included both patients with suspected and confirmed CAD. (24, 32-46)

Gould et al. (2021) prospectively examined the relationship between regional, artery-specific MFR (called CFR in this analysis) and coronary flow capacity (CFC) and mortality in patients with suspected or known CAD who received and did not receive revascularization. (47) Patients were recruited from a single center institution that routinely performs quantitative PET myocardial perfusion imaging in all patients with or at risk of CAD. CFC color maps are created using 5 color ranges for combined CFR and stress perfusion values of each pixel, which is mapped back to its location in the left ventricle. For the CFC maps, any with pixels that had both MFR ≤1.27 and stress perfusion ≤0.83 were defined as severely reduced CFC (CFCsevere). A total of 5274 patients were included in the cohort who were followed for 4.2 years on average. Thirty-eight percent of patients had established CAD and 73% were male. Within 90 days of the PET scan, 245 patients (7.4%) received a coronary angiogram; of those patients, 76% underwent a revascularization procedure and 24% were deemed to not be appropriate candidates due to diffuse or complex CAD. Among the patients undergoing revascularization procedures (n=187), 152 (81%) were classified as CFCsevere and 35 (19%) were classified as moderately reduced CFC (no CFCsevere). Severely reduced regional MFR of 1.0 to 1.5 was associated with an increasing risk of all-cause death, myocardial infarction, stroke, or revascularization. Cox regression modeling showed that mortality risk was 54% lower (HR, 0.46; 95% CI, 0.26 to 0.79) after revascularization in patients classified as CFCsevere. For global assessments, patients with a global MFR <2.0 and global stress perfusion <1.8 had a significantly lower mortality risk with revascularization compared to no revascularization (p<.003). For other combinations with less severe global MFR or global stress perfusion, revascularization had no statistically significant impact on mortality risk. The authors note that generalizability may be a limitation as protocols, methodologies, and thresholds for intervention vary among institutions.

Patel et al. (2020) retrospectively evaluated the association between MFR and mortality, and whether the association was modified by early revascularization in a cohort of 12,549 patients referred for rest/stress 82Rb PET myocardial perfusion imaging. (48) Patients with a history of CABG or LVEF <40% were excluded. The primary outcome was all-cause mortality; cardiac mortality was a secondary outcome. Early revascularization was defined as receipt of percutaneous coronary intervention or CABG within 90 days of the myocardial perfusion imaging test. All patients had at least 1 year of follow-up and the median duration was 3.2 years. The majority of patients (77.4%) did not have a documented history of CAD and 47.2% were male. Chest pain was the predominant presenting symptom in approximately 60% of all patients. Mean MFR values were classified as low (<1.8), intermediate (1.8 to 2), and normal (≥2); 38.5%, 15%, and 46.4% of the cohort fell into these categories, respectively. Early revascularization was performed in 897 patients; of those, 66.8%, 10.8%, and 22.4% had MFR values of low, intermediate, or normal, respectively. The all-cause mortality rate through the study follow-up period was 13.5% for the entire cohort. The mortality rate in the low, intermediate, and normal MFR was 21.9%, 12.4%, and 6.9%, respectively (p<.001). Adjusted HR estimates found that every 0.1-unit decrease in MFR was associated with 9% greater hazard of all-cause death (HR, 1.09; 95% CI, 1.08 to 1.10). In the fully adjusted Cox proportional hazards model, there was a significant interaction between MFR and early revascularization; such that patients with MFR ≤1.8 had a survival benefit with early revascularization (HR, 0.76; 95% CI,

0.62 to 0.94), and those with MBFR >1.8 had similar or worse outcomes with early revascularization (HR, 1.39; 95% CI, 1.01 to 1.94).

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, more effective therapy, or avoid unnecessary therapy or 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 RCTs.

No RCTs comparing clinical outcomes for patients undergoing PET to calculate MFR with patients who did not undergo PET were identified.

Chain of Evidence

Indirect evidence on clinical utility rests on clinical validity and explication of evidence-based decisions informed by the test. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Specificity on how the test would fit into current management guidelines for making treatment decisions is needed to evaluate a chain of evidence.

Section Summary: Myocardial Blood Flow Quantification

Evidence is accumulating on the association between quantitative MBF and MFR and cardiovascular outcomes, including if quantifying MFR can assist in identifying patients who may gain a survival benefit from early revascularization. Meta-analyses of cohort studies and individual cohorts have found that impaired MFR is significantly associated with an increase in all-cause mortality. Interpretation of the available literature is complicated due to differences in populations studied, procedures and radiotracers used, cut points used for classification, covariates used in models, lack of reclassification analyses, and potential for publication bias. Recent prospective and retrospective cohorts have reported that identification of MFR can assist in identifying patients who may receive a survival benefit with early revascularization compared to medical therapy. The benefits observed in these single-center studies may be difficult to generalize due to differences in protocols, methodologies, and thresholds for intervention among institutions. These methods are considered to be in a developmental stage for clinical use. Large, prospective clinical trials are needed to better define the potential utility of MBF quantification.

Cardiac Sarcoidosis

Clinical Context and Test Purpose

The purpose of PET scanning in individuals with suspected cardiac sarcoidosis is to diagnose sarcoidosis via detection of inflammatory lesions.

There are no universally accepted diagnostic criteria for cardiac sarcoidosis. The American Thoracic Society guideline (2020) notes that diagnosis is based on 3 major criteria: compatible clinical presentation, finding nonnecrotizing granulomatous inflammation in ≥1 tissue samples, and the exclusion of alternative causes of granulomatous disease. (49) Imaging techniques are commonly used for cardiac sarcoidosis detection, along with the collection of additional clinical data. Transthoracic echocardiogram, cardiac MRI, and FDG-PET have all been evaluated for making a sarcoidosis diagnosis.

The following PICO was used to select literature to inform this policy.

Populations
The population of interest is individuals with suspected cardiac sarcoidosis who cannot undergo MRI.

Interventions
The intervention of interest is PET scanning.

Comparators
The following tests and practices are currently being used to make decisions about managing cardiac sarcoidosis: clinical evaluation and myocardial biopsy.

Outcomes
For individuals with suspected cardiac sarcoidosis, the outcome of interest is a diagnosis confirmation.

Study Selection Criteria
For the evaluation of the clinical validity of cardiac PET perfusion imaging, studies that met the following eligibility criteria were considered:

- Reported on the accuracy of the marketed version of the technology (including any algorithms used to calculate scores);
- Included a suitable reference standard (describe the reference standard);
- Patient/sample clinical characteristics were described;
- Patient/sample selection criteria were described.

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).

Diagnostic Performance
Studies evaluating the diagnostic performance of PET for cardiac sarcoidosis are limited by the absence of a gold standard reference. (50) The Japanese Ministry of Health and Welfare (JMHW), the modified JMHW, or the Heart Rhythm Society diagnostic criteria are often used as the reference standard, but all have imperfect diagnostic accuracy.

Systematic Review
Aitken et al. (2022) conducted a systematic review on the diagnostic performance of 18F-FDG PET or MRI for cardiac sarcoidosis. (51) Cardiac MRI was evaluated in 17 studies (n=1031) and 18F-FDG PET was evaluated in 26 studies (N=1363). Results demonstrated that cardiac MRI and 18F-FDG PET had similar specificity (85% vs. 82%; p=.85), but MRI demonstrated higher sensitivity (95% vs. 84%; p=.002).

Kim et al. (2020) conducted a systematic review on the diagnostic performance of 18F-FDG PET or PET/CT for cardiac sarcoidosis. (53) A total of 17 studies (N=891) were identified for inclusion. Thirteen studies were retrospectively designed, with the other 4 studies enrolling patients prospectively. The reference standards used in the included studies was the JMHW guideline or the modified JMHW. Across all studies, the pooled sensitivity was 84% (95% CI, 71% to 91%; I^2=77.5) and the pooled specificity was 83% (95% CI, 74% to 89%; I^2=80.0). The pooled sensitivity and specificity for the 6 studies that evaluated 18F-FDG PET alone was 92% (95% CI, 79% to 97%) and 66% (95% CI, 47% to 81%), respectively. The pooled sensitivity and specificity for the 11 studies that evaluated combination 18F-FDG PET/CT was 72% (95% CI, 66% to 78%) and 89% (95% CI, 86% to 92%), respectively. The overall positive likelihood ratio was 4.9 (95% CI, 3.3 to 7.3) and the negative likelihood ratio was 0.2 (95% CI, 0.11 to 0.35). The pooled diagnostic OR was 27 (95% CI, 14 to 55). Pooled accuracy was assessed using a summary receiver operator characteristic curve; the area under the curve was 0.90 (95% CI, 0.87 to 0.92). The authors concluded that further large multicenter studies are necessary to substantiate the diagnostic accuracy of 18F-FDG PET for cardiac sarcoidosis.

Nonrandomized Studies
Wicks et al. (2018) reported on results of simultaneous PET/MRI to diagnose cardiac sarcoidosis including 51 consecutive patients in the U.K. with known or suspected cardiac sarcoidosis. (53) The PET and MRI images were analyzed qualitatively in consensus by 2 experienced blinded readers. Using the JMHW guidelines as the reference standard, the prevalence of cardiac sarcoidosis was 65%. Twenty-eight (55%) patients had abnormal cardiac PET findings. The sensitivity of PET and cardiac MRI alone for diagnosing cardiac sarcoidosis was 85% (95% CI, 68% to 95%) and 82% (95% CI, 65% to 93%), respectively. The sensitivity, specificity, positive predictive value, and NPV for hybrid PET/MRI were 94% (95% CI, 80% to 99%), 44% (95% CI, 22% to 69%), 76% (95% CI, 60% to 88%), and 80% (95% CI, 44% to 97%), respectively.

Lapa et al. (2016) published a study to determine whether PET/CT using radiolabeled somatostatin receptor ligands for visualization of inflammation would accurately diagnose cardiac sarcoidosis. (54) Fifteen patients with sarcoidosis and suspicion of cardiac involvement underwent both somatostatin receptor-PET/CT and cardiac MRI. Concordant results between PET/CT and MRI occurred in 12 of the 15 patients.

<u>Clinically Useful</u>

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, more effective therapy, or avoid unnecessary therapy or 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 RCTs.

No studies evaluating the clinical utility of using PET or PET/CT in diagnosing cardiac sarcoidosis were identified.

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.

Cardiac sarcoidosis can lead to arrhythmia, heart failure, pericarditis, and myocardial infarction. There is no criterion standard for diagnosing cardiac sarcoidosis, but a clinical diagnosis is made through a combination of clinical evaluations and imaging. Results from nonrandomized studies have shown that PET can be a useful tool in the clinical diagnostic process.

Section Summary: Cardiac Sarcoidosis
Left untreated, cardiac sarcoidosis can lead to serious developments such as arrhythmia, heart failure, pericarditis, and myocardial infarction. However, there is no criterion standard for diagnosing cardiac sarcoidosis. A combination of clinical evaluations and results from imaging techniques are used in the clinician's assessment. Magnetic resonance imaging is generally recommended first-line for imaging of patients with suspected cardiac sarcoidosis; however, PET may be utilized in patients who are unable to undergo MRI. A meta-analysis found moderate sensitivity and specificity of 18F-FDG PET or PET/CT for diagnosis of cardiac sarcoidosis. A systematic review and 2 nonrandomized studies have been published comparing MRI and PET for diagnosis of cardiac sarcoidosis. Data demonstrate concordance between the 2 tests in their ability to detect cardiac sarcoidosis, thus supporting the use of PET scanning in patients with sarcoidosis unable to undergo MRI.

Summary of Evidence
For individuals with suspected coronary artery disease (CAD) and an indeterminate single photon emission computed tomography (SPECT) scan who receive cardiac positron emission tomography (PET) perfusion imaging, the evidence includes several systematic reviews and meta-analyses. Relevant outcomes are test accuracy, disease-specific survival, morbid events, and resource utilization. Meta-analyses of studies in which PET results were compared with results from coronary angiography and fractional flow reserve (FFR) have shown that PET is comparable in diagnostic accuracy to these referent standards. In meta-analyses of studies that included clinical outcomes such as mortality and adverse cardiac events, results have shown that PET is a useful prognostic tool. Meta-analyses have also found PET to have greater

sensitivity or specificity compared to SPECT, which provides further evidence to support the use of PET when SPECT is indeterminate. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with left ventricular (LV) dysfunction who are potential candidates for revascularization who receive cardiac PET scanning to assess myocardial viability, the evidence includes 2 RCTS and several small trials comparing SPECT with PET. Relevant outcomes are test accuracy, disease-specific survival, and morbid events. In the largest controlled trial, patients with LV dysfunction were randomized to care from physicians who would make management decisions based on PET images or to care from physicians who would make management decisions without PET images. Physicians who would make management decisions without PET images were permitted to administer other tests for myocardial viability, although details were not available as to which tests were performed, if any. At 1- and 5-year follow-ups, patients who received care indicated by the PET images were at a decreased risk for cardiac death, myocardial infarction, and recurrent hospital stays compared with patients who did not. One trial comparing SPECT with PET showed that both modalities were useful in managing patients considering revascularization; however, this trial was small and may have been underpowered to detect a difference in outcomes. Evidence-based recommendations from specialty societies have concluded that PET scanning is at least as good as, and likely superior, to SPECT scanning for this purpose. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with CAD who require myocardial blood flow (MBF) quantification for cardiac event risk stratification who receive quantitative cardiac PET perfusion imaging, the evidence includes observational studies and meta-analyses of those observational studies. Relevant outcomes are disease-specific survival and morbid events. Studies evaluating PET-derived quantitative MBF and myocardial flow reserve (MFR) have found that impaired MFR is significantly associated with an increase in all-cause mortality and can assist in identifying patients who may receive a survival benefit with early revascularization compared to medical therapy. The benefits observed in these single-center studies may be difficult to generalize due to differences in protocols, methodologies, and thresholds for intervention among institutions. These methods are considered to be in a developmental stage for clinical use. Large, prospective clinical trials are needed to better define the potential utility of MBF quantification. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with suspected cardiac sarcoidosis who cannot undergo magnetic resonance imaging (MRI), the evidence includes nonrandomized studies and meta-analyses of observational studies. Relevant outcomes are disease-specific survival, test accuracy, and morbid events. Currently, there is no criterion standard for diagnosing cardiac sarcoidosis. A combination of clinical evaluations and results from imaging techniques, usually MRI, are used during the clinician's assessment. Meta-analyses have found moderate sensitivity and specificity of fluorine 18-labeled fluorodeoxyglucose PET or PET/computed tomography for diagnosis of cardiac sarcoidosis. Two small studies have evaluated variations in PET techniques

such as using a radiolabeled somatostatin receptor ligand and adding a simultaneous cardiac MRI. Reported results were positive in these small studies, showing concordance between MRI and PET, but larger samples are needed to confirm the usefulness of these changes. While MRI is the technique most often used to evaluate cardiac sarcoidosis, for patients who are unable to undergo MRI (e.g., patients with a metal implant), evidence supports PET scanning as the preferred test. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Practice Guidelines and Position Statements

American College of Cardiology et al.

The American College of Cardiology (ACC) Foundation and American Heart Association (AHA) (2009) collaborated with 6 other imaging societies to develop Appropriate Use Criteria for cardiac radionuclide imaging. (55) Their report stated:

"...use of cardiac radionuclide imaging for diagnosis and risk assessment in intermediate- and high-risk patients with coronary artery disease (CAD) was viewed favorably, while testing in low-risk patients, routine repeat testing, and general screenings in certain clinical scenarios were viewed less favorably. Additionally, use for perioperative testing was found to be inappropriate except for high selected groups of patients."

In 2021, the ACC in collaboration with several other medical societies published a guideline on the evaluation and diagnosis of chest pain. (56) Per the guideline, after an acute coronary syndrome has been ruled out, positron emission tomography (PET) or single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI) allows for detection of perfusion abnormalities, measures of left ventricular function, and high-risk findings, such as transient ischemic dilation. The guideline goes on to state that: "For PET, calculation of myocardial blood flow reserve (MBFR, the ratio of peak hyperemia to resting myocardial blood flow) adds diagnostic and prognostic information over MPI data."

In 2023, the ACC and several other medical societies authored a guideline on the management of chronic coronary disease. (57) The guideline recommends PET or SPECT MPI, cardiovascular MRI, or stress echocardiography, in patients with chronic coronary disease and a change in symptoms or functional capacity despite guideline-directed medical therapy (strong recommendation, moderate quality evidence). This testing facilitates detection of myocardial ischemia, estimation of the risk of major cardiovascular events, and therapeutic decisions. Preference is given to PET (over SPECT) due to greater diagnostic accuracy.

American College of Radiology

The American College of Radiology (ACR) Appropriateness Criteria (2021) considered both SPECT and PET to be appropriate for the evaluation of patients with a high probability of CAD. (58) The ACR indicated that PET perfusion imaging has advantages over SPECT, including higher spatial and temporal resolution. Routine performance of both PET and SPECT are unnecessary. The 2021 update stated:

"Hybrid PET scanners use CT [computed tomography] for attenuation correction (PET/CT) following completion of the PET study. By coupling the PET perfusion examination findings to a CCTA [cardiac computed tomographic angiography], PET/CT permits the fusion of anatomic coronary arterial and functional (perfusion) myocardial information and enhances diagnostic accuracy. The fused examinations can accurately measure the atherosclerotic burden and identify the hemodynamic functional significance of coronary stenosis. The results of the combined examinations can more accurately identify patients for revascularization."

The ACR Appropriateness Criteria (2018) also recommended PET for the evaluation of patients with chronic chest pain that is unlikely to be from a noncardiac etiology and low-to-intermediate probability of CAD. (59)

The ACR does not recommend PET for patients with acute nonspecific chest pain who have a low probability of CAD (60) or for asymptomatic patients at risk for CAD. (61)

American Heart Association

The American Heart Association (AHA) published a scientific statement on the diagnosis and management of cardiac sarcoidosis (CS) in 2024. (62) The statement notes, "FDG-PET is an integral tool in the evaluation and management of CS. FDG-PET is generally performed in conjunction with [Cardiac Magnetic Resonance] (CMR) to assess disease activity and monitor treatment response. FDG-PET should also be performed if a high pretest probability remains despite negative, nondiagnostic, or equivocal CMR results or in situations when CMR is contraindicated."

American Society for Nuclear Cardiology/Society of Nuclear Medicine and Molecular Imaging

The American Society of Nuclear Cardiology (ASNC) published a PET model coverage policy in 2023. (63) The document may be referred to for a comprehensive listing of clinical indications for conducting a cardiac PET study, along with supporting literature.

The ASNC and the Society of Nuclear Medicine and Molecular Imaging (SNMMI) (2016) updated their joint guideline on procedure standards for cardiac PET procedures. (64) PET MPI is used "to detect physiologically significant coronary artery narrowing to guide clinical management of patients with known or suspected CAD [coronary artery disease] and those without overt CAD but with cardiovascular risk factors in order to: evaluate the progression of atherosclerosis, determine cause of ischemic symptoms and recommend medical or revascularization therapy, estimate the potential for future adverse events, and improve patient survival." Perfusion defects can be reported through qualitative scoring, semiquantitative scoring systems, or absolute quantification of myocardial blood flow (MBF). The guideline is limited by not providing direct recommendations with associated levels of evidence and strength of recommendations. However, the authors note that "quantitative absolute MBF measurements with PET appear most helpful in:

- Patients without known prior history of cardiac disease who present with symptoms suspicious for myocardial ischemia,
- Patients with known CAD, in whom more specific physiological assessment is desired,

- Identifying an increased suspicion for multivessel CAD,
- Situations with a disparity between visual perfusion abnormalities and apparently normal coronary angiography, in order to assess possible microvascular dysfunction, and
- Heart transplant when there is a question of vasculopathy.

In contrast, there are particular patients for whom reporting hyperemic blood flow or flow reserve may not add diagnostic value or can be ambiguous or misleading, including:
- Patients post-CABG [coronary artery bypass graft] who can have diffuse reduction on MBF despite patent grafts,
- Patients with large transmural infarcts where resting flow may be severely reduced such that small increases in flow lead to normal or near-normal flow reserve,
- Patients with advanced severe chronic renal dysfunction who likewise often have diffuse coronary disease, and
- Patients with severe LV [left ventricular] dysfunction."

A joint position paper from SNMMI/ASNC (2018) further discussed clinical quantification of MBF. (65) Stress MBF and myocardial flow reserve (MFR) are associated with improved diagnostic sensitivity, but specificity has varied in studies. Treatment guidance noted that "[a]t present there are no randomized data supporting the use of any stress imaging modality for selection of patients for revascularization or for guidance of medical therapy. Observational data have established a paradigm that patients with greater degrees of ischemia on relative MPI are more likely to benefit from revascularization. This paradigm has been conceptually extended to include MFR and stress MBF but has not yet been evaluated prospectively." The following key points were highlighted:
- "Use of stress MBF and MFR for diagnosis is complex, as diabetes, hypertension, age, smoking, and other risk factors may decrease stress MBF and MFR without focal epicardial stenosis.
- Patients with preserved stress MBF and MFR are unlikely to have high-risk epicardial CAD.
- Preserved stress MBF of more than 2 mL/min/g and MFR of more than 2 reliably exclude the presence of high-risk angiographic disease (negative predictive value >95%) and are reasonable to report when used in clinical interpretation.
- A severely decreased global MFR (<1.5 mL/min/g) should be reported as a high-risk feature for adverse cardiac events but is not always due to multivessel obstructive disease. The likelihood of multivessel obstructive disease may be refined by examination of the electrocardiogram, regional perfusion, coronary calcification, and cardiac volumes and function.
- Regional decreases in stress MBF (<1.5 mL/min/g) and MFR (<1.5) in a vascular territory may indicate regional flow-limiting disease."

The position paper additionally calls for further data on quantifying MBF and MFR in suspected or established CAD: "[t]hese methods are at the cusp of translation to clinical practice. However, further efforts are necessary to standardize measures across laboratories, radiotracers, equipment, and software. Most critically, data are needed supporting improved clinical outcomes when treatment selection is based on these measures."

A joint expert consensus document from ASNC/SNMMI (2017) covered the role of Fluorine 18 fluorodeoxyglucose (18F-FDG) PET for cardiac sarcoidosis detection and therapy monitoring. (50) The document discusses the need to integrate multiple sources of data, including 18F-FDG PET in some cases, to diagnose cardiac sarcoidosis. The following outlines clinical scenarios where cardiac PET may be useful in patients with suspected or known disease. Associated levels of evidence and strength of recommendations were not provided with these scenarios.

- "Patients with histologic evidence of extraCS [extracardiac sarcoidosis], and abnormal screening for CS [cardiac sarcoidosis], defined as one or more of following:
    - Abnormal electrocardiographic findings of complete left or right bundle branch block or presence of unexplained pathologic Q waves in two or more leads
    - Echocardiographic findings of regional wall motion abnormality, wall aneurysm, basal septum thinning, or LVEF [left ventricular ejection fraction] ≤50%
    - Holter findings of sustained or nonsustained ventricular tachycardia
    - Cardiac MRI findings suggestive of CS
    - Unexplained palpitations or syncope
- Young patients (<60 y) with unexplained, new onset, significant conduction system disease (such as sustained second- or third-degree atrioventricular block)
- Patients with idiopathic sustained ventricular tachycardia, defined as not fulfilling any of the following criteria:
    - Typical outflow tract ventricular tachycardia
    - Fascicular ventricular tachycardia
    - Ventricular tachycardia secondary to other structural heart disease (coronary artery disease or any cardiomyopathy other than idiopathic)
- Patients with proven CS as adjunct to follow response to treatment."

In 2021, the ASNC/SNMMI published a guide for interpretation and reporting of MBF with cardiac PET MPI to encourage and assist clinicians in the implementation of this relatively new approach to evaluate patients with known or suspected CAD. (23) The guide notes that "MBF evaluation provides complementary information to MPI that adds considerably to the value of the testing procedure in the diagnosis and risk stratification of CAD and cardiac events."

Per this guide, the clinical value of MBF reserve for patients with known CAD is as follows:

- "Often abnormal after CABG, CAD history, myocardial infarction
- Cardiomyopathy less useful but if normal, helps exclude CAD
- Renal failure patients generally abnormal
- Post PCI [percutaneous coronary intervention] may be abnormal, but most useful if pre-PCI data available
- Identify non-responder: all patients."

<u>American Thoracic Society</u>

The American Thoracic Society (2020) published guideline recommendations on the detection and diagnosis of sarcoidosis. (49) This guideline generally recommends cardiac MRI over PET or transthoracic echocardiography (TTE) for obtaining diagnostic or prognostic information in

patients with sarcoidosis and potential cardiac involvement. In cases where cardiac MRI is unavailable or inconclusive, PET is recommended over TTE to obtain diagnostic or prognostic information. Both of these recommendations are conditional, and based on very low-quality evidence.

Society of Nuclear Medicine and Molecular Imaging, et al.

In 2023, the SNMMI published an expert panel consensus document on PET MPI for coronary microvascular dysfunction. (66) The document recommends PET imaging to detect coronary microvascular dysfunction in patients with chest pain but no evidence of CAD. Several scenarios are described that can facilitate test interpretation and application to therapeutic decision-making.

A joint guidance from SNMMI/ACC/ASNC/AHA/Canadian Cardiovascular Society/Canadian Society of Cardiovascular Nuclear and CT Imaging/Society of Cardiovascular CT/American College of Physicians/European Association of Nuclear Medicine (2020) developed appropriate use criteria for PET MPI for the most common scenarios encountered. (67) The criteria were updated in 2025. (68) Scenarios for which stress-rest perfusion PET is appropriate (or may be appropriate) include:

- Intermediate or high pretest probability for CAD
- Symptoms of CAD in patients in the hospital or emergency department with unlikely acute coronary syndrome based on troponin levels and/or electrocardiogram (ECG)
- Asymptomatic patients with an intermediate atherosclerotic cardiovascular disease (ASCVD) risk who are unable to exercise or have a calcium score of 400 to 1000
- Asymptomatic patients with a high ASCVD risk or calcium score >1000
- Asymptomatic patients with peripheral vascular disease, familial hyperlipidemia, equivocal or abnormal prior coronary angiography testing, LV dysfunction, new left bundle branch block, atrial fibrillation, abnormal ECG findings (pathologic Q waves or ST segment abnormalities), history of PCI >2 years prior or coronary artery bypass graft (CABG) >5 years prior, prior heart transplant, reduced LV function during or after chemotherapy or radiation therapy, history of coronary vasculitis (with structural abnormalities), history of high risk coronary anomalies
- Known CAD without prior revascularization
- Candidates for solid organ transplant
- Heart failure with reduced ejection fraction and no history of CAD
- Heart failure with preserved ejection fraction and no history of CAD
- Cardiac sarcoidosis unless radionuclide PET is planned
- Sustained ventricular tachycardia with intermediate or high risk of CAD
- Nonsustained or exercise-induced ventricular tachycardia
- Frequent premature ventricular contractions with low or intermediate risk of CAD, or infrequent premature ventricular contractions with intermediate or high risk of CAD
- New-onset atrial fibrillation with intermediate or high risk of CAD
- Risk of CAD before starting antiarrhythmic medications
- Syncope and intermediate or high risk of CAD

- Symptomatic patients with either positive or negative exercise stress test and other risk factors (e.g., diabetes, obesity, pulmonary artery hypertension, postmenopausal, large breasts or dense breast tissue, congenital heart disease, familial hypercholesterolemia)
- Asymptomatic patients with a positive exercise stress test
- Ongoing chest pain syndrome
- Symptoms after undergoing CABG
- Transplant vasculopathy and suspected cardiac graft rejection
- Suspected vasculitis and arteritis
- Abnormal, equivocal, or discordant prior exercise ECG stress test
- Abnormal prior calcium score (Agatston score 100 to 400)
- Undergoing intermediate risk surgery or vascular surgery.

For the evaluation of patients with known or suspected cardiac sarcoidosis, "rest PET MPI was rated by the experts as appropriate in patients undergoing assessment of myocardial inflammation with ^{18}F-FDG PET at baseline and during reevaluation for response to therapy or recurrent inflammation. (69) In contrast, stress MPI was rated as may be appropriate in the evaluation of patients with suspected sarcoidosis who have not been previously evaluated for CAD, and as rarely appropriate in patients with suspected sarcoidosis who have been previously evaluated for CAD."

Medicare National Coverage

Effective January 1, 2022, the Centers for Medicare & Medicaid Services removed the umbrella national coverage determination (NCD) for PET scans. (70) In the absence of an NCD, coverage determinations for all oncologic and non-oncologic uses of PET that are not included in another NCD under section 220.6 will be made by the Medicare Administrative Contractors (MACs) under section 1862(a)(1)(A) of the Social Security Act. All PET indications currently covered or non-covered under NCDs under section 220.6 remain unchanged and MACs shall not alter coverage for indications covered under NCDs.

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this review are listed in Table 4.

Table 4. Summary of Key Trials

NCT Number	Trial Name	Planned Enrollment	Completion Date
NCT05634031	Development and Validation of a Non-invasive Algorithm for Diagnosis of Microvascular Angina Among Patients With Ischemia and Non-obstructive Coronary Artery Disease (IMAGING-CMD Study)	70	Mar 2027
NCT00756379	Randomized Trial of Comprehensive Lifestyle Modifications, Optimal Pharmacological Treatment and PET Imaging for Detection	1085	May 2027

	and Management of Stable Coronary Artery Disease		
NCT05954507	Prospective Comparative Multicenter Study Evaluating the Prognostic Interest of PET/MRI in Cardiac Sarcoidosis	180	Mar 2030
NCT01288560	Alternative Imaging Modalities in Ischemic Heart Failure (AIMI-HF) Project I-A of Imaging Modalities to Assist with Guiding Therapy and the Evaluation of Patients With Heart Failure (IMAGE-HF)	1390	Oct 2022

NCT: national clinical trial.

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	78429, 78430, 78431, 78432, 78433, 78434, 78459, 78491, 78492
HCPCS Codes	A9526, A9552, A9555, A9598

*Current Procedural Terminology (CPT®) ©2024 American Medical Association: Chicago, IL.

References

1. Centers for Disease Control and Prevention. Heart Disease Facts. Updated October 24, 2024. Available at: <https://www.cdc.gov> (accessed July 22, 2025).
2. Diamond GA, Forrester JS, Hirsch M, et al. Application of conditional probability analysis to the clinical diagnosis of coronary artery disease. J Clin Invest. May 1980; 65(5):1210-1221. PMID 6767741
3. Waller AH, Blankstein R, Kwong RY, et al. Myocardial blood flow quantification for evaluation of coronary artery disease by positron emission tomography, cardiac magnetic resonance imaging, and computed tomography. Curr Cardiol Rep. May 2014; 16(5):483. PMID 24718671
4. Akaike G, Itani M, Shah H, et al. PET/CT in the Diagnosis and Workup of Sarcoidosis: Focus on Atypical Manifestations. Radiographics. 2018; 38(5):1536-1549. PMID 30118393
5. Food and Drug Administration (FDA). PET drugs - current good manufacturing practice (CGMP) (2009). Available at <https://www.fda.gov> (accessed July 22, 2025).

6. Food and Drug Administration (FDA). PET drugs - current good manufacturing practice (CGMP) (small entity compliance guide) (2011). Available at <https://www.fda.gov> (accessed July 22, 2025).
7. Food and Drug Administration (FDA). Guidance: Investigational New Drug Applications for Positron Emission Tomography (PET) Drugs (2012). Available at <https://www.fda.gov> (accessed July 22, 2025).
8. Beanlands RS, Chow BJ, Dick A, et al. CCS/CAR/CANM/CNCS/CanSCMR joint position statement on advanced noninvasive cardiac imaging using positron emission tomography, magnetic resonance imaging and multidetector computed tomographic angiography in the diagnosis and evaluation of ischemic heart disease--executive summary. Can J Cardiol. Feb 2007; 23(2):107-119. PMID 17311116
9. Xu J, Cai F, Geng C, et al. Diagnostic performance of CMR, SPECT, and PET imaging for the identification of coronary artery disease: A meta-analysis. Front Cardiovasc Med. 2021; 8:621389. PMID 34026862
10. Knuuti J, Ballo H, Juarez-Orozco LE, et al. The performance of noninvasive tests to rule in and rule out significant coronary artery stenosis in patients with stable angina: a meta-analysis focused on posttest disease probability. Eur Heart J. Sep 14 2018; 39(35):3322-3330. PMID 29850808
11. Dai N, Zhang X, Zhang Y, et al. Enhanced diagnostic utility achieved by myocardial blood analysis: A meta-analysis of noninvasive cardiac imaging in the detection of functional coronary artery disease. Int J Cardiol. Oct 15 2016; 221:665-673. PMID 27423088
12. Takx RA, Blomberg BA, El Aidi H, et al. Diagnostic accuracy of stress myocardial perfusion imaging compared to invasive coronary angiography with fractional flow reserve meta-analysis. Circ Cardiovasc Imaging. Jan 2015; 8(1):e002666. PMID 25596143
13. Bateman TM, Heller GV, McGhie AI, et al. Diagnostic accuracy of rest/stress ECG-gated Rb-82 myocardial perfusion PET: comparison with ECG-gated Tc-99m sestamibi SPECT. J Nucl Cardiol. 2006; 13(1):24-33. PMID 16464714
14. Chen A, Wang H, Fan B, et al. Prognostic value of normal positron emission tomography myocardial perfusion imaging in patients with known or suspected coronary artery disease: a meta-analysis. Br J Radiol. Jun 2017; 90(1074):20160702. PMID 28306335
15. Smulders MW, Jaarsma C, Nelemans PJ, et al. Comparison of the prognostic value of negative non-invasive cardiac investigations in patients with suspected or known coronary artery disease-a meta-analysis. Eur Heart J Cardiovasc Imaging. Sep 1 2017; 18(9):980-987. PMID 28329376
16. Knešaurek K, Machac J. Comparison of 18F SPECT with PET in myocardial imaging: a realistic thorax-cardiac phantom study. BMC Nucl Med. Oct 31 2006; 6:5. PMID 17076890
17. Slart RH, Bax JJ, de Boer J, et al. Comparison of 99mTc-sestamibi/18FDG DISA SPECT with PET for the detection of viability in patients with coronary artery disease and left ventricular dysfunction. Eur J Nucl Med Mol Imaging. Aug 2005; 32(8):972-979. PMID 15824927
18. Mielniczuk LM, O'Meara E, Wiefels C, et al. The Alternative Imaging Modalities in Ischemic Heart Failure (AIMI-HF) Trial - IMAGE HF Project 1A. CJC Open. Available online July 16, 2025. Available at <https://www.sciencedirect.com> (accessed July 23, 2025).
19. Beanlands RS, Nichol G, Huszti E, et al. F-18-fluorodeoxyglucose positron emission tomography imaging- assisted management of patients with severe left ventricular

dysfunction and suspected coronary disease: a randomized, controlled trial (PARR-2). J Am Coll Cardiol. Nov 13 2007; 50(20):2002-2012. PMID 17996568
20. Mc Ardle B, Shukla T, Nichol G, et al. Long-term follow-up of outcomes with F-18-fluorodeoxyglucose positron emission tomography imaging-assisted management of patients with severe left ventricular dysfunction secondary to coronary disease. Circ Cardiovasc Imaging. Sep 2016; 9(9):e004331. PMID 27609816
21. Siebelink HM, Blanksma PK, Crijns HJ, et al. No difference in cardiac event-free survival between positron emission tomography-guided and single-photon emission computed tomography-guided patient management: a prospective, randomized comparison of patients with suspicion of jeopardized myocardium. J Am Coll Cardiol. Jan 2001; 37(1):81-88. PMID 11153777
22. Srivatsava MK, Indirani M, Sathyamurthy I, et al. Role of PET-CT in the assessment of myocardial viability in patients with left ventricular dysfunction. Indian Heart J. 2016; 68(5):693-699. PMID 27773409
23. Bateman TM, Heller GV, Beanlands R, et al. Practical guide for interpreting and reporting cardiac PET measurements of myocardial blood flow: An information statement from the American Society of Nuclear Cardiology, and the Society of Nuclear Medicine and Molecular Imaging. J Nucl Med. Nov 2021; 62(11):1599-1615. PMID 33789935
24. Herzog BA, Husmann L, Valenta I, et al. Long-term prognostic value of 13N-ammonia myocardial perfusion positron emission tomography added value of coronary flow reserve. J Am Coll Cardiol. Jul 7 2009; 54(2):150-156. PMID 19573732
25. Schindler TH, Schelbert HR, Quercioli A, et al. Cardiac PET imaging for the detection and monitoring of coronary artery disease and microvascular health. JACC Cardiovasc Imaging. Jun 2010; 3(6):623-640. PMID 20541718
26. Beanlands RS, Ziadi MC, Williams K. Quantification of myocardial flow reserve using positron emission imaging the journey to clinical use [editorial]. J Am Coll Cardiol. Jul 7 2009; 54(2):157-159. PMID 19573733
27. Gould KL, Johnson NP, Bateman TM, et al. Anatomic versus physiologic assessment of coronary artery disease. Role of coronary flow reserve, fractional flow reserve, and positron emission tomography imaging in revascularization decision-making. J Am Coll Cardiol. Oct 29 2013; 62(18):1639-1653. PMID 23954338
28. Ahmed AI, Saad JM, Alahdab F, et al. Prognostic value of positron emission tomography derived myocardial flow reserve: A systematic review and meta-analysis. Atherosclerosis. Oct 2023; 382:117280. PMID 37742396
29. Jensen SM, Prescott EIB, Abdulla J. The prognostic value of coronary flow reserve in patients with non-obstructive coronary artery disease and microvascular dysfunction: a systematic review and meta-analysis with focus on imaging modality and sex difference. Int J Cardiovasc Imaging. Dec 2023; 39(12):2545-2556. PMID 37716916
30. Green R, Cantoni V, Acampa W, et al. Prognostic value of coronary flow reserve in patients with suspected or known coronary artery disease referred to PET myocardial perfusion imaging: A meta-analysis. J Nucl Cardiol. Jun 2021; 28(3):904-918. PMID 31875285
31. Juárez-Orozco LE, Tio RA, Alexanderson E, et al. Quantitative myocardial perfusion evaluation with positron emission tomography and the risk of cardiovascular events in

patients with coronary artery disease: a systematic review of prognostic studies. Eur Heart J Cardiovasc Imaging. Oct 1 2018; 19(10):1179-1187. PMID 29293983
32. Tio RA, Dabeshlim A, Siebelink HM, et al. Comparison between the prognostic value of left ventricular function and myocardial perfusion reserve in patients with ischemic heart disease. J Nucl Med. Feb 2009; 50(2):214-219. PMID 19164219
33. Ziadi MC, Dekemp RA, Williams KA, et al. Impaired myocardial flow reserve on rubidium-82 positron emission tomography imaging predicts adverse outcomes in patients assessed for myocardial ischemia. J Am Coll Cardiol. Aug 9 2011; 58(7):740-748. PMID 21816311
34. Fukushima K, Javadi MS, Higuchi T, et al. Prediction of shortterm cardiovascular events using quantification of global myocardial flow reserve in patients referred for clinical 82Rb PET perfusion imaging. J Nucl Med. May 2011; 52(5):726-732. PMID 21498538
35. Slart RH, Zeebregts CJ, Hillege HL, et al. Myocardial perfusion reserve after a PET driven revascularization procedure: a strong prognostic factor. J Nucl Med. Jun 2011; 52(6):873-879. PMID 21571798
36. Farhad H, Dunet V, Bachelard K, et al. Added prognostic value of myocardial blood flow quantitation in rubidium-82 positron emission tomography imaging. Eur Heart J Cardiovasc Imaging. Dec 2013; 14(12):1203-1210. PMID 23660750
37. Maaniitty T, Stenstrom I, Bax JJ, et al. Prognostic value of coronary CT angiography with selective PET perfusion imaging in coronary artery disease. JACC Cardiovasc Imaging. Nov 2017; 10(11):1361-1370. PMID 28528146
38. Gupta A, Taqueti VR, van de Hoef TP, et al. Integrated noninvasive physiological assessment of coronary circulatory function and impact on cardiovascular mortality in patients with stable coronary artery disease. Circulation. Dec 12 2017; 136(24):2325-2336. PMID 28864442
39. Murthy VL, Naya M, Foster CR, et al. Improved cardiac risk assessment with noninvasive measures of coronary flow reserve. Circulation. Nov 15 2011; 124(20):2215-2224. PMID 22007073
40. Taqueti VR, Hachamovitch R, Murthy VL, et al. Global coronary flow reserve is associated with adverse cardiovascular events independently of luminal angiographic severity and modifies the effect of early revascularization. Circulation. Jan 6 2015; 131(1):19-27. PMID 25400060
41. Murthy VL, Naya M, Taqueti VR, et al. Effects of sex on coronary microvascular dysfunction and cardiac outcomes. Circulation. Jun 17 2014; 129(24):2518-2527. PMID 24787469
42. Majmudar MD, Murthy VL, Shah RV, et al. Quantification of coronary flow reserve in patients with ischaemic and non-ischaemic cardiomyopathy and its association with clinical outcomes. Eur Heart J Cardiovasc Imaging. Aug 2015; 16(8):900-909. PMID 25719181
43. Taqueti VR, Everett BM, Murthy VL, et al. Interaction of impaired coronary flow reserve and cardiomyocyte injury on adverse cardiovascular outcomes in patients without overt coronary artery disease. Circulation. Feb 10 2015; 131(6):528-535. PMID 25480813
44. Assante R, Acampa W, Zampella E, et al. Prognostic value of atherosclerotic burden and coronary vascular function in patients with suspected coronary artery disease. Eur J Nucl Med Mol Imaging. Dec 2017; 44(13):2290-2298. PMID 28815291

45. Taqueti VR, Solomon SD, Shah AM, et al. Coronary microvascular dysfunction and future risk of heart failure with preserved ejection fraction. Eur Heart J. Mar 07 2018; 39(10):840-849. PMID 29293969
46. Gebhard C, Fiechter M, Herzog BA, et al. Sex differences in the long-term prognostic value of 13 N-ammonia myocardial perfusion positron emission tomography. Eur J Nucl Med Mol Imaging. Oct 2018; 45(11):1964-1974. PMID 29779046
47. Gould KL, Kitkungvan D, Johnson NP, et al. Mortality prediction by quantitative PET perfusion expressed as coronary flow capacity with and without revascularization. JACC Cardiovasc Imaging. May 2021; 14(5):1020-1034. PMID 33221205
48. Patel KK, Spertus JA, Chan PS, et al. Myocardial blood flow reserve assessed by positron emission tomography myocardial perfusion imaging identifies patients with a survival benefit from early revascularization. Eur Heart J. Feb 01 2020; 41(6):759-768. PMID 31228200
49. Crouser ED, Maier LA, Wilson KC, et al. Diagnosis and Detection of Sarcoidosis. An Official American Thoracic Society Clinical Practice Guideline. Am J Respir Crit Care Med. Apr 15 2020; 201(8):e26-e51. PMID 32293205
50. Chareonthaitawee P, Beanlands RS, Chen W, et al. Joint SNMMI-ASNC expert consensus document on the role of 18 F-FDG PET/CT in cardiac sarcoid detection and therapy monitoring. J Nucl Med. Aug 2017; 58(8):1341-1353. PMID 28765228
51. Aitken M, Chan MV, Urzua Fresno C, et al. Diagnostic accuracy of cardiac MRI versus FDG PET for cardiac sarcoidosis: A systematic review and meta-analysis. Radiology. Sep 2022; 304(3):566-579. PMID 35579526
52. Kim SJ, Pak K, Kim K. Diagnostic performance of F-18 FDG PET for detection of cardiac sarcoidosis; A systematic review and meta-analysis. J Nucl Cardiol. Dec 2020; 27(6):2103-2115. PMID 30603894
53. Wicks EC, Menezes LJ, Barnes A, et al. Diagnostic accuracy and prognostic value of simultaneous hybrid 18Ffluorodeoxyglucose positron emission tomography/magnetic resonance imaging in cardiac sarcoidosis. Eur Heart J Cardiovasc Imaging. Jul 1 2018; 19(7):757-767. PMID 29319785
54. Lapa C, Reiter T, Kircher M, et al. Somatostatin receptor based PET/CT in patients with the suspicion of cardiac sarcoidosis: an initial comparison to cardiac MRI. Oncotarget. Nov 22 2016; 7(47):77807-77814. PMID 27780922
55. Hendel RC, Berman DS, Di Carli MF, et al. ACCF/ASNC/ACR/AHA/ASE/SCCT/SCMR/SNM 2009 Appropriate Use Criteria for Cardiac Radionuclide Imaging: A Report of the American College of Cardiology Foundation Appropriate Use Criteria Task Force, the American Society of Nuclear Cardiology, the American College of Radiology, the American Heart Association, the American Society of Echocardiography, the Society of Cardiovascular Computed Tomography, the Society for Cardiovascular Magnetic Resonance, and the Society of Nuclear Medicine. J Am Coll Cardiol. Jun 09 2009; 53(23):2201-2229. PMID 19497454
56. 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

57. Virani SS, Newby LK, Arnold SV, et al. 2023 AHA/ACC/ACCP/ASPC/NLA/PCNA Guideline for the Management of Patients With Chronic Coronary Disease: A Report of the American Heart Association/American College of Cardiology Joint Committee on Clinical Practice Guidelines. J Am Coll Cardiol. Aug 29 2023; 82(9):833-955. PMID 37480922
58. American College of Radiology (ACR). ACR Appropriateness Criteria: Chronic Chest Pain -- High Probability of Coronary Artery Disease (2021). Available at <https://acsearch.acr.org> (accessed July 19, 2025).
59. American College of Radiology (ACR). ACR Appropriateness Criteria: Chronic Chest Pain - Low to Intermediate Probability of Coronary Artery Disease (2018). Available at <https://acsearch.acr.org> (accessed July 20, 2025).
60. American College of Radiology (ACR). ACR Appropriateness Criteria: Acute Nonspecific Chest Pain--Low Probability of Coronary Artery Disease (2020). Available at <https://acsearch.acr.org> (accessed July 22, 2025).
61. American College of Radiology (ACR). ACR Appropriateness Criteria: Asymptomatic Patient at Risk for Coronary Artery Disease (2020). Available at <https://acsearch.acr.org> (accessed July 21, 2025).
62. Cheng RK, Kittleson MM, Beavers CJ, et al. Diagnosis and Management of Cardiac Sarcoidosis: A Scientific Statement From the American Heart Association. Circulation. May 21 2024; 149(21):e1197-e1216. PMID 38634276
63. Horgan S, Sanghani R, Miller S, et al. ASNC model coverage policy: 2023 cardiac positron emission tomography. J Nucl Cardiol. Oct 2023; 30(5):2114-2185. PMID 37670174
64. Dilsizian V, Bacharach SL, Beanlands RS, et al. ASNC imaging guidelines/SNMMI procedure standard for positron emission tomography (PET) nuclear cardiology procedures. J Nucl Cardiol. Oct 2016; 23(5):1187-1226. PMID 27392702
65. Murthy VL, Bateman TM, Beanlands RS, et al. Clinical quantification of myocardial blood flow using PET: Joint position paper of the SNMMI Cardiovascular Council and the ASNC. J Nucl Med. Feb 2018; 59(2):273-293. PMID 29242396
66. Schindler TH, Fearon WF, Pelletier-Galarneau M, et al. Myocardial Perfusion PET for the Detection and Reporting of Coronary Microvascular Dysfunction: A JACC: Cardiovascular Imaging Expert Panel Statement. JACC Cardiovasc Imaging. Apr 2023; 16(4):536-548. PMID 36881418
67. Schindler TH, Bateman TM, Berman DS, et al. Appropriate Use Criteria for PET Myocardial Perfusion Imaging. J Nucl Med. Aug 2020; 61(8):1221-1265. PMID 32747510
68. Society of Nuclear Medicine & Molecular Imaging. Updated Appropriate Use Criteria for PET Myocardial Perfusion Imaging 2.0. February 5, 2025. Available at <https://snmmi.org> (accessed July 22, 2025).
69. Centers for Medicare & Medicaid Services (CMS). Coverage and Related Claims Processing Requirements for Positron Emission Tomography (PET) Scans for Breast Cancer and Revised Coverage Conditions for Myocardial Viability. Transmittal AB-02-065. 2023 [Retired]; Available at <https://www.cms.gov> (accessed July 22, 2025).

Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

Policy History/Revision	
Date	**Description of Change**
12/15/2025	Document updated. Coverage slightly reworded without change to intent. Added references 18 and 68.
02/01/2025	Document updated with literature review. Coverage unchanged. References 27, 28, 56, 61, 62, 65, 67 added. Others updated.
12/01/2023	Reviewed. No changes.
01/01/2023	Document updated with literature review. Minor language change in coverage with no intent to change intention i.e., Patients changed to individuals. References 1, 9, 22, 27, 38-45, 47-49, 52-53, 55 and 60 added; others removed.
02/01/2022	Reviewed. No changes.
03/01/2021	Document updated with literature review. Coverage unchanged. References 3, 4, 44, 45 and 49 added; others removed.
07/15/2020	Reviewed. No changes.
05/01/2019	Document updated with literature review. Coverage unchanged. References 8, 2829, 3135, and 43 added; others removed.
11/15/2018	Reviewed. No changes.
12/01/2017	Document updated with literature review. Policy content modified to address only cardiac applications of PET, without change to Coverage. Information on oncologic and other miscellaneous applications of PET, in addition to positron emission mammography, can now be found in eviCore guidelines. Modified language in Description related to risk assessment ratings for coronary heart disease. Title changed from: Positron Emission Tomography (PET).
04/15/2017	Reviewed. No changes.
03/01/2016	Document updated with literature review. The following coverage language criterion, specific to lymphoma was changed under subsequent treatment strategy planning for oncologic indications to now read: “PET or PET/CT imaging for subsequent treatment strategy planning may be considered medically necessary when the initial diagnostic PET criteria were met and PET is needed: for the purpose of detecting residual disease within 12

	months after completion of therapy for lymphoma or within 6 months after completion of therapy for all other malignancies". In addition, the following note was added under surveillance of asymptomatic patients after completion of therapy for malignancy: "NOTE: Surveillance utilizing PET or PET/CT is defined as a scan performed for patients without signs or symptoms of cancer recurrence who are six (6) months or more from completion of cancer treatment or 12 months or more from completion of treatment for lymphoma".
10/15/2015	Document updated with literature review. The following was added as an experimental, investigational and/or unproven indication for cardiac applications of positron emission tomography: Cardiac positron emission tomography scanning is considered experimental, investigational and/or unproven for quantification of myocardial blood flow in patients diagnosed with coronary artery disease. The following editorial clarification made to investigational, experimental and unproven exclusions specific to melanoma to note: PET or PET/CT is considered experimental, investigational and/or unproven for evaluation of patients with clinically localized melanoma who are candidates to undergo sentinel node biopsy.
01/01/2014	The following was added to Coverage: Sodium 18F-Fluoride (NaF-18) radiotracer for positron emission tomography (PET) bone scans is considered experimental, investigational and unproven for non-oncologic indications, including but not limited to osteomyelitis.
01/01/2012	Document updated with literature review for cardiac applications of PET. The following changes were made: 1) Requirements for cardiac PET scanning to assess myocardial perfusion defects was revised to eliminate the BMI cutoff and replace it with the phrase "in patients for whom SPECT could be reasonably expected to be suboptimal in quality on the basis of body habitus"; 2) An additional indication for PET scanning was added: "Cardiac PET scanning may be considered medically necessary for the diagnosis of cardiac sarcoidosis in patients who are unable to undergo MRI scanning. Examples of patients who are unable to undergo MRI include, but are not limited to, patients with pacemakers, automatic implanted cardioverter-defibrillators (AICDs) or other metal implants"; 3) Criteria for breast cancer, prostate cancer, and melanoma were revised to only include the individual exclusions.
06/01/2011	Document updated with literature review. The following change was made: PET or PET/CT imaging for subsequent treatment strategy planning may be considered medically necessary when the initial diagnostic PET criteria were met, and the listed conditions are also met. (The list of specific diagnoses has been removed).
06/15/2010	Revised/updated document with literature review. The following changes were made: 1) New medical necessity criteria for oncologic uses of PET or PET/CT include: a) initial treatment strategy planning when criteria are met

	(with additional criteria and exclusions for breast cancer, melanoma, and prostate cancer); and b) subsequent treatment strategy planning for cancers of the breast, cervix, colon and rectum, esophagus, head and neck, non-small cell lung, lymphoma, melanoma, myeloma, ovary, and thyroid; c) PET or PET/CT is considered experimental, investigational and unproven for subsequent treatment strategy planning for any other tumor/cancer not listed above. (This includes, but is not limited to pancreatic cancer); d) PET or PET/CT is considered not medically necessary for patients ≥12 months after completion of therapy for lymphoma, or ≥6 months after completion of therapy for all other malignancies, unless the patient demonstrates signs, symptoms, laboratory or other objective findings suggestive of recurrence or spread of the original malignancy. 2) Positron emission mammography (PEM) was added to coverage: PEM is considered experimental, investigational and unproven for breast cancer screening, diagnosis or management. 3) The AHA/ACC Joint Statement for assessment of cardiovascular risk was added to the Description section to assist determination of intermediate-risk.
10/01/2009	Revised/updated entire document
07/01/2009	Policy revised to allow coverage of PET for ovarian cancer, pancreatic cancer, small cell lung cancer, and soft tissue sarcoma.
03/01/2008	Revised/Updated Entire Document
02/01/2005	Revised/Updated Entire Document
10/16/2004	Revised/Updated Entire Document
10/01/2003	Codes Revised/Added/Deleted
08/01/2003	Revised/Updated Entire Document
05/01/2000	Codes Revised/Added/Deleted
01/01/2000	Codes Revised/Added/Deleted
09/01/1999	Codes Revised/Added/Deleted
04/01/1999	Codes Revised/Added/Deleted
05/01/1996	Codes Revised/Added/Deleted
10/01/1994	Codes Revised/Added/Deleted
10/01/1992	Codes Revised/Added/Deleted
07/01/1992	Codes Revised/Added/Deleted
01/01/1992	Codes Revised/Added/Deleted
05/01/1990	New Medical Document