APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

Cardiac Computed Tomography (CT) Angiography

Policy Number: HS-022

Original Effective Date: 5/15/2008


Easy Choice Health Plan, Inc.
Harmony Health Plan of Illinois, Inc.
Missouri Care, Inc.
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CARDIAC COMPUTED TOMOGRAPHY
(CT) ANGIOGRAPHY
HS-022

DISCLAIMER

The Clinical Coverage Guideline is intended to supplement certain standard WellCare benefit plans. The terms of a member’s particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member’s benefit plan may contain specific exclusions related to the topic addressed in this Clinical Coverage Guideline. When a conflict exists between the two documents, the Member’s Benefit Plan always supersedes the information contained in the Clinical Coverage Guideline. Additionally, Clinical Coverage Guidelines relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any. Note: The lines of business (LOB) are subject to change without notice; consult www.wellcare.com/Providers/CCGs for list of current LOBs.

BACKGROUND

Coronary artery disease (CAD), also called coronary heart disease (CHD), is the most common cardiac disorder and the leading cause of death in the United States. Approximately 17 million people have CAD and CAD accounts for more than 650,000 deaths annually. A diagnosis of CAD is generally made when there is least one high-grade stenosis in the coronary tree; patients may or may not be symptomatic. A diagnosis of CAD is generally indicated if there is presence of at least one high-grade stenosis in the coronary tree. In general, symptoms include chest pain (angina), dizziness or light-headedness, rapid or irregular heartbeats, and shortness of breath. Some patients, however, may not present with symptoms. To diagnose and treat the disorder effectively, many experts consider that the development of accurate cardiac imaging techniques is critical. Current techniques used to detect and diagnose CAD include but are not limited to:

- **Stress tests**: Comparison of blood flow with and without exercise
- **Echocardiograms combined with stress tests and nuclear ventriculography**: High-resolution visualization of the heart using radioactive tracers
- **Coronary angiography (CAG)**: Invasive visualization of blood flow through the arteries using contrast material
- **Electron-beam computed tomography (EBCT)**: Detects calcium within vessel walls
- **Intravascular ultrasound (IVUS)**: Visualization of arteries using sound waves
- **Magnetic resonance angiography (MRA)**: Magnetic fields and radio waves used to view arteries

To diagnose and treat the disorder effectively, the development of accurate cardiac imaging techniques is critical. Modalities for detecting and diagnosing CAD include but are not limited to stress tests, echocardiograms combined with nuclear ventriculography, coronary angiography (CAG), electron-beam computed tomography (EBCT), intravascular ultrasound (IVUS), and magnetic resonance angiography (MRA). Multislice computed tomography (MSCT) is also known as multidetector computed tomography (MDCT), multidetector-row computed tomography (MDCT), and multissection computed tomography. As early as 2001, MSCT has been investigated as a viable tool for diagnosing CAD. MSCT is noninvasive and is currently the standard procedure used in several imaging applications. The MSCT scanner generates multiple cross-sectional images at a very fast rate. During the last 2 years, aggressive advancements in MSCT have moved this technology to the verge of being useful for diagnosing CAD. There have been improvements in temporal resolution, spatial resolution, and speed of volume coverage (from 4 slices through 64 slices).

There is sufficient evidence in the peer-reviewed scientific literature supporting the use of noninvasive multidetector-row computed tomography angiography (CTA) as a vascular imaging technique that can be performed rapidly and safely for the assessment of many vascular diseases. Studies have demonstrated the high degree of accuracy of CTA compared to invasive angiography for imaging of vessels of the head, neck, thorax and abdomen. CTA is indicated for patients with suspected congenital anomalies of coronary circulation or great vessels. CTA has shown comparable diagnostic accuracy to DSA in the detection of pulmonary embolism. Also, CTA was shown to be at least as good as DSA in imaging peripheral vascular disease.

Also, there is sufficient evidence in the peer-reviewed scientific literature to support the use of 64-slice CTA as an adjunct to other testing as medically indicated in a specific cardiac population subset with intermediate pretest probability of coronary artery disease (CAD). Physicians should utilize established methods of determining risk/probability of CAD (e.g., ACC/AHA Multiple-Risk-Factor Assessment [Age, Gender, and Symptoms] Framingham Risk Score calculation). The literature regarding CTA performed on a multidetector-row scanner with...
less than 64 slices is not consistent, as is 64-slice literature in demonstrating high accuracy for the detailed diagnosis of CAD. Because of improved spatial and temporal resolution, 64-slice provides improvement in the assessable segments and inclusion of more distal branches for analysis. However, current literature does not provide sufficient evidence to support a role for CTA in any other CAD population. The literature does not support its use as a screening tool.

Although definitive patient selection criteria have not been established, there is evidence to support the use of MSCT as a triage tool to rule out CAD in symptomatic patients with no history of CAD and who are at low risk for CAD to decide whether patients should be referred for invasive CAG. There is some evidence to suggest that high body mass index (BMI) and calcium scores affect the diagnostic accuracy of MSCT. Generally, patients must be able to tolerate iodinated contrast media and beta-blockers, have sinus rhythm, and be able to hold their breath for at least 12 seconds.

Chest Pain Syndrome and Acute Chest Pain (Angina)

Determination of CT angiogram use is dependent on several factors including whether the patient is presenting with Chest Pain Syndrome or acute chest pain (angina). (Note: see policy for exact use of these determinations). Chest Pain Syndrome is defined by the American College of Cardiology as “any constellation of symptoms that the physician feels may represent a complaint consistent with obstructive CAD. Examples of such symptoms include, but are not exclusive to: chest pain, chest tightness, burning, dyspnea, shoulder pain, and jaw pain.” Namely, the definition of the syndrome includes pain that is not localized to the chest area. Upon determination of the presence of symptoms consistent with obstructive CAD, pre-test probability of CAD should be determined.

According to the ACC, angina can be classified into two types: 1) typical, (definite) and 2) atypical (probable). Typical angina is defined as a) substernal chest pain or discomfort that is b) provoked by exertion or emotional stress and can c) be relieved by rest and/or nitroglycerin. Atypical angina is chest pain or discomfort that lacks one of the characteristics of typical angina. Angina can also be defined as acute chest pain, localized to the substernal region. Lastly, non-anginal chest pain is chest pain or discomfort that meets one or none of the typical angina characteristics.

During the pre-test evaluation period a patient can be considered asymptomatic (presenting with no symptomatology of CAD) or symptomatic (presenting with symptoms consistent with CAD). This symptom grading is essential to the proper pre-test evaluation of the patient and determines whether a CT angiogram should be performed. The pre-test probability of Coronary Artery Disease in symptomatic members should be determined before CT angiography or any other cardiac assessment is performed. Pre-test probability of CAD is determined by analyzing factors such as age, gender, and symptoms. These factors are analyzed using a matrix style grid (see adapted table below).

<table>
<thead>
<tr>
<th>Table B1</th>
<th>Pre-Test Probability of CAD by Age, Gender, and Symptom*</th>
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<tbody>
<tr>
<td><strong>Age (yrs)</strong></td>
<td><strong>Gender</strong></td>
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<td>------------</td>
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<tr>
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<td></td>
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</tr>
<tr>
<td>20–39</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
</tbody>
</table>

*High: Greater than 90th pre-test probability; Intermediate: Between 10th and 90th pre-test probability; Low: Between 5th and 20th pre-test probability; Very Low: Less than 5th pre-test probability. Pre-test probability may estimate the difference between patients less than 60 years or greater than 60 years, but it can be assumed that prevalence of CAD increases with age. In a few cases, patients with ages at the extremes of the decade fitted may have probabilities slightly outside the high or low range.

Reproduced with permission from ACC/AHA 2002 Guideline Update for Exercise Testing (11).
The multi-detector helical computed tomography (MDCT) technology requires thin (up to 1 mm) slices, 0.5 to 0.75 mm reconstructions, multiple simultaneous images (e.g., 16, 32, 64 or more slices), and cardiac gating (often requiring beta blockers for ideal heart rate). There is significant post-processing, depending on the number of slices per second for image generation. For coronary artery imaging, the resulting images show a high correlation with stenotic lesions noted on diagnostic cardiac catheterization but more importantly, with atheromas on intracoronary ultrasound. Current available body of evidence demonstrates that CCTA can reliably rule out the presence of significant coronary artery disease (CAD) in patients with a low to intermediate probability of having CAD and can reliably achieve a high degree of diagnostic accuracy and technical performance necessary to replace conventional angiography. In some circumstances, CCTA may be proposed instead of, or in addition to, other noninvasive cardiac tests. This is particularly useful in the commonly encountered clinical scenario of patients having an equivocal stress myocardial perfusion test. The information from CCTA may be used to guide further diagnostic evaluation and/or appropriate therapy (e.g., revascularization versus medical management) and this may over the long term influence the morbidity from CAD.

**POSITION STATEMENT**

**Applicable To:**
- Medicaid – Florida, Georgia, Hawaii, Kentucky
- Medicare – Easy Choice Health Plan, Florida, Georgia, Hawaii, Kentucky

For markets noted below, please refer to Care Core Radiology / Imaging available at www.wellcare.com/provider/CCGs.

- Medicaid – Illinois, Missouri, New Jersey, New York, South Carolina
- Medicare – Connecticut, Illinois, Louisiana, New Jersey, New York, Ohio, Texas, Windsor

WellCare considers Cardiac Computed Tomography/Computed Tomography Angiography (CCTA) A/B/C (including calcium scoring when appropriate) **medically necessary** for any (ONE) of the following indications:

1. Evaluation of Chest Pain Syndrome in patients with *intermediate* pre-test probability of CAD and an uninterpretable ECG or inability to exercise. When the recurrence of symptoms in patients with known coronary artery disease may be related to progression/exacerbation of underlying disease. The use of CCTA in this setting would be to evaluate the extent of previously diagnosed coronary artery disease. Patients with known disease may have had remote invasive angiography and/or stress testing to evaluate prior events or symptoms. New or recurrent symptoms may relate to a change in the coronary anatomy that can be assessed with CCTA.4,5

2. Evaluation of Chest Pain Syndrome in patients with an uninterpretable or equivocal stress test (exercise, perfusion, or stress echo). A noninvasive coronary anatomic test (CCTA) allows an alternate method of assessing the coronary arteries, which would limit the number of negative invasive coronary angiograms.4,5

3. Evaluation of Acute Chest Pain in patients determined to be at *intermediate* pre-test probability of CAD with no ECG changes and serial enzymes are negative. The test may be medically necessary in patients presenting to the emergency room with complaints consistent with cardiac ischemia, but without diagnostic electrocardiography (ECG) or enzymes. The test may be considered medically necessary in patient's status post revascularization procedures who present with recurrent symptoms not clearly identifiable as ischemic. CCTA may be used in lieu of an imaging stress test for patient's presenting with chest pain syndrome. Clinicians must have a high degree of suspicion that CAD is high on the differential diagnosis of the symptoms.4,5,6


5. Assessment of complex congenital heart disease including anomalies of coronary circulation, great vessels, and cardiac chambers and valves. The cross-sectional nature of the technique allows one to determine
accurately both the presence and possible future harm that could result from the anomaly; it is often used after an anomaly has been identified following a different test such as prior invasive coronary angiogram. CCTA is also used to decide if surgery is indicated and for surgical planning.  

7. Evaluation of suspected aortic dissection or thoracic aortic aneurysm.*
8. Evaluation of suspected pulmonary embolism.*
9. Evaluation of cardiac mass (suspected tumor or thrombus) or pericardial conditions (pericardial mass, constrictive pericarditis, or complications of cardiac surgery) following echocardiogram, MRI, or TEE resulting in technically limited images.
10. Evaluation of pulmonary vein anatomy prior to invasive radiofrequency ablation for atrial fibrillation. Pulmonary vein catheter ablation can isolate electrical activity from the pulmonary veins and allow for the elimination of recurrent atrial fibrillation. The presence of a pulmonary venous anatomic map may help eliminate procedural complications and allow for the successful completion of the procedure.  

11. Noninvasive coronary vein mapping prior to placement of biventricular pacemaker.
12. Noninvasive coronary arterial mapping, including internal mammary artery prior to repeat cardiac surgical revascularization.
13. The patient undergoing non-coronary artery cardiac surgery. Certain patients who have non-coronary artery cardiac surgery (valve or ascending aortic surgery) may need a pre-operative invasive coronary angiogram. The surgical planning may also depend upon the exact location of the coronary arteries. The rationale for the use of CCTA in these patient subsets is to avoid potentially unnecessary invasive testing and still provide appropriate pre-surgical information.  

14. When patients with prior bypass surgery or intracoronary artery stent placement present with chest pain or dyspnea. Coronary bypass grafts are relatively well seen with CCTA. The rationale for CCTA would be to determine the patency and severity of possible graft stenoses that may be the source of chest pain. Patients with prior intracoronary stents often present with recurrent chest pain. The rationale for a CCTA as an alternative to invasive angiography is to rule out in-stent restenosis as the cause of symptoms. (Accurate assessment of in-stent restenosis may be limited by the artifact caused by the stent material itself and the quality of the scan and scanner).  

WellCare considers all other indications for Computed Tomography Angiography, Cardiac Computed Tomography, or Calcium Scoring not medically necessary as there are other diagnostic procedures available, and the American College of Cardiology has determined that the appropriateness of this technology in evaluating these other indications is either inappropriate or uncertain.

Notes
A. For CT angiography, patients are assumed not to present with any of the following:
   a. Irregular rhythm (e.g., atrial fibrillation/flutter, frequent irregular premature ventricular contractions or premature atrial contractions, and high grade heart block);
   b. Very obese patients, body mass index greater than 40 kg/m2;
   c. Renal insufficiency, creatinine greater than 1.8 mg/dL;
   d. Heart rate greater than 70 beats/min refractory to heart-rate-lowering agents (e.g., a combination of beta-blocker and calcium-channel blocker);
   e. Metallic interference (e.g., surgical clips, pacemaker, and/or defibrillator wires, or tissue expander).

B. For CT angiography, patients must be able to:
   a. Hold still;
   b. Follow breathing instruction;
   c. Take nitroglycerin (for performing coronary CT angiography only);
   d. Take iodine in spite of steroid prep for contrast allergy;
   e. Lift both arms above the shoulders.

C. Cardiac computed tomography imaging equipment and personnel are available that have the minimal technical capabilities required for the indication (the number of detector rows, spatial and temporal resolution, and acquisition protocols).  
* Non-gated CT angiogram which has a sufficiently large field of view for these specific indications.
Limitations

a. Test is never covered for screening, i.e., in the absence of signs, symptoms or disease.

b. Test will be considered not medically necessary if the anticipated results are not expected to provide new, additional information to that already previously obtained from other tests (such as stress myocardial perfusion images or cardiac ultrasound). New or additional information should facilitate the management decision, not merely add a new layer of testing.

c. Test may be denied, on post-pay review, as not medically necessary when used for cardiac evaluation of a patient where there is a pre-test knowledge of sufficiently extensive calcification of the coronary segment in question that would diminish the interpretive value.

d. Test will be considered not medically necessary if it is anticipated that the patient would require invasive cardiac angiography for further diagnosis or for therapeutic intervention. (e.g., angina decubitus, unstable angina, Prinzmetal angina, etc.).

e. Test may be denied, on post-pay review, as not medically necessary when used for cardiac evaluation if there were pre-test knowledge of sufficiently extensive calcification of the suspect coronary segment that would diminish the interpretive value.

f. Administration of beta blockers and the monitoring of the patient during MDCT/CCTA by a physician experienced in the use of cardiovascular drugs is included as part of the test and is not a separately payable service.

g. Studies must be ordered by the physician/qualified non-physician practitioner treating the patient and who will use the results of the test in the management of the patient.

h. For contrast enhanced examinations a physician must be present for direct supervision during testing similar to the stress myocardial perfusion imaging.

i. Test must be performed under the direct supervision of a physician.

j. LCD does not address electron beam tomography (EBT) technology or Ultrafast CT for coronary artery examination. There is no extension of coverage of EBT based on this policy.

k. Quantitative calcium scoring (CPT code 0144T for dates of service prior to 01/01/2010, and CPT 75571 on or after 01/01/2010) is not a covered service and will be denied as not medically necessary. Calcium scoring reported in isolation is considered a screening service. When performed in association with CT angiography, there is neither separate nor additional included reimbursement for the calcium scoring.

l. Selection of the test should be made within the context of other testing modalities such as stress myocardial perfusion images or cardiac ultrasound result so that the resulting information facilitates the management decision, not merely adds a new layer of testing.

m. Coverage of this modality for coronary artery assessment is limited to devices that process thin, high resolution slices (1 mm or less). The multi-detector scanner must have at least 64 slices per rotation capability.

n. Administration of beta blockers and the monitoring of the patient during CCTA by a physician experienced in the use of cardiovascular drugs are included and are not separately payable services.

o. Atrial fibrillation by itself is not an indication; atrial fibrillation with planned ablation therapy is allowed.

p. CPT code 75571: Quantitative evaluation of coronary calcium by CCT (separate payment), EBCT or other technology (CPT code 75571) is not covered.

CODING

Covered CPT® Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>75571</td>
<td>Computed Tomography, Heart, without contrast material, with quantitative evaluation of coronary calcium</td>
</tr>
<tr>
<td>75572</td>
<td>Computed Tomography, Heart, with contrast material for evaluation of cardiac structure and morphology (including 3D Image post processing, assessment of cardiac function, and evaluation of venous structures, if performed)</td>
</tr>
<tr>
<td>75573</td>
<td>Computed Tomography, Heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of Congenital Heart Disease (including 3D image post processing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)</td>
</tr>
<tr>
<td>75574</td>
<td>Computed Tomographic Angiography, Heart, Coronary Arteries and Bypass Grafts (when present),</td>
</tr>
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with contrast material, including 3D Image post processing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed.)

**HCPCS Level II Codes** - No applicable codes.

**Covered ICD-9 Procedure Code**
87.42  CT Angiography – Cardiac Computed Tomography

**Covered DRAFT ICD-10-PCS Codes**
BW03ZZZ  Plain Radiography of chest

**Covered ICD-9 Diagnosis Codes**
Note: It is not enough to link the procedure code to a correct, payable ICD-9-CM code. The diagnosis or clinical signs/symptoms must be present for the procedure to be paid.

- **402.00 - 402.91** Hypertensive Heart Disease
- **411.1** Intermediate Coronary Syndrome
- **412** Old Myocardial Infarction
- **413.0 - 413.9** Angina Pectoris
- **414.00 - 414.07** Other forms of chronic ischemic heart disease
- **414.10 - 414.19** Aneurysm of Heart (Wall) – Other Aneurysm of Heart
- **414.8** Other Specified Forms of Chronic Ischemic Heart Disease
- **414.9** Chronic Ischemic Heart Disease Unspecified
- **415.19** Other Pulmonary Embolism
- **420.0 - 420.99** Acute Pericarditis
- **424.3** Pulmonary Valve Disorders
- **427.31** Atrial Fibrillation
- **428.9** Heart Failure, unspecified
- **429.4** Functional disturbances following cardiac surgery
- **441.00 - 441.9** Aortic Aneurysm and Dissection
- **444.0 - 444.9** Arterial Embolism and thrombosis
- **745.0 - 745.9** Bulbus cordis anomalies and anomalies of cardiac septal closure
- **746.00 - 746.9** Other Congenital Anomalies of Heart
- **747.40 - 747.49** Congenital Anomalies of great veins
- **786.05** Shortness of Breath
- **786.50** Unspecified Chest Pain
- **786.51** Precordial Pain
- **786.59** Other Chest Pain
- **794.30** Unspecified Abnormal Function Study of Cardiovascular System
- **794.31** Nonspecific Abnormal Electrocardiogram (ECG) (EKG)

**Covered Draft ICD-10-CM Diagnosis Codes**

- **A18.84** Tuberculosis of heart
- **I11.0** Hypertensive heart disease with heart failure
- **I11.9** Hypertensive heart disease with heart failure
- **I13.11** Hypertensive heart and chronic kidney disease w/o heart failure, with stage 5 CKD, or ESRD
- **I20.0 - I20.9** Angina pectoris
- **I25.10 - I25.9** Chronic ischemic heart disease
- **I26.01 - I26.99** Pulmonary embolism
- **I30** Other forms of pericarditis
- **I32** Pericarditis in diseases classified elsewhere
- **I37.0 - I37.9** Nonrheumatic pulmonary valve disorders
- **I48.0** Paroxysmal atrial fibrillation
- **I50.9** Heart Failure, unspecified
- **I71.00 - I71.9** Aortic aneurysm and dissection

Clinical Coverage Guideline
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<th>Description</th>
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<tr>
<td>I74</td>
<td>Embolism and thrombosis</td>
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<tr>
<td>I79.0</td>
<td>Aneurysm of aorta in diseases classified elsewhere</td>
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<tr>
<td>I97.0 - I97.191</td>
<td>Intraoperative &amp; postprocedural complications and disorders of circulatory system, NEC</td>
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<td>M32.12</td>
<td>Pericarditis in systemic lupus erythematos</td>
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<td>Q20.0 - Q26.9</td>
<td>Congenital malformation of the circulatory system</td>
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<td>R06.02</td>
<td>Shortness of breath</td>
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<td>R07.9</td>
<td>Chest pain, unspecified</td>
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<td>R07.2</td>
<td>Precordial pain</td>
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<tr>
<td>R07.89</td>
<td>Other chest pain</td>
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<tr>
<td>R94.30</td>
<td>Abnormal result of a cardiovascular function study, unspecified</td>
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<tr>
<td>R94.31</td>
<td>Abnormal electrocardiogram [ECG] [EKG]</td>
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**REFERENCES**


**MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS**

<table>
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<th>Action</th>
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<tr>
<td>7/11/2015</td>
<td>Approved by MPC. No changes.</td>
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<td>8/7/2014</td>
<td>Approved by MPC. Included information from CMS LCDs.</td>
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<tr>
<td>8/9/2013</td>
<td>Reinstated for markets where CareCore is not a vendor.</td>
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<tr>
<td>12/1/2011</td>
<td>New template design approved by MPC.</td>
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