



# CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all health benefit plans administered by CIGNA Companies including plans formerly administered by Great-West Healthcare, which is now a part of CIGNA.

**Subject** Ultrasound Screening for Abdominal Aortic Aneurysms

**Effective Date** ..... 5/15/2010  
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**Coverage Policy Number** ..... 0341

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## Hyperlink to Related Coverage Policies

Endovascular Repair of Abdominal Aortic Aneurysms

### INSTRUCTIONS FOR USE

Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document **always supercedes** the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. Proprietary information of CIGNA. Copyright ©2011 CIGNA

## Coverage Policy

Some benefit plans exclude coverage for preventive health services. Please refer to specific plan language to determine the terms, conditions and limitations of coverage.

If coverage for preventive health services is available, CIGNA covers as medically necessary a one-time screening for abdominal aortic aneurysm (AAA) by ultrasonography in men aged 65 to 75 who have ever smoked.

**Note:** This Coverage Policy does not preclude coverage for periodic ultrasound surveillance of patients with known abdominal aortic aneurysms.

## General Background

An aneurysm consists of focal enlargement of the aorta to at least 1.5 times its normal size, with involvement of all three layers of the arterial wall. Aneurysms are subject to rupture due to wall tension, which is determined by the arterial pressure within the aneurysm and the radius of the aneurysm. Abdominal aortic aneurysms (AAAs), located in the abdominal aorta below the kidneys (i.e., infrarenal), are much more common than thoracic aortic aneurysms and are potentially life-threatening. Up to 50% of patients with untreated AAAs will die of rupture within five years. Men are 4–5 times more likely than women to develop an AAA and are 10 times more likely to have an AAA of 4 cm or greater in diameter, although some studies suggest that women have a higher risk of aneurysm rupture than men. Smoking is the risk factor most strongly linked to AAA. Age is also an important risk

factor, with the incidence of AAA increasing rapidly after age 55 in men and 70 in women. Hypertension, hyperlipidemia and atherosclerosis are also risk factors. Patients with family histories of AAA are at increased risk as well, with aneurysms occurring at a younger age and with greater likelihood of rupture. AAAs are responsible for approximately 9000 deaths in the United States each year, with most occurring in men over age 65 (Fleming, et al., 2005).

Ultrasound of the abdomen has been shown to be an effective and reliable method of detecting AAAs. When an individual is found to have an AAA  $\geq 5.5$  cm, immediate surgical repair is warranted provided the patient is appropriate for surgery. Surgical AAA repair, however, is associated with significant risk, including operative mortality, myocardial infarction, respiratory and renal failure, and changes in functional status (Fleming, et al., 2005). Periodic surveillance appears reasonable for those with 3.0-3.9 cm AAAs, which have a very low risk of rupture. Screening is defined as the search for disease in people without symptoms, while surveillance is considered to be the screening of individuals known to be at an increased risk. The sensitivity of ultrasound scanning for an AAA is 95%, the specificity is close to 100%, and the test is reliable and reproducible (Fleming, et al., 2005). A physical examination may also detect AAAs, in particular those large enough to warrant surgery; however, physical examination may not be a suitable for population screening due to high false positive and false-negative rates. Other imaging modalities, such as computed tomography and magnetic resonance imaging, are also accurate and reliable for assessing aortic size, but are not as available as ultrasound imaging (Fleming, et al., 2005).

### **Literature Review**

In 2005, on the basis of new evidence, a systematic review and meta-analysis was conducted by investigators from the Oregon Evidence-Based Practice Center in collaboration with the USPSTF and the Agency for Healthcare Research and Quality (AHRQ) (USPSTF, 2005; Fleming, et al., 2005). The investigators reviewed the results of four population-based screenings published since 1996: the Multicentre Aneurysm Screening Study (MASS) (Ashton, et al., 2002), from the United Kingdom; the Chichester, United Kingdom, screening study (Scott, et al., 1995; Scott, et al., 2002; Vardulaki, et al., 2002); the Viborg County, Denmark, screening study (Lindholt, et al., 2002); and the Western Australia screening study (Norman, et al., 2004). These four randomized, controlled trials were the basis for the USPSTF revised recommendations for screening for AAA published in 2005. These trials included more than 125,000 total participants. No data were provided on race or ethnicity, and only the Chichester study included women. All trials were rated as good or fair quality according to the USPSTF rating criteria, and outcomes at 4–5 years of follow-up were considered for all trials.

The USPSTF found good evidence that screening for AAA and surgical repair of large AAAs (5.5 cm or larger) in men ages 65–75 who have ever smoked leads to an estimated 43% reduction in AAA-specific mortality. A history of ever smoking was defined in the surveys as 100 cigarettes in a person's lifetime. They also found that abdominal ultrasonography, performed in a setting with adequate quality assurance, such as in an accredited facility with credentialed technologists, is an accurate screening test for AAA. The USPSTF report stated that there is also good evidence of important harms associated with AAA screening and early treatment, including short-term psychological harms and an increased number of surgeries with clinically significant morbidity and mortality. Based on the moderate magnitude of net benefit, the task force concluded that the benefits of screening for AAA in men ages 65–75 who have ever smoked outweighed the harms and supports the recommendation of one-time screening for AAA by ultrasonography in men ages 65–75 who have ever smoked.

The USPSTF found good evidence that screening for AAA in men ages 65–75 who have never smoked in this group leads to decreased AAA-specific mortality; however, there is a lower prevalence of large AAAs in men who have never smoked compared to those who have smoked, so the potential benefit from screening is small. The task force concluded that the balance between the benefits and harms of screening in this population is too close to make a general recommendation. The USPSTF found that in women the prevalence of large AAAs in women is low, and the number of AAA-related deaths that can be prevented is small which led to conclusion that the harms of screening women for AAA outweigh the benefits. The USPSTF stated, however, that clinicians must individualize recommendations according to a patient's risk and likelihood of benefit and that screening may be indicated in male nonsmokers nearing age 65 or female smokers in their early 70s with a first-degree family history of AAA that required surgery.

The USPSTF found that for most men, 75 years may be considered the upper age limit for screening, since patients in general cannot benefit from screening and subsequent surgery unless they have a reasonable life expectancy. The increased prevalence of comorbidities in patients over age 75 decreases the likelihood of any

benefit from screening. The USPSTF stated in its recommendations that one-time screening is sufficient and that there is negligible benefit from repeat screening of patients who have normal aortic diameters on initial screening. The task force reported that, for men with intermediate-sized AAAs (i.e., 4.0–5.4 cm), periodic surveillance provides mortality benefit comparable to that of routine elective surgery, with the added benefit of fewer operations. They reported that, though there is no evidence to support the effectiveness of any intervention in those with small AAAs (i.e., 3.0–3.9 cm), there are recommendations based on expert opinion that favor periodic repeat ultrasonography for these patients.

Lindholt et al. (2006) published additional follow-up data on the Viborg County trial, described above. During a ten-year period, screening for AAA in Viborg County reduced the average frequency of emergency operations by 68% and reduced mortality from AAA by 73% in the screened group compared to the control group. The authors concluded that the study supports a substantial long-term benefit of screening for AAA. Another follow-up study by Lindholt et al. (2007) evaluated whether screening for AAA could be restricted to men with cardiovascular diseases and chronic obstructive pulmonary disease (COPD), conditions that are associated with AAA. Limiting screening to high-risk men with COPD and/or other cardiovascular diseases would have reduced the number of patients screened by 73% but at a cost of missing 52% of the AAAs in the overall population. Screening decreased mortality among men with and without known COPD or cardiovascular disease.

Kim et al. (2007) evaluated the longer-term mortality benefit and cost effectiveness of ultrasound AAA screening in a follow-up of the MASS study, one of four studies used to develop the USPSTF recommendations discussed above. A total of 67,770 men were randomly assigned to screening (n=33,887) or to a control group of standard medical care (n=33,883). Of those assigned to screening, 27,204 attended and 1334 AAAs were identified. The mean age at randomization was 69.2 in both groups. The hazard ratio was 0.53 (95% confidence interval [CI], 0.42–0.68) for AAA-related mortality in the group invited to screening. At the seven-year follow-up, the rupture rate in men with normal results on the initial ultrasound remained low, at 0.54 ruptures (CI 0.25–1.02 ruptures) per 10,000 person-years. The observed hazard ratio for all-cause mortality was 0.96 (CI 0.93–1.0). The authors stated that the mortality benefit of screening that had been observed at four years was maintained at seven years. The group invited to screening had approximately half the risk, and those who attended screening demonstrated an even greater risk reduction. The rates for AAA mortality diverged at a constant rate after one year, and the life-years gained were therefore substantially greater for years 5–7 than for years 1–4.

In 2009, Thompson et al. reported on 10 year mortality and cost effectiveness results from the above-noted MASS study. Over 10 years 155 deaths related to AAA (absolute risk 0.46%) occurred in the invited group and 296 (0.87%) in the control group (relative risk reduction 48%, 95% CI 37–57%). It was noted that the degree of benefit seen in earlier years of follow-up was maintained in later years. The authors concluded that the mortality benefit of AAA screening men aged 65–74 is maintained up to 10 years and cost effectiveness becomes more favorable over time. The study also indicated that rescreening of those originally screened as normal is not justified.

The Peoria Regional Outpatient Medical Imaging Study (Project PROMIS), a prospective, population-based study of ultrasound AAA screening, was conducted from July 2004 to December 2006 (Chiou et al., 2008). The primary objective was to identify patients with unknown AAA and to identify the associated risk factors. Patients were recruited through media and advertising outlets, and completed questionnaires regarding pertinent medical history with a focus on AAA risk factors. A total of 979 patients (n=672 male; n=307 female) were included in the final analysis. The overall incidence of AAA was 2.8% (27 patients) of the total population. AAA was found only in male patients age 60 or older (4% of the male population). Aneurysm size ranged from three to ten centimeters. Of the patients diagnosed with AAA, 85% were current or past smokers, and 70% had hypercholesterolemia. The AAA incidence in male smokers  $\geq$  60 years old with hypercholesterolemia was 6%.

Cosford and Leng (2007) conducted a Cochrane systematic review of randomized controlled trials of population screening for AAA. The four trials that met the inclusion criteria were MASS, Viborg, Chichester, and Western Australia studies. These are the same studies included in the systematic review and meta-analysis, described above, on which the USPSTF recommendations are based. The authors concluded that there is evidence of a significant reduction in mortality from AAA in men aged 65–79 years who undergo ultrasound screening. There is insufficient evidence to demonstrate benefit in women. The most significant gap in the current research, according to the authors, is the balance of benefits and harms in women, and this should be the focus for further research. The psychological effect of screening on patients and their partners also needs additional study. The authors commented that there is a question of how far and how fast positive effects of screening can be

generalized outside of centers that have developed special expertise in performing the procedure over many years.

### Professional Societies/Organizations

**American College of Cardiology (ACC)/American Heart Association (AHA):** These organizations published guidelines for the management of patients with peripheral arterial disease that states that multiple studies suggest that ultrasound is an appropriate means to determine the presence or absence of an infrarenal aortic aneurysm in more than 95% of candidates, with specificity at nearly 100% and sensitivity ranging from 92%–99%. The guideline also states that the reproducibility and intraobserver variability of ultrasound measurements are quite satisfactory and similar to those for computed tomographic (CT) scanning, and that ultrasound is an excellent tool for screening and surveillance for individual patients and for screening programs (Hirsch, et al., 2005).

**Society for Vascular Surgery (SVS):** This organization published a position statement on vascular screening. The statement includes the following recommendations regarding AAA screening (SVS, 2010; Chaikof, et al., 2009):

- One-time ultrasound screening for AAA is recommended for all men at or older than 65 years. Screening men as early as 55 years is appropriate for those with a family history of AAA
- One-time ultrasound screening for AAA is recommended for all women at or older than 65 years with a family history of AAA or who have smoked.
- Re-screening patients for AAA is not recommended if an initial ultrasound scan performed on patients 65 years of age or older demonstrates an aortic diameter of less than 2.6 cm.

**U.S. Preventive Services Task Force (USPSTF):** In 2005, the USPSTF published evidenced-based recommendations on screening for abdominal aortic aneurysm. The recommendations include the following (USPSTF, 2005; Fleming, et al., 2005):

- Recommends one-time screening for abdominal aortic aneurysm (AAA) by ultrasonography in men aged 65 to 75 who have ever smoked.
- No recommendation for or against screening for AAA in men aged 65 to 75 who have never smoked.
- Recommends against routine screening for AAA in women.

### Summary

Ultrasound of the abdomen has been shown to be an effective and reliable method of detecting abdominal aortic aneurysms (AAAs). There is substantial evidence that one-time screening for AAA and surgical repair of large AAAs (i.e., 5.5 cm or larger) in men ages 65–75 who have ever smoked leads to an estimated 43% reduction in AAA-specific mortality. One-time ultrasound screening for AAA may also be indicated for other high-risk populations, including male nonsmokers nearing age 65 with a family history of AAA, and female smokers age 70 or older with a family history of AAA.

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## Coding/Billing Information

**Note:** This list of codes may not be all-inclusive.

**Covered when medically necessary:**

CPT* Codes	Description
76700	Ultrasound, abdominal, real time with image documentation; complete
76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)
76770	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete
76775	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited

HCPCS Codes	Description
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G0389	Ultrasound B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening
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ICD-9-CM Diagnosis Codes	Description
V15.82	Personal history of tobacco use presenting hazards to health
V81.2	Screening for other and unspecified cardiovascular conditions

**\*Current Procedural Terminology (CPT®) © 2010 American Medical Association: Chicago, IL.**

## References

1. Ashton HA, Buxton MJ, Day NE, Kim LG, Marteau TM, Scott RA, et al.; Multicentre Aneurysm Screening Study Group. The Multicentre Aneurysm Screening Study (MASS) into the effect of abdominal aortic aneurysm screening on mortality in men: a randomised controlled trial. *Lancet*. 2002 Nov 16;360(9345):1531-9.
2. Ashton HA, Gao L, Kim LG, Druce PS, Thompson SG, Scott RA. Fifteen-year follow-up of a randomized clinical trial of ultrasonographic screening for abdominal aortic aneurysms. *Br J Surg*. 2007 Jun;94(6):696-701.
3. Brady AR, Thompson SG, Fowkes FG, Greenhalgh RM, Powell JT; UK Small Aneurysm Trial Participants. Abdominal aortic aneurysm expansion: risk factors and time intervals for surveillance. *Circulation*. 2004 Jul 6;110(1):16-21. Epub 2004 Jun 21.
4. Centers for Medicare and Medicaid Services (CMS). CMS Manual System. Implementation of an ultrasound screening for abdominal aortic aneurysms (AAA). Accessed March 30, 2010. Available at URL address: <http://www.cms.hhs.gov/Transmittals/downloads/R1113CP.pdf>
5. Chaikof EL, Brewster DC, Dalman RL, Makaroun MS, Illig KA, Sicard GA; Society for Vascular Surgery. The care of patients with an abdominal aortic aneurysm: the Society for Vascular Surgery practice guidelines. *J Vasc Surg*. 2009 Oct;50(4 Suppl):S2-49.
6. Cosford PA, Leng GC. Screening for abdominal aortic aneurysm. *Cochrane Database Syst Rev*. 2007 Apr 18;(2):CD002945.
7. Dynda DI, Andrews JA, Chiou AC, DeBord JR. Project PROMIS: Peoria Regional Outpatient Medical Imaging Study. *Am J Surg*. 2008 Mar;195(3):322-7.
8. Eckstein HH, Böckler D, Flessenkämper I, Schmitz-Rixen T, Debus S, Lang W. Ultrasonographic screening for the detection of abdominal aortic aneurysms. *Dtsch Arztebl Int*. 2009 Oct;106(41):657-63.
9. Fleming C, Whitlock EP, Beil TL, Lederle FA. Screening for abdominal aortic aneurysm: a best-evidence systematic review for the U.S. Preventive Services Task Force. Rockville MD: Agency for Healthcare Research and Quality (AHRQ); 2005. Accessed March 30, 2010. Available at URL address: <http://www.ahrq.gov/clinic/uspstf05/aaascr/aaarev.htm>
10. Hirsch AT, Haskal ZJ, Hertzner NR, Bakal CW, Creager MA, Halperin JL, et al; American Association for Vascular Surgery; Society for Vascular Surgery; Society for Cardiovascular Angiography and Interventions; Society for Vascular Medicine and Biology; Society of Interventional Radiology; ACC/AHA Task Force on Practice Guidelines Writing Committee to Develop Guidelines for the Management of Patients With Peripheral Arterial Disease; American Association of Cardiovascular and Pulmonary Rehabilitation; National Heart, Lung, and Blood Institute; Society for Vascular Nursing; TransAtlantic Inter-Society Consensus; Vascular Disease Foundation. ACC/AHA 2005 Practice Guidelines for the management of patients with peripheral arterial disease (lower extremity, renal, mesenteric, and

abdominal aortic): a collaborative report from the American Association for Vascular Surgery/Society for Vascular Surgery, Society for Cardiovascular Angiography and Interventions, Society for Vascular Medicine and Biology, Society of Interventional Radiology, and the ACC/AHA Task Force on Practice Guidelines (Writing Committee to Develop Guidelines for the Management of Patients With Peripheral Arterial Disease): endorsed by the American Association of Cardiovascular and Pulmonary Rehabilitation; National Heart, Lung, and Blood Institute; Society for Vascular Nursing; TransAtlantic Inter-Society Consensus; and Vascular Disease Foundation. *Circulation*. 2006 Mar 21;113(11):e463-654.

11. Institute for Clinical Systems Improvement (ICSI) Health Care Guideline. Preventive services for adults. ICSI, 15<sup>th</sup> ed; 2009 Oct. Accessed March 30, 2010. Available at URL address: [www.icsi.org](http://www.icsi.org)
12. Isselbacher EM. Thoracic and abdominal aortic aneurysms. *Circulation*. 2005 Feb 15;111(6):816-28.
13. Kent KC, Zwolak RM, Jaff MR, Hollenbeck ST, Thompson RW, Schermerhorn ML, et al.; Society for Vascular Surgery; American Association of Vascular Surgery; Society for Vascular Medicine and Biology. Screening for abdominal aortic aneurysm: a consensus statement. *J Vasc Surg*. 2004 Jan;39(1):267-9.
14. Kim LG, Scott AP, Ashton HA, Thompson SG, for the Multicentre Aneurysm Screening Study Group. A sustained mortality benefit from screening for abdominal aortic aneurysm. *Ann Intern Med*. 2007 May 15;146(10):699-706. Erratum in: *Ann Intern Med*. 2007 Aug 7;147(3):216.
15. Lederle FA. Ultrasonographic screening for abdominal aortic aneurysms. *Ann Intern Med*. 2003 Sep 16;139(6):516-22. Review. Erratum in: *Ann Intern Med*. 2003 Nov 18;139(10):873.
16. Lederle FA, Wilson SE, Johnson GR, Reinke DB, Littooy FN, Acher CW, et al.; Aneurysm Detection and Management Veterans Affairs Cooperative Study Group. Immediate repair compared with surveillance of small abdominal aortic aneurysms. *N Engl J Med*. 2002 May 9;346(19):1437-44.
17. Lindholt JS, Juul S, Fasting H, Henneberg EW. High-risk and Low-risk Screening for Abdominal Aortic Aneurysm Both Reduce Aneurysm-related Mortality. A Stratified Analysis from a Single-centre Randomised Screening Trial. *Eur J Vasc Endovasc Surg*. 2007 Feb 27; [Epub ahead of print]
18. Lindholt JS, Juul S, Fasting H, Henneberg EW. Hospital costs and benefits of screening for abdominal aortic aneurysms. Results from a randomised population screening trial. *Eur J Vasc Endovasc Surg*. 2002 Jan;23(1):55-60.
19. Lindholt JS, Juul S, Fasting H, Henneberg EW. Preliminary ten year results from a randomised single centre mass screening trial for abdominal aortic aneurysm. *Eur J Vasc Endovasc Surg*. 2006 Dec;32(6):608-14. Epub 2006 Aug 8.
20. Lindholt JS, Juul S, Fasting H, Henneberg EW. Screening for abdominal aortic aneurysms: single centre randomised controlled trial. *BMJ*. 2005 Apr 2;330(7494):750. Epub 2005 Mar 9.
21. Norman PE, Jamrozik K, Lawrence-Brown MM, Le MT, Spencer CA, et al. Population based randomised controlled trial on impact of screening on mortality from abdominal aortic aneurysm. *BMJ*. 2004 Nov 27;329(7477):1259. Epub 2004 Nov 15. Erratum in: *BMJ*. 2005 Mar 12;330(7491):596.
22. Ogata T, MacKean GL, Cole CW, Arthur C, Andreou P, Tromp G, et al. The lifetime prevalence of abdominal aortic aneurysms among siblings of aneurysm patients is eightfold higher than among siblings of spouses: an analysis of 187 aneurysm families in Nova Scotia, Canada. *J Vasc Surg*. 2005 Nov;42(5):891-7.
23. Schermerhorn M, Zwolak R, Velazquez O, Makaroun M, Fairman R, Cronenwett J. Ultrasound screening for abdominal aortic aneurysm in medicare beneficiaries. *Ann Vasc Surg*. 2008 Jan;22(1):16-24. Epub 2007 Dec 4.

24. Scott RA, Bridgewater SG, Ashton HA. Randomized clinical trial of screening for abdominal aortic aneurysm in women. Br J Surg. 2002 Mar;89(3):283-5.
25. Scott RA, Vardulaki KA, Walker NM, Day NE, Duffy SW, Ashton HA. The long-term benefits of a single scan for abdominal aortic aneurysm (AAA) at age 65. Eur J Vasc Endovasc Surg. 2001 Jun;21(6):535-40.
26. Scott RA, Wilson NM, Ashton HA, Kay DN. Influence of screening on the incidence of ruptured abdominal aortic aneurysm: 5-year results of a randomized controlled study [abstract]. Br J Surg. 1995 Aug;82(8):1066-70.
27. Society for Vascular Surgery. SVS Statement on Vascular Screening. Updated January 2010. Accessed April 15, 2010. Available at URL address: <http://www.vascularweb.org/patients/screenings/screenings.html>
28. Spencer CA, Norman PE, Jamrozik K, Tuohy R, Lawrence-Brown M. Is screening for abdominal aortic aneurysm bad for your health and well-being? ANZ J Surg. 2004 Dec;74(12):1069-75.
29. Thompson SG, Ashton HA, Gao L, Scott RA; Multicentre Aneurysm Screening Study Group. Screening men for abdominal aortic aneurysm: 10 year mortality and cost effectiveness results from the randomised Multicentre Aneurysm Screening Study. BMJ. 2009 Jun 24;338:b2307. doi: 10.1136/bmj.b2307.
30. U.S. Preventive Services Task Force (USPSTF). Screening for abdominal aortic aneurysms: recommendation statement. Rockville, MD: Agency for Healthcare Research and Quality (AHRQ); 2005. Accessed March 30, 2010. Available at URL address: <http://www.ahrq.gov/clinic/uspstf/uspसानeu.htm>
31. United Kingdom Small Aneurysm Trial Participants. Long-term outcomes of immediate repair compared with surveillance of small abdominal aortic aneurysms. N Engl J Med. 2002 May 9;346(19):1445-52.
32. Vardulaki KA, Walker NM, Couto E, Day NE, Thompson SG, Ashton HA. Late results concerning feasibility and compliance from a randomized trial of ultrasonographic screening for abdominal aortic aneurysm. Br J Surg. 2002 Jul;89(7):861-4.

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## Policy History

<b>Pre-Merger Organizations</b>	<b>Last Review Date</b>	<b>Policy Number</b>	<b>Title</b>
CIGNA HealthCare	05/15/2008	0341	Ultrasound Screening for Abdominal Aortic Aneurysms

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