**National Quality Forum—Evidence (subcriterion 1a)**

**Measure Number** (*if previously endorsed*)**:** Click here to enter NQF number

**Measure Title**: Percutaneous Coronary Intervention (PCI): Comprehensive Documentation of Indications for PCI

**IF the measure is a component in a composite performance measure, provide the title of the Composite Measure here:** Click here to enter composite measure #/ title

**Date of Submission**: 12/23/2013

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| **Instructions**  *For composite performance measures:*  *A separate evidence form is required for each component measure unless several components were studied together.*  *If a component measure is submitted as an individual performance measure, attach the evidence form to the individual measure submission.*   * Respond to all questions as instructed with answers immediately following the question. All information needed to demonstrate meeting the evidence subcriterion (1a) must be in this form. An appendix of *supplemental* materials may be submitted, but there is no guarantee it will be reviewed. * If you are unable to check a box, please highlight or shade the box for your response. * Maximum of 10 pages (*incudes questions/instructions*; minimum font size 11 pt; do not change margins). ***Contact NQF staff if more pages are needed.*** * Contact NQF staff regarding questions. Check for resources at [Submitting Standards webpage](http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx). |

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| **Note: The information provided in this form is intended to aid the Steering Committee and other stakeholders in understanding to what degree the evidence for this measure meets NQF’s evaluation criteria.**   1a. Evidence to Support the Measure Focus The measure focus is evidence-based, demonstrated as follows:   * Health outcome: [**3**](#Note3) a rationale supports the relationship of the health outcome to processes or structures of care. Applies to patient-reported outcomes (PRO), including health-related quality of life/functional status, symptom/symptom burden, experience with care, health-related behavior. * Intermediate clinical outcome: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4)that the measured intermediate clinical outcome leads to a desired health outcome. * Process: [**5**](#Note5) a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured process leads to a desired health outcome. * Structure: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured structure leads to a desired health outcome. * Efficiency: [**6**](#Note6) evidence not required for the resource use component.   **Notes**  **3.** Generally, rare event outcomes do not provide adequate information for improvement or discrimination; however, serious reportable events that are compared to zero are appropriate outcomes for public reporting and quality improvement.  **4.** The preferred systems for grading the evidence are the U.S. Preventive Services Task Force (USPSTF) [grading definitions](http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm) and [methods](http://www.uspreventiveservicestaskforce.org/methods.htm), or Grading of Recommendations, Assessment, Development and Evaluation [(GRADE) guidelines](http://www.gradeworkinggroup.org/publications/index.htm).  **5.** Clinical care processes typically include multiple steps: assess → identify problem/potential problem → choose/plan intervention (with patient input) → provide intervention → evaluate impact on health status. If the measure focus is one step in such a multistep process, the step with the strongest evidence for the link to the desired outcome should be selected as the focus of measurement. Note: A measure focused only on collecting PROM data is not a PRO-PM.  **6.** Measures of efficiency combine the concepts of resource use and quality (see NQF’s [Measurement Framework: Evaluating Efficiency Across Episodes of Care](http://www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx); [AQA Principles of Efficiency Measures](http://www.aqaalliance.org/files/PrinciplesofEfficiencyMeasurementApril2006.doc)). |

**1a.1.This is a measure of**: (*should be consistent with type of measure entered in De.1*)

Outcome

Health outcome: Click here to name the health outcome

Patient-reported outcome (PRO): Click here to name the PRO

*PROs include HRQoL/functional status, symptom/symptom burden, experience with care, health-related behaviors*

Intermediate clinical outcome (*e.g., lab value*): Click here to name the intermediate outcome

Process: Click here to name the process

Structure: Click here to name the structure

Other: Click here to name what is being measured

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**HEALTH OUTCOME/PRO PERFORMANCE MEASURE**  *If not a health outcome or PRO, skip to* [*1a.3*](#Section1a3)

**1a.2.** **Briefly state or diagram the path between the health outcome (or PRO) and the healthcare structures, processes, interventions, or services that influence it.**

**1a.2.1.** **State the rationale supporting the relationship between the health outcome (or PRO) to at least one healthcare structure, process, intervention, or service (*i.e., influence on outcome/PRO*).**

*Note: For health outcome/PRO performance measures, no further information is required; however, you may provide evidence for any of the structures, processes, interventions, or service identified above.*

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**intermediate outcome, PROCESS, or STRUCTURE PERFORMANCE measure**

**1a.3.****Briefly state or diagram the path between structure, process, intermediate outcome, and health outcomes**. Include all the steps between the measure focus and the health outcome.

In certain clinical situations, PCI confers benefits to the patient, in terms of survival and improved health outcomes including symptoms, functional status and quality of life. The primary objective of the Appropriate Use Criteria (AUC) – recently updated by the American College of Cardiology Foundation (ACCF), Society for Cardiovascular Angiography and Interventions (SCAI), Society of Thoracic Surgeons (STS), and the American Association for Thoracic Surgery (AATS), with other key specialty societies – is to improve physician decision making and patient education regarding the clinical indications and expected benefits from revascularization. The AUC incorporates 5 clinical indications in determinations of appropriateness of PCI.

1. Clinical presentation

2. Symptom severity

3. Ischemia severity

4. Extent of medical therapy

5. Extent of coronary anatomical findings on angiography

The clear documentation of these indications is critically important in considerations of appropriateness of PCI based on individual patient characteristics; thus, this performance measure is essential to ensuring that this process can take place. Recent evidence suggests that the requisite data for determining the appropriateness of PCI is not always complete. (See Importance Section 1.b3 of NQF Submission Form for this measure)

**1a.3.1.** **What is the source of the systematic review of the body of evidence that supports the performance measure?**

Clinical Practice Guideline recommendation – ***complete sections*** [***1a.4***](#Section1a4)***, and*** [***1a.7***](#Section1a7)

US Preventive Services Task Force Recommendation – ***complete sections*** [***1a.5***](#Section1a5) ***and*** [***1a.7***](#Section1a7)

Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*) – ***complete sections*** [***1a.6***](#Section1a6) ***and*** [***1a.7***](#Section1a7)

Other – ***complete section*** [***1a.8***](#Section1a8)

*Please complete the sections indicated above for the source of evidence. You may skip the sections that do not apply.*

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**1a.4. CLINICAL PRACTICE GUIDELINE RECOMMENDATION**

**1a.4.1.** **Guideline citation** (*including date*) and **URL for guideline** (*if available online*):

**2012 Appropriate Use Criteria (AUC) for Coronary Revascularization**

Patel MR, Dehmer GJ, Hirshfeld JW, Smith PK, Spertus JA. ACCF/SCAI/STS/AATS/AHA/ASNC/HFSA/SCCT 2012 appropriate use criteria for coronary revascularization focused update: a report of the American College of Cardiology Foundation Appropriate Use Criteria Task Force, Society for Cardiovascular Angiography and Interventions, Society of Thoracic Surgeons, American Association for Thoracic Surgery, American Heart Association, American Society of Nuclear Cardiology, and the Society of Cardiovascular Computed Tomography. *J Am Coll Cardiol* 2012;59:857–81.

URL: <http://content.onlinejacc.org/article.aspx?articleid=1201161>

**2011 ACCF/AHA/SCAI guideline for percutaneous coronary intervention**

Levine GN, Bates ER, Blankenship JC, et al. 2011 ACCF/AHA/ SCAI guideline for percutaneous coronary intervention: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines and the Society for Cardiovascular Angiography and Interventions. *Circulation.* 2011;124:e574-e651.

URL: <http://my.americanheart.org/professional/General/2011-ACCFAHASCAI-Guideline-for-Percutaneous-Coronary-Intervention_UCM_433333_Article.jsp>

**1a.4.2.** **Identify guideline recommendation number and/or page number** and **quote verbatim, the specific guideline recommendation**.

The AUC classifies the clinical indications used to determine the appropriateness of coronary revascularization including PCI and CABG. The documentation of these indications is the focus of this measure, but we focus on its application to PCI given the target of this performance measure.

In turn, the ACCF/AHA/SCAI guidelines provide the evidence on the benefits and risks of PCI to assist physicians in selecting the optimal strategy for an individual patient.

In conjunction, the AUC and the clinical guideline provide the foundation for this measure.

From the ACCF/SCAI/STS/AATS/AHA/ASNC/HFSA/SCCT 2012 appropriate use criteria (AUC) for coronary revascularization (pp. 860-861):

Indications for coronary revascularization were developed considering the following common variables:

* The clinical presentation (e.g., acute coronary syndrome, stable angina);
* Severity of angina (asymptomatic, Canadian Cardiovascular Society [CCS] Class I, II, III, or IV);
* Extent of ischemia on noninvasive testing and the presence or absence of other prognostic factors, such as congestive heart failure, depressed left ventricular function, or diabetes;
* Extent of medical therapy; and
* Extent of anatomic disease (1-, 2-, 3-vessel disease, with or without proximal LAD or left main coronary disease).

From the 2011 ACCF/AHA/ SCAI guideline for percutaneous coronary intervention (pp. e582-e583):

1. PCI to improve survival is reasonable as an alternative to CABG in selected stable patients with significant (≥50% diameter stenosis) unprotected left main CAD with: 1) anatomic conditions associated with a low risk of PCI procedural complications and a high likelihood of good long-term outcome (e.g., a low SYNTAX\* score [≤22], ostial or trunk left main CAD); and 2) clinical characteristics that predict a significantly increased risk of adverse surgical outcomes (e.g., STS-predicted risk of operative mortality ≥5%). (**Class IIa**, Level of Evidence: B)

\* Synergy between Percutaneous Coronary Intervention with TAXUS and Cardiac Surgery (SYNTAX) developed under the direction of the SYNTAX Steering Committee.

Available at: <http://www.syntaxscore.com/>

1. PCI to improve survival may be reasonable as an alternative to CABG in selected stable patients with significant (≥50% diameter stenosis) unprotected left main CAD with: 1) anatomic conditions associated with a low to intermediate risk of PCI procedural complications and an intermediate to high likelihood of good long-term outcome (e.g., low-intermediate SYNTAX score of <33, bifurcation left main CAD); and 2) clinical characteristics that predict an increased risk of adverse surgical outcomes (e.g., moderate-severe chronic obstructive pulmonary disease, disability from previous stroke, or previous cardiac surgery; STS-predicted risk of operative mortality >2%). (**Class IIb**, Level of Evidence: B)
2. PCI to improve survivalshould not be performed in stable patients with significant (≥50% diameter stenosis) unprotected left main CAD who have unfavorable anatomy for PCI and who are good candidates for CABG. (**Class III**, Level of Evidence: B)
3. CABG or PCI to improve survival is beneficial in survivors of sudden cardiac death with presumed ischemia-mediated ventricular tachycardia caused by significant (≥70% diameter) stenosis in a major coronary artery. (**Class I**, Level of Evidence: C)
4. The usefulness of PCI to improve survival is uncertain in patients with 2- or 3-vessel CAD (with or without involvement of the proximal LAD artery) or 1-vessel proximal LAD disease. (**Class IIb**, Level of Evidence: B)
5. CABG or PCI should not be performed with the primary or sole intent to improve survival in patients with SIHD with 1 or more coronary stenoses that are not anatomically or functionally significant (e.g., <70% diameter non–left main coronary artery stenosis, FFR>0.80, no or only mild ischemia on noninvasive testing), involve only the left circumflex or right coronary artery, or subtend only a small area of viable myocardium. (**Class III**, Level of Evidence: B)
6. CABG or PCI to improve symptoms is beneficial in patients with 1 or more significant (≥70% diameter) coronary artery stenoses amenable to revascularization and unacceptable angina despite [guideline-directed medical therapy (GDMT)]. (**Class I**, Level of Evidence: A)
7. CABG or PCI to improve symptoms is reasonable in patients with 1 or more significant (≥70% diameter) coronary artery stenoses and unacceptable angina for whom GDMT cannot be implemented because of medication contraindications, adverse effects, or patient preferences. (**Class IIa**, Level of Evidence: C)
8. CABG or PCI to improve symptoms should not be performed in patients who do not meet anatomic (≥50% diameter left main or ≥70% non–left main stenosis diameter) or physiological (e.g., abnormal FFR) criteria for revascularization. (**Class III**, Level of Evidence: C)

**1a.4.3.** **Grade assigned to the quoted recommendation with definition of the grade:**

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| --- | --- |
| Recommendation #  (see 1a.4.2 above) | Grade (for definitions see 1a.4.4 below) |
| 1 | Class IIa |
| 2 | Class IIb |
| 3 | Class III |
| 4 | Class I |
| 5 | Class IIb |
| 6 | Class III |
| 7 | Class I |
| 8 | Class IIa |
| 9 | Class III |

**1a.4.4. Provide all other grades and associated definitions for recommendations in the grading system.** (*Note: If separate grades for the strength of the evidence, report them in section 1a.7.*)

Class of Recommendation (COR) is an estimate of the size of the treatment effect considering risks versus benefits in addition to evidence and/or agreement that a given treatment or procedure is or is not useful/effective or in some situations may cause harm.

Class I: Procedure/Treatment should be performed/administered

Class IIa: It is reasonable to perform procedure/administer treatment

Class IIb: Procedure/Treatment may be considered

Class III: No benefit (Not helpful or No proven benefit)

Class III: Harm (Excess cost w/o benefit or Harmful to patients)

Specific COR definitions are included in Table 1 below.

**Table 1. Applying Classification of Recommendation and Level of Evidence**

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**1a.4.5. Citation and URL for methodology for grading recommendations** (*if different from 1a.4.1*)**:**

ACCF/AHA Task Force on Practice Guidelines. Methodology Manual and Policies From the ACCF/AHA

Task Force on Practice Guidelines. American College of Cardiology Foundation and American Heart

Association, Inc. Cardiosource.com. 2010. Available at:

<http://assets.cardiosource.com/Methodology_Manual_for_ACC_AHA_Writing_Committees.pdf> and

<http://my.americanheart.org/idc/groups/ahamah-public/@wcm/@sop/documents/downloadable/ucm_319826.pdf>

**1a.4.6. If guideline is evidence-based (rather than expert opinion), are the details of the quantity, quality, and consistency of the body of evidence available (e.g., evidence tables)?**

Yes **→ *complete section*** [***1a.7***](#Section1a7)

No **→ *report on another systematic review of the evidence in sections*** [***1a.6***](#Section1a6) ***and*** [***1a.7***](#Section1a7)***; if another review does not exist, provide what is known from the guideline review of evidence in*** [***1a.7***](#Section1a7)

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**1a.5.** **UNITED STATES PREVENTIVE SERVICES TASK FORCE RECOMMENDATION**

**1a.5.1.** **Recommendation citation** (*including date*) and **URL for recommendation** (*if available online*):

**1a.5.2.** **Identify recommendation number and/or page number** and **quote verbatim, the specific recommendation**.

**1a.5.3.** **Grade assigned to the quoted recommendation with definition of the grade**:

**1a.5.4. Provide all other grades and associated definitions for recommendations in the grading system.** (*Note: the* *grading system for the evidence should be reported in section 1a.7.*)

**1a.5.5. Citation and URL for methodology for grading recommendations** (*if different from 1a.5.1*)**:**

***Complete section*** [***1a.7***](#Section1a7)

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**1a.6. OTHER SYSTEMATIC REVIEW OF THE BODY OF EVIDENCE**

**1a.6.1.** **Citation** (*including date*) and **URL** (*if available online*):

**1a.6.2.** **Citation and** **URL for methodology for evidence review and grading** (*if different from 1a.6.1*)**:**

***Complete section*** [***1a.7***](#Section1a7)

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**1a.7. FINDINGS FROM SYSTEMATIC REVIEW OF BODY OF THE EVIDENCE supporting the measure**

*If more than one systematic review of the evidence is identified above, you may choose to summarize the one (or more) for which the best information is available to provide a summary of the quantity, quality, and consistency of the body of evidence. Be sure to identify which review is the basis of the responses in this section and if more than one, provide a separate response for each review.*

**1a.7.1.** **What was the specific structure, treatment, intervention, service, or intermediate outcome addressed in the evidence review?**

This measure focuses on the documentation of clinical indications for PCI. As mentioned above, the documentation of clinical indications is an aspect of care that generally does not have a direct body of supporting evidence. However, thorough documentation of clinical indications is critically important in the determination of appropriateness of PCI.

The evidence review included in the clinical practice guideline, focused on the appropriate performance of coronary revascularization (CABG or PCI) as a measure of the likelihood of improved survival, symptoms or functional status versus the risks.

**1a.7.2.** **Grade assigned for the quality of the quoted evidence with definition of the grade**:

An overall grade for the quality of evidence was not assigned. Rather, the quality of a study (or set of studies) supporting a recommendation was graded on an estimate of the certainty or precision of the treatment effect.

From the 2011 ACCF/AHA/ SCAI guideline for percutaneous coronary intervention:

1. PCI to improve survival is reasonable as an alternative to CABG in selected stable patients with significant (≥50% diameter stenosis) unprotected left main CAD with: 1) anatomic conditions associated with a low risk of PCI procedural complications and a high likelihood of good long-term outcome (e.g., a low SYNTAX score [≤22], ostial or trunk left main CAD); and 2) clinical characteristics that predict a significantly increased risk of adverse surgical outcomes (e.g., STS-predicted risk of operative mortality ≥5%). (Class IIa, **Level of Evidence: B**)
2. PCI to improve survival may be reasonable as an alternative to CABG in selected stable patients with significant (≥50% diameter stenosis) unprotected left main CAD with: 1) anatomic conditions associated with a low to intermediate risk of PCI procedural complications and an intermediate to high likelihood of good long-term outcome (e.g., low-intermediate SYNTAX score of <33, bifurcation left main CAD); and 2) clinical characteristics that predict an increased risk of adverse surgical outcomes (e.g., moderate-severe chronic obstructive pulmonary disease, disability from previous stroke, or previous cardiac surgery; STS-predicted risk of operative mortality >2%). (Class IIb**, Level of Evidence: B**)
3. PCI to improve survival should not be performed in stable patients with significant (≥50% diameter stenosis) unprotected left main CAD who have unfavorable anatomy for PCI and who are good candidates for CABG. (Class III, **Level of Evidence: B**)
4. CABG or PCI to improve survival is beneficial in survivors of sudden cardiac death with presumed ischemia-mediated ventricular tachycardia caused by significant (≥70% diameter) stenosis in a major coronary artery. (Class I, **Level of Evidence: C**)
5. The usefulness of PCI to improve survival is uncertain in patients with 2- or 3-vessel CAD (with or without involvement of the proximal LAD artery) or 1-vessel proximal LAD disease. (Class IIb, **Level of Evidence: B**)
6. CABG or PCI should not be performed with the primary or sole intent to improve survival in patients with SIHD with 1 or more coronary stenoses that are not anatomically or functionally significant (e.g., <70% diameter non–left main coronary artery stenosis, FFR>0.80, no or only mild ischemia on noninvasive testing), involve only the left circumflex or right coronary artery, or subtend only a small area of viable myocardium. (Class III, **Level of Evidence: B**)
7. CABG or PCI to improve symptoms is beneficial in patients with 1 or more significant (≥70% diameter) coronary artery stenoses amenable to revascularization and unacceptable angina despite [guideline-directed medical therapy (GDMT)]. (Class I, **Level of Evidence: A**)
8. CABG or PCI to improve symptoms is reasonable in patients with 1 or more significant (≥70% diameter) coronary artery stenoses and unacceptable angina for whom GDMT cannot be implemented because of medication contraindications, adverse effects, or patient preferences. (Class IIa, **Level of Evidence: C**)
9. CABG or PCI to improve symptoms should not be performed in patients who do not meet anatomic (≥50% diameter left main or ≥70% non–left main stenosis diameter) or physiological (e.g., abnormal FFR) criteria for revascularization. (Class III, **Level of Evidence: C**)

**1a.7.3. Provide all other grades and associated definitions for strength of the evidence in the grading system.**

The Level of Evidence (LOE) is an estimate of the certainty or precision of the treatment effect.

Level A: Multiple populations evaluated; Data derived from multiple randomized clinical trials or meta-analysis

Level B: Limited populations evaluated; Data derived from a single randomized trial or nonrandomized studies

Level C: Very limited populations evaluated; only consensus opinion of experts, case studies or standard of care

Specific LOE definitions are included in Table 1 found in Section 1a.4.4. above.

**1a.7.4.** **What is the time period covered by the body of evidence? (*provide the date range, e.g., 1990-2010*). Date range**: 1975-2011

**QUANTITY AND QUALITY OF BODY OF EVIDENCE**

**1a.7.5.****How many and what type of study designs are included in the body of evidence**? (*e.g., 3 randomized controlled trials and 1 observational study*)

This measure focuses on the documentation of clinical indications for PCI. As mentioned above, the documentation of clinical indications is an aspect of care that generally does not have a direct body of supporting evidence. However, thorough documentation of clinical indications is critically important in the determination of appropriateness of PCI and evidence suggests this is not always done.

The body of evidence supporting the recommendations on the indications for performing a PCI to improve survival and provide symptom relief includes:

13 randomized controlled trials

19 cohort studies

3 observational studies

2 systematic reviews

3 meta-analyses

2 multicenter registry analyses

**1a.7.6.** **What is the overall quality of evidence across studies in the body of evidence**? (*discuss the certainty or confidence in the estimates of effect particularly in relation to study factors such as design flaws, imprecision due to small numbers, indirectness of studies to the measure focus or target population*)

The documentation component is directly based on the AUC and the indications included therein that are required in decision-making regarding the appropriateness of PCI.

The Clinical Practice Guideline used as the source of the systematic review of the body of evidence used to delineate the clinical indications for PCI does not make any qualifying statements about the overall quality of studies.

**ESTIMATES OF BENEFIT AND CONSISTENCY ACROSS STUDIES IN BODY OF EVIDENCE**

**1a.7.7.** **What are the estimates of benefit—magnitude and direction of effect on outcome(s) across studies in the body of evidence**? (*e.g., ranges of percentages or odds ratios for improvement/ decline across studies, results of meta-analysis, and statistical significance*)

There is no expectation that documenting clinical indications for PCI would pose a risk of harm. The reasonable expectation is that having the information necessary for decision making related to the appropriateness of PCI – based on patient characteristics and clinical presentation – would benefit a patient in terms of improved survival and symptom relief.

The clinical guideline writing committee formulated the recommendations, used as the foundation for this measure, based on a body of evidence on the survival and symptom benefits after coronary revascularization with CABG or PCI. The evidence provides indications supporting CABG, supporting PCI, supporting either CABG or PCI, and evidence supporting the equivalence of CABG and PCI for survival and symptom relief. The clinical guideline does not, however, provide a quantitative estimate of benefit across the entire body of evidence cited.

**1a.7.8.** **What harms were studied and how do they affect the net benefit (benefits over harms)?**

Coronary revascularization is appropriate when the expected benefits, in terms of survival or health outcomes (symptoms, functional status, and/or quality of life) exceed the expected negative consequences of the procedure.

There is no expectation that documenting clinical indications for PCI would pose a risk of harm. The reasonable expectation is that having the information necessary for decision making related to the performance of PCI based on patient characteristics and clinical presentation would benefit a patient in terms of improved survival and symptom relief. The clinical guideline does not include a focused attention to net benefit and harm as a result of coronary revascularization.

**UPDATE TO THE SYSTEMATIC REVIEW(S) OF THE BODY OF EVIDENCE**

**1a.7.9.** **If new studies have been conducted since the systematic review of the body of evidence, provide for each new study: 1) citation, 2) description, 3) results, 4) impact on conclusions of systematic review**.

Recently completed studies that relate to coronary revascularization do not focus on the documentation of clinical indications and are mostly focused on the clinical efficacy and safety of various pharmacologic agents (eg, clopidogrel, rivaroxaban, cangrelor, atorvastatin, among others) in patients who undergo PCI.

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**1a.8 OTHER SOURCE OF EVIDENCE**

*If source of evidence is NOT from a clinical practice guideline, USPSTF, or systematic review, please describe the evidence on which you are basing the performance measure.*

The AUC classifies the clinical indications used to determine the appropriateness of PCI. The documentation of these indications is the focus of this measure.

In turn, the ACCF/AHA/SCAI guidelines provide the evidence on the benefits and risks of PCI to assist physicians in selecting the optimal strategy for an individual patient.

In conjunction, the AUC and the clinical guideline provide the foundation for this measure.

**1a.8.1** **What process was used to identify the evidence?**

**1a.8.2.** **Provide the citation and summary for each piece of evidence.**