

Stress CMR remains underused worldwide. We can fix this together with knowledge, training, and advocacy

Giandomenico Bisaccia MD-PhD, MSc and Vass Vassiliou, MD, PhD, FSCMR

Few tests in cardiology can match the evidence base behind stress CMR. A single test yields function, ischemia and scar assessment, and it has held up in head-to-head comparisons. In CE-MARC, stress CMR was more sensitive than SPECT against invasive angiography (86.5% vs 66.5%) ([Greenwood et al., Lancet](#)). In MR-INFORM, a CMR-guided strategy was non-inferior to FFR for major adverse cardiac events and led to fewer revascularizations (35.7% vs 45.0%) ([Nagel et al., NEJM](#)). And in SPINS, a multicenter US registry, stress CMR gave robust risk stratification in routine practice, including in Medicare-eligible adults, in whom inducible ischemia carried an adjusted HR of 2.80 (95% CI 1.93–4.05) for CV death or MI ([Ge et al., JACC Cardiovascular Imaging](#)). Stress CMR is now firmly embedded in both European and North American guidelines as a recommended functional imaging option for appropriately selected patients with suspected or known coronary disease

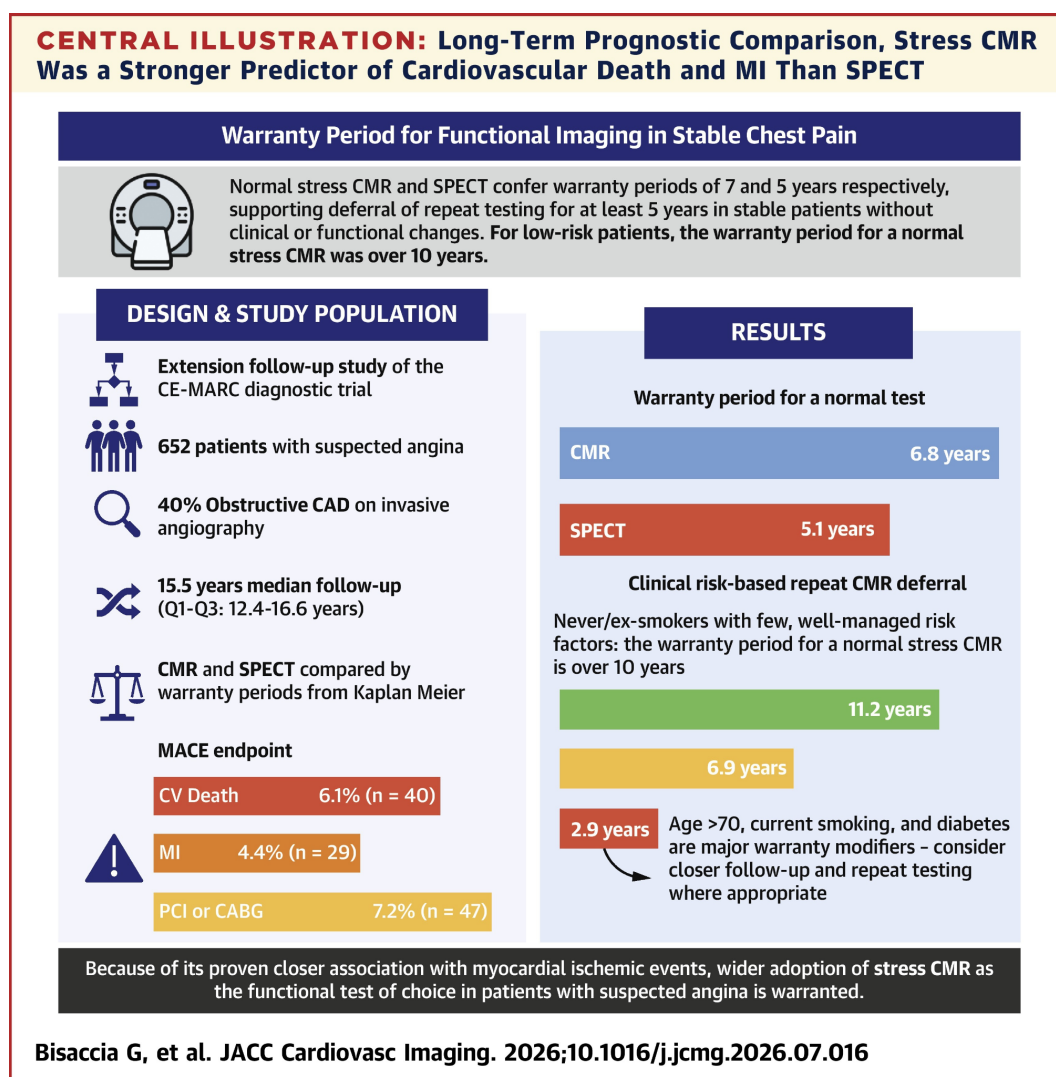
Strong evidence, niche practice

Despite this, stress CMR is still a niche test. Among US Medicare beneficiaries in 2022, SPECT MPI myocardial perfusion imaging outnumbered stress CMR by 268. Whilst an improvement from the 1,179 to 1 seen in 2011, this is still marginal next to PET and coronary CT angiography, which grew much faster ([Cohen et al., Circulation: Cardiovascular Imaging](#)). Access to CMR remains uneven too. There are about 16 CMR centers per million US Medicare beneficiaries, ranging from 52.6 per million in Minnesota to 4.4 in Maine ([Li et al., JCMR](#)).

Europe shows a similar pattern. A 2025 EACVI study surveyed 283 respondents from 46 countries. They named inadequate reimbursement (46%), insufficient training (38%) and limited scanner capacity (29%) as the main barriers to CMR, and training gaps were four times more common in Eastern Europe than in Northern and Southern Europe (56% vs 14%, $P < 0.001$) ([Androulakis et al., EHJ Imaging Methods and Practice](#)). Across nine Asian regions, cost, scanner availability and a shortage of trained staff came up again ([Park et al., Korean Journal of Radiology](#)). The pattern is clear: evidence is not what holds stress CMR back. Reimbursement, workforce and training are.

How long does the reassurance of a normal stress CMR last?

Value also depends on how often a test has to be repeated. A new long-term analysis of CE-MARC, published in JACC: Cardiovascular Imaging, looked at this question. Of the 752 patients with suspected angina in the trial, 652 who had both CMR and SPECT were followed for a median of 15.5 years. After adjustment for cardiovascular risk factors, an abnormal stress CMR remained a strong independent predictor of major adverse cardiovascular events (HR 2.74; 95% CI 1.70–4.42; $P < 0.001$). The study defined the "warranty period" as the time during which patients with a normal result stayed 97.5% free of events. It was 6.8 years for stress CMR and 5.1 years for SPECT. Age, smoking and diabetes shortened it. This does not mean that every patient should wait seven years before reassessment, but it suggests that after a normal stress CMR the period of low event risk can extend for many years. That matters for patients, scanner capacity and health-system budgets, while age, smoking and diabetes identify patients in whom that reassurance is shorter. In practice, for most patients a normal stress CMR can safely delay repeat testing for almost seven years, which matters for patients, for scanner capacity and for health-system budgets ([Bisaccia et al., JACC Cardiovascular Imaging](#)).



Closing the training gap: two SCMR stress courses this month

If training is a main bottleneck, the fix is to train more people. SCMR runs two hands-on stress courses in the last week of September 2026. Both have registration fees tiered by membership and country income level.



[SCMR Stress Perfusion Course – Kaunas, Lithuania](#) (September 24–25, 2026, Faculty of Nursing, Medical Academy of the Lithuanian University of Health Sciences). The course is directed by Prof. Vanessa Ferreira (SCMR President, University of Oxford) and Prof. Tomas Lapinskas (Lithuanian University of Health Sciences). Faculty include Raymond Kwong, Sebastian Kelle, Sven Plein, Amedeo Chiribiri, Ellen Ostenfeld and Tomaz Podlesnikar. The two days combine practical lectures with many case presentations, hands-on quantitative perfusion analysis using post-processing software, and live scanning demonstrations.



[SCMR Stress MR 4 in DC: From Starting a Service to Advanced Analysis – Washington, DC, USA](#) (September 25–26, 2026, ACC Heart House). The course is directed by Dr. Ibrahim Saeed and Dr. Patricia Bandettini. It combines didactic sessions, case-based learning and hands-on training, and covers everything from setting up a stress CMR service to quantifying myocardial blood flow. It is aimed at cardiologists, radiologists, pediatricians, technologists and scientists, and CME credits are available.

If you cannot make them this year, keep an eye on the SCMR [Upcoming Events](#) calendar for future training opportunities.

Training alone won't fix it. We need advocates

SCMR's US Advocacy Committee works with the American College of Cardiology and the American College of Radiology on coding and payment. That work produced two new CPT Category III add-on codes, +0899T and +0900T, effective July 1, 2024. They cover absolute quantification of myocardial blood flow during pharmacologic stress CMR. Category III codes are temporary and do not guarantee payment, but they build the usage data needed to argue for permanent codes. SCMR also publishes a yearly billing guide and a payer engagement guide for its members. Beyond the US, SCMR's Advocacy Committee supports national bids for reimbursement codes, including supporting the Australian CMR community in its ongoing application for a Medicare Benefits Schedule code for CMR in myocarditis. Lithuania shows what joined-up advocacy can do. Cardiologist Tomas Lapinskas, President of the Lithuanian Society of Cardiology, brought CMR back to a country with no clinical service. SCMR has since highlighted his work with radiology colleagues as a model of cardiologists and radiologists building CMR together. An SCMR Level I course followed in 2025, and this month's stress course builds on it.

Stress CMR has the evidence behind it. To make it routine practice, we now need more trained readers, more scanner time and fair reimbursement. **See you in one of the SCMR courses, or the SCMR Annual Scientific Sessions in February 17-20, 2027, in Rome, Italy!**