

Policy: MP150

Section: Medical Benefit Policy

Subject: Carotid Artery Stent

Applicable line of business:

Commercial	x	Medicaid	x
Medicare	x	ACA	x
CHIP	x		

I. Policy: Carotid Artery Stent

II. Purpose/Objective:

To provide a policy of coverage regarding Carotid Artery Stent

III. Responsibility:

- A. Medical Directors
- B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

Commercial

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Medicare

Geisinger Gold Medicare Advantage HMO, PPO, and HMO D-SNP plans are offered by Geisinger Health Plan/Geisinger Indemnity Insurance Company, health plans with a Medicare contract. Continued enrollment in Geisinger Gold depends on contract renewal. Geisinger Health Plan/Geisinger Indemnity Insurance Company are part of Geisinger, an integrated health care delivery and coverage organization.

CHIP

Geisinger Health Plan Kids (GHP Kids) is a Children's Health Insurance Program (CHIP) offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Medicaid

Geisinger Health Plan Family (GHP Family) is a Medical Assistance (Medicaid) insurance program offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

DESCRIPTION:

Carotid stents are positioned at the site of carotid stenotic or occlusive lesions to enhance primary patency following percutaneous transluminal angioplasty.

INDICATIONS:

Coverage is limited to the use of FDA approved carotid stents for FDA approved indications when the following criteria are met:

- Documented evidence of a reference vessel diameter within the range of 4.0mm and 9.0mm; **and one of the following:**
 - Member is at high risk* for carotid endarterectomy (CEA) with one of the following:
 - symptomatic (e.g., transient ischemic attack or monocular blindness) carotid stenosis greater than 50% or more by angiogram or 70% or more by ultrasound; **or**
 - asymptomatic carotid artery stenosis of 60% or more by angiogram or 70% or more by ultrasound**and**
 - anatomic contraindication for carotid endarterectomy (e.g., prior radiotherapy or neck surgery, surgically inaccessible lesions, spinal immobility, or tracheostomy).**or**
 - Members who are at high risk for CEA and have asymptomatic carotid artery stenosis $\geq 80\%$, in accordance with the Category B IDE clinical trials regulation (42 CFR 405.201)

*CMS defines high risk as those "having significant comorbidities and/or anatomic risk factors (i.e., recurrent stenosis and/or previous radical neck dissection), and who would be poor candidates for CEA in the opinion of a surgeon". Significant comorbid conditions include but are not limited to:

- congestive heart failure (CHF) class III/IV;
- left ventricular ejection fraction (LVEF) $< 30\%$;
- unstable angina;
- contralateral carotid occlusion;
- recent myocardial infarction (MI);
- previous CEA with recurrent stenosis ;
- prior radiation treatment to the neck; and
- other conditions that were used to determine patients at high risk for CEA in the prior carotid artery stenting trials and studies, such as ARCHER, CABERNET, SAPPHIRE, BEACH, and MAVERIC II.

EXCLUSIONS:

Carotid artery stenting will be limited to the placement of an FDA-approved carotid stent for an FDA – approved indication when furnished in accordance with FDA- approved protocols governing post-approval studies. Placement of carotid stents not meeting these requirements is considered **experimental, investigational or unproven** and is **NOT COVERED**.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

Medicaid Business Segment:

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

CODING ASSOCIATED WITH: Carotid Artery Stent

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

- 37215 transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection
- 37216 transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection
- 37217 transcatheter placement of an intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, via open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision innominate artery by retrograde treatment, via open ipsilateral cervical carotid artery exposure including angioplasty, when performed, and radiological supervision
- 37218 transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation
- 37236 transcatheter placement of an intravascular stent(s)(except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation
- 37237 transcatheter placement of an intravascular stent(s)(except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation
- 37238 transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein
- 37239 transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed, each additional vein
- 0075T transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), including radiological supervision and interpretation, percutaneous; initial vessel
- 0076T transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), including radiological supervision and interpretation, percutaneous; each additional vessel

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LINE OF BUSINESS:

Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:

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This policy will be revised as necessary and reviewed no less than annually.

Devised: 1/05

Revised: 3/05 (CMS expanded criteria); 3/06 (Provider Criteria expanded); 5/07; 2/11(removal of PA). 4/17 (clarified criteria); 4/18 (add CMS criteria); 4/24 (expand criteria)

Reviewed: 5/08, 5/09, 5/10, 5/11, 5/12, 5/13, 5/14, 5/15, 5/16, 4/19, 4/20, 4/21, 4/22, 4/23, 4/25

CMS UM Oversight Committee Approval: 12/23, 7/24, 6/25

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Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.