

Medical Policy



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Title: Extracranial Carotid Artery Stenting

Professional

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| Populations | Interventions | Comparators | Outcomes |
|---|--|---|--|
| Individuals: <ul style="list-style-type: none"> With carotid artery stenosis | Interventions of interest are: <ul style="list-style-type: none"> Carotid artery stenting | Comparators of interest are: <ul style="list-style-type: none"> Carotid endarterectomy | Relevant outcomes include: <ul style="list-style-type: none"> Overall survival Morbid events Treatment-related mortality Treatment-related morbidity |

DESCRIPTION

Carotid artery angioplasty with stenting is a treatment for carotid stenosis that is intended to prevent future stroke. It is an alternative to medical therapy and a less-invasive alternative to carotid endarterectomy (CEA).

OBJECTIVE

The objective of this policy is to determine whether the use of extracranial carotid artery stenting improves the net health outcome in patients with carotid artery stenosis.

BACKGROUND

Combined with optimal medical management, carotid angioplasty with or without stenting has been evaluated as an alternative to carotid endarterectomy (CEA). Carotid artery stenting (CAS) involves the introduction of coaxial systems of catheters, microcatheters, balloons, and other devices. The procedure is most often performed through the femoral artery, but a transcervical approach can also be used to avoid traversing the aortic arch. The procedure typically takes 20–40 minutes.

Interventionalists almost uniformly use an embolic protection device (EPD) designed to reduce the risk of stroke caused by thromboembolic material dislodged during CAS. Embolic protection devices can be deployed proximally (with flow reversal) or distally (using a filter). Carotid angioplasty rarely is performed without stent placement.

Proposed advantages of CAS over CEA include:

- General anesthesia is not used (although CEA can be performed under local or regional anesthesia)
- Cranial nerve palsies are infrequent sequelae (although almost all following CEA resolve over time)
- Simultaneous procedures may be performed on the coronary and carotid arteries

REGULATORY STATUS

A number of carotid artery stents and embolic protection devices (EPDs) have been approved by the U.S. Food and Drug Administration (FDA) through the premarket approval process or 510(k) process. Examples are provided in table 1.

Table 1. FDA-Approved Carotid Artery Stents and Embolic Protection Devices

| Manufacturer | Stents and Devices | PMA/510(k) Date |
|------------------------------------|--|--------------------|
| Guidant, now Abbott Vascular | Acculink™ and RX Acculink™ carotid stents | Aug 2004 |
| Guidant, now Abbott Vascular | AccUNET™ and RX AccUNET™ cerebral protection filters | Aug 2004 |
| Abbott Vascular | Xact® RX carotid stent system | Sep 2005 |
| Abbott Vascular | Emboshield® embolic protection system | Sep 2005 |
| Cordis Corp. | Precise® nitinol carotid stent system | Sep 2006 |
| Cordis Corp. | AngioGuard™ XP and RX emboli capture guidewire systems | Sep 2006 |
| EndoTex Interventional Systems | NexStent® carotid stent over-the-wire and monorail delivery systems | Oct 2006 |
| Boston Scientific | FilterWire EZ™ embolic protection system | Oct 2006 |
| ev3, Arterial Evolution Technology | Protégé® Rx and SpideRx® | Jan 2007 |
| Boston Scientific | Carotid Wallstent® | Oct 2008 |
| GORE | GORE® Flow Reversal System | Feb 2009 |
| GORE | GORE® Embolic Filter | May 2011 |
| Medtronic/Invatec | Mo.Ma® Ultra Proximal Cerebral Protection Device | Oct 2009 |
| Silk Road Medical | ENROUTE™ Transcarotid Stent System and ENROUTE Transcarotid Neuroprotection System | May 2015 |

FDA: Food and Drug Administration; PMA: premarket approval.

Each FDA-approved carotid stent is indicated for combined use with an EPD to reduce risk of stroke in patients considered to be at increased risk for periprocedural complications from CEA who are symptomatic with greater than 50% stenosis, or asymptomatic with greater than 80% stenosis—degree of stenosis being assessed by ultrasound or angiogram with computed tomography (CT) angiography also sometimes used. Patients are considered at increased risk for complications during CEA if affected by any item from a list of anatomic features and comorbid conditions included in each stent system's Information for Prescribers.

The RX Acculink™ Carotid Stent System is also approved for use in conventional risk patients (not considered at increased risk for complications during CEA) with symptoms and $\geq 70\%$ stenosis by ultrasound or $\geq 50\%$ stenosis by angiogram, and asymptomatic patients with $\geq 70\%$ stenosis by ultrasound or $\geq 60\%$ stenosis by angiogram.

FDA-approved stents and EPDs differ in the deployment methods used once they reach the target lesion, with the RX (rapid exchange) devices designed for more rapid stent and filter expansion. The FDA has mandated postmarketing studies for EPDs, including longer follow-up for patients already reported to the FDA and additional registry studies, primarily to compare outcomes as a function of clinician training and facility experience. Each manufacturer's system is available in various configurations (eg, straight or tapered) and sizes (diameters and lengths) to match the vessel lumen that will receive the stent.

In February 2015, FDA cleared for marketing the ENROUTE™ Transcarotid NPS through the 510(k) process. The ENROUTE™ is a flow-reversal device designed to be placed via direct carotid access.

FDA product codes: NIM (stents) and NTE (EPDs).

POLICY

- A. Carotid angioplasty with associated stenting and embolic protection may be considered **medically necessary** in patients with:
1. 50% to 99% stenosis (North American Symptomatic Carotid Endarterectomy Trial [NASCET] measurement); **AND**
 2. Symptoms of focal cerebral ischemia (transient ischemic attack or monocular blindness) in the previous 120 days, symptom duration less than 24 hours, or nondisabling stroke; **AND**
 3. Anatomic contraindication for carotid endarterectomy (eg, prior radiotherapy or neck surgery, lesions surgically inaccessible, spinal immobility, or tracheostomy).

- B. Carotid angioplasty with associated stenting and embolic protection is considered **experimental / investigational** for all other indications, including, but not limited to, patients with carotid stenosis who are suitable candidates for carotid endarterectomy and patients with carotid artery dissection.
- C. Carotid angioplasty without associated stenting and embolic protection is considered **experimental / investigational** for all indications, including, but not limited to, patients with carotid stenosis who are suitable candidates for carotid endarterectomy and patients with carotid artery dissection.

Policy Guidelines

The intent of Item C above is that carotid angioplasty with embolic protection but without stenting is experimental / investigational. There may be unique situations where the original intent of surgery was to perform carotid angioplasty with stenting and embolic protection, but anatomic or other considerations prohibited placement of the stent.

RATIONALE

This policy is updated periodically with literature review. The last update with literature review covers the period through March 5, 2018.

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function—including benefits and harms. Every clinical condition has specific outcomes that are important to patients and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, 2 domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Risk-Benefit Ratio of Invasive Carotid Procedures

Endovascular carotid artery stenting (CAS) and surgical endarterectomy (CEA) for carotid artery disease trades procedure-related harms of stroke and death for the benefit of reduced stroke risk over subsequent years—the balance determines whether either intervention will result in a net clinical benefit. That balance has been scrutinized for CEA but not for CAS; accordingly, results from trials of CEA must be extrapolated to assess outcomes for CAS.

A series of landmark clinical trials from the late 1980s through the 1990s compared the benefits and harms of CEA with best medical therapies then available in symptomatic and asymptomatic individuals with carotid artery stenosis.¹⁻⁷ Those trial results defined the magnitude of risk reduction for stroke and the periprocedural stroke and death rates for 30 days, that must be offset to achieve a net clinical benefit (benefit outweighing harm)—less than 3% for asymptomatic (>60% stenosis), and less than 6% for symptomatic patients (50%-69% or 70%-99% stenosis). Furthermore, because periprocedural harms are immediate, but benefit accrues over time, a net clinical benefit is obtained only for those patients surviving long enough to counterbalance the immediate harms. The necessary life expectancy defined by the trial duration needed to demonstrate benefit, is summarized in Table 2.

Table 2. Acceptable Periprocedural Death or Stroke Rate in Clinical Trials of CEA

| Symptoms | Stenosis, % | Acceptable Periprocedural Death/Stroke Rate, % | Anticipated Life Expectancy, y |
|----------|-------------|--|--------------------------------|
| No | 60-99 | <3 | 5 |
| Yes | 50-69 | <6 | 5 |
| | 70-99 | <6 | 2 |

CEA: carotid endarterectomy.

As an example of the fine line between benefit and harm, Arazi et al (2008)⁸ performed a decision analysis of benefit for patients with asymptomatic stenosis using a base case derived from the Asymptomatic Carotid Surgery Trial (ACST) (periprocedural death/stroke rate, 1.8%).⁷ Over a 5-year time horizon, CEA provided 4 days of stroke-free survival and a net harm when periprocedural death or disabling stroke rates exceeded 2.1%.

Since the landmark trials, there has been considerable improvement in medical care resulting in a substantial decline in stroke rates among patients with asymptomatic carotid disease.^{9,10} Current medical therapies such as aggressive lipid-lowering medications, were inconsistently used in the landmark trials. Also, surgeons in contemporary clinical trials have achieved CEA periprocedural death and stroke rates lower than those in the pivotal trials used to establish the benchmarks. For example, in the Carotid Revascularization Endarterectomy vs Stenting Trial (CREST), the death or stroke rate for symptomatic patients was 3.2% and for asymptomatic patients was 1.4%.¹¹ Accordingly, the benchmarks established decades ago may no longer be appropriate. A recent consensus document by De Rango et al (2013) has suggested benchmarks of 2.0% for asymptomatic and 4.0% for symptomatic individuals.¹²

Excluded from landmark CEA trials were patients with significant comorbidities judged likely to cause death within 5 years that might also increase periprocedural and anesthetic risk for complications. Therefore, CAS has appeal as a treatment option for patients with potentially higher periprocedural risk due to medical (eg, severe cardiac dysfunction, requirement for combined coronary and carotid revascularization, severe renal or pulmonary dysfunction, and other characteristics associated with increased surgical risk); or anatomic reasons (eg, surgically inaccessible stenosis, prior radiation, prior neck surgery, spinal immobility, prior laryngeal nerve palsy, contralateral occlusion, prior ipsilateral CEA, restenosis after CEA).

Although the general anesthetic risk is considered a potential reason to use CAS, CEA can be safely performed under local or regional anesthesia,¹³ as confirmed in the 95-center General Anesthesia versus Local Anesthesia (GALA) trial.¹⁴ GALA trial investigators randomized 3526 patients undergoing CEA to general or local anesthesia and found no difference in 30-day death, stroke, or myocardial infarction (MI) rates based on anesthetic approach (relative risk [RR], 0.94; 95% confidence interval [CI], 0.70 to 1.3).¹⁴

Randomized Controlled Trials of CAS vs CEA

SAPPHIRE Trial

The first major RCT comparing CAS with CEA was the Stenting and Angioplasty, with Protection in Patients at High Risk for Endarterectomy (SAPPHIRE) trial reported by Yadav et al (2004).¹⁵

Relevant conclusions are summarized below:

- For patients with symptomatic stenosis at increased risk for periprocedural complications from CEA (n=96), the sample size was small, resulting in wide CIs for estimated effects; differences between arms in 30-day and 1-year outcomes were not statistically significant.
- For patients with asymptomatic stenosis at increased risk for periprocedural complications from CEA (n=238), differences in 30-day outcomes also had wide CIs and were not statistically significant.
- Early study closed early due to slow recruitment as nonrandomized stent registries were established, resulting in fewer study patients than planned, which compromised the evaluation of noninferiority.
- Variance in differential complication rates for the 2 treatments across sites might have influenced results, because 5 of 34 sites contributed 64% of randomized patients, and data were unavailable for comparison.
- Direct comparative evidence was lacking for optimal medical management alone as an alternative to adding CAS with an embolic protection device (EPD) or CEA for patients with increased risk of surgical complications.

Long-term follow-up of SAPPHIRE was reported at 3 years.^{16,17} For asymptomatic and symptomatic patients combined, ipsilateral strokes from day 31 to day 1080 were observed in 4.4% of patients undergoing CAS and in 3.6% with CEA (estimated from digitized figure). Cumulative 3-year repeat target vessel revascularization (a proxy for restenosis) was more common after CEA, but the difference was not statistically significant (7.1% vs 3.0%; p=0.26).

SPACE Trial

Ringleb et al (2006) published results from the Stent-supported Percutaneous Angioplasty of the Carotid Artery versus Endarterectomy (SPACE) trial. This trial randomized 1200 patients within 180 days of neurologic symptoms, transient ischemic attack, or moderate (nondisabling) stroke, and with 50% or more stenosis of the ipsilateral carotid artery, to CAS (n=605) with or without EPD (73% of procedures performed without), or to CEA (n=595).¹⁸ The analysis (n=1183) failed to conclude that CAS was noninferior to CEA by a margin of 2.5% for the primary outcome of ipsilateral ischemic stroke or death by 30 days after randomization. Periprocedural (30-day) event rates were 6.8% for the CAS group and 6.3% for the CEA group. The absolute between-group difference favored CEA and was 0.5% (90% CI, -1.9% to 2.9%) by intention-to-treat analysis and 1.3% (90% CI, -1.1% to 3.8%) in per-protocol analysis.

Editorialists pointed to some methodologic issues raised with SPACE trial, including the high rate of rejection for potential participating collaborators (\approx 25%, based on their prior outcomes records, but review criteria were not reported), and the lack of a requirement to use an EPD with CAS (although 30-day event rates were 7.3% with vs 6.7% without EPD).^{19,20}

Long-term follow-up of the SPACE trial was reported at 2 years.¹⁷ Approximate annual ipsilateral stroke rates from day 31 through longest follow-up for CAS and CEA were 0.4% in each group. Following the periprocedural period (ie, 31 days to longest follow-up), stroke risk reduction in symptomatic patients not selected based on medical or anatomic comorbidities was similar for

CAS and CEA. Recurrent stenosis greater than 70% was more frequent at 2 years with CAS (10.7%) than with CEA (4.6%; $p=0.001$).

EVA-3S Trial

The Endarterectomy Versus Stenting in Patients with Symptomatic Severe Carotid Stenosis (EVA-3S) trial was a noninferiority comparison of CAS (with EPD in 92%) to CEA in symptomatic patients at average risk for complications from CEA with 60% or more stenosis of the ipsilateral carotid artery.²¹ The trial was terminated prematurely (n=527 enrolled; original target, N=872), based on interim analysis of 30-day outcomes. The incidence of any stroke or death through 30 days was 3.9% (95% CI, 2.0% to 7.2%) after CEA and 9.6% (95% CI, 6.4% to 14%) after CAS (RR=2.5; 95% CI, 1.2 to 5.1; $p=0.01$).

Over a mean 2.1 years of follow-up, restenosis ($\geq 50\%$) was more frequent following CAS (12.5%) than CEA (5.0%).²² Long-term follow-up from EVA-3S was reported at 4 years.²³ Approximate annual ipsilateral stroke rates from day 31 through longest follow-up for CAS and CEA, respectively, were 1.1% and 0.9%. These results supported a conclusion that following the periprocedural period (ie, 31 days to longest follow-up), stroke risk reduction in symptomatic patients not selected based on medical or anatomic comorbidities was similar for CAS and CEA.

Editorialists criticized EVA-3S for recommending but not requiring antiplatelet premedication (3 days of aspirin plus ticlopidine or clopidogrel) and for not requiring interventionalists to be adequately experienced with the specific stent, and EPDs used to treat trial subjects.^{19,20} Participating interventionalists were required to have completed 12 or more CAS procedures compared with 25 or more CEAs for vascular surgeons. EVA-3S also permitted the use of 5 different stents and 7 different EPDs but required only 2 prior procedures with a new device before an investigator could use that device on a patient randomized to CAS.

Mas et al (2014) published long-term follow-up (median, 7.2 years) from the EVA-3S trial.²⁴ Complete follow-up until death or the final telephone interview was obtained in 493 (94%) of the 527 patients. At the 5-year follow-up, the main composite end point (ipsilateral stroke after randomization or procedural stroke or death) occurred in 29 (11%) of 265 subjects in the CAS group and 16 (6.1%) of 262 subjects in the CEA group (5-year absolute risk reduction, 4.7%). The hazard ratio (HR) for CAS vs CEA was 1.85 (95% CI, 1.0 to 3.40; $p=0.04$). At the 10-year follow-up, the HR for the main composite end point for CAS vs CEA was 1.70 (95% CI, 0.95 to 3.06; $p=0.07$).

International Carotid Stenting Study

The International Carotid Stenting Study (ICSS) enrolled 1713 symptomatic patients at 50 academic medical centers across Europe, Australia, New Zealand, and Canada between May 2001 and October 2008.²⁵ EPDs were recommended but not required (used in 72% of procedures), and a number of different stents and EPD types were used. Based on plausible event rates, a target study sample size of 1500 was estimated to be able to define a between-group difference less than 3.3% in disabling stroke or death and a 3.0% difference in 30-day stroke, death, or MI. Only interim 30- and 120-day results were included in the initial report. From a per-protocol analysis, the 7.1% periprocedural death or stroke death rates accompanying CAS both exceeded the rate established to provide a net clinical benefit and was more than twice that following CEA (3.4%). In a subgroup analysis of 231 ICSS participants, new ischemic brain lesions were approximately 3-fold more frequent following CAS, and protective devices did not appear to mitigate their occurrence.²⁶ Interim results were consistent with the accompanying editorialist's conclusion that "routine stenting in symptomatic patients must now be difficult to justify..."²⁷

Bonati et al (2015) published longer term follow-up results from ICSS.²⁸ The cumulative 5-year risk of fatal or disabling stroke did not differ significantly between the CAS (6.4%) and the CEA groups (6.5%; HR=1.06; 95% CI, 0.72 to 1.57; p=0.77). However, the 5-year cumulative risk of any stroke was higher in the CAS group (15.2%) than in the CEA group (9.45%; HR=1.71; 95% CI, 1.28 to 2.3; p<0.001). The authors noted that the difference between CEA and CAS groups in stroke risk after the procedural period was mainly attributable to strokes occurring in the contralateral carotid or vertebrobasilar territory in the CAS group. Functional outcomes, measured by modified Rankin Scale scores, did not differ significantly between groups.

Altinbas et al (2014) reported that periprocedural rates of hemodynamic instability in the ICSS differed between CEA and CAS groups.²⁹ Hemodynamic depression occurred more commonly in CAS patients (13.8% vs 7.2%; RR=1.9; 95% CI, 1.4 to 2.6; p<0.000), while hypertension requiring treatment occurred less commonly in CAS patients (RR=0.2; 95% CI, 0.1 to 0.4; p<0.000). Hemodynamic instability was not associated with the ICSS study's primary composite outcome.

Featherstone et al (2016) published a health technology assessment on ICSS funded by the National Institute for Health Research.³⁰ The assessment reviewed the data presented above, concluding that "the functional outcome after stenting is similar to endarterectomy, but stenting is associated with a small increase in the risk of nondisabling stroke. The choice between stenting and endarterectomy should take into account the procedural risks related to individual patient characteristics."

CREST

CREST was conducted between December 2000 and July 2008, and enrolled 2522 patients at 117 centers across the United States and Canada.¹¹ Of 427 interventionalists who applied to participate in CREST, only 224 (52%) were approved.³¹ Inclusion was initially restricted to recently symptomatic patients. Due to slow enrollment, the protocol was amended to include asymptomatic patients. A March 2004 protocol amendment excluded further enrollment of patients 80 years and older due to poor outcomes. Of the 1271 patients randomized to CAS, 65 underwent CEA and 54 neither procedure; of the 1251 patients randomized to CEA, 13 underwent CAS and 44 neither procedure. Twenty patients were excluded from 1 site due to reported data fabrication. A sample size of 2500 was targeted to detect a 46% reduction in the HR for the primary end point of any stroke, MI, or death during the periprocedural period or ipsilateral stroke within 4 years after randomization.

In the entire sample (symptomatic and asymptomatic patients), investigators reported no difference between CAS and CEA for the primary outcome. Stroke was more frequent following CAS; MI more frequent after CEA. The periprocedural MI rate after CEA (2.3%) was considerably higher in CREST than any comparable trial (eg, in EVA-3S, 0.8%; SPACE, 0%; ICSS, 0.6%). This might be attributable to a somewhat higher prevalence of coronary artery disease among participants and routine cardiac enzyme assays, but the relative difference was large. Periprocedural CAS death or stroke rates were the lowest reported in any trial. Although participating interventionalists performing CAS were highly selected, periprocedural death or stroke rates following CAS exceeded those for CEA: in symptomatic patients, 5.6% vs 2.4%, respectively (the lowest rate for CAS reported in any trial); in asymptomatic patients, 2.6% vs 1.4%, respectively.³² The RR for periprocedural death or stroke in the symptomatic group was 1.89 (95% CI, 1.11 to 3.21) and in the asymptomatic group, it was 1.85 (95% CI, 0.79 to 4.34).

The trial had limited power to detect a difference between procedures in the asymptomatic group. In CREST, 2-year restenosis (>70%) or reocclusion rates were similar following CEA (6.3%) and CAS (6.0%)—2-year restenosis alone was 5.8% with either procedure.³³

Brott et al (2016) reported on long-term follow-up from CREST. There were no significant differences in the primary composite outcome (any periprocedural stroke, MI, death, or postprocedural ipsilateral stroke) between the CEA (9.9%) and CAS (11.8%; HR=1.10) groups when measured out to 10 years.³⁴ The second primary end point (postprocedural ipsilateral stroke rates) also did not differ significantly between CEA (5.6%) and CAS (6.9%; HR=0.99).

Interventionalists in CREST were the most carefully selected in any trial, and the lack of similar selection criteria has been a critique of the other trials.³⁵ Analyses of CAS in Medicare patients between 2005 and 2007 found that few CAS operators had the experience of CREST investigators.³⁶ Among the 11,846 procedures with documented operator experience, 68% were performed by operators having performed fewer than 12 procedures.

In a follow-up analysis of CREST data, Gonzales et al (2014) reported no differences in efficacy and safety outcomes for subjects based on receiving treatment in high-, medium-, or low-volume centers.³⁷

Asymptomatic Carotid Trial

The Asymptomatic Carotid Trial I was a noninferiority trial reported by Rosenfield et al (2016) who compared CAS with CEA in asymptomatic individuals, not at high risk for surgical complications.³⁸ Enrollment began in 2005, with a target of 1658 participants; but, because of slow enrollment, the trial was halted in 2013 at 1453 participants. The primary composite end point (death, stroke, or MI within 30 days or ipsilateral stroke within 1 year) was met by 3.8% of CAS and 3.4% of CEA patients, while the cumulative 5-year rate of stroke-free survival was 93.1% with CAS and 94.7% with CEA (p=0.44). This trial did not answer how best to treat asymptomatic patients, because it did not include a medical therapy arm. Patients treated with current best medical therapy might have had an ipsilateral stroke rate of only 0.5% to 1% per year.³⁹

Additional RCTs

Several other smaller trials have compared CEA with CAS. Li et al (2014) published a trial that randomized 130 subjects at high risk of stroke due to angiographically confirmed carotid stenosis ($\geq 50\%$) to CEA (n=65) or CAS (n=65).⁴⁰ The authors reported a 3-month postoperative risk of mortality of 1.5% with CAS compared with 9.2% with CEA. However, “existence of complete follow-up data” was an inclusion criterion, and insufficient details were provided about enrollment and randomization procedures to permit conclusions about the trial.

Kuliha et al (2015) published results of an RCT that allocated 150 subjects with at least 70% internal carotid artery stenosis to CEA (n=73) or CAS (n=77).⁴¹ New infarctions on magnetic resonance imaging were found more frequently after CAS (49% vs 25%; p=0.002).

Section Summary: Randomized Controlled Trials of CAS vs CEA

RCTs comparing CEA with CAS enrolled a mix of symptomatic and asymptomatic patients and employed different selection criteria for participating centers. Periprocedural stroke and death rates following CAS exceeded those after CEA. Following the early perioperative period (≥ 31 days), the rates of ipsilateral stroke and/or transient ischemic attack appear to be similar for the 2 procedures. While some trials found higher restenosis rates after CAS (SAPPHIRE, SPACE, EVA-

3S), restenosis in CREST occurred at similar frequency following either procedure. The rates of early complications in SPACE, EVA-3S, and ICSS exceeded 6.0%. In CREST, periprocedural death or stroke rates with CAS were less than 6% in symptomatic and 3% in asymptomatic patients. Interventionalists in CREST were the most carefully selected in any trial, and the criteria used to credential in other trials has been a focus of criticisms, along with the inconsistent use of EPDs.⁴²

No RCTs have compared CAS with medical therapy. Therefore, it is not possible to determine whether CAS is superior to medical therapy. Since the pivotal CEA vs medical therapy trials, there has been a marked improvement in medical therapy and declining stroke rates in asymptomatic patients with carotid stenosis. In 1993, the ACST trial⁴ reported that the annual ipsilateral stroke rate was approximately 2.0% with medical therapy.¹⁰ A meta-analysis of studies completing enrollment between 2000 and 2010 found a pooled estimate for annual ipsilateral stroke incidence of 1.13%. This decrease in stroke risk has been used to argue that medical therapy in asymptomatic patients is preferable to surgical intervention.^{27,43,44}

Systematic Reviews

Several TEC Assessments and meta-analyses have been published, all reporting similar findings.⁴⁵⁻⁴⁹ In average-risk symptomatic patients, the body of evidence has demonstrated worse periprocedural outcomes with CAS than with CEA. While data have shown secular improvement in periprocedural outcomes following CAS, there is evidence of net harm compared with CEA.^{32,50} A 2010 individual patient data meta-analysis of SPACE, EVA-3S, and ICSS indicated some uncertainty in comparative periprocedural death or stroke rates for younger symptomatic patients.⁵¹ Still, that subgroup result must be considered carefully given the larger body of evidence, lack of stratified randomization, as well as the evidence on restenosis. Meta-analyses have generally found that restenosis is more common following CAS than CEA. In a meta-analysis of 13 trials, among those reporting restenosis rates, Bangalore et al (2011) reported pooled relative odds for restenosis following CAS compared with CEA of 2.8 (95% CI, 2.0 to 4.0; $P=0\%$).⁴⁷ Of note was the individual patient data meta-analysis (N=3433) of SPACE, EVA-3S, and ICSS.⁵¹ In these symptomatic patients, the 30-day death or stroke risk (per-protocol analyses) with CAS was 7.7% vs 4.4% following CEA (RR=1.74; 95% CI, 1.32 to 2.30).

The Carotid Stenting Trialists' Collaboration (2016) published an individual patient data meta-analysis (total N=4754 patients) of SPACE, EVA-3S, and ICSS data, plus data from symptomatic patients in CREST to evaluate the association between age and risk of stroke or death with CEA and CAS.⁵² The periprocedural period was defined as 120 days, which is considerably longer than the conventional 30-day periprocedural definition. For symptomatic patients assigned to CEA, there was no increase in the periprocedural or postprocedural risk of death or stroke for patients older than 65 compared with those younger than 60. In contrast, for patients assigned to CAS, the risk of periprocedural events increased with age, from a 2.1% risk for patients less than 60 years, to 11% for patients over 70 years. These analyses found increased periprocedural stroke risk for CAS vs CEA in patients approximately 65 years and older, but not among those younger patients (an age threshold was not defined). Age was not significantly associated with postprocedural stroke risk. The results would suggest that the risk-benefit profile for CAS in symptomatic patients enrolled in these trials could be modified by age, but there was considerable imprecision in the age-specific CAS vs CEA comparisons for periprocedural risk. For example, among patients ages 60 to 64 years, the HR comparing CAS with CEA for the periprocedural risk of stroke or death was 1.07 (95% CI, 0.56 to 2.01).

Paraskevas et al (2014) conducted a systematic review of studies comparing cognitive outcomes after CEA with those after CAS.⁵³ Thirteen studies were included, with heterogeneity in the types

of cognitive outcome measures reported. In qualitative analysis, reviewers found that most studies did not report a significant difference between CEA and CAS regarding cognitive outcomes and that heterogeneity across outcomes reported precluded more definitive conclusions.

Galyfos et al (2014) reported on results of a meta-analysis that included 9 trials (total N=5959 patients) with a focus on the risk of periprocedural symptomatic or asymptomatic myocardial ischemia or MI.⁵⁴ Four trials did not report their definitions for myocardial ischemia, and other studies varied in their definitions. In the pooled analysis, compared with CEA, CAS was associated with decreased risk of cardiac damage (pooled RR=0.37; 95% CI, 0.22 to 0.61; p<0.000). However, reviewers provided incomplete information on the selection of studies for inclusion, which limits conclusions that can be drawn.

Vincent et al (2015) conducted a meta-analysis of 8 RCTs (total N=7091 patients).⁵⁵ Studies selected compared CAS with CEA, enrolled more than 50 patients, and reported periprocedural or long-term outcomes. Included were the CREST, ICSS, SPACE, EVA-3S, and SAPPHERE trials (described above), along with CAVATAS, an RCT comparing surgical management with endovascular treatment in 504 patients with symptomatic carotid stenosis. CAS was associated with an increased risk of any periprocedural stroke (RR=1.49; 95% CI, 1.11 to 2.01), a similar risk of a disabling or major stroke, and a decreased risk of periprocedural MI (RR=0.47; 95% CI, 0.29 to 0.78) compared with CEA. However, in long-term follow-up (range, 2-10 years), stenting was associated with an increased risk of stroke (RR=1.36; 95% CI, 1.16 to 1.61) and an increased risk of the composite end point of ipsilateral stroke, periprocedural stroke, or periprocedural death (RR=1.45; 95% CI, 1.20 to 1.75) compared with CEA. This analysis supported a conclusion that CEA remains the treatment of choice for most patients due to the increase in adverse events with CAS.

Section Summary: Systematic Reviews

The systematic reviews have corroborated the results of individual RCTs that early adverse events are higher with CAS than with CEA, that long-term stroke rates following the perioperative period are similar, and that restenosis rates are higher with CAS. These data would indicate that, for the average-risk patient with carotid stenosis, CAS is associated with net harm compared with CEA.

Periprocedural Death or Stroke Rates Following CAS

Systematic Reviews

Questions of periprocedural death or stroke rates were assessed in a TEC Assessment (2010).⁵⁶ Given that CAS (like CEA) trades the procedure-related risks of stroke and death for a reduced risk of stroke over subsequent years, and limits for periprocedural stroke and death rates that can be assumed to achieve a net clinical benefit outlined in current guidelines are less than 3% for asymptomatic and less than 6% for symptomatic patients, the Assessment sought evidence to address 2 questions: (1) Is the periprocedural rate of death or stroke with CAS less than 3% for asymptomatic and less than 6% for symptomatic patients? (2) For those subgroups defined by (a) medical comorbidities or (b) unfavorable anatomy, are periprocedural rates of death or stroke with CAS less than 3% for asymptomatic and less than 6% for symptomatic patients?

To the first question, the Assessment identified 18 multicenter prospective registries collectively enrolling 20,194 patients. Eleven of those registries enrolled patients in accordance with the U.S. Food and Drug Administration labeling and with 30-day outcomes available for analysis by symptomatic status (13,783 asymptomatic, 3353 symptomatic). In 9 of those registries, 30-day

death or stroke rates were either reported or obtained from investigators and in the remaining 2, death or stroke rates were estimated from 30-day death/stroke/MI and MI rates. An independent assessment of neurologic outcomes was required in all but 1 registry. For asymptomatic patients, the pooled periprocedural death or stroke rate was 3.9% (95% CI, 3.3% to 4.4%; $I^2=57%$); for symptomatic patients, it was 7.4% (95% CI, 6.0% to 9.0%; $I^2=59%$).

A subsequent systematic review, without consideration to the Food and Drug Administration labeling, reported results consistent with the TEC Assessment (pooled periprocedural death/stroke rates in asymptomatic patients of 3.3% [95% CI, 2.6% to 4.1%; 23 studies; n=8504 patients] and in symptomatic patients of 7.6% [95% CI, 6.3% to 9.1%; 42 studies; 4910 patients]).⁵⁰

To the second question, the Assessment found that combined data from 2 registries reported periprocedural death or stroke rates for patients with unfavorable anatomy^{57,58} but included only 371 asymptomatic (30-day death or stroke rate, 2.7%; 95% CI, 1.5% to 4.9%) and 60 symptomatic patients (30-day death or stroke rate, 1.7%; 95% CI, 0.3% to 8.9%). No other registry reported results by symptomatic status for those subgroups.

Since of the 2010 TEC Assessment, additional evidence has been published on rates of periprocedural stroke and death following CAS, particularly for subgroups defined by medical comorbidities. Spangler et al (2014) evaluated patients treated with isolated primary CEA (n=11,336) or primary CAS (n=544) at 29 centers between 2003 and 2013 to assess periprocedural mortality and stroke risks for those considered at medically high risk.⁵⁹ A Cox proportional hazards model was used to generate predicted 5-year mortality, and patients in the highest risk score quartile were considered high risk. For asymptomatic patients, there were no significant differences between CEA and CAS for major periprocedural outcomes (major or minor stroke, MI, death) for either high- or low-risk patients. Periprocedural death or stroke rates with CAS were 1.1% for low-risk patients and 1.6% for high-risk patients. For symptomatic patients, periprocedural death or stroke rates were higher with CAS than with CEA for both low- and high-risk groups. For low-risk symptomatic patients, periprocedural death or stroke rates were 6.0% for CAS and 2.2% for CEA ($p<0.01$). For high-risk symptomatic patients, periprocedural death or stroke rates were 9.3% for CAS and 2.5% for CEA ($p<0.01$).

Retrospective Analyses

Salzler et al (2017) conducted a large retrospective analysis of the increased use of CAS since the Centers for Medicare & Medicaid guidelines recommended CAS for high-risk patients needing carotid revascularization.⁶⁰ Data from the Nationwide Inpatient Sample were searched for patients undergoing carotid revascularization. From 2005 (when the guidelines were published) to 2011, 20,079 CEAs and 3447 CASs were performed on high-risk patients. During the study period, CAS utilization increased significantly among all high-risk patients. A subgroup analysis of symptomatic high-risk patients did not show an increase in CAS use, indicating that the increase in CAS was primarily in asymptomatic high-risk patients. The odds of in-hospital mortality (odds ratio, 2.6; 95% CI, 1.2 to 5.6) and postoperative in-hospital stroke (odds ratio, 1.5; 95% CI, 1.1 to 3.7) were independently and significantly higher in patients undergoing CAS compared with CEA in the overall sample of high-risk patients.

CAS for Carotid Dissection

Carotid dissection is uncommon (incidence \approx 2 per 100,000/year) and generally occurs in younger individuals.⁶¹ With a frequently favorable prognosis, conservative therapy with anticoagulants to restore blood flow is typically employed while surgical intervention is reserved for patients whose

symptoms fail to respond to conservative care. Some have described CAS as a potential treatment in those instances⁶²⁻⁶⁴; however, there are no clinical trials comparing alternative strategies and interventions. Current guidelines (detailed below) rate CAS for this indication as a class IIb (level of evidence: C) recommendation.

SUMMARY OF EVIDENCE

For individuals who have carotid artery stenosis who receive CAS, the evidence includes randomized controlled trials and systematic reviews of these trials. Relevant outcomes are overall survival, morbid events, and treatment-related mortality and morbidity. A substantial body of RCT evidence has compared outcomes of CAS with CEA for symptomatic and asymptomatic patients with carotid stenosis. The evidence does not support the use of CAS in carotid artery disease for the average-risk patient, because early adverse events are higher with CAS and long-term outcomes are similar between the 2 procedures. Data from RCTs and large database studies have established that the risk of death or stroke with CAS exceeds the threshold considered acceptable to indicate overall benefit from the procedure. Therefore, for patients with carotid stenosis who are suitable candidates for CEA, CAS does not improve health outcomes. The evidence is sufficient to determine that the technology is unlikely to improve the net health outcome.

CLINICAL INPUT RECEIVED THROUGH PHYSICIAN SPECIALTY SOCIETIES AND ACADEMIC MEDICAL CENTERS

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests, input was received through 4 physician specialty societies (6 reviewers) and 4 academic medical centers while this policy was under review in 2009. (In addition, 1 unsolicited response from a specialty society was received.) Input strongly supported use of CAS in recently symptomatic patients where surgical CEA cannot be performed due to anatomic reasons, although acknowledging the limited evidence pertaining to this subgroup. The lack of alternative treatments for recently symptomatic patients and the established increased risk of stroke were factors supporting this opinion.

PRACTICE GUIDELINES AND POSITION STATEMENTS

American Stroke Association

In 2011, the American Stroke Association, with 13 other medical societies, issued guidelines on the management of extracranial carotid and vertebral artery diseases, which are summarized in Table 3.⁶⁵⁻⁶⁷

Table 3. Guidelines on Management of Patients With Extracranial Carotid and Vertebral Artery Disease

| Recommendation | COR ^a | LOE ^b |
|---|------------------|------------------|
| CAS is indicated as an alternative to CEA for symptomatic patients at average or low risk of complications associated with endovascular intervention when the diameter of the lumen of the internal carotid artery is reduced by >70%, as documented by noninvasive imaging or >50% as documented by catheter angiography and the anticipated rate of periprocedural stroke or mortality is <6% (360) | I | B |
| Selection of asymptomatic patients for carotid revascularization should be guided by an assessment of comorbid conditions, life expectancy, and other individual factors and should | I | C |

| Recommendation | COR ^a | LOE ^b |
|--|------------------|------------------|
| include a thorough discussion of the risks and benefits of the procedure with an understanding of patient preferences | | |
| It is reasonable to choose CEA over CAS when revascularization is indicated in older patients, particularly when arterial pathoanatomy is unfavorable for endovascular intervention | IIa | B |
| It is reasonable to choose CAS over CEA when revascularization is indicated in patients with neck anatomy unfavorable for arterial surgery | IIa | B |
| When revascularization is indicated for patients with TIA or stroke and there are no contraindications to early revascularization, intervention within 2 wks of the index event is reasonable rather than delaying surgery | IIa | B |
| Prophylactic CAS might be considered in highly selected patients with asymptomatic carotid stenosis (minimum 60% by angiography, 70% by validated Doppler ultrasound), but its effectiveness compared with medical therapy alone in this situation is not well established | IIb | B |
| In symptomatic or asymptomatic patients at high risk of complications for carotid revascularization by either CEA or CAS because of comorbidities, the effectiveness of revascularization versus medical therapy alone is not well established | IIb | B |
| Carotid angioplasty and stenting might be considered when ischemic neurologic symptoms have not responded to anti-thrombotic therapy after acute carotid dissection | IIb | C |
| Except in extraordinary circumstances, carotid revascularization by either CEA or CAS is not recommended when atherosclerosis narrows the lumen by <50% | III | A |
| Carotid revascularization is not recommended for patients with chronic total occlusion of the targeted carotid artery | III | C |
| Carotid revascularization is not recommended for patients with severe disability caused by cerebral infarction that precludes preservation of useful function | III | C |

CAS: carotid artery angioplasty with stenting; CEA: carotid endarterectomy; LOE: level of evidence; TIA; transient ischemic attack.

^a COR: class I: benefit >>> risk; class IIa benefit >> risk; class IIb benefit ≥ risk; class III: no benefit.

^b LOE: A (data derived from multiple randomized controlled trials or meta-analyses; multiple populations evaluated); B (data derived from a single randomized controlled trial or nonrandomized studies; limited populations evaluated); C (only consensus opinion of experts, case studies, or standard of care; very limited populations evaluated).

Society for Vascular Surgery

In 2011, the Society for Vascular Surgery (SVS) issued updated guidelines for management of extracranial carotid disease, which are summarized in Table 4.⁶⁸

Table 4. Guidelines for Management of Extracranial Carotid Disease

| Recommendation | Grade ^a | LOE ^b |
|--|--------------------|------------------|
| In most patients with carotid stenosis who are candidates for intervention, CEA is preferred to CAS for reduction of all-cause and periprocedural death | I | B |
| CAS is preferred over CEA in symptomatic patients with >50% stenosis and tracheal stoma, situations where local tissues are scarred and fibrotic from prior ipsilateral surgery or external beam radiotherapy, prior cranial nerve injury, and lesions that extend proximal to the clavicle or distal to the C2 vertebral body | II | B |
| CAS is preferred over CEA in symptomatic patients with >50% stenosis and severe uncorrectable coronary artery disease, congestive heart failure, or chronic obstructive pulmonary disease | II | C |
| There are insufficient data to recommend CAS as primary therapy for neurologically asymptomatic patients with 70%-99% diameter stenosis. In properly selected asymptomatic patients, CAS is equivalent to CEA in the hands of experienced interventionalists with a combined stroke and death rate <3% | II | B |

CAS: carotid artery angioplasty with stenting; CEA: carotid endarterectomy; LOE: level of evidence.

^a Grade I: benefit clearly outweighs risk; grade II: benefits and risks are more closely matched and are more dependent on specific clinical scenarios.

^b LOE: A (high quality); B (moderate quality); C (low quality).

European Society of Cardiology

In 2018,⁶⁹ the European Society of Cardiology updated its 2011⁷⁰ guidelines on the diagnosis and treatment of peripheral artery diseases, which included recommendations on CAS.

Recommendations are summarized in Table 5.

Table 5. Guidelines for the Diagnosis and Treatment of Carotid Artery Disease

| Recommendation | COR ^a | LOE ^b |
|---|------------------|------------------|
| In asymptomatic patients who have been deemed “high risk for CEA” and who have an asymptomatic 60%-99% stenosis in the presence of clinical and/or imaging characteristics that may be associated with an increased risk of late ipsilateral stroke, CAS should be considered, provided documented perioperative stroke/death rates are <3% and the patient’s life expectancy is >5 years | I1a | B |
| In “average surgical risk” patients with an asymptomatic 60–99% stenosis in the presence of clinical and/or imaging characteristics that may be associated with an increased risk of late ipsilateral stroke, CAS may be an alternative to CEA provided documented perioperative stroke/death rates are <3% and the patient’s life expectancy is >5 years | I1b | B |
| In recently symptomatic patients with a 50%-99% stenosis who present with adverse anatomical features or medical comorbidities that are considered to make them ‘high risk for CEA’, CAS should be considered, provided the documented procedural death/stroke rate is <6% | I1a | B |
| When revascularization is indicated in “average surgical risk” patients with symptomatic carotid disease, CAS may be considered as an alternative to surgery, provided the documented procedural death/stroke rate is <6%. | I1b | B |

CAS: carotid artery angioplasty with stenting; CEA: carotid endarterectomy; COR: class of recommendation; LOE: level of evidence.

^a COR: I1a: should be considered; I1b: may be considered.

^b Levels of evidence: A (data from multiple randomized clinical trials or meta-analyses); B (data from a single randomized clinical trial or large nonrandomized studies); C (consensus of opinion of the experts and/or small studies, retrospective studies, registries).

National Institute for Health and Care Excellence

The National Institute for Health and Care Excellence issued the following guidance in 2011 on coronary artery stenting (CAS)⁷¹:

“Current evidence on the safety of CAS placement for asymptomatic extracranial carotid stenosis shows well documented risks, in particular, the risk of stroke. The evidence on efficacy is inadequate in quantity. Therefore, this procedure should only be used with special arrangements for clinical governance, consent, and audit or research.”

Royal Australasian College of Physicians et al

The Royal Australasian College of Physicians, Royal Australasian College of Surgeons, and Royal Australian and New Zealand College of Radiologists issued joint recommendations in 2011 on CAS⁷²:

- “CAS may be considered as a treatment option for patients with symptomatic severe carotid stenosis who are at high risk of stroke, but are surgically unsuitable for CEA [carotid endarterectomy], namely postradiation therapy, block dissection of the neck, in situ tracheostomy, recurrent stenosis following previous CEA, severe cervical spine arthritis, surgically inaccessible carotid stenosis (e.g., obesity, high carotid bifurcation), contralateral recurrent laryngeal nerve injury, and contralateral internal carotid occlusion.”
- “The overall results of randomized controlled trials indicate that CAS is not as safe as CEA for treatment of symptomatic carotid stenosis for prevention of ipsilateral stroke.”
- “There is currently no evidence to support CAS as a treatment for asymptomatic carotid stenosis.”

U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATIONS

Not applicable.

ONGOING AND UNPUBLISHED CLINICAL TRIALS

Some currently unpublished trials that might influence this review are listed in Table 6. There are no ongoing or direct comparisons of CAS with CEA in patients at increased risk for CEA complications.^{74,75} Particularly problematic is the lack of adequate data, from either randomized or nonrandomized studies, to separately compare outcomes of the alternatives (CAS vs CEA vs

current optimal medical management) in symptomatic and asymptomatic increased-risk subgroups.

Table 6. Summary of Key Trials

| NCT No. | Trial Name | Planned Enrollment | Completion Date |
|----------------|---|--------------------|-----------------|
| Ongoing | | | |
| NCT02538276 | Carotid Endarterectomy and Carotid Artery Stenting in Brazil | 500 | Jul 2019 |
| NCT00883402 | Asymptomatic Carotid Surgery Trial-2 (ACST-2): an International Randomised Trial to Compare Carotid Endarterectomy With Carotid Artery Stenting to Prevent Stroke | 3600 | Dec 2019 |
| ISRCTN78592017 | Stent-protected angioplasty in asymptomatic carotid artery stenosis vs endarterectomy: two two-arm clinical trials (SPACE-2) | 5000 | Jul 2020 |
| NCT02089217 | Carotid revascularization and medical management for asymptomatic carotid stenosis trial (CREST-2) | 2480 | Dec 2020 |
| ISRCTN97744893 | European Carotid Surgery Trial 2 (ECST-2): a randomized controlled trial | 2000 | Mar 2022 |

NCT: national clinical trial.

CODING

The following codes for treatment and procedures applicable to this policy are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

CPT/HCPCS

- 37215 Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection
- 37216 Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty when performed, and radiological supervision and interpretation; without distal embolic protection
- 37217 Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation
- 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

ICD-10 Diagnoses

- I63.031 Cerebral infarction due to thrombosis of right carotid artery
- I63.032 Cerebral infarction due to thrombosis of left carotid artery
- I63.033 Cerebral infarction due to thrombosis of bilateral carotid arteries
- I63.039 Cerebral infarction due to thrombosis of unspecified carotid artery
- I63.131 Cerebral infarction due to embolism of right carotid artery
- I63.132 Cerebral infarction due to embolism of left carotid artery

| | |
|---------|--|
| 163.133 | Cerebral infarction due to embolism of bilateral vertebral arteries |
| 163.139 | Cerebral infarction due to embolism of unspecified carotid artery |
| 163.231 | Cerebral infarction due to unspecified occlusion or stenosis of right carotid arteries |
| 163.232 | Cerebral infarction due to unspecified occlusion or stenosis of left carotid arteries |
| 163.233 | Cerebral infarction due to unspecified occlusion or stenosis of bilateral carotid arteries |
| 165.21 | Occlusion and stenosis of right carotid artery |
| 165.22 | Occlusion and stenosis of left carotid artery |
| 165.23 | Occlusion and stenosis of bilateral carotid arteries |

REVISIONS

| | |
|------------|--|
| 12-09-2011 | Updated the Description section. |
| | Updated the Rationale section. |
| | In the coding section: <ul style="list-style-type: none"> ▪ Diagnosis nomenclature updated. |
| | Added the Revisions section |
| | Updated Reference section. |
| 09-05-2013 | Updated Description section. |
| | Updated Rationale section. |
| | In Coding section: <ul style="list-style-type: none"> ▪ Added ICD-10 Diagnosis (<i>Effective October 1, 2014</i>) |
| | Updated Reference section. |
| 12-31-2013 | In Coding section: <ul style="list-style-type: none"> ▪ Added CPT code 37217 (<i>New code, effective January 1, 2014</i>) |
| 01-01-2015 | In Coding section: <ul style="list-style-type: none"> ▪ Added CPT Code: 37218 (<i>Effective January 1, 2015</i>) ▪ Revised CPT Codes: 0075T, 0076T (<i>Effective January 1, 2015</i>) |
| 05-13-2015 | Updated Description section. |
| | Updated Rationale section. |
| | Updated References section. |
| 08-17-2016 | Title revised from "Extracranial Carotid Angioplasty/Stenting" |
| | Updated Description section. |
| | Updated Rationale section. |
| | In Coding section: <ul style="list-style-type: none"> ▪ Removed CPT codes: 0075T, 0076T. |
| | Updated References section. |
| 10-01-2016 | In Coding section: <ul style="list-style-type: none"> ▪ Added ICD-10 codes effective 10-01-2016: I63.033, I63.133, I63.233 |
| 10-25-2017 | Updated Description section. |
| | In Policy section: <ul style="list-style-type: none"> ▪ Removed previous language: "A. Extracranial carotid artery angioplasty and stent placement (CAS) is considered medically necessary in patients who meet one or more of the following criteria: 1. Symptomatic stenosis equal to or greater than 50%, or asymptomatic stenosis equal to or > 80% in a patient at a high risk for surgery due to one or more of the following conditions: a. Age > 80 years; or b. Congestive heart failure (NYHA Class III/IV) and/or left ventricular ejection fraction < 30%; or c. Open heart surgery needed within the next 6 weeks; or d. Recent myocardial infarction (> 24 hours and < 4 weeks); or e. Severe chronic obstructive pulmonary disease; or f. Unstable angina (CCS class III/IV); OR 2. Symptomatic |

| | |
|-------------------|---|
| | <p>stenosis equal to or greater than 50% or asymptomatic stenosis equal to or greater than 80% and one or more of the following conditions: a. Contralateral laryngeal nerve palsy; or b, Existence of lesions distal or proximal to the usual location; or c. Radiation-induced stenosis following previous radiation therapy to the neck or radical neck dissection; or d. Restenosis after carotid endarterectomy (CEA); or e. Severe tandem lesions that may require endovascular therapy; or f. Stenosis secondary to arterial dissection; or g. Stenosis secondary to fibromuscular dysplasia; or h. Stenosis secondary to Takayasu arteritis; or i. Stenosis that is surgically difficult to access (e.g., high bifurcation requiring mandibular dislocation); or j. Stenosis associated with contralateral carotid artery occlusion; or k. Pseudoaneurysm; OR 3. Inability to move the neck to a suitable position for surgery; OR 4. Tracheostomy. B. Carotid artery angioplasty and stent placement (CAS) is considered experimental / investigational when the above criteria are not met, including but not limited to, the following conditions: 1. Complete occlusion (100% stenosis) of the relevant carotid artery; 1. Severe symptomatic carotid stenosis in patients not meeting the criteria above; 3. Symptomatic stenosis < 50% of the relevant carotid artery; 4. Asymptomatic stenosis < 80% of the relevant carotid artery. C. Percutaneous angioplasty (PTA) with or without associated stenting is considered experimental / investigational when used in the treatment of atherosclerotic stenosis of: A. Extracranial vertebral arteries; 2. Intracranial arteries."</p> <ul style="list-style-type: none"> ▪ Added new language: Carotid angioplasty with associated stenting and embolic protection may be considered medically necessary in patients with: 1. 50% to 99% stenosis (North American Symptomatic Carotid Endarterectomy Trial [NASCET] measurement); AND 2. symptoms of focal cerebral ischemia (transient ischemic attack or monocular blindness) in the previous 120 days, symptom duration less than 24 hours, or nondisabling stroke; AND 3. anatomic contraindication for carotid endarterectomy (eg, prior radiotherapy or neck surgery, lesions surgically inaccessible, spinal immobility, or tracheostomy). B. Carotid angioplasty with associated stenting and embolic protection is considered investigational for all other indications, including but not limited to, patients with carotid stenosis who are suitable candidates for carotid endarterectomy and patients with carotid artery dissection. C. Carotid angioplasty without associated stenting and embolic protection is considered investigational for all indications, including but not limited to, patients with carotid stenosis who are suitable candidates for carotid endarterectomy and patients with carotid artery dissection." |
| | <p>Updated Rationale section.</p> |
| | <p>In Coding section:</p> <ul style="list-style-type: none"> ▪ Updated nomenclature to CPT codes: 37215, 37216, 37217. |
| | <p>Updated References section.</p> |
| <p>07-18-2018</p> | <p>Updated Description section.</p> |
| | <p>Updated Rationale section.</p> |
| | <p>In Coding section:</p> <ul style="list-style-type: none"> ▪ Removed ICD-9 codes. |
| | <p>Updated References section.</p> |

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