

Extracranial Carotid Angioplasty and Stenting

Effective: January 1, 2021

Next Review: September 2021

Last Review: November 2020

IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

Extracranial carotid angioplasty/stenting (CAS) is the insertion of a stent (wire-mesh tube) into a narrowed carotid artery. CAS is a treatment for carotid stenosis that is intended to prevent future stroke.

MEDICAL POLICY CRITERIA

Note: This policy does not address percutaneous angioplasty and stenting of intracranial or venous vessels, which are addressed in separate policies (see Cross References section).

- I. Extracranial carotid angioplasty and stenting may be considered **medically necessary** for the treatment of carotid artery dissection.
- II. Extracranial carotid angioplasty with associated stenting and embolic protection may be considered **medically necessary** when all of the following criteria (A. – C.) are met:
 - A. Documented stenosis of at least 50%; and
 - B. Symptoms with duration less than 24 hours of focal ischemia (transient ischemic attack or monocular blindness) in previous 120 days, or nondisabling stroke; and

- C. One or more of the following anatomic contraindications for carotid endarterectomy are present:
1. Tissue changes from prior extensive ipsilateral neck radiation
 2. Prior ipsilateral radical neck resection
 3. Anatomical malformation that prevents collateral circulation to the brain during open carotid endarterectomy
 4. Lesions surgically inaccessible (such as high internal carotid lesion that cannot be accessed from the neck)
 5. Spinal immobility preventing open carotid endarterectomy
 6. Tracheostomy

III. Extracranial carotid angioplasty is considered **investigational** for all indications that do not meet Criteria I or II.

NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.

LIST OF INFORMATION NEEDED FOR REVIEW

It is critical that the list of information below is submitted for review to determine if the policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome.

- History and physical/chart notes
- Current symptomology
- Documentation of percent of stenosis
- Documentation of focal ischemia, including duration and date of occurrence, or nondisabling stroke, for symptomatic patients
- Contraindications for carotid endarterectomy, including one or more listed in policy

CROSS REFERENCES

1. [Percutaneous Angioplasty and Stenting of Veins](#), Surgery, Policy No. 109

BACKGROUND

The procedure is proposed as an alternative to medical therapy and a less invasive alternative to carotid endarterectomy (CEA). CAS involves the insertion of a stent (wire-mesh tube) into a narrowed carotid artery. A catheter (a long hollow tube) is inserted into a groin or neck artery and guided through the arteries to the narrowing in the carotid artery. A balloon at the end of the catheter is inflated to push open the narrowed area, and a metal stent is inserted to keep this area from narrowing again. The procedure is performed with the patient fully awake and without sedation. At present, most practitioners also use a distally placed embolic protection device (EPD) that is designed to reduce the risk of stroke caused by thromboembolic material dislodged during CAS. Carotid angioplasty is rarely performed without stent placement.

REGULATORY STATUS

The U.S. Food and Drug Administration (FDA) has approved several carotid artery stents and EDPs from various manufacturers. The FDA has mandated postmarketing studies for these devices. Each FDA-approved carotid stent system is indicated for combined use with a EPD.

EVIDENCE SUMMARY

This evidence review is focused on carotid angioplasty with stenting (CAS) compared with carotid endarterectomy (CEA) for treatment of carotid stenosis, and not on carotid stenting as a treatment for carotid artery dissection. Evidence from well-designed, well-conducted randomized controlled trials (RCTs) is necessary to establish the safety and efficacy of CAS as compared with CEA for stenosis treatment.

SYSTEMATIC REVIEWS

A systematic review and meta-analysis of RCTs by Li (2016) assessed the long-term efficacy and safety of CAS compared to CEA.^[1] Eight trials, including the large RCTs ACT I, CREST, ICCS, EVA-3S, CAVATAS, and BACASS, with a total of 7,005 patients were included in the analysis. All studies had at least four years of follow-up. Seven of the trials contributed data on stroke risk, which was significantly higher with stenting event rate (9.3% vs 6.8%, odds ratio [OR] 1.45, 95% confidence interval [CI] 1.22 to 1.73, $p < 0.0001$). Stenting was also associated with an increased risk for the composite endpoint of death, ipsilateral stroke, or periprocedural stroke compared with CEA in eight trials (OR 1.25, 95% CI 1.05 to 1.48, $p = 0.01$).

Vincent (2015) conducted a similar meta-analysis of eight RCTs (total $n = 7,091$ patients).^[2] Studies were selected that compared CAS to CEA, enrolled more than 50 patients, and reported periprocedural or long-term outcomes, and included CREST, ICSS, SPACE, EVA-3S, CAVATAS, and SAPPHIRE. CAS was associated with an increased rate of any type of periprocedural stroke (relative risk [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 myocardial infarction (RR 0.47, 95% CI 0.29 to 0.78). However, in follow-up ranging from 2 to 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 a composite end point of ipsilateral stroke, periprocedural stroke, or periprocedural death (RR 1.45, 95% CI 1.20 to 1.75). This analysis supports the conclusion that CEA remains the treatment of choice for most patients, due to the increase in adverse events with CAS.

Three systematic reviews and meta-analyses compared CEA and CAS outcomes in patients with asymptomatic stenosis. The review by Kakkos (2017) included nine RCTs with a total of 3,709 patients (CEA $n = 1,479$, CAS $n = 2,230$).^[3] In this analysis, CAS was associated with a higher rate of stroke or death at 30 days (2.9% vs. 1.9% with CEA, OR 1.57, 95% CI 1.01 to 2.44). Myocardial infarction (MI) at 30 days did not differ significantly between groups, but cranial nerve injury at 30 days was lower in the CAS group (OR 0.13, 95% CI 0.07 to 0.26). The composite outcome of stroke or death at 30 days plus ipsilateral stroke at one year was higher for CAS than CEA (OR 1.51, 95% CI 1.02 to 2.24). A similar review by Moresoli (2017) included 11 reports of five RCTs with 3,019 asymptomatic patients.^[4] They found a trend toward higher incidences of periprocedural stroke with CAS, which was not statistically significant (RR 1.95, 95% CI 0.98 to 3.89). A review by Galyfos (2019) included 10 randomized trials (total $n = 8,771$) and concluded that CEA was associated with a lower risk of early stroke in asymptomatic patients compared with CAS, but other outcomes were not significantly different.^[5]

Paraskavas (2014) conducted a systematic review of studies comparing cognitive outcomes after CEA with those after CAS.^[6] Thirteen studies were included, with heterogeneity in the types of cognitive outcome measures reported. In a qualitative analysis, the authors report that the majority of studies did not report a significant difference between CEA and CAS in terms of cognitive outcomes, but that the heterogeneity in outcomes reported precluded more definitive conclusions.

Galyfos (2014) reported results of a systematic review that included nine trials (n=5,959) with a focus on risk of periprocedural symptomatic or asymptomatic myocardial ischemia or infarction.^[7] Four studies did not report their definition used for myocardial ischemia, and other studies varied in their definitions. In pooled analysis, compared with CEA, CAS was associated with decreased risk for cardiac damage (pooled RR 0.37, 95% CI 0.22 to 0.61, p=0.0001). However, the study provides incomplete information about selection of studies for inclusion, which limits conclusions that can be drawn.

A 2012 updated Cochrane Review systematically reviewed all RCTs comparing carotid angioplasty and stenting with carotid endarterectomy or medical care.^[8] The Cochrane Review found strong evidence that endovascular treatment in patients with symptomatic carotid stenosis is associated with a higher risk of death or stroke than CEA up to 30 days after the procedure. The evidence was also rated strong for an association between patient age and excess risk with endovascular treatment. There was insufficient evidence to determine whether the comparative risks of endovascular treatment versus CEA depended on the patient's sex, vascular anatomy, or characteristics of atherosclerotic plaque. Little is known on the long-term durability of endovascular treatment beyond four years, especially with respect to restenosis and recurrent stroke rates. The combined results of two large^[9, 10] and three small trials showed no significant increase in severe restenosis after primary stenting compared with endarterectomy, but there was a wide confidence interval surrounding the effect measure and evidence of substantial heterogeneity ($I^2 = 58\%$). The available evidence does not rule out the possibility of a small increase in restenosis rates among patients receiving stent treatment compared with endarterectomy, and it is not known if restenosis increases the risk of recurrent stroke. The existing evidence does not allow any firm conclusions on the comparative safety and efficacy of endovascular treatment versus endarterectomy in patients with asymptomatic carotid stenosis.

A 2012 Agency for Healthcare Research and Quality (AHRQ) report evaluated the evidence from 60 eligible studies of treatment strategies for patients with asymptomatic carotid artery stenosis.^[11, 12] The report noted that the definitions of "asymptomatic" patients were heterogeneous across the evaluated studies (i.e., patients without symptoms, patients with symptoms present for at least six months before their enrollment in the study but recently [within six months] asymptomatic, or patients with symptoms in a vascular territory other than ipsilateral carotid [e.g., vertebrobasilar territory]). The report focused on evidence for the following treatments:

- Medical therapy alone
- CEA and medical therapy compared with medical therapy alone
- CAS and medical therapy compared with medical therapy alone
- CAS and medical therapy compared with CEA and medical therapy.

For evidence on CAS and medical therapy compared with CEA and medical therapy, the review concluded that "one recent large trial (CREST) reported higher rates of postprocedural

ipsilateral stroke (including any periprocedural stroke) and its composite primary endpoint in the CAS[group], as compared with CEA, but this did not reach statistical significance in patients with asymptomatic carotid stenosis. The CREST and the SAPPHIRE trials randomized patients with symptomatic and asymptomatic carotid stenosis stratified according to symptom status. Therefore, the treatment assignment was randomized among the subgroup of patients with asymptomatic carotid stenosis. However, neither trial was powered to detect a significant difference in the primary composite endpoint among subgroups of patients with asymptomatic carotid stenosis. The failure to find a significant difference does not rule out the possibility that real difference exists between the intervention modalities tested.” The authors also stated that “future trials should focus not only on whether CAS is equivalent or superior to CEA, but also on whether an invasive interventional procedure is likely to translate into any significant benefit to the patient treated with current best medical therapy.”

The 2007 and 2009 BlueCross BlueShield Association Technology Evaluation Center (TEC) assessments did not identify reliable evidence in support of CAS.^[13, 14] Five major randomized trials of CAS vs. CEA were reviewed in the TEC Assessments (SPACE, EVA-3S, SAPPHIRE, ICSS, and CREST) and all had significant limitations, including early termination (SPACE and EVA-3S), small numbers of symptomatic vs. asymptomatic patients (SAPPHIRE), significant loss to follow-up (CREST),^[15] and lack of power to reliably detect differences between treatment arms overall as well as in the subanalyses (CREST)^[15].

Khan (2014) published a systematic review with meta-analysis of risk factors associated with stroke and/or death in patients undergoing CAS.^[16] The following were reported to be independent risk factors for 30-day stroke and death following CAS:

- Symptomatic carotid stenosis compared with asymptomatic stenosis
- Age >80 years for 30-day stroke/death
- Age >70 years for 4-year stroke/death
- Lesion characteristics (e.g., ulceration, irregularity, calcification, length)
- Final residual stenosis >30%

No significantly increased risk of 30-day post-CAS stroke and/or death was found for gender, cardiac disease, or cardiovascular risk factors including hypertension, hyperlipidemia chronic obstructive pulmonary disease, peripheral artery disease, cigarette smoking. Mixed and unclear associations with risk were found for chronic renal failure, diabetes mellitus, high C-reactive protein levels, timing of procedure relative to the index ischemic event. Pre- and postprocedural use of statin medications was reported to be associated with lower periprocedural stroke and/or death.

Many other meta-analyses of the studies that compare carotid angioplasty/stenting (CAS) with endarterectomy (CEA) have been published.^[17-31] These analyses reported inconsistent findings, most of which favor CEA over CAS for symptomatic carotid stenosis. The reliability of the conclusions from these meta-analyses is limited by pooling results from unreliable, heterogeneous primary studies (different patient samples, endovascular procedures, duration of follow-up and/or completion status of the trials). A review of 17 systematic reviews comparing these procedures found that none fulfilled all items of the AMSTAR-2, an appraisal tool for systematic reviews, and graded the overall confidence in the results of 16 of the reviews as critically low.^[32]

RANDOMIZED CONTROLLED TRIALS

The Asymptomatic Carotid Trial (ACT I)

The Asymptomatic Carotid Trial (ACT) I was a noninferiority trial of CAS versus CEA in asymptomatic individuals who were not at high risk for surgical complications.^[33] Enrollment began in 2005 with a target of 1,658 participants, but because of slow enrollment, the trial was halted in 2013 with 1,453 participants. The primary composite endpoint of death, stroke, MI within 30 days, or ipsilateral stroke within one year was obtained in 3.8% of CAS and 3.4% of CEA patients, while the cumulative five-year rate of stroke-free survival was 93.1% with CAS and 94.7% with CEA ($p=0.44$). This study does not answer the question of how best to treat asymptomatic patients, since it does not include a medical therapy arm. Patients who are treated with current best medical therapy may have an ipsilateral stroke rate of only 0.5% to 1% per year.^[34]

The Carotid Revascularization Endarterectomy versus Stenting Trial (CREST)

Brott (2016) reported long-term follow-up for CREST.^[35] 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. The second primary endpoint of post procedural ipsilateral stroke rate was also not significantly different between CEA (5.6%) and CAS (6.9%, HR 0.99).

Several publications have analyzed data from the CREST trial to compare specific outcomes of CAS vs. CEA or investigate the safety of these procedures in different subgroups.^[36-38] However, any findings based on the CREST data are unreliable due to the biases introduced by the loss to follow-up and inadequate statistical power. In a follow up analysis of the CREST trial data, Gonzalez (2014) reported no differences in outcomes for subjects treated in high-, medium-, or low-volume centers.^[39]

The International Carotid Stenting Study (ICSS)

Featherstone (2016) published a health technology assessment (HTA) on ICSS funded by the U.K.'s National Institute for Health Research Health Technology Assessment program.^[40] The HTA reviewed the all of the data from the study, concluding that “the functional outcome after stenting is similar to endarterectomy, but stenting is associated with a small increase in the risk of non-disabling stroke. The choice between stenting and endarterectomy should take into account the procedural risks related to individual patient characteristics.”

Altinbas (2014) reported that periprocedural rates of hemodynamic instability in ICSS differed between CEA and CAS groups.^[41] Hemodynamic depression occurred more commonly in CAS patients (13.8% vs 7.2%, RR 1.9, 95% CI 1.4 to 2.6, $p<0.0001$), while hypertension requiring treatment occurred less commonly in CAS patients (RR 0.2, 95% CI 0.1 to 0.4, $p<0.0001$). Hemodynamic instability was not associated with the ICSS study's primary composite outcome.

Other Randomized Controlled Trials

Reiff (2019) published one-year interim results of the Stent-supported Percutaneous Angioplasty of the Carotid Artery versus Endarterectomy 2 (SPACE-2) RCT.^[42] The SPACE-2 RCT was originally planned to compare best medical treatment (BMT) to CEA plus BMT or CAS plus BMT in 3,550 patients with high grade asymptomatic extracranial carotid artery stenosis. But, because patient recruitment was slow, the RCT was amended in 2013 to become two parallel randomized studies (BMT alone versus CEA plus BMT, and BMT alone

versus CAS plus BMT). After recruitment continued to be slow, SPACE-2 was ultimately stopped early in 2016 after only 513 patients were randomized. Although the interim analysis did not find significant differences between CEA and CAS in one-year rates of stroke or all-cause mortality, SPACE-2 authors noted that it is insufficiently powered to detect such differences.

Additional smaller trials not included in the systematic reviews above have compared CEA with CAS. A study by Li (2014) randomized 130 subjects at high risk of stroke due to angiographically confirmed carotid stenosis ($\geq 50\%$) to CEA (n=65) or CAS (n=65).^[43] The authors reported a three-month post-operative risk of mortality of 1.5% with CAS, compared with 9.2% with CEA. However, “existence of complete follow-up data” is an inclusion criterion, and insufficient details are provided about enrollment and randomization procedures to allow conclusions to be drawn about the study. Kuliha (2015) published results of an RCT which randomized 150 subjects with at least 70% carotid stenosis to CEA (n=73) or CAS (n=77). New infarctions on MRI were found more frequently after CAS (49% vs 25%, $p=0.002$).^[44] A randomized trial comparing CAS to CEA in 136 asymptomatic patients with $>70\%$ carotid stenosis was published by Mannheim and Karmeli (2016). After a mean follow-up time of 26 months, they found no difference in short- or long-term outcomes.^[45]

NON-RANDOMIZED STUDIES

Columbo (2018) published an analysis of long-term outcomes for registry patients who underwent CEA (n=29,235) or CAS (n=4,415) between 2003 and 2013.^[46] Mortality among these patients from the Vascular Quality Initiative registry was tracked through the patients' Medicare claims files. After adjustment for age, sex and comorbidities, CEA was associated with lower five-year mortality compared with CAS (HR 0.75, 95% CI 0.69 to 0.82). Similar results were seen in a propensity-matched analysis (n=4,261 matched pairs).

Hussain (2017) reported on a multi-center, population-based Canadian study comparing long-term outcomes for CAS and CEA for 15,525 patients treated between 2002 and 2014.^[47] The incidence of the primary composite outcome, which included 30-day death, stroke, or MI, and any stroke during follow-up, was higher with CAS than CEA (adjusted hazard ratio [HR] 1.57, 95% CI 1.43 to 1.73, $p<0.001$). This was primarily due to the higher rates of 30-day death, 30-day stroke, and stroke during follow-up seen in patients with stenting. However, CAS was associated with a lower incidence of 30-day MI (adjusted HR 0.70, 95% CI 0.57 to 0.86).

Salzler (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.^[48] 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 3,447 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 (OR 2.6, 95% CI 1.2 to 5.6) and postoperative in-hospital stroke (OR 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.

Additional evidence has been published related to rates of periprocedural stroke/death following CAS, particularly related to subgroups defined by medical comorbidities. Spangler (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 patients considered medically high risk.^[49] A Cox proportional hazards model was used to generate predicted five-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, myocardial infarction, death) for either high- or low-risk patients. Periprocedural death/stroke rates with CAS were 1.1% for low-risk patients and 1.6% for high-risk patients. For symptomatic patients, periprocedural death/stroke rates were higher with CAS than CEA for both low- and high-risk groups. For low-risk symptomatic patients, periprocedural death/stroke rates were 6.0% for CAS, compared with 2.2% for CEA (p<0.01). For high-risk symptomatic patients, periprocedural death/stroke rates were 9.3% for CAS, compared with 2.5% for CEA (p<0.01).

A number of other nonrandomized studies, case series, and registries on carotid angioplasty and stenting (CAS) have been published.^[49-66] While these studies contribute to the body of knowledge by providing direction for future research, evidence from these studies does not permit conclusions due to methodological limitations such as nonrandom allocation of treatment and lack of appropriate comparison groups. In addition, registry data may be unreliable due to incomplete reporting. Finally, the technology under investigation may change over time, further limiting the ability to carry out reliable comparisons based on the registry data.

PRACTICE GUIDELINE SUMMARY

AMERICAN HEART ASSOCIATION/AMERICAN STROKE ASSOCIATION COUNCIL ON STROKE (AHA/ASA)

The 2014 update of the evidence-based guideline on stroke prevention from the AHA/ASA includes the following recommendations:^[67]

Asymptomatic Carotid Stenosis

- It is reasonable to consider performing CEA in asymptomatic patients who have >70% stenosis of the internal carotid artery if the risk of perioperative stroke, MI, and death is low (<3%). However, its effectiveness compared with contemporary best medical management alone is not well established (Class IIa; Level of Evidence A).
- 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 (Class IIb; Level of Evidence B).
- In asymptomatic patients at high risk of complications for carotid revascularization by either CEA or CAS, the effectiveness of revascularization versus medical therapy alone is not well established (Class IIb; Level of Evidence B).

The 2014 updated AHA/ASA evidence-based guideline for patients with stroke or transient ischemic attack (TIA) includes the following recommendations:

Symptomatic Carotid Stenosis^[68]

CEA is recommended for the following patients with recent (i.e., in the past 6 months) TIA or ischemic stroke if the perioperative morbidity and mortality risk is estimated to be less than 6%:

- With severe ipsilateral carotid stenosis (between 70% and 99% of the lumen diameter), (Class I; Level of Evidence A)
- With moderate carotid stenosis (50% to 69% of the vessel lumen), depending on patient-specific factors such as age, gender, and comorbidities. (Class I; Level of Evidence B)
- When revascularization is indicated, it is reasonable to perform the procedure within 2 weeks if there are no contraindications to early revascularization (Class IIa; Level of Evidence 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 ICA is reduced by >70% by noninvasive imaging or >50% (Class IIa; Level of Evidence B).
- It is reasonable to consider patient age in choosing between CAS and CEA. For older patients (ie, older than ≈70 years), CEA may be associated with improved outcome compared with CAS, particularly when arterial anatomy is unfavorable for endovascular intervention. For younger patients, CAS is equivalent to CEA in terms of risk for peri-procedural complications (Class IIa; Level of Evidence B)
- Among patients with symptomatic severe stenosis (>70%) in whom anatomic or medical conditions are present that greatly increase the risk for surgery or when other specific circumstances exist such as radiation-induced stenosis or restenosis after CEA, CAS is reasonable (Class IIa; Level of Evidence B)
- When the degree of stenosis is <50%, CEA and CAS are not recommended (Class III; Level of Evidence A)

ASA/ACCF/AHA/AANN/AANS/ACR/ASNR/CNS/SAIP/SCAI/SIR/SNIS/SVM/SVS

The 2011 Guideline on the Management of Patients with Extracranial Carotid and Vertebral Artery Disease^[69] specifies the circumstances in which CAS may be indicated as an alternative to CEA, as well as the circumstances when it may be reasonable to choose CAS over CEA. However, the recommendations are based on B level of evidence, the lower level of evidence defined in the guideline as derived from a single randomized trial or non-randomized studies. Further, the specific randomized trials referenced for these determinations are the CREST and SAPHIRE trials. The findings from these trials are considered unreliable due to significant study limitations as explained above.

SUMMARY

There is enough research to show that carotid artery stenting (CAS) can improve health outcomes for patients with carotid artery dissection. Therefore, CAS is considered medically necessary for this indication.

There is enough research to show that carotid artery stenting (CAS) improves health outcomes compared with carotid endarterectomy (CEA) for certain higher-risk patients with carotid artery stenosis that should not have CEA, and in these patients CAS may provide better health outcomes. Therefore, CAS is considered medically necessary for patients who meet policy criteria.

There is not enough research to show that carotid artery stenting (CAS) improves health outcomes compared with carotid endarterectomy (CEA) except in a select group of patients

identified in the policy criteria. Therefore, for patients that do not meet these criteria, CAS is considered investigational.

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70. BlueCross BlueShield Association Medical Policy Reference Manual "Extracranial Carotid Angioplasty/Stenting." Policy No. 7.01.68

CODES

Codes	Number	Description
CPT	37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection
	37216	;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 and interpretation
	37246	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery
	37247	;each additional artery (List separately in addition to code for primary procedure)
HCPCS	None	

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