Extracranial Carotid Artery Stenting

(Formerly Extracranial Carotid Angioplasty/Stenting)

Medical Benefit

Effective Date: 10/01/12
Next Review Date: 05/18

Preauthorization: Yes

Review Dates: 01/08, 09/08, 09/09, 09/10, 09/11, 07/12, 05/13, 05/14, 05/15, 05/16, 05/17

Preauthorization is required.

The following protocol contains medical necessity criteria that apply for this service. The criteria are also applicable to services provided in the local Medicare Advantage operating area for those members, unless separate Medicare Advantage criteria are indicated. If the criteria are not met, reimbursement will be denied and the patient cannot be billed. Please note that payment for covered services is subject to eligibility and the limitations noted in the patient’s contract at the time the services are rendered.

<table>
<thead>
<tr>
<th>Populations</th>
<th>Interventions</th>
<th>Comparators</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals: With carotid artery stenosis</td>
<td>Interventions of interest are: Carotid artery stenting</td>
<td>Comparators of interest are: Carotid endarterectomy</td>
<td>Relevant outcomes include: Overall survival, Morbid events, Treatment-related mortality, Treatment-related morbidity</td>
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</tbody>
</table>

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).

Summary of Evidence

For individuals who have carotid artery stenosis who receive carotid artery stenting (CAS), the evidence includes randomized controlled trials (RCTs) and systematic reviews of RCTs. Relevant outcomes are overall survival, morbid events, and treatment-related mortality and morbidity. A substantial body of RCT evidence compares outcomes of CAS to CEA for symptomatic and asymptomatic patients with carotid stenosis. The evidence does not support 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 no better. Data from RCTs and large database studies have established that the risk of CAS exceeds the threshold set 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 qualitatively that the technology is unlikely to improve the net health outcome.

Policy

Carotid angioplasty with associated stenting and embolic protection may be considered medically necessary in patients with:
• 50–99% stenosis (North American Symptomatic Carotid Endarterectomy Trial [NASCET] measurement); AND
• symptoms of focal cerebral ischemia (transient ischemic attack or monocular blindness) in previous 120 days, symptom duration less than 24 hours, or nondisabling stroke; AND
• anatomic contraindication for carotid endarterectomy (such as prior radiation treatment or neck surgery, lesions surgically inaccessible, spinal immobility, or tracheostomy).

Carotid angioplasty with or without 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.

Policy Guidelines

The intent of the policy statement is that carotid angioplasty with embolic protection but without stenting is 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.

Medicare Advantage

For all indications coverage is limited to procedures performed using FDA-approved carotid artery stents and FDA-approved or -cleared embolic protection devices.

In addition CAS with embolic protection is reasonable and necessary only if performed in facilities that have been determined to be competent in performing the evaluation, procedure and follow-up necessary to ensure optimal patient outcomes (see Medicare Advantage Policy Guidelines).

For Medicare Advantage, PTA of the carotid artery concurrent with the placement of an FDA-approved carotid stent with embolic protection is considered medically necessary for the following:

• patients who are at high risk for CEA (see Medicare Advantage Policy Guidelines) and
• who also have symptomatic carotid artery stenosis greater than or equal to 70%.

All indications for PTA with or without stenting to treat obstructive lesions of the vertebral arteries remain investigational.

If deployment of the embolic protection device is not technically possible, and not performed, then the procedure is considered investigational.

All other indications for PTA without stenting are investigational.

For Medicare Advantage PTA of the carotid artery concurrent with the placement of an FDA-approved carotid stent with embolic protection is also considered medically necessary related to these Food and Drug Administration (FDA)-approved Category B Investigational Device Exemption (IDE) Clinical Trials:

• Patients who are at high risk for CEA and have symptomatic carotid artery stenosis between 50% and 70%, in accordance with the Category B IDE clinical trials regulation (42 CFR 405.201), as a routine cost of clinical trials, or in accordance with the NCD on carotid artery stenting (CAS) post-approval studies (Medicare NCD Manual 20.7);
• Patients who are at high risk for CEA and have asymptomatic carotid artery stenosis greater than or equal to 80%, in accordance with the Category B IDE clinical trials regulation (42 CFR 405.201), as a routine cost of clinical trials, or in accordance with the NCD on CAS post-approval studies (Medicare NCD Manual 20.7).
Medicare Advantage Policy Guidelines

Refer to the Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms) Protocol for policy on cerebral arteries.

CAS with embolic protection is reasonable and necessary only if performed in Medicare approved facilities found at [https://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilities/Carotid-Artery-Stenting-Facilities.html](https://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilities/Carotid-Artery-Stenting-Facilities.html).

Patients at high risk for CEA are defined as having significant comorbidities and/or anatomic risk factors (i.e., recurrent stenosis and/or previous radical neck dissection), and would be poor candidates for CEA. Significant comorbid conditions include but are not limited to:

- Congestive heart failure (CHF) class III/IV;
- Left ventricular ejection fraction (LVEF) less than 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.

Symptoms of carotid artery stenosis include carotid transient ischemic attack (distinct focal neurological dysfunction persisting less than 24 hours), focal cerebral ischemia producing a nondisabling stroke (modified Rankin scale less than three with symptoms for 24 hours or more), and transient monocular blindness (amaurosis fugax). Patients who have had a disabling stroke (modified Rankin scale greater than or equal to three) shall be excluded from coverage.

Background

Combined with optimal medical management, carotid angioplasty with or without stenting has been evaluated as an alternative to CEA. 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 to 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. EPDs 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/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. Examples include:

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

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

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—with degree of stenosis assessed by ultrasound or angiogram with computed tomography 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 70% or more stenosis by ultrasound or 50% or more stenosis by angiogram, and asymptomatic patients with 70% or more stenosis by ultrasound or 60% or more stenosis by angiogram.

FDA-approved stents and EPDs differ in the deployment methods used once they reach the target lesion, with the rapid exchange (RX) devices designed for more rapid stent and filter expansion. FDA has mandated postmarketing studies for EPDs, including longer follow-up for patients already reported to 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 (e.g., straight or tapered) and sizes (diameters and lengths) to match the vessel lumen that will receive the stent.

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

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

Related Protocols

Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Endovascular Therapies for Extracranial Vertebral Artery Disease
Services that are the subject of a clinical trial do not meet our Technology Assessment Protocol criteria and are considered investigational. For explanation of experimental and investigational, please refer to the Technology Assessment Protocol.

It is expected that only appropriate and medically necessary services will be rendered. We reserve the right to conduct prepayment and postpayment reviews to assess the medical appropriateness of the above-referenced procedures. Some of this protocol may not pertain to the patients you provide care to, as it may relate to products that are not available in your geographic area.

References

We are not responsible for the continuing viability of web site addresses that may be listed in any references below.

2. MRC European Carotid Surgery Trial: interim results for symptomatic patients with severe (70-99%) or with mild (0-29%) carotid stenosis. European Carotid Surgery Trialists’ Collaborative Group. Lancet. May 25, 1991; 337(8752):1235-1243. PMID 1674060


27. Rothwell PM. Carotid stenting: more risky than endarterectomy and often no better than medical treatment alone [Comment]. Lancet. Mar 20 2010; 375(9719):957-959. PMID 20304225


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