STENTING FOR VASCULAR OCCLUSIVE DISEASE
MED202.032

COVERAGE:

CORONARY ARTERY, NON-CORONARY ARTERY AND VENOUS STENTS

Coronary artery, non-coronary artery and venous stenting MAY BE ELIGIBLE FOR COVERAGE when used electively or emergently to prevent restenosis after angioplasty with one exception. See the paragraph below for the carotid artery angioplasty and stenting exception.

CAROTID ARTERY STENTS

Carotid angioplasty with or without associated stenting is considered investigational and IS NOT ELIGIBLE FOR COVERAGE.

DESCRIPTION:

Stents are medical devices used to prevent restenosis of an artery/vein after an angioplasty. They act as a scaffold for the artery or vein, thus maintaining the desired intravessel luminal diameter. Stents are commonly used in the following vessels: coronary, carotid, iliac, femoral, subclavian, and renal arteries.

Patients who appear to benefit most from elective angioplasty/stenting are those who are at particularly high risk for restenosis because of large target vessels and new focal lesions, or those who have developed restenosis after angioplasty one or more times.

Patients who develop abrupt vessel closure immediately following angioplasty are candidates for stenting as emergency management, e.g., the "bail-out" indication.

In-stent restenosis becomes more likely with smaller reference vessel diameters, smaller post-stent minimal lumen diameter, and longer stent length. Diabetes mellitus and end-stage renal disease are also associated with both increased in-stent restenosis and restenosis following simple PTCA. These risk factors should be considered when evaluating treatment strategies for arteries or veins with high risk morphology.

RATIONALE:

Interventional cardiology has improved outcomes since the development of stents. While not every coronary intervention should include a stent, 50% to 70% of patients undergoing coronary intervention may benefit greatly from stent placement.

Percutaneous transluminal angioplasty and stent placement for aortoiliac disease yields similar complication rates, but the technical success rate is higher after stent placement and the risk of long-term failure is reduced.
Carotid angioplasty with or without associated stenting has been investigated as a minimally invasive alternative to open carotid endarterectomy, currently considered the gold standard of treatment of patients with significantly obstructing atherosclerosis.

Although there are data to suggest that carotid artery angioplasty and stenting are technically feasible, early studies have also suggested that there is a high rate of peri-procedural stroke (9.6%) compared to as low as 1.7% in case series of carotid endarterectomy. Safety is a particular concern with percutaneous techniques in the carotid artery. While open surgery is an option for coronary and peripheral angioplasty in the event of an acute closure, it is unknown whether the same approach would be effective in a timely manner for acute closure of the carotid artery.

In 1998, the American Heart Association (AHA) issued a warning regarding the premature adoption of these percutaneous techniques. In support of this warning, the AHA remarked on the known overall safety and efficacy of carotid endarterectomy compared with the uncertain morbidity and mortality of angioplasty and stenting. Also, the morbidity and mortality of treatment of restenosis after angioplasty and stenting are unknown. The statement concluded that, at a minimum, the equivalence of percutaneous approaches to surgical carotid endarterectomy must be established in sufficiently powered, prospective randomized trials.

Medicare considers carotid angioplasty ineligible for coverage.

Renal artery stent revascularization in the presence of normal or mildly impaired renal function has a beneficial effect on the following:

- blood pressure control,
- serum creatinine,
- blood urea nitrogen (BUN),

and has a nondeleterious effect on renal function. Stent placement for the treatment of atherosclerotic ostial renal artery stenosis has a high success rate and low incidence of restenosis.

DISCLAIMER:

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, takes precedence over Medical Policy and must be considered first in determining coverage. The member’s contract benefits in effect on the date that services are rendered must be used. Any benefits are subject to the payment of premiums for the date on which services are rendered. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

HMO Blue Texas physicians who are contracted/affiliated with a capitated IPA/medical group must contact the IPA/medical group for information regarding HMO claims/reimbursement information and other general polices and procedures.