Cohere Medical Policy - Arterial Stenting, Other

Clinical Policy for Medical Necessity Review

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Important Notices

Notices & Disclaimers:

GUIDELINES ARE SOLELY FOR COHERE'S USE IN PERFORMING MEDICAL NECESSITY REVIEWS AND ARE NOT INTENDED TO INFORM OR ALTER CLINICAL DECISION-MAKING OF END USERS.

Cohere Health, Inc. ("**Cohere**") has published these clinical guidelines to determine the medical necessity of services (the "**Guidelines**") for informational purposes only, and solely for use by Cohere's authorized "**End Users**". These Guidelines (and any attachments or linked third-party content) are not intended to be a substitute for medical advice, diagnosis, or treatment directed by an appropriately licensed healthcare professional. These Guidelines are not in any way intended to support clinical decision-making of any kind; their sole purpose and intended use is to summarize certain criteria Cohere may use when reviewing the medical necessity of any service requests submitted to Cohere by End Users. Always seek the advice of a qualified healthcare professional regarding any medical questions, treatment decisions, or other clinical guidance. The Guidelines, including any attachments or linked content, are subject to change at any time without notice.

Other Notices:

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Policy Information:

Specialty Area: Cardiovascular Disease
Policy Name: Cohere Medical Policy - Arterial Stenting, Other
Type: [**X**] Adult (18+ yo) | [**X**] Pediatric (0-17 yo)

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Medical Necessity Criteria

Service: Arterial Stenting, Other

Cohere Health takes an evidence-based approach to reviewing imaging and procedure requests, meaning that sufficient clinical information must be provided at the time of submission to determine medical necessity. Documentation must include a recent and detailed history, physical examination related to the onset or change in symptoms, relevant lab results, prior imaging, and details of previous treatments. Advanced imaging or procedures should be requested after a recent clinical evaluation by the treating provider, which may include referral to a specialist.

- When a specific clinical indication is not explicitly addressed in the Cohere Health medical policy, medical necessity will be determined based on established clinical best practices, as supported by evidence-based literature, peer-reviewed sources, professional society guidelines, and state or national recommendations, unless otherwise directed by the health plan.
- Requests submitted without clinical documentation, or those that do not align with the provided clinical information—such as mismatched procedure, laterality, body part, or CPT code—may be denied for lack of medical necessity due to insufficient or inconsistent clinical information.
- When there are multiple diagnostic or therapeutic procedures requested simultaneously or within the past three months, each will be reviewed independently. Clinical documentation must clearly justify all of the following:
    - The medical necessity of each individual request
    - Why prior imaging or procedures were inconclusive or why additional/follow-up studies are needed
    - How the results will impact patient management or treatment decisions
- Requests involving adjacent or contiguous body parts may be considered not medically necessary if the documentation demonstrates that the patient's primary symptoms can be adequately assessed with a single study or procedure.

Description

Arterial stent placement is used in a variety of clinical scenarios to treat both aneurysmal and occlusive arterial pathology. There are two types of arterial stents: (1) Bare metal stents; and (2) covered stents (a bare metal stent covered with fabric or graft material). Stents are further classified as either balloon-expandable or self-expanding. Lastly, bare metal stents may also be coated with a drug that is intended to reduce the risk of restenosis.
Stents are often placed via a transcatheter route, but they can also be placed through an open approach (e.g., arterial cutdown).[1-3] Exceptions to the scope of this policy include lower extremity arterial occlusive disease, extracranial carotid artery occlusive disease, extracranial vertebral artery occlusive disease, intrathoracic carotid artery occlusive disease, intracranial arterial occlusive disease, and coronary artery disease.

Medical Necessity Criteria

Indications

Arterial stenting is considered appropriate if **ANY** of the following is **TRUE**:

- The patient has **ANY** of the following aneurysmal conditions[1,2]:
  - Any symptomatic aneurysm; **OR**
  - Asymptomatic lower extremity aneurysmal disease as indicated by **ANY** of the following:
    - An iliac artery aneurysm greater than 3 cm in diameter; **OR**
    - A common femoral artery aneurysm greater than 2.5 cm in diameter; **OR**
    - A profunda femoral artery aneurysm greater than 2 cm in diameter; **OR**
    - A superficial femoral artery (SFA) aneurysm greater than 2 times the diameter of the normal native SFA (with or without mural thrombus); **OR**
    - A popliteal artery aneurysm greater than or equal to 2 cm in diameter (with or without mural thrombus) with documentation that the patient has a high surgical risk[3]; **OR**
  - Asymptomatic upper extremity aneurysm; **OR**
  - Asymptomatic visceral artery aneurysm as indicated by **ANY** of the following:
    - Renal artery aneurysms greater than 3 cm in diameter; **OR**
    - Renal artery aneurysms of any size in women of childbearing age; **OR**
    - Splenic artery aneurysms greater than 3 cm in diameter; **OR**
    - Splenic artery aneurysms of any size in women of childbearing age; **OR**
    - All splenic artery pseudoaneurysms; **OR**
    - Hepatic artery aneurysms greater than 2 cm in diameter[4]; **OR**
    - A hepatic artery aneurysm that has enlarged by greater than 0.5 cm in a year[4]; **OR**
    - Gastric, gastroepiploic, pancreaticoduodenal, and gastroduodenal aneurysms of any size[4]; **OR**
    - Superior mesenteric artery aneurysms of any size[4]; **OR**
    - Celiac artery aneurysms greater than 2 cm in diameter[4]; **OR**
- The patient has symptomatic upper extremity arterial occlusive disease indicated by **ALL** of the following[5]:

    - Subclavian, axillary, or brachial artery stenosis (greater than 50% diameter reduction or 75% cross-sectional area stenosis); **AND**
    - **ANY** of the following:
        - Lifestyle-limiting, exercise-induced ipsilateral upper extremity fatigue; **OR**
        - Limb-threatening ischemia of the upper extremity (e.g., rest pain, ulceration, tissue loss, or gangrene); **OR**
        - Subclavian steal syndrome; **OR**
        - Subclavian artery occlusive disease causing cardiac ischemia in patients with a prior and patent ipsilateral internal mammary artery to coronary artery bypass; **OR**
- Visceral occlusive disease, as indicated by **ANY** of the following:
    - Symptomatic acute or chronic mesenteric ischemia[6]; **OR**
    - Symptomatic renal artery stenosis (RAS) with **ANY** of the following[7-9]:
        - Bilateral RAS with **ALL** of the following:
            - Greater than 70% stenosis; **AND**
            - **ANY** of the following:
                - Intolerance to guideline-directed medical therapy (GDMT) (e.g., angiotensin-converting enzyme [ACE] inhibitors, angiotensin II receptor blockers [ARB], calcium channel blockers, diuretics); **OR**
                - Insufficient blood pressure response to GDMT (e.g., angiotensin-converting enzyme [ACE] inhibitors, angiotensin II receptor blockers [ARB], calcium channel blockers, diuretics); **OR**
        - Unilateral RAS with intolerance to GDMT (e.g., increased serum creatinine level upon initiation of a renin-angiotensin system inhibitor, blood pressure that does not respond to therapy); **OR**
        - Chronic end-stage renal disease (ESRD) with hemodialysis dependence less than or equal to 3 months; **OR**
        - Progressive renal functional impairment determined to be secondary to renal artery stenosis; **OR**
        - Unilateral renal artery stenosis (greater than 70%) in a uninephric patient; **OR**
        - Recurrent flash pulmonary edema or refractory heart failure secondary to renal artery occlusive disease; **OR**
- The patient has complex congenital heart disease, including **ANY** of the following:

    - Pulmonary artery stenosis[10-12]; **OR**
    - Aortic coarctation[10,13-15]; **OR**
    - Patent ductus arteriosus (PDA); **OR**
- Bare metal or covered stent placement and **ANY** of the following peri-procedural clinical scenarios[14,16]:
    - Acute arterial occlusion; **OR**
    - Flow-limiting dissection; **OR**
    - Elastic recoil or refractory spasm; **OR**
    - Residual stenosis greater than 30%; **OR**
    - Trans-stenotic resting pressure gradient greater than 5 mmHg; **OR**
- Covered stent placement or stent graft placement for **ANY** of the following peri-procedural clinical scenarios[16]:
    - Arterial perforation; **OR**;
    - Arterial occlusion; **OR**
    - Arterial pseudoaneurysm; **OR**
    - Arteriovenous fistula; **OR**
- Repeat or secondary stenting and **ANY** of the following[13,16,17]:
    - Restenosis; **OR**
    - Suboptimal result; **OR**
    - Stent fracture (in association with restenosis or another complication such as pseudoaneurysm); **OR**
    - Stent recoil; **OR**
    - Re-coarctation of the aorta; **OR**
    - Impending or documented bypass graft failure; **OR**
- Asymptomatic peripheral artery occlusive disease with a documented need for intervention.[17]

Non-Indications

Arterial stenting is not considered appropriate if **ANY** of the following is **TRUE**:

- Known allergic reactions to stent or stent graft material (e.g., nitinol, dacron, expanded polytetrafluoroethylene [ePTFE]).

Level of Care Criteria

Inpatient or Outpatient

Procedure Codes (CPT/HCPCS)

CPT/HCPCS Code	Code Description
37236	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery
37237	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)

Medical Evidence

A 2021 multicenter prospective study of patients with aortic coarctation examined the long-term consequences of primary stenting to resolve the coarctation. 248 patients with aortic coarctation were enrolled, and data were collected at regular follow-up intervals for up to 60 months. Stenting was selected as a less invasive alternative to traditional open-chest surgery to reduce antihypertensive medication intake, especially for pediatric patients. A notable decrease in antihypertensive use was observed at a rate of 53% immediately after surgery; this decreased to 29% at late follow-up (between 48 and 60 months). Stent fracture was also observed among 24.4% of patients at late follow-up. The authors acknowledged the early, short-term efficacy and safety of arterial stenting for aortic coarctation, particularly if the goal of care is to allow a pediatric patient to reach a more suitable age for surviving open-chest definitive repair of their congenital heart disease.[18]

Laird et al. (2019) reported on the safety and efficacy of the iCAST covered stent for the treatment of atherosclerotic iliac artery lesions. The authors enrolled 152 participants with multiple lesions and/or stents as part of the iCARUS trial. Participants were treated with an iCAST covered stent, and primary endpoint was a composite of death at 30 days, target lesion revascularization at 9 months, and restenosis at 9 months after the procedure, with a target composite endpoint rate of 16.57%. The authors reported a composite endpoint rate of 8.1%, indicating that the iCAST covered stent was safe and effective for treating atherosclerotic iliac artery lesions.[19]

Rundbeck et al. (2017) reported on 9-month outcomes following the VISIBILITY Iliac study, which evaluated the safety and efficacy of the Visi-Pro stent. In this study, 75 patients with Rutherford category 2-4 ischemia and atherosclerotic lesions less than or equal to 10 cm in length underwent iliac artery stenting. The main outcome of interest was the number of major adverse events at 9 months after the procedure. A total of 81 stents were implanted in the participants with a mean lesion length of 29.3 mm. Three patients experienced a major adverse event at 9 months, demonstrating the safety and efficacy of the Visi-Pro stent.[20]

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Policy Revision History/Information

Original Date: September 25, 2023		
Review History		
Version 2	12/12/2024	Annual policy review and restructure. Updated recommended clinical approach to the current format. Consolidated upper extremity bullet points. Consolidated aneurysmal indications into one bullet. Replaced prior mesenteric ischemia indication with appropriate (e.g., non-emergent, non-acute) criteria. Added indication for secondary or repeat stenting. Removed one non-indication, which was already covered by the CPT codes. Updated medical evidence section. Updated references.
Version 3	12/18/2025	Annual review. Updated medical evidence section. Minor edits for clarity and concision throughout Indications section.