Clinical Policy: Carotid Artery Stenting

Reference Number: WA.CP.MP.516
Date of Last Revision: 05/25
Effective Date: 07/01/25

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity guidelines for carotid artery stenting.

Policy/Criteria

I. It is the policy of Coordinated Care of Washington, Inc., and Coordinated Care Corporation, in accordance with the Health Care Authority's (HCA) Health Technology Assessment (HTA) and HCA Billing Guidelines, that carotid artery stenting is considered **medically necessary** when *one* of the following criteria are met:

A. High surgical risk for carotid endarterectomy (CEA) and symptomatic carotid artery stenosis > 50% or
B. High surgical risk for CEA and asymptomatic carotid artery stenosis >= 80%.

Definition of high risk includes:

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

i. Congestive heart failure class III/IV
ii. Left ventricular ejection fraction < 30%
iii. Unstable angina
iv. Contralateral carotid occlusion
v. Recent myocardial infarction
vi. Previous CEA with recurrent stenosis
vii. Prior radiation treatment to the neck
viii. 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.

II. It is the policy of Coordinated Care of Washington, Inc., in accordance with the HCA's HTA and HCA Billing Guidelines, that carotid artery stenting must be done with FDA-approved stents and FDA-approved or FDA-cleared embolic protection devices and must be conducted in an HCA accredited facility as determined by CMS.

III. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority's Health Technology Assessment, that carotid artery stenting of intracranial arteries is **not medically necessary**.

Background

This policy is based entirely on Washington State Health Care Authority (HCA) Health Technology Assessment (HTA) and Health Care Authority Billing Guidelines.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty when performed; with distal embolic protection
37216	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty when performed; with distal embolic protection
37217	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery
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	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; each additional artery (List separately in addition to code for primary procedure)

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed.	10/19	10/19
Annual review. References updated.	09/20	10/20
Annual review. References updated. Added additional criteria for "high risk" from HCA Billing Guideline. Changed statement regarding intracranial stents from not covered to not medically necessary. Removed 37217, 37218, 0075T and 0076T from code list.	09/21	10/21
Annual review. References updated. Removed HTA criteria from policy.	09/22	09/22
Annual review. References updated. Removed InterQual guidelines and edited section I. to reflect current HTA criteria.	09/23	09/23

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Annual review. References updated. CPT codes updated to include 37217, 37246, and 37247 per billing guidelines. Section I. C. removed as criteria and changed to informational note defining "high risk" per HTA criteria. Section II verbiage updated to align with HCA Billing Guideline requirement for accredited facility.	08/24	09/24
Updated logo and added "Coordinated Care Corporation".	05/25	05/25

References

1. Skelly, A., Brodt, E., Hashimoto, R., Schenk-Kisser, J., Junge, M., Holmer, H. Spectrum Research. *Stenting for Treatment of Atherosclerotic Stenosis of the Extracranial Carotid Arteries or Intracranial Arteries*. Washington Health Technology Assessment. August 13, 2013.
2. Washington State Health Care Authority. Physician-related Services/Health Care Billing Guide. https://www.hca.wa.gov/assets/billers-and-providers/Physician-related-services-bg-20240701.pdf. Revision effective July 1, 2024.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/Enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.