blue of california

Medical Policy

Percutaneous Transluminal Intracranial Angioplasty and Stenting	
Type: Medical Necessity and Investigational / Experimental	**Policy Specific Section:** Surgery
Original Policy Date: June 12, 2002	**Effective Date:** January 11, 2013

Definitions of Decision Determinations

Medically Necessary: A treatment, procedure or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

Investigational/Experimental: A treatment, procedure or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California / Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a Split Evaluation, where a treatment, procedure or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Description

Percutaneous transluminal angioplasty (PTA) has been approached cautiously for use in the intracranial circulation due to technical difficulties in catheter and stent design and the risk of embolism. Thromboemobolic events in the posterior fossa or brain stem may result in devastating complications. However, technical improvements in the catheter, along with

procedural improvements; (e.g.,) track ability, catheterization of tortuous veins and the increased use of stents, has created ongoing interest in exploring PTA as a minimally invasive treatment of this difficult-to-treat population.

Intracranial stents are also being used in the treatment of cerebral aneurysms. Stent-assisted coiling began as an approach to treat fusiform or wide-neck aneurysms in which other surgical or endovascular treatment strategies may not be feasible. As experience grew, stenting was also used in smaller berry aneurysms as an approach to decrease the rate of retreatment needed in patients who receive coiling.

Policy

Percutaneous transluminal intracranial angioplasty and stenting may be considered **medically necessary** as part of the endovascular treatment of intracranial aneurysms when **all** of the following criteria are met:

- Surgical treatment is not appropriate
- Standard endovascular techniques do not allow for complete isolation of the aneurysm due to **either** of the following conditions:
    - Wide-neck aneurysm (equal to or greater than 4 mm)
    - Sack-to-neck ratio of less than 2:1

Percutaneous transluminal intracranial angioplasty and stenting is considered **investigational** for all other indications including, but not limited to, treatment of atherosclerotic cerebrovascular disease.

Policy Guideline

There are specific CPT codes for intracranial angioplasty and stent placement:

- 61630: Balloon angioplasty, intracranial (e.g., atherosclerotic stenosis), percutaneous
- 61635: Transcatheter placement of intravascular stent(s), intracranial (e.g., atherosclerotic stenosis), including balloon angioplasty, if performed

Internal Information

There is an MD Determination Form for this Medical Policy. It can be found on the following Web page:
http://myworkpath.com/healthcareservices/MedicalOperations/PSR_Determination_Pages.htmT
here is a Medical Management Guideline for this Medical Policy. It can be found on the following Web page:
http://myworkpath.com/healthcareservices/MedicalOperations/med_ops_guidelines.htm

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Documentation Required for Clinical Review
• History and physical including: o Description and measurements of intracranial aneurysm(s) • All imaging reports related to current event • Consultation report(s) from Neurologist • Procedure report(s) from Interventional Radiologist

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available

Click here to view the appendix for this policy

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