



Louisiana

Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Policy # 00198

Original Effective Date: 02/23/2006

Current Effective Date: 07/13/2020

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Note: Extracranial Carotid Angioplasty Stenting is addressed separately in medical policy 00155.

When Services Are Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider intracranial stent placement to be **eligible for coverage**** as part of the endovascular treatment of intracranial aneurysms for patients when surgical treatment is not appropriate and standard endovascular techniques do not allow for complete isolation of the aneurysm, e.g., wide-neck aneurysm (≥ 4 mm) or a sack-to-neck ratio less than 2:1.

When Services May Be Eligible for Coverage

Based on review of available data, the Company may consider intracranial flow-diverting stents with U.S. Food and Drug Administration (FDA) approval for the treatment of intracranial aneurysms to be **eligible for coverage**** as part of the endovascular treatment of intracranial aneurysms for patients that meet the patient selection criterion and are not amenable to surgical treatment or standard endovascular therapy.

Patient Selection Criterion

Coverage eligibility for intracranial flow-diverting stents with FDA approval for the treatment of intracranial aneurysms will be considered when the criterion below is met:

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- Flow-diverting stents are indicated for the treatment of large or giant wide-necked intracranial aneurysms, with a size of 10 mm or more and a neck diameter of 4 mm or more, in the internal carotid artery from the petrous to the superior hypophyseal segments.

Based on review of available data, the Company may consider the use of endovascular mechanical embolectomy using a device with U.S. Food and Drug Administration (FDA) approval for the treatment of acute ischemic stroke to be **eligible for coverage**** as part of the treatment of acute ischemic stroke for patients that meet the patient selection criteria.

Patient Selection Criteria

Coverage eligibility for the use of endovascular mechanical embolectomy using a device with FDA approval for the treatment of acute ischemic stroke will be considered when ALL of the criteria below is met:

- Have a demonstrated occlusion within the proximal intracranial anterior circulation (intracranial internal carotid artery, or M1 or M2 segments of the middle cerebral artery, or A1 or A2 segments of the anterior cerebral artery); AND
- Can receive endovascular mechanical embolectomy within 12 hours of symptom onset OR within 24 hours of symptom onset if there is evidence of a mismatch between specific clinical and imaging criteria (see Policy Guidelines); AND
- Have evidence of substantial and clinically significant neurologic deficits (see Policy Guidelines section); AND
- Have evidence of salvageable brain tissue in the affected vascular territory (see Policy Guidelines section); AND
- Have no evidence of intracranial hemorrhage or arterial dissection on computed tomography (CT) or magnetic resonance imaging (MRI).

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers intracranial stent placement in the treatment of intracranial aneurysms, except as noted above, to be **investigational.***

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Based on review of available data, the Company considers intracranial percutaneous transluminal angioplasty with or without stenting in the treatment of atherosclerotic cerebrovascular disease to be **investigational**.*

Based on review of available data, the Company considers endovascular interventions for the treatment of acute ischemic stroke when the above criteria are not met to be **investigational**.*

Policy Guidelines

Patient Selection for Endovascular Mechanical Embolectomy for Acute Ischemic Stroke

The major randomized controlled trials (RCTs) demonstrating a benefit with endovascular mechanical embolectomy vary in criteria for selecting patients based on the presence or absence of salvageable brain tissue. Several RCTs use the Alberta Stroke Program Early Computed Tomography Score, which is a 10-point quantitative computed tomography (CT) score to assess the presence of early ischemic changes. MR CLEAN (Berkhemer et al, 2015) did not specify imaging criteria to demonstrate salvageable brain tissue. Table PG1 lists the criteria used by other trials.

Table PG1. Trial Selection Criteria for Salvageable Brain Tissue

Trial	Inclusion or Exclusion	Criteria
REVASCAT (Jovin et al, 2015)	Exclusion	<p>Hypodensity on CT or restricted diffusion demonstrated by:</p> <ul style="list-style-type: none"> • An ASPECTS <7 on CT, CT perfusion CBV, CTA source imaging; OR • An ASPECTS <6 on DWI MRI
ESCAPE (Goyal et al, 2015)	Exclusion	<ul style="list-style-type: none"> • Baseline non-contrast CT with extensive early ischemic changes of ASPECTS of 0-5 in the territory of symptomatic intracranial occlusion; OR • Other confirmation of a moderate-to-large core defined 1 of 3 ways:

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		<p>oOn a single phase, multiphase, or dynamic CTA: no or minimal collaterals in a region greater than 50% of the MCA territory when compared with pial filling on the contralateral side (multiphase/dynamic CTA preferred); OR</p> <p>oOn CT perfusion (>8 cm coverage): a low CBV and very low CBF, ASPECTS <6 AND in the symptomatic MCA territory; OR</p> <p>oOn CT perfusion (<8 cm coverage): a region of low CBV and very low CBF greater than one-third of the CT perfusion-imaged symptomatic MCA territory</p>
EXTEND-IA (Campbell et al, 2015)	Inclusion	<p>Based on CT perfusion imaging using CT or MRI with a Tmax more than 6-s delay perfusion volume and either CT regional CBF or DWI infarct core volume as follows:</p> <ul style="list-style-type: none"> • Mismatch ratio >1.2; AND • Absolute mismatch volume >10 mL; AND • Infarct core lesion volume <70 mL
SWIFT-PRIME (Saver et al, 2015)	Exclusion	<p>Related to imaging-demonstrated core infarct and hypoperfusion:</p> <ul style="list-style-type: none"> • MRI-assessed core infarct lesion greater than: <ul style="list-style-type: none"> o50 cm³ for subjects age 18-79 y; o20 cm³ for subjects age 80-85 y; • CT-assessed core infarct lesion greater than: <ul style="list-style-type: none"> o40 cm³ for subjects age 18-79 y; o15 cm³ for subjects age 80-85 y;

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		<ul style="list-style-type: none"> • For all subjects, severe hypoperfusion lesion (≥ 10-s Tmax lesion $> 100 \text{ cm}^3$); • For all subjects, ischemic penumbra of $\geq 15 \text{ cm}^3$ and mismatch ratio > 1.8
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ASPECTS: Alberta Stroke Program Early Computed Tomography Score; CBF: cerebral blood flow; CBV: cerebral blood volume; CT: computed tomography; CTA: computed tomography angiography; DWI: diffusion-weighted imaging; MCA: middle cerebral artery; MRI: magnetic resonance imaging.

The RCTs demonstrating a benefit to endovascular mechanical embolectomy in acute stroke generally had some inclusion criteria to reflect stroke severity-with the exception of the EXTEND-IA trial. The REVASCAT and ESCAPE trials both required a baseline (poststroke) National Institutes of Health Stroke Scale (NIHSS) score of 6 or higher. MR CLEAN specified a clinical diagnosis of acute stroke with a deficit on the NIHSS score of 2 points or more; SWIFT-PRIME specified an NIHSS score of 8 or more and less than 30 at the time of randomization.

The DAWN and DEFUSE 3 studies enrolled patients from 6 up to 24 hours of the time last time known to be well if there was evidence of a mismatch between specific clinical and imaging criteria (infarct size and volume was assessed with the use of diffusion-weighted magnetic resonance imaging or perfusion CT) (see Table PG2).

Table PG2. Trial Selection Criteria for Patients 6 to 25 Hours Post Infarct

Trial	Inclusion or Exclusion	Criteria
DAWN Trial (Nogueira et al, 2018)	Inclusion	6 to 24 hours related to mismatch between severity of clinical deficit and infarct volume: <ul style="list-style-type: none"> • ≥ 80 years of age, score ≥ 10 on the NIHSS, and had an infarct volume $< 21 \text{ mL}$; OR • ≤ 80 years age, score of ≥ 10 on the NIHSS, and had an infarct volume $< 31 \text{ mL}$; OR

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		<ul style="list-style-type: none"> • ≤ 80 years of age, had a score ≥ 20 on the NIHSS, and had an infarct volume of 31 to < 51 mL
DEFUSE 3 Trial (Albers et al, 2018)	Inclusion	<p>6 to 16 hours related to mismatch between severity of clinical deficit and infarct volume:</p> <ul style="list-style-type: none"> • Infarct size of < 70 mL; AND • Ratio of ischemic tissue volume to infarct volume of ≥ 1.8; AND • Ischemic penumbra of ≥ 15 cm³

NIHSS: National Institutes of Health Stroke Scale.

Other Policy Guidelines

Flow-diverting stents are indicated for the treatment of large or giant wide-necked intracranial aneurysms, with a size of 10 mm or more and a neck diameter of 4 mm or more, in the internal carotid artery from the petrous to the superior hypophyseal segments.

This policy only addresses endovascular therapies used on intracranial vessels.

These policy statements are not intended to address the use of rescue endovascular therapies, including intra-arterial vasodilator infusion and intracranial percutaneous transluminal angiography, in delayed cerebral ischemia after aneurysmal subarachnoid hemorrhage.

Background/Overview

Cerebrovascular Diseases

Cerebrovascular diseases include a range of processes affecting the cerebral vascular system, including arterial thromboembolism, arterial stenosis, and arterial aneurysms, all of which can restrict cerebral blood flow due to ischemia or hemorrhage. Endovascular techniques, including endovascular mechanical embolectomy with various devices types of devices (ie, stents), and angioplasty with or without stenting have been investigated for the treatment of cerebrovascular diseases.

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Acute Stroke

Acute stroke is the third leading cause of death in the United States, Canada, Europe, and Japan; further, it is the leading cause of adult disability in the United States. Eighty-seven percent of strokes are ischemic and 13% hemorrhagic. Differentiation between the two types of stroke is necessary to determine the appropriate treatment. Ischemic stroke occurs when an artery to the brain is blocked by a blood clot, which forms in the artery (thrombotic), or when another substance (ie, plaque, fatty material) travels to an artery in the brain causing a blockage (embolism). Recanalization of the artery, particularly in the first few hours after occlusion, reduces rates of disability and death.

Intracranial Arterial Stenosis

It is estimated that intracranial atherosclerosis causes about 8% of all ischemic strokes. Intracranial stenosis may contribute to stroke in two ways: either due to embolism or low-flow ischemia in the absence of collateral circulation. Recurrent annual stroke rates are estimated at 4% to 12% per year with atherosclerosis of the intracranial anterior circulation and 2.5% to 15% per year with lesions of the posterior (vertebrobasilar) circulation.

Intracranial Aneurysms

Compared with acute ischemic stroke, cerebral aneurysms have a much lower incidence in the United States, with prevalence between 0.5% and 6% of the population. However, they are associated with significant morbidity and mortality due to subarachnoid hemorrhage resulting from aneurysm rupture.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Several devices for endovascular treatment of intracranial arterial disease were cleared for marketing by the FDA through the 510(k) process or the humanitarian device exemption (HDE) process. By indication, approved devices are as follows.

Acute Stroke

Table 1 summarizes the first generation devices with the FDA clearance for the endovascular treatment of acute stroke and subsequent approval of stent retrievers.

Table 1. FDA-Cleared Mechanical Embolectomy Devices for Acute Stroke

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Device	510(k) No. for Original Device	Approval Date for Original Device	Indications
Merci [®] ‡ Retriever (Concentric Medical; acquired by Stryker Neurovascular in 2011)	K033736	Aug 2004 (modified device approved May 2006)	Patients with acute ischemic stroke and who are ineligible for or who fail IV tPA therapy
Penumbra System [®] ‡ (Penumbra)	K072718	Dec 2007	Patients with acute ischemic stroke secondary to intracranial large vessel occlusive disease within 8 h of symptom onset
Stent retrievers			
Solitaire [™] ‡ FR Revascularization Device (Covidien/ev3 Neurovascular)	K113455	Mar 2012	Patients with acute ischemic stroke due to large intracranial vessel occlusion who are ineligible for or who fail IV tPA
Trevo [®] ‡ Retriever device (Stryker Neurovascular)	K122478	Aug 2012	Patients with acute ischemic stroke due to large intracranial vessel occlusion who are ineligible for or who fail IV tPA
EmboTrap [®] ‡ II Revascularization Device	K173452	May 2018	Patients with ischemic stroke within 8 hours of symptom onset who are ineligible for or who fail IV t-PA

FDA: Food and Drug Administration; IV: intravenous; tPA: tissue plasminogen activator.

Intracranial Arterial Stenosis

Two devices were approved by the FDA through the HDE process for atherosclerotic disease. This form of the FDA approval is available for devices used to treat conditions with an incident rate of 4000 or fewer cases per year; the FDA only requires data showing “probable safety and effectiveness.” Devices with their labeled indications are as follows.

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Policy # 00198

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Current Effective Date: 07/13/2020

Neurolink System[®]‡

“The Neurolink system [Guidant] is indicated for the treatment of patients with recurrent intracranial stroke attributable to atherosclerotic disease refractory to medical therapy in intracranial vessels ranging from 2.5 to 4.5 mm in diameter with $\geq 50\%$ stenosis and that are accessible to the stent system.”

Wingspan[™]‡ Stent System

“The Wingspan Stent System [Boston Scientific] with Gateway PTA Balloon Catheter is indicated for use in improving cerebral artery lumen diameter in patients with intracranial atherosclerotic disease, refractory to medical therapy, in intracranial vessels with $\geq 50\%$ stenosis that are accessible to the system.”

Intracranial Aneurysms

In 2011, the Pipeline[®]‡ Embolization Device (Covidien/eV3 Neurovascular), an intracranial aneurysm flow-diverter, was approved by the FDA through the premarket approval process (P100018) for the endovascular treatment of adults (≥ 22 years) with large or giant wide-necked intracranial aneurysms in the internal carotid artery from the petrous to the superior hypophyseal segments. Approval was based on the Pipeline for Uncoilable for Failed Aneurysms Study, a single-arm, open-label feasibility study, reported by Becske et al (2013) that included 108 patients, ages 30 to 75 years, with unruptured large and giant wide-necked aneurysms.

In 2018, Surpass Streamline Flow Diverter (Stryker Neurovascular) was approved by the FDA through the premarket approval process (P170024) for use in the endovascular treatment of patients (18 years of age and older) with unruptured large or giant saccular wide-neck (neck width ≥ 4 mm or dome-to-neck ratio < 2) or fusiform intracranial aneurysms in the internal carotid artery from the petrous segment to the terminus arising from a parent vessel with a diameter ≥ 2.5 mm and ≤ 5.3 mm. The approval was based on one-year results of the Surpass Intracranial Aneurysm Embolization System Pivotal Trial to Treat Large or Giant Wide Neck Aneurysms (SCENT) study. The SCENT study is continuing follow-up to five years post-procedure as a post-approval study.

The following stents have been approved by the FDA through the HDE process for treatment of intracranial aneurysms.

Neuroform[™]‡ Microdelivery Stent System

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Policy # 00198

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In 2002, based on a series of approximately 30 patients with 6-month follow-up, the Neuroform Microdelivery Stent System (Stryker) was approved by the FDA through the HDE process (H020002) for use with embolic coils for the treatment of wide-neck intracranial aneurysms that cannot be treated by surgical clipping.

Enterprise™‡ Vascular Reconstruction Device and Delivery System

In 2007, based on a series of approximately 30 patients with 6-month follow-up, the Enterprise Vascular Reconstruction Device and Delivery (Cordis Neurovascular) was approved by the FDA through the HDE process (H060001) for use with embolic coils for the treatment of wide-neck, intracranial, saccular or fusiform aneurysms.

The Low-Profile Visualized Intraluminal Support Device

In 2014, the Low-Profile Visualized Intraluminal Support Device (LVIS™ and LVIS™ Jr.; MicroVention)‡ was approved by the FDA through the HDE process (H130005) for use with embolic coils for the treatment of unruptured, wide-neck (neck, ≥ 4 mm or dome-to-neck ratio, < 2), intracranial, saccular aneurysms arising from a parent vessel with a diameter of 2.5 mm or greater and 4.5 mm or smaller.

PulseRider Aneurysm Neck Reconstruction Device

In 2017, the PulseRider Aneurysm Neck Reconstruction Device (Pulsar Vascular, Inc.) was approved by the FDA through the HDE process (H160002) for use with neurovascular embolic coils for treatment of unruptured wide-necked intracranial aneurysms with neck width at least 4 mm or dome to neck ratio greater than 2.

Rationale/Source

Intracranial arterial disease includes thromboembolic events, vascular stenoses, and aneurysms. Endovascular techniques have been investigated for the treatment of intracranial arterial disease. Endovascular therapy is used as an alternative or adjunct to intravenous tissue plasminogen activator and supportive care for acute stenosis and as an adjunct to risk-factor modification for chronic stenosis. For cerebral aneurysms, stent-assisted coiling and the use of flow-diverting stents have been evaluated as an alternative to endovascular coiling in patients whose anatomy is not amenable to simple coiling.

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For individuals who have acute ischemic stroke due to occlusion of an anterior circulation vessel who receive endovascular mechanical embolectomy, the evidence includes randomized clinical trials (RCTs) comparing endovascular therapy with standard care and systematic reviews of these RCTs. The relevant outcomes are overall survival (OS), morbid events, functional outcomes, and treatment-related mortality and morbidity. From 2013 to 2015, 8 RCTs were published comparing endovascular therapies with noninterventional care for acute stroke in patients with anterior circulation occlusions. Several trials that were ongoing at the time of publication of these eight RCTs were stopped early and results with the limited enrollment have been published. Trials published from 2014 to 2015 demonstrated a significant benefit regarding reduced disability at 90 days post treatment. The trials that demonstrated a benefit for endovascular therapy either exclusively used stent retriever devices or allowed the treating physician to select a device, mostly a stent retriever device, and had high rates of mechanical embolectomy device use in patients randomized to endovascular therapy. Studies that demonstrated a benefit for endovascular therapy required demonstration of a large vessel, anterior circulation occlusion for enrollment. Also, they were characterized by fast time-to-treatment. Two trials published in 2018 demonstrated that it was possible to extend the window for mechanical thrombectomy up to about 24 hours for select patients. To achieve results in real-world settings similar to those in the clinical trials, treatment times, clinical protocols, and patient selection criteria should be similar to those in the RCTs. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have acute ischemic stroke due to basilar artery occlusion who receive endovascular mechanical embolectomy, the evidence includes a nonrandomized comparative study and several case series. The relevant outcomes are OS, morbid events, functional outcomes, and treatment-related mortality and morbidity. These studies have indicated that high rates of recanalization can be achieved with mechanical thrombectomy. However, additional comparative studies are needed to demonstrate that mechanical thrombectomy is superior to standard therapy. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have symptomatic intracranial arterial stenosis who receive intracranial percutaneous transluminal angioplasty with or without stenting, the evidence includes two RCTs and a number of nonrandomized comparative studies and case series. The relevant outcomes are OS, symptoms, morbid events, functional outcomes, and treatment-related mortality and morbidity. Both available RCTs have demonstrated no significant benefit with endovascular therapy. In particular,

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Policy # 00198

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Current Effective Date: 07/13/2020

the Stenting and Aggressive Medical Management for Preventing Recurrent Stroke in Intracranial Stenosis (SAMMPRIS) trial was stopped early due to harms, because the rate of stroke or death at 30 days post treatment was higher in the endovascular arm, which received percutaneous angioplasty with stenting. Follow-up of SAMMPRIS subjects has demonstrated no long-term benefit from endovascular therapy. Although some nonrandomized studies have suggested a benefit from endovascular therapy, the available evidence from two RCTs does not suggest that intracranial percutaneous transluminal angioplasty with or without stenting improves outcomes for individuals with symptomatic intracranial stenosis. The evidence is sufficient to determine that the technology is unlikely to improve the net health outcome.

For individuals who have intracranial aneurysm(s) who receive endovascular coiling with intracranial stent placement or intracranial placement of a flow-diverting stent, the evidence includes an RCT, several nonrandomized comparative studies, and multiple single-arm studies. The relevant outcomes are OS, morbid events, functional outcomes, and treatment-related mortality and morbidity. The available nonrandomized comparative studies have reported occlusion rates for stent-assisted coiling that are similar to or higher than coiling alone and recurrence rates that may be lower than those for coiling alone. For stent-assisted coiling with self-expanding stents, some evidence has also shown that adverse event rates are relatively high, and a nonrandomized comparative trial has reported that mortality is higher with stent-assisted coiling than with coiling alone. For placement of flow-diverting stents, a pragmatic RCT and registry study have compared flow diversion with standard management (observation, coil embolization, or parent vessel occlusion) in patients for whom flow diversion was considered a promising treatment. The pragmatic study was stopped early after crossing a predefined safety boundary when 16% of patients treated with flow diversion were dead or dependent at three months or later. Flow diversion was also not as effective as the investigators had hypothesized. A nonrandomized study comparing the flow-diverting stents with endovascular coiling for intracranial aneurysms has demonstrated higher rates of aneurysm obliteration in those treated with the Pipeline endovascular device than those treated with coiling, with similar rates of good clinical outcomes. The evidence does not provide high certainty whether stent-assisted coiling or placement of a flow-diverting stent improves outcomes for patients with intracranial aneurysms because the risk-benefit ratio cannot be adequately defined. The evidence is insufficient to determine the effects of the technology on health outcomes.

Clinical input obtained in 2011 indicated strong support for the use of stent-assisted coiling for the treatment of aneurysms that are not amenable to surgery or simple coiling. Clinical input obtained

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in 2014 indicated general support for the use of flow-diverting stents for certain types of aneurysms when surgical treatment is not appropriate.

Supplemental Information

Clinical Input From Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

2014 Input

In response to requests, input was received from 4 physician specialty societies and 2 academic medical centers while this policy was under review in 2014. Input focused on the use of flow-diverting stents such as the Pipeline Embolization Device for the treatment of intracranial aneurysms. There was general support for the use of intracranial stent placement for intracranial aneurysms meeting the criteria outlined in the policy statements. There was also general support for the use of flow-diverting stents for the treatment of intracranial aneurysms and general support for the statement that flow-diverting stents are preferable to other stents for certain aneurysm characteristics.

There was general support for the use of endovascular interventions for the treatment of acute stroke, particularly for patients: (1) patients who have failed to respond to intravenous tissue plasminogen activator; and (2) patients who present outside the range of time for which tissue plasminogen activator would be considered (≤ 8 hours of last known normal state or symptom onset).

2011 Input

In response to requests, input was received from 3 physician specialty societies and 3 academic medical centers while this policy was under review in 2011. For treatment of intracranial stenosis, most providing input would consider the use of this technology in selected patients who remained symptomatic from intracranial atherosclerotic disease, despite maximum medical therapy. There was unanimous support for the use of this technology in select patients with intracranial aneurysms; ie, in those patients for whom surgical treatment is not possible and for whom endovascular treatment (coils) does not completely isolate the aneurysm.

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Louisiana

Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Policy # 00198

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Practice Guidelines and Position Statements

Society of Vascular and Interventional Neurology

The Society of Vascular and Interventional Neurology (2016) published recommendations on comprehensive stroke center requirements and endovascular stroke systems of care. The recommendations were based on five multicenter, prospective, randomized, open-label, blinded endpoint clinical trials that demonstrated the benefits of endovascular therapy with mechanical thrombectomy in acute ischemic strokes with large vessel occlusions. Their recommendation pertinent to this evidence review is:

“Endovascular mechanical thrombectomy, in addition to treatment with IV tPA [intravenous tissue plasminogen activator] in eligible patients, is recommended for anterior circulation large vessel occlusion ischemic strokes in patients presenting within 6 h of symptom onset.”

American Heart Association and American Stroke Association

The American Heart Association and the American Stroke Association (2018) published joint guidelines on the early management of patients with acute ischemic stroke. These guidelines included several recommendations relevant to the use of endovascular therapies for acute stroke.

Table 2. Recommendations on Use of Endovascular Therapies to Manage Acute Stroke

Recommendation	COR	LOE
“Mechanical thrombectomy requires the patient to be at an experienced stroke center with rapid access to cerebral angiography, qualified neurointerventionalists, and a comprehensive periprocedural care team. Systems should be designed, executed, and monitored to emphasize expeditious assessment and treatment. Outcomes for all patients should be tracked. Facilities are encouraged to define criteria that can be used to credential individuals who can perform safe and timely intra-arterial revascularization procedures.”	I	C
"Patients should receive mechanical thrombectomy with a stent retriever if they meet all the following criteria: <ul style="list-style-type: none"> • "Prestroke mRS score 0 to 1, • "Causative occlusion of the internal carotid artery or MCA (M1), • "Age ≥18 years, 	I	A

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Louisiana

Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Policy # 00198

Original Effective Date: 02/23/2006

Current Effective Date: 07/13/2020

Recommendation	COR	LOE
<ul style="list-style-type: none"> NIHSS score of ≥ 6, "ASPECTS of ≥ 6, and "Treatment can be initiated (groin puncture) within 6 hours of symptom onset." 		
In selected patients with acute ischemic stroke within 6 to 16 hours of last known normal who have LVO in the anterior circulation and meet other DAWN or DEFUSE 3 eligibility criteria, mechanical thrombectomy is recommended.	I	A
"The technical goal of the thrombectomy procedure should be a reperfusion to a modified TICI 2b/3 angiographic result to maximize the probability of a good functional clinical outcome."	I	A
As with intravenous alteplase, reduced time from symptom onset to reperfusion with endovascular therapies is highly associated with better clinical outcomes. To ensure benefit, reperfusion to TICI grade 2b/3 should be achieved as early as possible and within the therapeutic window."	I	B-R
<p>"Use of stent retrievers is indicated in preference to the MERCI device."</p> <p>"The use of mechanical thrombectomy devices other than stent retrievers may be reasonable in some circumstances."</p>	I IIb	A B-NR
"The use of proximal balloon guide catheter or a large bore distal access catheter rather than a cervical guide catheter alone in conjunction with stent retrievers may be beneficial. Future studies should examine which systems provide the highest recanalization rates with the lowest risk for nontarget embolization."	IIa	C-LD
In selected patients with AIS within 16 to 24 hours of last known normal who have LVO in the anterior circulation and meet other DAWN eligibility criteria, mechanical thrombectomy is reasonable.	IIa	B-R
"In carefully selected patients with anterior circulation occlusion who have contraindications to intravenous r-tPA, endovascular therapy with stent retrievers completed within 6 hours of stroke onset is reasonable. There are inadequate data available at this time to determine the clinical efficacy of endovascular therapy with stent retrievers for those patients whose contraindications are time-based or	IIa	C

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Louisiana

Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Policy # 00198

Original Effective Date: 02/23/2006

Current Effective Date: 07/13/2020

Recommendation	COR	LOE
nontime based (eg, prior stroke, serious head trauma, hemorrhagic coagulopathy, or receiving anticoagulant medications)."		
"Although the benefits are uncertain, use of mechanical thrombectomy with stent retrievers may be reasonable for carefully selected patients with acute ischemic stroke in whom treatment can be initiated (groin puncture) within 6 hours of symptom onset and who have causative occlusion of the M2 or M3 portion of the MCAs."	Iib	B-R
"Although the benefits are uncertain, use of mechanical thrombectomy with stent retrievers may be reasonable for carefully selected patients with acute ischemic stroke in whom treatment can be initiated (groin puncture) within 6 hours of symptom onset and who have causative occlusion of the anterior cerebral arteries, vertebral arteries, basilar artery, or posterior cerebral arteries."	Iib	C
"Although the benefits are uncertain, use of mechanical thrombectomy with stent retrievers may be reasonable for patients with acute ischemic stroke in whom treatment can be initiated (groin puncture) within 6 hours of symptom onset and who have prestroke mRS score of >1, ASPECTS <6, or NIHSS score <6 and causative occlusion of the internal carotid artery or proximal MCA (M1). Additional randomized trial data are needed."	Iib	B-R
In patients under consideration for mechanical thrombectomy, observation after IV alteplase to assess for clinical response should not be performed.	III	B-R
"Use of salvage technical adjuncts including intra-arterial fibrinolysis may be reasonable to achieve these angiographic results"	Iib	C-LD
"Intra-arterial fibrinolysis initiated within 6 hours of stroke onset in carefully selected patients who have contraindications to the use of intravenous alteplase might be considered, but the consequences are unknown."	Iib	C-EO

AIS: acute ischemic stroke; ASPECTS: Alberta Stroke Program Early Computed Tomography Score; COR: class of recommendation; LOE: level of recommendation; LVO: large vessel occlusion; MCA: middle cerebral artery; mRS: modified Rankin Scale; NIHSS: National Institutes of Health Stroke Scale; r-tPA: recombinant tissue plasminogen activator; TICI: Thrombolysis in Cerebral Infarction.

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Louisiana

Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Policy # 00198

Original Effective Date: 02/23/2006

Current Effective Date: 07/13/2020

The 2 associations also published joint guidelines on the management of patients with unruptured intracranial aneurysms in 2015. These guidelines included the following recommendations relevant to the use of endovascular therapies for aneurysms.

Table 3. Recommendations on Management of Unruptured Intracranial Aneurysms

Recommendation	COR	LOE
“...coil embolization may be superior to surgical clipping with respect to procedural morbidity and mortality, length of stay, and hospital costs, so it may be reasonable to choose endovascular therapy over surgical clipping in the treatment of select unruptured intracranial aneurysms, particularly in cases for which surgical morbidity is high, such as at the basilar apex and in the elderly”	IIb	B
“...coil embolization may be superior to surgical clipping with respect to procedural morbidity and mortality, length of stay, and hospital costs, so it may be reasonable to choose endovascular therapy over surgical clipping in the treatment of select unruptured intracranial aneurysms, particularly in cases for which surgical morbidity is high, such as at the basilar apex and in the elderly”	IIb	B
“Endovascular treatment of unruptured intracranial aneurysms is recommended to be performed at high-volume centers.”	I	B

COR: class of recommendation; LOE: level of recommendation.

U.S. Preventive Services Task Force Recommendations

No U.S. Preventive Services Task Force recommendations for treatment of intracranial arterial disease were identified. The Task Force has recommended against screening for asymptomatic carotid artery stenosis in the general population.

Medicare National Coverage

A Medicare national coverage determination on intracranial angioplasty and stenting was released by the Centers for Medicare & Medicaid Services in 2008. This decision was based on a review of available studies at that time, which consisted of several uncontrolled case series. The Centers for Medicare & Medicaid Services review indicated that this evidence was promising and that, while further well-designed randomized controlled trials were needed to confirm whether outcomes were improved, coverage should be allowed. The national coverage determination contained the following coverage determinations:

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Louisiana

Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Policy # 00198

Original Effective Date: 02/23/2006

Current Effective Date: 07/13/2020

1. "Medicare coverage for angioplasty and or stenting for symptomatic patients with greater than 70 percent intracranial arterial stenosis; and
2. Medicare coverage for intracranial angioplasty and stenting for other patients within the context of Category B investigational device exemption (IDE) trials under coverage with evidence development (CED) within a registry."

Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 4.

Table 4. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Endovascular interventions for acute ischemic stroke			
<i>Ongoing</i>			
NCT02216643 ^a	Randomization of Endovascular Treatment With Solitaire FR [®] ‡ vs. Best Medical Therapy in Acute Ischemic Stroke Due to Large Vessel Occlusion Trial (RESILIENT)	690	Sep 2019
NCT02737189	Randomized Trial of Revascularization With Solitaire Stentriever Versus Best Medical Therapy in the Treatment of Acute Ischemic Stroke Due to Basilar Artery Occlusion Presenting Within 6-24 Hours of Symptom Onset	318	Dec 2020
<i>Unpublished</i>			
NCT01455935	Wake up Symptomatic Stroke in Acute Brain Ischemia (WASSABI) Trial	90	Feb 2014 (unknown)
NCT01983644	RECO Flow Restoration Device Versus Intravenous t-PA for Stroke Within 4.5h of Symptom Onset: a Prospective Randomized Control Trial (RESTORE)	130	Dec 2017
NCT02441556	Acute Basilar Artery Occlusion: Endovascular Interventions vs Standard Medical Treatment	131	Dec 2017

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Louisiana

Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Policy # 00198

Original Effective Date: 02/23/2006

Current Effective Date: 07/13/2020

Endovascular interventions for symptomatic intracranial atherosclerotic disease			
Unpublished			
NCT01763320	China Angioplasty & Stenting for Symptomatic Intracranial Severe Stenosis (CASSISS): A Prospective Multicenter, Randomized Controlled Trial	380	Dec 2017
Stent-assisted endovascular treatment of intracranial aneurysms			
Ongoing			
NCT01340612	Stenting in the Treatment of Aneurysm Trial (STAT)	600	Jan 2020
NCT01340612	Stenting in the Treatment of Large, Wide-necked or Recurring Intracranial Aneurysms	600	Jan 2020
NCT02998229 ^a	ARTISSE Aneurysm Treatment Using Intrasaccular Flow Diversion With the ARTISSE™ [‡] Device	150	Sep 2022
NCT01716117 ^a	The Surpass Intracranial Aneurysm Embolization System Pivotal Trial to Treat Large or Giant Wide Neck Aneurysms (SCENT Trial)	180	Dec 2020
Unpublished			
NCT01762137	LARGE Aneurysm Randomized Trial: Flow Diversion Versus Traditional Endovascular Coiling Therapy	23	Feb 2017 (terminated)
NCT01811134	Flow Diverter Stent for Endovascular Treatment of Unruptured Saccular Wide-necked Intracranial Aneurysms (EVIDENCE)	130	Nov 2017
NCT03269942	Results of Revascularization Versus Endovascular Flow Diversion in Treatment of Complex Intracranial Aneurysms of Anterior Circulation	110	Jun 2018

NCT: national clinical trial.

^a Denotes industry-sponsored or cosponsored trial.

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Policy # 00198

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Louisiana

Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Policy # 00198

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Louisiana

Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Policy # 00198

Original Effective Date: 02/23/2006

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Louisiana

Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Policy # 00198

Original Effective Date: 02/23/2006

Current Effective Date: 07/13/2020

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Louisiana

Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Policy # 00198

Original Effective Date: 02/23/2006

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Louisiana

Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Policy # 00198

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Louisiana

Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Policy # 00198

Original Effective Date: 02/23/2006

Current Effective Date: 07/13/2020

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Louisiana

Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Policy # 00198

Original Effective Date: 02/23/2006

Current Effective Date: 07/13/2020

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Louisiana

Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Policy # 00198

Original Effective Date: 02/23/2006

Current Effective Date: 07/13/2020

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Louisiana

Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Policy # 00198

Original Effective Date: 02/23/2006

Current Effective Date: 07/13/2020

From the American Heart Association/American Stroke Association. Stroke. Aug 2015;46(8):2368-2400. PMID 26089327.

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Policy History

Original Effective Date: 02/23/2006

Current Effective Date: 07/13/2020

- 02/01/2006 Medical Director review
- 02/15/2006 Medical Policy Committee review
- 02/23/2006 Quality Care Advisory Council approval
- 07/07/2006 Format revision, including addition of FDA and or other governmental regulatory approval and rationale/source. Coverage eligibility unchanged.
- 04/02/2008 Medical Director review
- 04/16/2008 Medical Policy Committee approval. No change in policy statement. Rationale totally rewritten with focus on FDA approved devices.
- 04/02/2009 Medical Director review
- 04/15/2009 Medical Policy Committee approval. No change to coverage eligibility.
- 04/08/2010 Medical Policy Committee approval
- 04/21/2010 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
- 04/07/2011 Medical Policy Committee review
- 04/13/2011 Medical Policy Implementation Committee approval. Changed title from “Percutaneous Transluminal Angioplasty of Intracranial Atherosclerotic Stenoses With or Without Stenting” to “Endovascular Procedures (Angioplasty and/or Stenting) for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)”. Added that intracranial stent placement is eligible for coverage as part of the endovascular treatment of intracranial aneurysms for patients when surgical treatment is not appropriate and standard endovascular techniques do not allow for complete isolation of the aneurysm, e.g., wide-neck aneurysm (4mm or more) or sack-to-neck ratio less than 2:1. Added that intracranial stent placement in the treatment of intracranial aneurysms, except as noted above, is investigational.
- 04/12/2012 Medical Policy Committee review

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Louisiana

Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Policy # 00198

Original Effective Date: 02/23/2006

Current Effective Date: 07/13/2020

04/25/2012 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

04/04/2013 Medical Policy Committee review

04/24/2013 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

04/03/2014 Medical Policy Committee review

04/23/2014 Medical Policy Implementation Committee approval. Coverage eligibility unchanged. Policy 00366 (Mechanical Embolectomy for Treatment of Acute Stroke) retired and combined with this policy.

04/02/2015 Medical Policy Committee review

04/20/2015 Medical Policy Implementation Committee approval. Added new coverage statement for Intracranial flow diverting stents with FDA approval and patient selection criterion. Updated rationale and references.

04/07/2016 Medical Policy Committee review

04/20/2016 Medical Policy Implementation Committee approval. Policy statement revised to indicate that mechanical embolectomy for acute stroke may be considered medically necessary with criteria.

10/01/2016 Coding update

01/01/2017 Coding update: Removing ICD-9 Diagnosis Codes and CPT coding update

05/04/2017 Medical Policy Committee review

05/17/2017 Medical Policy Implementation Committee approval. No change to coverage.

06/07/2018 Medical Policy Committee review

06/20/2018 Medical Policy Implementation Committee approval. Policy statements changed to reflect extension of the time window for mechanical thrombectomy up to 24 hours after symptom onset for select patients. Added Policy Guidelines section.

01/01/2019 Coding update

06/06/2019 Medical Policy Committee review

06/19/2019 Medical Policy Implementation Committee approval. Coverage eligibility unchanged. Reformatted the coverage section for clarity.

06/04/2020 Medical Policy Committee review

06/10/2020 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

Next Scheduled Review Date: 06/2021

Coding

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Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Policy # 00198

Original Effective Date: 02/23/2006

Current Effective Date: 07/13/2020

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Code Type	Code
CPT	36227, 36228, 61624, 61630, 61635, 61645, 61650, 61651
HCPCS	No codes
ICD-10 Diagnosis	I60.0-I60.8, I63.0-I63.9, I66.01-I66.9, I67.0-I67.9

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

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Louisiana

Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Policy # 00198

Original Effective Date: 02/23/2006

Current Effective Date: 07/13/2020

- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
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 - 2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
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- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Policy # 00198

Original Effective Date: 02/23/2006

Current Effective Date: 07/13/2020

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