



CLINICAL GUIDELINES

Peripheral Vascular Intervention

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eviCore healthcare Clinical Decision Support Tool Diagnostic Strategies: This tool addresses common symptoms and symptom complexes. Imaging requests for individuals with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist and/or individual's Primary Care Physician (PCP) may provide additional insight.

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Table of Contents

Guideline	Page
Glossary of Terms and Abbreviations	3
Arterial Intervention Guidelines	6
Documentation requirements for arterial intervention requests.....	7
Carotid revascularization.....	10
Thoracic and Thoracoabdominal Aorta.....	16
Abdominal Aorta.....	22
Peripheral vascular, non-coronary stents.....	27
Venous Intervention Guidelines	37
General information for venous intervention requests.....	38
Treatment of Saphenovenous Reflux.....	40
Treatment of Varicose Saphenous Vein Tributaries.....	45
Treatment of pathologic perforators.....	49
Treatment of Iliac vein stenosis/occlusion/compression.....	52

Glossary of Terms and Abbreviations

Guideline	Page
Glossary.....	4

Glossary

Terms and abbreviations

- **Aneurysm** — Defined as a diameter 1.5x the normal arterial diameter.
- **Angioplasty** — A procedure that utilizes a catheter with a balloon that is inflated to enlarge a stenotic area.
- **Ankle-Brachial Index (ABI)** — Ratio of the systolic blood pressure (SBP) measured at the ankle to the brachial SBP.
- **Atherectomy** — A procedure that utilizes a catheter with a sharp blade on the end of the catheter to remove plaque from a blood vessel.
- **Crescendo TIA** — Multiple recurrent episodes of TIA over hours to days.
- **Critical limb ischemia** — Severe stenosis or occlusion in the vessels supplying the lower extremity such that limb loss will result without treatment. Symptoms of critical limb ischemia in the lower extremities include non-healing wounds, gangrene and ischemic rest pain.
- **Dissection** — Disruption of the media layer of the aorta with bleeding within and along the wall of the aorta.
- **Graft** — Fabric material used to replace a segment of an artery or bypass an occluded segment of artery.
- **High-grade stenosis** — A high grade stenosis is defined as a stenosis limiting flow by at least 80% or greater.
- **Ischemic rest pain** — Pain arises from severe arterial occlusive disease in the lower extremities such that the patient experiences pain in the distal aspect of the foot and toes while the limb is in the supine position as would occur with sleep. The pain is relieved with the limb in the dependent position or "dangling from the bed" as the limb is depending on gravity to assist with perfusion.
- **NASCET** — North American Symptomatic Carotid Endarterectomy Trial
- **Pseudo-aneurysm** — Outpouching of blood resulting from disruption of the arterial wall with extravasation of blood contained by periarterial connective tissue and not by the arterial wall layers.
- **PTA** — Percutaneous transluminal angioplasty.
- **Spider veins** — Enlarged, tortuous veins that are usually distributed in a web like cluster. These veins are typically <3mm in diameter.
- **Stent** — A metal scaffold placed inside the artery to maintain patency.
- **Stent-graft** — A metal scaffold covered by fabric material placed inside an artery.
- **Symptomatic carotid stenosis** — Characterized by either a transient ischemic attack or cerebrovascular accident that is in the distribution of known severe carotid stenosis, e.g. transient right sided upper and lower extremity paralysis in the setting of 70% left internal carotid artery stenosis.
- **Symptomatic aneurysm** — Unrelenting non-positional back pain in the setting of a known abdominal or thoracic aortic aneurysm. Patients with a symptomatic aneurysm may or may not have evidence of a free or contained rupture. The presence of symptoms indicate impending rupture.

- **Varicose veins** — Enlarged, tortuous veins often caused by incompetent valves. Veins are typically ≥ 3 mm in diameter.
- **Velocity ratio (V1/V2)** — Ratio of peak systolic velocity in the diseased segment of blood vessel demonstrating elevated flow velocities to the peak systolic velocity of blood flow in normal vessel just proximal to area of concern in arteries, or just distal in veins.
- **Venous reflux** — Characterized by incompetent or "leaky" valves that no longer function as one way valves facilitating the flow of blood from the lower extremities to the heart. This results in pooling of blood in the lower extremities leading to distended engorged veins when the lower extremities are in the dependent position as in sitting or standing.

Arterial Intervention Guidelines

Guideline	Page
Documentation requirements for arterial intervention requests.....	7
Carotid revascularization.....	10
Thoracic and Thoracoabdominal Aorta.....	16
Abdominal Aorta.....	22
Peripheral vascular, non-coronary stents.....	27

Documentation requirements for arterial intervention requests

VAS.AI.100.A

v1.0.2023

Guideline	Page
General requirements.....	7
Information to establish medical necessity.....	7
Documentation requirements for arterial intervention requests.....	7
Emergent and urgent requests.....	8
Supporting information.....	9

General requirements

Introduction

eviCore applies an evidence-based approach to evaluate the most appropriate medically necessary care for each patient. This evaluation requires submission of legible medical records pertinent to the test, treatment, or procedure requested by the provider.

Information to establish medical necessity

Medical necessity for the request cannot be established when the medical records provided cannot be read or do not include sufficiently detailed information to understand the patient's current clinical status.

Specific elements of a patient's medical records commonly required to establish medical necessity include, but are not limited to

- Recent (within 6 months) in-person clinical evaluation which includes a detailed history and physical examination
- Laboratory studies
- Imaging studies
- Pathology reports
- Procedure reports
- Reports from other providers participating in treatment of the relevant condition

Documentation requirements for arterial intervention requests

Documentation requirements needed to complete a prior authorization request for vascular surgery include **ALL** of the following:

- Procedure proposed
- Condition being treated

- Detailed documentation of provider-directed conservative treatment, duration and frequency of treatment, and the response to such treatments, if applicable
- Detailed documentation of location and size of aneurysmal disease, if present
- Detailed documentation regarding nature of the critical limb ischemia: non-healing wound or ischemic rest pain, if applicable
- Recent (within 6 months) written reports of any of the following diagnostic imaging modalities acceptable for purposes of the Vascular Surgery guidelines:
 - Ankle-brachial indices, segmental pressures and pulse volume recordings as applicable
 - Arterial duplex including carotid, lower extremity and abdominal
 - CTA abdomen/pelvis with or without lower extremity run-off
 - MRA abdomen/pelvis with or without lower extremity run-off
 - Angiogram
- Recent (within 6 months) clinical evaluation documenting:
 - Patient symptoms (if lifestyle-limiting, detailed documentation regarding quality of life parameters that are affected)
 - Physical exam findings

Emergent and urgent requests

Individuals being evaluated for vascular/endovascular surgery should be screened for the presence of a medical condition that warrants urgent/emergent definitive surgical treatment. Provider directed non-surgical management is **not** required when there is documentation, supported by imaging studies or clinical assessment, of any of the following urgent/emergent conditions:

- Critical limb ischemia
- Symptomatic carotid stenosis
- Crescendo TIA's (multiple recurrent episodes of TIA over hours to days)
- Symptomatic or ruptured aneurysms

An urgent/emergent request based on 2018 NCQA standards for utilization management occurs when the time frame for making routine or non-life threatening determinations on care **either**:

- Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

Procedures to treat arterial disease may be indicated on an intra-operative basis

Supporting information

Prior-authorization requests should be submitted at least two weeks prior to the anticipated date of an elective surgery

Written reports/interpretations of advanced diagnostic imaging studies (e.g., ankle-brachial indices, arterial duplex, CTA, MRA, angiogram) by an independent radiologist or clinician holding RPVI (registered physician in vascular interpretation) credentialing shall supersede any discrepancies (when present) in interpretation

Carotid revascularization

VAS.AI.101.A

v1.0.2023

Guideline	Page
Coding.....	10
Carotid revascularization - Criteria.....	11
Supporting information.....	14
References.....	15

Coding

Procedures indicated for carotid revascularization

Procedure	CPT®
Cerebrovascular Angiography	CPT®
Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological S&I, includes arch, when performed	36221
Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological S&I, includes arch	36222
Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological S&I, includes angiography of the extracranial carotid and cervicocerebral arch, when performed	36223
Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation, includes angiography of the extracranial carotid and cervicocerebral arch	36224
Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological S&I, includes angiography of the arch, when performed	36225
Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological S&I, includes angiography of the arch, when performed	36226
Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and radiological S&I	36227
Carotid Angioplasty/Stent	CPT®

Procedure	CPT®
Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological S&I; with distal embolic protection	37215
Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; without distal embolic protection	37216
Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation	37217
Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation	37218
Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; initial vessel	0075T
Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; each additional vessel (List separately in addition to code for primary procedure)	0076T
Carotid Endarterectomy	CPT®
Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision	35301
Reoperation, carotid, thromboendarterectomy, more than 1 month after original operation (List separately to code for primary procedure)	35390
Transcarotid Stenting with Dynamic Flow Reversal (TCAR)	CPT®
Transcatheter placement cervical carotid open or percutaneous with embolic protection	37215

Carotid revascularization - Criteria

General information

The determination of medical necessity for the performance of carotid revascularization is always made on a case-by-case basis based on the following information:

- For prior authorization requirements, see Prior Authorization Requirements
- The presence of urgent/emergent indications/conditions warrants definitive surgical/ endovascular treatment in lieu of provider-directed non-surgical management.

Urgent/emergent conditions for carotid revascularization include ANY of the following

- Crescendo TIA's
- Transient monocular blindness, amaurosis fugax
- Free-floating thrombus
- Enlarging carotid pseudoaneurysm
- Infection of carotid patch placed during prior carotid endarterectomy
- Recent CVA or TIA
- Confirmatory imaging studies and clinical notes are required

Carotid endarterectomy (CEA)

Indications

Carotid endarterectomy is a procedure that involves making an incision into the internal carotid artery with surgical removal of atherosclerotic plaque and subsequent closure of the artery primarily or with a patch

- CEA is considered **medical necessary** when **one** of the following is met
 - Symptomatic carotid stenosis-when there is documentation of both
 - Carotid lesion corresponds anatomically to the individual's symptoms or CTA or MRA findings in the distribution of carotid lesion and one of the following:
 - 50-99% stenosis by angiogram, CTA, MRA
 - Carotid duplex >70% (the lower value should be >70% if reported as a range) otherwise CTA or MRA needed to confirm
 - Documentation of any of the following
 - Transient ischemic attack (TIA)
 - Focal cerebral ischemia producing a non-disabling stroke
 - Transient monocular blindness (amaurosis fugax)
 - Asymptomatic carotid stenosis (as documented by clinical notes):
 - Stenosis between 70%-99% on carotid duplex, CTA, MRA, or angiogram within last 6 months. Radiologist/Surgeons read using NASCET criteria must be documented for CTA/MRA/angiogram, providing an precise degree of stenosis

Carotid angioplasty or stent

Carotid stenting (CAS)

Carotid stenting (CAS) for atherosclerotic disease is considered medically necessary when **all** of the following

- Criteria for CEA has been met with **one** of the following
 - Symptomatic carotid stenosis (as documented by clinical notes) demonstrated to be $\geq 70\%$ via carotid duplex, CTA or MRA or angiography within six months and any of the following:

- Transient ischemic attack (TIA)
- Focal cerebral ischemia producing a non-disabling stroke
- Transient monocular blindness (amaurosis fugax)
- Asymptomatic carotid stenosis (as documented by clinical notes) >80% demonstrated via carotid duplex, CTA, MRA or angiography within six months (carotid stenosis documented by duplex must be confirmed by angiography prior to performing the procedure)
- Individual is considered **high risk** for CEA due to a documented history of **any** of the following significant comorbidities or anatomic risk factors:
 - Significant comorbid conditions including but not limited to
 - Congestive heart failure (CHF) class III/IV
 - Left ventricular ejection fraction (LVEF) <30 %
 - Unstable angina
 - Angina with known >2 vessel CAD
 - Severe COPD
 - ESRD
 - Age 75 or older
 - Recent (within the last six months) myocardial infarction (MI)
 - Anatomic risk factors include
 - Recurrent stenosis in the setting of a previous CEA at any time
 - Prior radiation treatment to the neck
 - Previous radical neck dissection at any time
 - Permanent contralateral cranial nerve injury
 - Contralateral carotid occlusion
 - Tandem high grade stenosis on the same side
 - High cervical carotid stenosis above C2 vertebral body
- Carotid artery stenosis shall be measured by carotid duplex, CT or MR imaging or angiography and recorded in the patient's medical records (carotid stenosis documented by duplex must be confirmed by angiography prior to performing the procedure)
 - If the stenosis is measured by ultrasound prior to the procedure, then the degree of stenosis must be confirmed by angiography at the start of the procedure. Angiography can be performed at the time of the planned intervention.

Transcarotid stenting (TCAR)

- TCAR is considered medically necessary when criteria for CEA has been met AND
 - Has one high risk criteria for CEA (see above), AND
 - Has no disease at common carotid artery (CCA) entry site in addition to all of the following:
 - CCA is at least 6 mm diameter

- no prior CCA intervention including stenting
- no concern for contralateral vagus or recurrent laryngeal nerve injury
- CCA length of at least 5 cm prior to bifurcation

Carotid revascularization non-indications

Carotid revascularization (CEA or CAS) is not medically necessary in individuals who have had a disabling stroke (modified Rankin scale ≥ 3)

Asymptomatic carotid patients should have an adequate life expectancy to benefit from a carotid intervention.

Supporting information

Carotid Endarterectomy

Symptoms of carotid stenosis include transient ischemic attack (distinct focal neurological dysfunction persisting less than 24 hours), focal cerebral ischemia producing a non-disabling stroke (modified Rankin scale <3 with symptoms for 24 hours or more), and transient monocular blindness (amaurosis fugax).

Carotid endarterectomy is a procedure that involves making an incision into the internal carotid artery with surgical removal of atherosclerotic plaque and subsequent closure of the artery primarily or with a patch. The procedure can involve the use of measures supportive of intracranial circulation during clamp time including placement of an intra-arterial shunt or neuromonitoring such as electroencephalogram (EEG) or somatosensory evoked potentials (SEPS). In some patients who are noted to be at high risk for CEA secondary to medical co-morbidities or anatomic risk factors such as prior radiation or redo operation, carotid stenting can be considered.

Carotid Angioplasty and Stenting and TCAR

Carotid angioplasty/stenting form of carotid revascularization for atherosclerotic disease in which a stent and more often than not a balloon prior to that are placed over a wire through the lesion of interest to dilate and resolve a stenosis. Since threading a wire through plaque can potentially lead to fracturing and embolization of the plaque into the distal intracranial circulation, an embolic protection device is generally employed during carotid stenting. Carotid stenting is also indicated to treat aneurysmal disease involving the carotid artery. Carotid stenting is an option for patients who are considered high risk for CEA and is offered as an alternative to CEA.

CMS has determined that CAS with embolic protection is reasonable and necessary only if performed in facilities that have been determined to be competent in performing the evaluation, procedure and follow-up necessary to ensure optimal patient outcomes. Standards to determine competency include specific physician training standards, facility support requirements and data collection to evaluate outcomes during a required re-evaluation.

TCAR is a method of deploying a transcatheter stent under reverse carotid flow to reduce the incidence of cerebral embolization. This offers low procedural stroke rates in individuals who are considered high risk.

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Thoracic and Thoracoabdominal Aorta

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Guideline	Page
Coding.....	16
Thoracic and thoracoabdominal aorta - criteria.....	19
Supporting information.....	21
References.....	21

General information

Approach to pathology and repair of thoracic aortic pathology is almost universally divided between those affecting the ascending aorta and those affecting the descending thoracic aorta.

Procedures for repair of a thoracic aortic aneurysm include:

- Open surgical repair
- Thoracic endovascular aortic repair (TEVAR)

Coding

Procedures indicated for treatment of thoracic and thoracoabdominal aneurysms

Procedure	CPT®
Descending thoracic aorta graft, with or without bypass	33875
Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass	33877
TEVAR	CPT®
Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)	34701

Procedure	CPT®
Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)	34702
Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)	34703
Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)	34704
Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)	34705
Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)	34706

Procedure	CPT®
Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation)	34707
Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption)	34708
Endovascular repair of descending thoracic aorta	CPT®
Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin	33880
Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin	33881
Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension	33883
Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); each additional proximal extension (List separately in addition to code for primary procedure)	33884
Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta	33886

Thoracic and thoracoabdominal aorta - criteria

General guidelines

Indications for intervention include **one** of the following:

- Aneurysm formation, including pseudoaneurysm
- Traumatic aortic transection and its sequelae including rupture, hemothorax, pseudoaneurysm
- Dissection of the aorta, acute and chronic, including intramural hematoma
- Penetrating aortic ulcer
- Coarctation of the aorta

Urgent/emergent request with regard to thoracic aortic pathology are not rare and are indicated when patients are symptomatic, defined as **any** of the following:

- Cases of active bleeding in the area of the pathology (e.g., hemothorax, pericardial effusion, free fluid in the abdomen)
- Contained or uncontained rupture
- Acute limb ischemia
- Visceral ischemia, noted as abdominal pain from mesenteric ischemia or elevated creatinine from renal ischemia
- Paralysis of bilateral lower extremities secondary to spinal cord ischemia

Thoracic Aortic Aneurysm

Repair of a thoracic aortic aneurysm via open surgical repair or TEVAR is considered medically necessary when **any** of the following criteria are met:

- Thoracic aorta ≥ 5.5 cm in asymptomatic patients as documented by CTA/MRA chest
- Thoracic aorta of any size in a patient with a thoracoabdominal aneurysm in which the abdominal aortic aneurysm is ≥ 5 cm as documented by CTA/MRA chest
- Mycotic aneurysm (as documented by clinical notes including CTA/MRA chest or laboratory findings) of any size ≥ 4 cm
- Any aneurysm ≥ 4 cm in an individual with Marfan's syndrome, Ehlers-Danlos or Loeys-Dietz at the discretion of the surgeon
- Aneurysm growth rate of ≥ 0.5 cm/yr in an aorta with a diameter ≥ 4 cm and ≤ 5.5 cm as documented by CTA/MRA chest

Descending thoracic aortic dissection

These guidelines refer to either a type B dissection, distal to the descending thoracic aorta or to a previously repaired type A dissection with extension into the descending thoracic aorta.

- Repair of an acute type B (<48 hours from diagnosis) aortic dissection is considered medically necessary when **any** of the following:
 - Acute limb ischemia or malperfusion as documented by clinical notes
 - Persistent back pain despite adequate blood pressure control documented by clinical notes

- Aortic expansion ≥ 6 cm documented by CTA/MRA chest
- Progression of dissection to involve previously uninvolved areas of the aorta documented by CTA/MRA chest
- Repair of a sub-acute type B aortic dissection (<2 weeks from diagnosis) is considered medically necessary in the event of **any** of the following:
 - Persistent back pain despite adequate blood pressure control documented by clinical noted
 - Pseudoaneurysm formation documented by CTA/MRA chest
 - Progression of dissection to involve previously uninvolved sections of the aorta documented by CTA/MRA chest
 - Interval increase in the aortic diameter by ≥ 0.5 cm documented by CTA/MRA chest
 - Dynamic flap presenting with intermittent ischemia as detected by clinical presentation
- Repair of a chronic type B aortic dissection (≥ 2 weeks from diagnosis) is considered medically necessary in the event of **either**:
 - Aneurysmal degeneration of the aorta to a diameter ≥ 5.5 cm documented by CTA/MRA chest
 - Development of high grade stenosis of the aorta or its branches documented by CTA/MRA chest
- A TEVAR procedure is considered medically necessary for subsequent repair of the thoracic aorta in patients with a previously treated type A dissection with an elephant trunk or equivalent

Traumatic aortic transection

Typically, traumatic aortic transections are treated emergently but can in certain cases be monitored and treated expectantly.

TEVAR is considered medically necessary in patients with a known Grade 1 traumatic aortic transection if subsequent imaging demonstrates **any** of the following:

- Pseudoaneurysm formation
- Intramural hematoma formation
- Hemothorax without overt rupture of the thoracic aorta
- Suspected rupture of the thoracic aorta

Other pathologies

TEVAR is considered medically necessary to treat symptomatic high grade stenosis, aneurysmal disease, or impending or frank rupture when there are other pathologies affecting the thoracic aorta including but not limited to

- Coarctation of the aorta when **both**
 - Confirmed by CTA/MRA chest
 - Symptomatic clinical presentation

- Penetrating aortic ulcer confirmed by CTA/MRA chest
- Various vasculitides with high grade stenosis or aneurysm confirmed by CTA/MRA chest

Supporting information

The ascending aorta is generally the purview of the cardiothoracic surgeon and the descending thoracic aorta is generally within the purview of the vascular surgeon. If the pathology overlaps between the ascending and descending aorta, hybrid procedures involving first repair of the ascending aorta by the cardiothoracic surgeon and subsequent repair of the descending thoracic aorta by the vascular surgeon is common.

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Abdominal Aorta

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Guideline	Page
Coding.....	22
Abdominal Aorta - criteria.....	25
Supporting information.....	26
References.....	26

General information

Types of abdominal aortic pathology include

- Aneurysm formation, including pseudoaneurysm
- Dissection of the aorta, acute and chronic, including intramural hematoma
- Penetrating aortic ulcer
- Atherosclerotic occlusive disease

Aortic dissection affecting the abdominal aorta if symptomatic presents with ischemia of the visceral organs including the bowels and solid organs. Treatment can include repair of the intimal tear in the descending thoracic aorta or direct revascularization of the end organ with either stent placement or bypass graft.

Coding

Treatment of abdominal aortic aneurysms

Procedure codes	CPT®
Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)	34701
Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation)	34707

Procedure codes	CPT®
Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption)	34708
Endovascular repair of iliac artery at the time of aorto-iliac artery endograft placement by deployment of an iliac branched endograft including pre-procedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting, when performed, for rupture or other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer, traumatic disruption), unilateral (List separately in addition to code for primary procedure)	34717
Endovascular repair of iliac artery, not associated with placement of an aorto-iliac artery endograft at the same session, by deployment of an iliac branched endograft, including pre-procedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting, when performed, for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer), unilateral	34718
Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)	34841
Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])	34842

Procedure codes	CPT®
Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])	34843
Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including four or more visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])	34844
Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)	34845
Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])	34846
Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])	34847
Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including four or more visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])	34848

Abdominal Aorta - criteria

General Guidelines

Urgent/emergent requests are for symptomatic patients and are indicated in any of the following conditions:

- Cases of active bleeding
- Impending rupture
- Acute limb ischemia
- Paralysis

Abdominal Aortic Aneurysm - criteria

Repair of an abdominal aortic aneurysm via open surgical repair or EVAR is considered medically necessary when ANY of the following criteria are met:

- Abdominal aorta ≥ 5 cm in asymptomatic patients documented by imaging
- Abdominal aortic aneurysm of any size ≥ 3 cm in a patient with a thoracoabdominal aneurysm in which the thoracic aortic aneurysm is ≥ 6 cm documented by imaging
- Mycotic aneurysm of any size documented by imaging or elevated WBC or positive culture
- Patients with a growth rate of ≥ 0.5 cm/yr in an aorta that is between 3cm to 5 cm in diameter
- Patients with a small aneurysm between 3cm and 5 cm with extensive mural thrombus that is embolizing to the lower extremities

Abdominal Aortic Dissection - criteria

Repair of an acute type B aortic dissection is considered medically necessary in the event of **any** of the following:

- Acute limb ischemia or malperfusion as demonstrated clinically
- Persistent abdominal pain despite adequate blood pressure control (≥ 2 normal BP measurements) as documented by clinical notes
- Aortic expansion ≥ 5 cm as documented by imaging
- Progression of dissection to previously uninvolved portions of the aorta documented by imaging

Repair of a sub-acute type B aortic dissection (< 2 weeks) treated with medical management is considered medically necessary in the event of **any** of the following:

- Persistent back pain despite adequate blood pressure control as documented by clinical notes
- Pseudoaneurysm formation documented by imaging
- Progression of dissection to involve previously uninvolved portions of the aorta documented by imaging
- Continued expansion of the aortic diameter ≥ 0.5 cm documented by imaging
- Dynamic flap presenting with intermittent ischemia as documented by clinical signs/symptoms

Repair of a chronic type B aortic dissection (≥ 2 weeks) treated with medical management is considered medically necessary in the event of **either** of the following:

- Aneurysmal degeneration of the aorta to a diameter ≥ 5 cm
- Development of high grade stenosis of the aorta or its branches documented by imaging

Supporting information

Procedures to address abdominal aortic pathology fall into two broad categories open surgical repair conducted via a laparotomy and endovascular aortic repair (EVAR) which is a minimally invasive approach via the femoral artery to treat aortic pathology with a stent graft.

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Peripheral vascular, non-coronary stents

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Guideline	Page
Coding.....	27
Peripheral vascular, non-coronary stent - criteria.....	31
Supporting information.....	35
References.....	35

General information

Atherosclerosis is a systemic disease and patients will often present with multi-level disease. Intraoperative decision making may lead to changes in the original procedure requested. Sequential procedures may also be indicated during the procedure to maintain or re-establish patency. These additional procedures are necessary because the initial approach was unsuccessful or only partially successful with regard to patency of the target vessel.

Procedures for peripheral atherosclerosis can include:

- Surgery, including surgical exposure of vessels, endarterectomy or bypass
- Open or percutaneous thrombectomy
- Open or percutaneous embolectomy
- Atherectomy
- Catheter directed thrombolysis
- Additional PTA or stent placement

Coding

Procedures

Peripheral vascular non-coronary stent procedures

Procedure description	CPT®
Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	37220
Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	37221
Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	37222

Procedure description	CPT®
Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	37223
Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	37224
Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	37225
Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	37226
Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	37227
Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	37228
Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	37229
Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	37230
Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	37231
Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	37232
Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	37233

Procedure description	CPT®
Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	37234
Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	37235
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	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; each additional artery (List separately in addition to code for primary procedure)	37237
Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein	37238
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	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; each additional artery (List separately in addition to code for primary procedure)	37247
Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; renal artery	0234T

Procedure description	CPT®
Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; visceral artery (except renal), each vessel	0235T
Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; abdominal aorta	0236T
Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; brachiocephalic trunk and branches, each vessel	0237T
Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel	0238T
Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion	0505T
Aortography, thoracic, without serialography, radiological supervision and interpretation	75600
Aortography, thoracic, by serialography, radiological supervision and interpretation	75605
Aortography, abdominal, by serialography, radiological supervision and interpretation	75625
Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation	75630
Angiography, spinal, selective, radiological supervision and interpretation	75705
Angiography, extremity, unilateral, radiological supervision and interpretation	75710
Angiography, extremity, bilateral, radiological supervision and interpretation	75716
Angiography, visceral, selective or supraseductive (with or without flush aortogram), radiological supervision and interpretation	75726
Angiography, adrenal, unilateral, selective, radiological supervision and interpretation	75731

Procedure description	CPT®
Angiography, adrenal, bilateral, selective, radiological supervision and interpretation	75733
Angiography, pelvic, selective or supraseductive, radiological supervision and interpretation	75736
Angiography, pulmonary, unilateral, selective, radiological supervision and interpretation	75741
Angiography, pulmonary, bilateral, selective, radiological supervision and interpretation	75743
Angiography, pulmonary, by nonselective catheter or venous injection, radiological supervision and interpretation	75746
Angiography, internal mammary, radiological supervision and interpretation	75756
Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)	75774

Peripheral vascular, non-coronary stent - criteria

General Guidelines

It is expected that all lesions needing treatment will be addressed in one procedure. Staging of interventions is **not** indicated unless there is justification in the medical record. Valid reasons include any of the following:

- Patient instability
- Fluoroscopy use in excess of what is widely considered a safe radiation dosage
- A need to convert to general anesthesia but resources are not available
- Contrast volume given is greater than 250 ml

Primary stenting is medically necessary when Percutaneous Transluminal Angioplasty (PTA) alone is not expected to provide a durable result for patients with **either** of the following:

- Arterial occlusions that carry a high risk for distal embolization or rapid recurrence
- Occlusive lesions such as significantly calcified lesions, eccentric lesions, lesions related to external compression, and ostial lesions.

Lower extremity arterial indications

Initial treatment

Treatment of stenotic or occluded arteries perfusing the lower extremities (aorto-iliac, superficial femoral, popliteal and infra-popliteal arteries) is considered medical necessary when **all** of the following are met:

- Clinical history documents **one** of the following conditions:
 - Critical limb ischemia documented in the clinical note by **any** of the following:
 - Non-healing ischemic wounds present for \geq two weeks despite ongoing provider-directed wound care of at least two weeks
 - Gangrene where revascularization is felt to be needed to allow for minor amputation
 - Ischemic rest pain demonstrated by:
 - Symptomatology suggestive of rest pain (e.g., pain in the foot while recumbent that is relieved when foot is dependent present \geq 2 weeks) and either
 - Objective evidence of ABI's <0.5 in non-diabetics
 - Monophasic waveforms at the feet on noninvasive studies in individuals noted to have noncompressible vessels on ABI such as diabetics or patients with end-stage renal disease
 - Lifestyle limiting claudication when there is documentation of **all** of the following:
 - A failed trial of three months of provider directed conservative therapy which includes structured exercise program and/or medication
 - Functional limitations that significantly impact the quality of life and/or occupation of the patient
 - Risk factor modification including smoking cessation, optimization of lipids, and glycemic control are part of the medical evaluation and management
 - Symptoms correspond with the location of arterial insufficiency
 - aorto-iliac -lower back, hip, buttock, or thigh
 - superficial femoral - claudication in the calf muscle area
 - popliteal - calf or foot
 - infra - popliteal arteries- ankle and foot
- Imaging performed prior to the planned procedure confirms location and degree of stenosis ($\geq 70\%$)

Repeat intervention

- Re-intervention in a patient who has previously undergone angioplasty/stenting or bypass in the lower extremity arteries (aorto-iliac, superficial femoral and infra-popliteal arteries) for critical limb ischemia considered medically necessary for any **one** of the following:
 - Previous Endovascular Intervention: Drop in ABI of ≥ 0.15 on routine surveillance or duplex finding of peak systolic velocity (PSV) ≥ 190 cm/s or Velocity ratio ≥ 1.5 AND one of the following:
 - Recurrence of rest pain and/or claudication as documented by clinical notes
 - Progression of wound as defined by any increase in size of the wound, new infection or lack of 50% area reduction in 4 weeks
 - Previous Lower Extremity Bypass: Drop in ABI of ≥ 0.15 on routine surveillance AND

- Recurrence of rest pain and/or claudication as documented by clinical notes
- Progression of wound as defined by any increase in size of the wound, new infection or lack of 50% area reduction in 4 weeks OR
- If Vein bypass: PSV ≥ 180 cm/s or Velocity ratio ≥ 2 , or end diastolic velocity (EDV) < 45 cm/s
- If Prosthetic bypass: low graft velocity < 45 cm/s
- Re-intervention in a patient who has previously undergone angioplasty/stenting for claudication is appropriate when there is recurrent symptomatology in the setting of noninvasive studies demonstrating **any** of the following:
 - Drop in ABI of ≥ 0.15 or a drop from a normal ABI back to an abnormal ABI (< 0.9)
 - Recurrent lesion seen on recent duplex (within three months)
 - New lesion seen on recent duplex (within three months)
- In asymptomatic patients:
 - If Vein bypass: PSV ≥ 180 cm/s or Velocity ratio ≥ 2 , or EDV < 45 cm/s
 - If Prosthetic bypass: low graft velocity < 45 cm/s
 - Stent with high grade stenosis defined as PSV ≥ 275 cm/s or Velocity ratio ≥ 3.5
- Stent placement in infra-popliteal vessels is almost never indicated and in those cases, the rationale for stent placement must be thoroughly explained in the record.
- Atherectomy can be approved as an adjunct to angioplasty prior to stenting in lesions that are $\geq 70\%$ stenosis caused by a highly calcified eccentric plaque; AND able to pass a wire fully across the lesion into the true lumen; AND all of the following
 - Treatment of target lesion will establish inline flow to the foot, with at least 1 runoff vessel.
 - Lesion is 20 cm or less in length
 - Rutherford chronic ischemia classification 2 or higher, documented in clinical notes
 - Debulking to $< 30\%$ diameter stenosis is attainable.

Upper extremity and other peripheral artery indications

Brachiocephalic arteries

PTA and stenting is medically necessary for treatment of **any** of the following documented conditions:

- Symptomatic subclavian steal syndrome documented by **all** of the following:
 - Episodic dizziness
 - High grade stenosis or occlusion of the proximal subclavian artery demonstrated on advanced imaging
 - Presence of reversal of flow in the left vertebral artery on carotid/subclavian duplex

- Upper extremity claudication when there is documentation symptoms of fatigue with exertion of the arm and **both** of the following:
 - Symptoms are relieved with rest
 - Symptoms recur with activity at predictable intervals
- Ischemic rest pain of the arm and hand when **one** of the following criteria is met:
 - Objective measurements demonstrate severe ischemia on noninvasive studies
 - High-grade stenosis seen on advanced imaging
- Non-healing tissue ulceration and focal gangrene of the digits.
- Stenotic inflow arteries of an arteriovenous fistula when the inflow arteries, such as the innominate or brachiocephalic arteries, are demonstrated on advanced imaging to have a high grade stenosis

Renal artery

PTA and stenting for renal artery stenosis (RAS) is considered medically necessary when there is documentation of **any** of the following:

- Renal artery dissection
- Renal artery aneurysm ≥ 2 cm
- Renal artery atherosclerosis greater than 50% in a transplanted kidney
- In instances of severe hypertension leading to flash pulmonary edema or acute coronary syndrome
- Resistant or uncontrolled HTN (≥ 180 SBP or ≥ 120 DBP) with failure of maximally tolerated doses of at least three antihypertensive agents, one of which is a diuretic, or intolerance to medications
- Ischemic nephropathy with chronic kidney disease (CKD) with eGFR < 45 cc/min

PTA and stenting is **not** medically necessary for RAS under the following conditions:

- Unilateral, solitary or bilateral RAS with controlled BP and normal renal function
- Unilateral, solitary, or bilateral RAS with kidney size < 7 cm in pole to pole length
- Unilateral, solitary, or bilateral RAS with chronic end stage renal disease on hemodialysis ≥ 3 months
- Unilateral, solitary, or bilateral renal artery chronic total occlusion

Mesenteric vessels

This includes chronic mesenteric ischemia with documentation detailing the previous workup for the GI symptoms including **all** of the following:

- EGD
- Colonoscopy
- Symptoms that are felt to be a manifestation of chronic arterial insufficiency including **any** of the following:
 - Postprandial abdominal pain or bloating
 - Diarrhea

- Food fear
- Weight loss
- Prior imaging demonstrates at least two mesenteric vessels with critical high grade stenosis or occlusion

Peripheral vascular, non-coronary stents non-indications

Stent placement in infrapopliteal vessels is not medically necessary except in rare cases where it is deemed necessary intraoperatively.

PTA or stent is **not** considered medically necessary in **either**:

- Individuals who are asymptomatic
- Lesions that are **not** high-grade or critical ($\geq 70\%$)

Intravascular Ultrasound (IVUS)

IVUS for the treatment of lower extremity arterial occlusive disease is considered investigational, experimental or unproven as there is insufficient evidence to support its routine use for this type of treatment.

Supporting information

Atherosclerotic plaque can lead to stenosis and even occlusion of the peripheral vasculature. High-grade stenosis can lead to chronic ischemia of the end tissue, with resultant symptoms of arterial insufficiency. In the lower extremities, this can lead to claudication and/or critical limb ischemia. Treatment of stenotic or occlusive lesions can be performed with angioplasty alone which involves placing a balloon through a wire across the lesion and dilating the lesion to residual stenosis of $<30\%$. Stenting involves placing a metal stent permanent implant across a lesion dilating it with a balloon and leaving it in place effectively crushing and fixing the plaque against the arterial wall. Angioplasty can be performed alone or in conjunction with stenting. A stent may be placed as a planned adjunct to PTA rather than in response to a sub-optimal or failed PTA (so-called primary stent deployment).

Coverage for non-coronary vascular stents depends on the use of an FDA-approved stent for an FDA approved indication

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Venous Intervention Guidelines

Guideline	Page
General information for venous intervention requests.....	38
Treatment of Saphenovenous Reflux.....	40
Treatment of Varicose Saphenous Vein Tributaries.....	45
Treatment of pathologic perforators.....	49
Treatment of Iliac vein stenosis/occlusion/compression.....	52

General information for venous intervention requests

VAS.VI.100.A

v1.0.2023

Guideline	Page
General requirements.....	38
Information to establish medical necessity.....	38
Documentation requirements for venous intervention requests.....	38
Supporting information.....	39

General requirements

Introduction

eviCore applies an evidence-based approach to evaluate the most appropriate medically necessary care for each patient. This evaluation requires submission of legible medical records pertinent to the test, treatment, or procedure requested by the provider.

Information to establish medical necessity

Medical necessity for the request cannot be established when the medical records provided cannot be read or do not include sufficiently detailed information to understand the patient's current clinical status.

Specific elements of a patient's medical records commonly required to establish medical necessity include, but are not limited to

- Recent (within 6 months) in-person clinical evaluation which includes a detailed history and physical examination
- Laboratory studies
- Imaging studies
- Pathology reports
- Procedure reports
- Reports from other providers participating in treatment of the relevant condition

Documentation requirements for venous intervention requests

Documentation requirements needed to complete a prior authorization request for vascular surgery include **ALL** of the following:

- Procedure proposed
- Condition being treated

- Detailed documentation of provider-directed conservative treatment, duration and frequency of treatment, as well as subjective results of the conservative therapy, and the response to such treatments
- Recent (within 6 months) written reports (interpreted by an independent radiologist) of any of the following diagnostic imaging modalities acceptable for purposes of the Vascular Surgery guidelines:
 - Venous duplex
 - CTV abdomen/pelvis
 - MRV abdomen/pelvis
 - Venogram
 - IVUS – intravascular ultrasound
- Recent (within 6 months) clinical evaluation documenting:
 - Patient symptoms
 - Physical exam findings

Supporting information

Prior-authorization requests should be submitted at least two weeks prior to the anticipated date of an elective venous surgery

Office practices should have Intersocietal Accreditation Commission (IAC) Vein Center accreditation to be reimbursed for office-based superficial vein procedures.

Multiple procedures may be indicated in a patient to treat venous disease. They can be performed simultaneously or sequentially. In general, the larger veins are treated first with the expectation that it might limit the amount of smaller procedures performed. However, the more symptomatic veins can be treated first.

Venous duplex should be interpreted by a clinician holding RPVI (registered physician in vascular interpretation) credentialing or MD/DO holding RVT credential whose report shall supersede any discrepancies (when present) in interpretation.

Treatment of Saphenovenous Reflux

VAS.VI.101.A

v1.0.2023

Guideline	Page
Coding.....	40
Saphenovenous Reflux Treatment- Criteria.....	41
Supporting Information.....	42
References.....	43

General information

This section applies to the treatment of the following veins

- Greater saphenous vein
- Short saphenous vein
- Anterior Accessory Saphenous Vein
- Posterior Accessory Saphenous Vein

Endovenous ablation (radiofrequency or laser) or high ligation and stripping can be approved for the treatment of saphenovenous reflux

Coding

Procedures

Treatment options for saphenous ablation

Thermal options	CPT®
Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	36475
Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	36476
Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	36478
Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	36479

Non-thermal options	CPT®
Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated	36482
Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	36483
Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	36473
Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	36474
Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	36465
Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	36466
High ligation and stripping of the saphenous vein	CPT®
Ligation, division, and stripping, short saphenous vein	37718
Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	37722

Saphenovenous Reflux Treatment- Criteria

Endovenous ablation is the preferred treatment for saphenovenous reflux. High ligation and stripping can be considered when prior imaging demonstrates a **relative contraindication** to endovenous ablation including any of the following:

- Tortuous saphenous vein
- Aneurysmal saphenous vein (>20mm)
- Presence of intraluminal calcified valves precluding placement of catheter

Treatment of saphenovenous reflux **is not** medically necessary for an asymptomatic state or for purposes of cosmesis.

Treatment of saphenovenous reflux is **medically necessary** when **both** of the following apply

- Symptoms of venous reflux are documented by **one** of the following
 - Venous ulcer of the lower leg
 - Bleeding
 - Superficial phlebitis
 - Documentation of **both** of the following
 - Any of the following symptoms of venous reflux
 - Significant pain, heaviness, achiness, fatigue, or throbbing of the lower extremity after prolonged standing
 - Refractory venous edema that interferes with activities of daily living (when other causes of lower extremity swelling have been excluded)
 - Stasis dermatitis
 - Trial of 8 weeks of conservative therapy, including graded compression stockings, AND any of the following (exercise, periodic elevation, and weight loss (if applicable)), was unsuccessful due to **ANY** of the following reasons
 - No resolution of symptoms
 - Minimal improvement but continued life limiting symptoms
 - Symptoms worsened with conservative treatment and was stopped
- Results of a recent venous duplex (within 6 months before planned procedure) demonstrates **all** of the following
 - Presence of significant pathologic reflux measuring at least 500ms within ANY of the following vein to be treated:
 - great saphenous vein
 - lesser saphenous vein
 - anterior accessory saphenous
 - posterior accessory saphenous vein
 - Absence of DVT
 - Vein diameter ≥ 3 mm

Supporting Information

Endovenous ablation has been developed as a minimally invasive alternative to saphenous vein ligation and stripping. The procedure is designed to damage the intimal wall of the vein, resulting in fibrosis and subsequent obliteration of the lumen of a segment of the vessel thus eliminating reflux. Laser or radiofrequency ablation is performed by means of a specially designed catheter inserted through a small incision in the distal vein directed under ultrasound guidance to within 2 cm of the saphenofemoral junction. Laser or radiofrequency fibers on the tip of the catheter cause direct heating of the vessel wall, causing the vein to close as the catheter is slowly withdrawn.

Cyanoacrylate (VenaSeal™) closure is performed in a similar fashion, with small aliquots of glue placed along the course of the vein under ultrasound guidance, occluding the vein. Mechanochemical ablation is performed with the use of an oscillating catheter to disrupt the intima in conjunction with a sclerosant. Ablation with Varithena™ (polidocanol injectable foam) 1% is performed via injection of a non-compounded sclerosant into the vein via injection through a sheath or butterfly needle.

Since endovenous ablation via whatever method carries a 1% complication risk of DVT, a venous duplex (CPT® 93970, 93971) to rule out an acute DVT can be approved within seven days of the procedure.

High ligation and stripping is a more invasive method of treating saphenous vein reflux than endovenous ablation and has been declining in frequency. This surgery involves tying off the great or small saphenous vein at its junction with the deep system and stripping all or a large segment of the vein essentially removing the dysfunctional vein from the body. High ligation and stripping of the saphenous vein can also be accompanied by phlebectomy of individual varicose vein tributaries.

High ligation of the saphenous vein WITHOUT stripping should NOT be performed in the absence of stripping. High ligation of the saphenous vein in the absence of stripping has been shown to have a high rate of recurrence.

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Treatment of Varicose Saphenous Vein Tributaries

VAS.VI.102.A

v1.2023

Guideline	Page
Coding.....	45
Treatment of Varicose Veins - Criteria.....	46
Supporting information.....	47
References.....	47

General information

Saphenous vein tributaries and unnamed varicose veins ≥ 3 mm with pathologic reflux ≥ 500 ms.

Procedures indicated include

- Ambulatory phlebectomy – removal of the vein directly via small incisions
- Sclerotherapy – injection of a sclerosant agent, including non-compounded foam (Varithena), directly into the veins

Coding

Procedures indicated for treatment of saphenous vein tributaries and unnamed varicose veins

Procedure	CPT®
phlebectomy	
Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions	37765
Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions	37766
sclerotherapy	CPT®
Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	36465
Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	36466
Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk	36468

Procedure	CPT®
Injection of sclerosant; single incompetent vein (other than telangiectasia)	36470
Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg	36471
Ligation	CPT®
Ligation and division long saphenous vein at saphenofemoral junction, or distal interruptions	37700
Ligation, division, and stripping, short saphenous vein	37718
Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg with excision of deep fascia	37735
Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open, 1 leg	37760
Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg	37761
Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)	37780
Ligation, division, and/or excision of varicose vein cluster(s), 1 leg	37785

Treatment of Varicose Veins - Criteria

Treatment is indicated when **ALL** of the following have been met:

- Results of a recent venous duplex (completed within 6 months prior to date of scheduled procedure) demonstrate refluxing varicosities to be (**both**)
 - ≥ 3 mm in size
 - With ≥ 500 ms of reflux
- Documented symptoms/clinical findings of venous reflux include **any** of the following
 - Significant pain, heaviness, achiness, fatigue, throbbing of the lower extremity after prolonged standing despite conservative therapy of ≥ 8 weeks
 - Refractory venous edema that interferes with activities of daily living with exclusion of other causes of lower extremity swelling
- Documentation includes history of **one** or more of the following:
 - Venous ulcer of the lower leg
 - Bleeding associated with varicosities of the lower extremities
 - Superficial phlebitis
 - Stasis dermatitis

- Recent (within the last 6 months) trial of provider-directed 8 weeks of conservative therapy has failed due to (**any**)
 - No resolution of symptoms
 - Minimal improvement but continued life limiting symptoms
 - Symptoms worsened and conservative treatment was stopped

Individuals who have both documented saphenous vein reflux as well as non saphenous varicose veins, treatment of the nonsaphenous varicose veins can be initiated when **both** of the following apply:

- The saphenous veins have been treated first
- Symptoms have failed to resolve ≥ 6 weeks after the saphenous veins were treated (conservative therapy is not required).

Ambulatory phlebectomy and/or sclerotherapy < 6 weeks after endovenous ablation is **not** considered medically necessary

Sclerotherapy of veins < 3 mm is indicated in certain cases as follows:

- The spider/reticular vein is symptomatic with spontaneous bleeding episodes
- Documented signs and symptoms of venous stasis disease ulcerations and exhibits corona phlebectatica (spider veins at the ankle, predominantly the medial malleolus)

Supporting information

Phlebectomy involves the removal of individual varicose veins via small incisions in the skin and either via tying off or avulsing the vein. When saphenous vein reflux is present, this should be treated prior to phlebectomy.

Sclerotherapy treatment destroys the lining of the affected vein by injecting an irritant solution (either a detergent, osmotic solution, or a chemical irritant) directly into the vessel resulting in obliteration of the vessel. Types of sclerotherapy include liquid sclerotherapy with hypertonic saline, polidocanol or sotradecol or non compounded foam sclerotherapy (Varithena).

Post procedure assessment by imaging techniques is inappropriate to confirm efficacy or outcome of phlebectomy or sclerotherapy.

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Treatment of pathologic perforators

VAS.VI.103.A

v1.0.2023

Guideline	Page
Coding.....	49
Treatment of pathologic perforators- criteria.....	50
Supporting information.....	51
References.....	51

General information

Treatment of pathologic perforators ($\geq 3\text{mm}$ in size with $\geq 500\text{ms}$ of pathologic reflux) is via

- Endovenous ablation – insertion of a catheter emitting radiofrequency or laser that ablates the perforator
- Ligation - an open surgical procedure which involves tying off the pathologic perforator
- Sub-fascial endoscopic perforator surgery – a minimally invasive procedure that involves ligating pathologic perforators
- US guided foam sclerotherapy

Coding

Procedures

Treatment of pathologic perforators

Endovenous ablation	CPT®
Unlisted procedure, vascular injection	36299
Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	36465
Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	36466
Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	36475

Endovenous ablation	CPT®
Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	36476
Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	36478
Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	36479
Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated	36482
Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	36483
Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	36473
Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	36474
Sub-fascial endoscopic perforator surgery (SEPS)	CPT®
Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	37500
Unlisted vascular endoscopy procedure	37501

Treatment of pathologic perforators- criteria

Indications

Treatment of pathologic perforators is indicated when there is documentation of **ALL** of the following

- Venous stasis ulcer

- A recent (within past 6 months) US demonstrates signs of perforator vein incompetence with (**both**)
 - Reflux \geq 500ms
 - Vein diameter \geq 3mm
- Perforator vein is located in the vicinity of an active or healed ulcer
- Superficial refluxing saphenous veins have been previously eliminated

Supporting information

Perforating veins extend medially to laterally in a horizontal fashion and are located at numerous locations throughout the lower extremity and directly connect the superficial system to the deep system. Perforating veins usually penetrate the musculature to connect the superficial and deep venous systems. Pathologic perforators located directly under the wound bed of a non-healing ulcer can cause delays in wound healing and treatment can expedite closure of the wound. Treatment of pathologic perforators is not indicated for any other pathology other than stasis ulcer.

Sub-fascial endoscopic perforator surgery (SEPS) is a procedure used to ameliorate the venous hypertension that contributes to the formation and delayed healing of venous stasis ulcers. Via an endoscope through a small incision, an instrument is used to either ablate or ligate the pathologic perforator.

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Treatment of Iliac vein stenosis/occlusion/compression

VAS.VI.104.A

v1.0.2023

Guideline	Page
Coding.....	52
Iliac vein angioplasty/stenting.....	53
Supporting information.....	53
References.....	54

General information

Conditions treated- iliac vein stenosis/occlusion secondary to chronic DVT, stricture, or compression with May-Thurner

Coding

Procedures

Procedures performed for iliac vein stenosis/occlusion/compression

Iliac vein angioplasty/stenting	CPT®
Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein	37238
Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein (List separately in addition to code for primary procedure)	37239
Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (List separately in addition to code for primary procedure)	37252
Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)	37253

Iliac vein angioplasty/stenting

Indications

- Iliac vein angioplasty/stenting is indicated when there is documentation of the presence of **one** of the following conditions:
 - Acute lower extremity iliofemoral DVT with underlying iliac vein compression (50% area reduction) following thrombolysis
 - Non-thrombotic iliac vein stenosis (60% area reduction), or post-thrombotic venous obstruction, or occlusion with venous stasis ulceration and/or advanced stasis dermatitis
 - Venous claudication or lifestyle limiting ipsilateral edema and pain with no identifiable underlying non-vascular cause AND failed 8 weeks trial of conservative therapy including graded compression stockings, weight loss (if applicable) as evidenced by (**any**)
 - No improvement
 - Worsening of symptoms
 - Limited improvement with continued life-limiting symptoms

IVUS

The use of intravascular ultrasound is considered medically appropriate for the evaluation and treatment of iliac vein obstruction.

Supporting information

Individuals with incompletely lysed or residual DVT can develop post-thrombotic syndrome that can be characterized as chronic edema, venous stasis changes, pain and, in advanced cases, venous stasis ulceration.

Incompletely lysed DVT can cause luminal narrowing of the vein restricting venous outflow leading to stenosis or occlusion and /or can lead to valve dysfunction resulting in reflux of venous blood retrograde towards gravity. Both pathologies ultimately lead to chronic edema which can cause chronic pain and venous stasis disease. The mainstay of treatment for chronic deep venous thrombosis is compression stockings. Individuals whose symptoms are not relieved with conservative therapy may be a candidates for iliac vein angioplasty/stenting.

Iliac vein compression is an entity known as May-Thurner syndrome and affects the left iliac vein which can lead to chronic edema, varicose veins and venous stasis ulcerations. In approximately 25% of people, the right iliac artery overlies the left iliac vein over the fifth lumbar vertebra and its pulsations can compress the vein increasing the risk of DVT in the left extremity. Treatment is with iliac vein angioplasty/stenting for both acute and chronic left-sided DVT. Prophylactic treatment of May-Thurner syndrome in the absence of acute or chronic DVT OR chronic left lower extremity edema and its sequelae such as varicose veins or venous stasis ulcers is NOT considered medically necessary.

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