UM-CDG-020 Noncoronary Vascular Stents	Approved By: Director, Health Services	Effective Date: 10/22/2025

This Policy applies to all SECUR affiliates, associates, and subsidiaries.

Approved by Courtney Gonzales, Director of Health Services on behalf of the Utilization Management Committee.

PURPOSE

This coverage determination guideline serves to address non-coronary vascular stents that are used to enhance the primary patency in arteries and veins, usually at the site of stenotic or occlusive lesions. Stents may also be used as an adjunct to technically inadequate Percutaneous Transluminal Angioplasty (PTA) or in cases where PTA alone will not be expected to provide a durable result. Peripheral vascular stenting may be indicated for members with symptomatic arterial and venous disease resulting from occlusive process.

For SECUR Health Plan members, National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) will be applied to requests when applicable. SECUR Health Plan Coverage Determination Guidelines (CDG) will be utilized in the absence of an appropriate NCD and/or LCD.

DEFINITIONS

None

POLICY

SECUR Health Plan considers PTA and stenting of the vessels as medically necessary when all the following conditions are met:

1. Member has undergone prior thorough medical evaluation and management of symptoms.
2. Surgical intervention would otherwise be considered as an alternative treatment.
3. A stent may be placed as an adjunct to PTA rather than in response to a suboptimal or failed PTA, so called primary stent deployment. Primary stenting is justified for situations where PTA alone is not expected to provide a durable result, such as arterial or venous occlusions that carry a high risk for distal embolization or rapid recurrence, or occlusive lesions known to be unfavorable for PTA alone.

For non-coronary vascular stents, the stent placement will only be considered medically necessary when:

1. It is used for the US Food and Drug Administration (FDA) approved indication(s), or
2. Is used for indications supported by peer medical literature.

Specific Arterial Indications for PTA and Stenting

1. Brachiocephalic arteries may be indicated for PTA and stenting for treatment of flow-limiting stenosis resulting in conditions such as subclavian steal syndrome, upper extremity claudication, ischemic rest pain of the arm and hand, non-healing tissue ulceration, and focal gangrene. Stenting of inflow arteries is often useful when they are an inflow of an arteriovenous fistula for chronic hemodialysis and are significantly stenotic.

2. Pulmonary artery PTA and stenting may be indicated for certain members with congenital pulmonary artery stenosis.
3. Renal artery PTA and stenting may be indicated for renal artery stenosis. The following should be following when determining for renal artery stenosis:
   a) Renal artery stenting is considered appropriate for renal artery dissection, aneurysm, and atherosclerosis greater than 50% in a transplanted kidney.
   b) Renal artery stenting is appropriate under the following conditions:
      - Flash pulmonary edema or acute coronary syndrome (ACS) with severe hypertension
      - Resistant HTN (Uncontrolled hypertension 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 and global renal ischemia (unilateral significant renal artery stenosis with a solitary kidney or bilateral significant renal artery stenosis) without other explanation.
   c) Renal artery stenting may be considered appropriate under the following conditions:
      - Unilateral renal artery stenosis with CKD (eGFR <less than 45cc/min).
      - Unilateral renal artery stenosis with prior episodes of congestive heart failure (Stage C).
      - Anatomically challenging or high-risk lesion (early bifurcation, small vessel, severe concentric calcification, and severe aortic atheroma or mural thrombus).
   d) Renal artery stenting is rarely considered appropriate under the following conditions:
      - Unilateral solitary, or bilateral renal artery stenosis with controlled BP and normal renal function.
      - Unilateral, solitary, or bilateral renal artery stenosis with kidney size < 7cm in pole-to-pole length.
      - Unilateral, solitary, or bilateral renal artery stenosis with chronic end stage renal disease on hemodialysis > 3 months.
      - Unilateral, solitary, or bilateral renal artery chronic total occlusion.
4. For lower extremity arteries PTA and stent placement in infra-popliteal vessels is not expected to be often indicated and those cases should be thoroughly explained within the supporting documentation.
5. For limb threatening ischemia, PTA and stenting is considered appropriate.
6. For members who have failed medical management a home exercise program(s) and continue to have significant activity limiting disease(s) with an anatomically suitable lesion for intervention, PTA and stenting may be appropriate.
7. For members with peripheral artery disease, medical management should include Class I recommendations for antiplatelet therapy, statins, a home exercise program, smoking cessation with planning, if applicable, counseling and/or behavior modification, and pharmacotherapy if needed.
8. Stenting of mesenteric vessels is only covered when angioplasty of the vessels would not suffice and after the member had undergone a thorough medical evaluation and management of symptoms, for whom surgical intervention is the likely alternative. Eligible members are required to have multiple comorbidities documented making them poor candidates for open surgical procedures. In these instances, PTA and stenting would be considered as an alternative to surgery and not in addition to medical management.
9. PTA and stenting is indicated for hemodialysis access graft/fistula stenosis, restenosis, occlusion, and pseudoaneurysm.

Specific Venous Stents

1. PTA and stenting are medically necessary for superior vena cava syndrome, post-radiation venous stenosis, congenital stenosis, and thrombosis and embolism including acute thrombophlebitis. Stenting of the veins, such as the innominate, subclavian, or superior vena cava when they are the outflow vessels of an arteriovenous fistula for chronic hemodialysis and are significantly stenotic, is often useful.
2. Vena cava and iliofemoral venous occlusions and stenosis due to the following: post-radiation venous

stenosis, congenital stenosis or webs, extrinsic venous compression (May-Thurner syndrome), thrombophlebitis, and symptomatic post-traumatic venous stenosis.

Vascular obstructions may be caused by thrombosis, embolism, atherosclerosis, or other conditions and may be multifocal in a single vascular family or in multiple vascular families. Management options to maintain or re-establish the patency of a vessel in a particular vascular family include surgery, thrombectomy, embolectomy, endarterectomy, thrombolysis, atherectomy, angioplasty, and stent placement. These procedures may be performed alone or in sequence. The subsequent procedure(s) is necessary because the initial approach was unsuccessful or only partially successful in accomplishing the intended goal (that is, to maintain or re-establish the patency of a vessel). An example of this situation is when an atherectomy is followed by an angioplasty and the angioplasty followed by the placement of a stent.

SECUR Health Plan considers the placement of a stent in a vessel for which there is no objective related symptom or limitation of function not medically necessary as it is preventative.

Non-coronary intravascular stent(s) that carries an Investigation Device Exemption (IDE) may be considered medically necessary based upon its status with the FDA.

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