Medical Policy
Endovascular Therapies for Extracranial Vertebral Artery Disease

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Policy Number: 730
BCBSA Reference Number: 7.01.148
NCD/LCD: Local Coverage Determination (LCD): Category III CPT® Codes (L33392)

Related Policies
- Endovascular Procedures for Intracranial Arterial Disease, #323
- Carotid, Vertebral and Intracranial Artery Stent Placement with or without Angioplasty #219

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Endovascular therapy, including percutaneous transluminal angioplasty with or without stenting, is considered INVESTIGATIONAL for the management of extracranial vertebral artery disease.

Medicare HMO BlueSM and Medicare PPO BlueSM Members

This is not a covered service.

Local Coverage Determination (LCD): Category III CPT® Codes (L33392)

For medical necessity criteria and coding guidance for Medicare Advantage members living outside of Massachusetts, please see the Centers for Medicare and Medicaid Services website for information regarding your specific jurisdiction at https://www.cms.gov.

Prior Authorization Information
Pre-service approval is required for all inpatient services for all products.
See below for situations where prior authorization may be required or may not be required.
Yes indicates that prior authorization is required.
No indicates that prior authorization is not required.
N/A indicates that this service is primarily performed in an inpatient setting.

<table>
<thead>
<tr>
<th>Outpatient</th>
<th>Commercial Managed Care (HMO and POS)</th>
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<tbody>
<tr>
<td>This is not a covered service.</td>
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</table>
Commercial PPO and Indemnity: This is not a covered service.
Medicare HMO Blue SM: This is not a covered service.
Medicare PPO Blue SM: This is not a covered service.

**CPT Codes / HCPCS Codes / ICD Codes**
Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

*The following codes are included below for informational purposes only; this is not an all-inclusive list.*

The following CPT codes are considered investigational for **Commercial Members**: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

<table>
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<tr>
<th>CPT codes:</th>
<th>Code Description</th>
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<tr>
<td>0075T</td>
<td>Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; initial vessel</td>
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<tr>
<td>0076T</td>
<td>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)</td>
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**Description**

**Overview of Vertebrobasilar Circulation Ischemia**
Ischemia of the vertebrobasilar or posterior circulation accounts for about 20% of all strokes. Posterior circulation strokes may arise from occlusion of the innominate and subclavian arteries, the extracranial vertebral arteries, or the intracranial vertebral, basilar, or posterior cerebral arteries. Compared with carotid artery disease, relatively little is known about the true prevalence of specific causes of posterior circulation strokes, particularly the prevalence of vertebral artery disease. Reports from 1 stroke registry estimate that in 9% of cases, posterior circulation strokes are due to stenosis of the proximal vertebral artery. Patients who experience strokes or transient ischemic attacks of the vertebrobasilar circulation face a 25% to 35% risk of stroke within the subsequent 5 years. In particular, the presence of vertebral artery stenosis increases the 90-day risk of recurrent stroke by about 4-fold.

**Relevant Clinical Anatomy and Pathophysiology**
Large artery disease of the posterior circulation may be due to atherosclerosis (stenosis), embolism, dissection, or aneurysms. In about a third of cases, posterior circulation strokes are due to stenosis of the extracranial vertebral arteries or the intracranial vertebral, basilar, and posterior cerebral arteries. The proximal portion of the vertebral artery in the neck is the most common location of atherosclerotic stenosis in the posterior circulation. Dissection of the extracranial or intracranial vertebral arteries may also cause posterior circulation ischemia. In contrast, posterior cerebral artery ischemic events are more likely to be secondary to embolism from more proximal vessels.

The vertebral artery is divided into 4 segments, V1–V4, of which segments V1–V3 are extracranial. V1 originates at the subclavian artery and extends to the 5th or 6th cervical vertebrae; V2 crosses the bony canal of the transverse foramina from C2–C5; V3 starts as the artery exits the transverse foramina at C2 and ends as the vessel crosses the dura mater and becomes an intracranial vessel. The most proximal segment, V1, is the most common location for atherosclerotic occlusive disease to occur, while arterial dissections are most likely to involve the extracranial vertebral artery just before the vessel crosses the
dura mater. Compared with the carotid circulation, the vertebral artery system is more likely to be associated with anatomic variants, including a unilateral artery.

Atherosclerotic disease of the vertebral artery is associated with conventional risk factors for cerebrovascular disease. However, risk factors and the underlying pathophysiology of vertebral artery dissection and aneurysms differ. Extracranial vertebral artery aneurysms and dissections are most often secondary to trauma, particularly those with excessive rotation, distraction, or flexion/extension, or iatrogenic injury, such as during cervical spine surgeries. Spontaneous vertebral artery dissections are rare, and in many cases are associated with connective tissue disorders, including Ehlers-Danlos syndrome type IV, Marfan syndrome, autosomal-dominant polycystic kidney disease, and osteogenesis imperfecta type I.

**Management of Extracranial Vertebral Artery Disease**

The optimal management of occlusive extracranial vertebral artery disease is not well defined. Medical therapy with antiplatelet or anticoagulant medications is a mainstay of therapy to reduce stroke risk.

Medical therapy also typically involves risk reduction for classical cardiovascular risk factors. However, no randomized trials have compared specific antiplatelet or anticoagulant regimens.

Surgical revascularization may be used for vertebral artery atherosclerotic disease, but open surgical repair is considered technically challenging due to poor access to the vessel origin. Surgical repair may involve vertebral endarterectomy, bypass grafting, or transposition of the vertebral artery, usually to the common or internal carotid artery. Moderately sized, single-center case series of surgical vertebral artery repair from 2012 and 2013 report rates of overall survival of 90.7% and 77.3% at 3 and 6 years postoperatively, and arterial patency rates of 80% after 1 year of follow-up.4 Surgical revascularization may be used in cases of symptomatic vertebral artery stenosis that is not responsive to medical therapy, particularly when bilateral vertebral artery stenosis is present or when unilateral stenosis is present in the presence of an occluded or hypoplastic contralateral vertebral artery. Surgical revascularization may also be considered in patients with concomitant symptomatic carotid and vertebral disease who do not have relief of vertebrobasilar ischemia after carotid revascularization.

The management of extracranial vertebral artery aneurysms or dissections is controversial due to uncertainty about the risk of thromboembolic events associated with aneurysms/dissections. Antiplatelet therapy is typically used; surgical repair, which may include vertebral bypass, external carotid autograft, and vertebral artery transposition to the internal carotid artery, or endovascular treatment with stent placement or coil embolization may also be used.

Given the technical difficulties related to surgical access of the extracranial vertebral artery, endovascular therapies have been investigated for extracranial vertebral artery disease. Endovascular therapy may consist of PTA, with or without stent implantation.

**Summary**

Comparative evidence is lacking to determine whether endovascular therapy, including percutaneous transluminal angioplasty (PTA) with or without stent implantation, for extracranial vertebral disease improves outcomes compared with alternatives. For endovascular treatment of extracranial vertebral artery stenosis, there is 1 very small randomized controlled trial comparing endovascular therapy with medical therapy. Evidence from a large number of small- to moderate-sized noncomparative studies from single institutions indicates that vertebral artery stenting can be performed with high rates of technical success and low periprocedural morbidity and mortality. However, long-term follow-up demonstrates high rates of in-stent stenosis. Given the lack of data comparing endovascular therapy to either medical or surgical management, the evidence is insufficient to determine whether vertebral artery stenting or angioplasty improves the net health outcome.

The evidence related to the use of endovascular therapies for the treatment of extracranial vertebral artery dissections, aneurysms, and arteriovenous (AV) fistulae consists of small case series and case
reports. The available cases reports and case series indicate that endovascular therapy for extracranial vertebral artery disorders other than stenosis is feasible and may be associated with favorable outcomes. However, given the lack of evidence comparing endovascular therapies with alternatives, the evidence is insufficient to determine whether endovascular therapy for extracranial vertebral artery dissections, aneurysms, and AV fistulae improves the net health outcome.

Given the limitations in the evidence base, endovascular therapies are considered investigational for the treatment of extracranial vertebral artery disease.

**Policy History**

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<tr>
<td>7/2016</td>
<td>New references added from BCBSA National medical policy.</td>
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**Information Pertaining to All Blue Cross Blue Shield Medical Policies**

Click on any of the following terms to access the relevant information:

- Medical Policy Terms of Use
- Managed Care Guidelines
- Indemnity/PPO Guidelines
- Clinical Exception Process
- Medical Technology Assessment Guidelines

**References**


