Cardio Policy:

Carotid Duplex

POLICY NUMBER UM CARDIO_1081	SUBJECT Carotid Duplex		DEPT/PROGRAM UM Dept	PAGE 1 OF 4
DATES COMMITTEE REVIEWED 04/01/11, 11/07/12, 03/10/14, 11/08/14, 02/17/15, 08/12/15, 11/28/16, 12/21/16, 10/10/17, 02/13/19, 02/21/19, 04/24/19, 07/24/19, 12/11/19, 05/13/20, 07/13/20, 01/13/21, 02/10/21, 03/10/21, 05/12/21, 08/11/21, 01/12/22, 02/09/22, 03/08/23, 05/10/23, 12/20/23	APPROVAL DATE December 20, 2023	EFFECTIVE DATE December 22, 2023	COMMITTEE APPROVAL DATES 04/01/11, 11/07/12, 03/10/14, 11/08/14, 02/17/15, 08/12/15, 11/28/16, 12/21/16, 10/10/17, 02/13/19, 02/21/19, 04/24/19, 07/24/19, 12/11/19, 05/13/20, 07/13/20, 01/13/21, 02/10/21, 03/10/21, 05/12/21, 08/11/21, 01/12/22, 02/09/22, 03/08/23, 05/10/23, 12/20/23	
PRIMARY BUSINESS OWNER: UM		COMMITTEE/BOARD APPROVAL Utilization Management Committee		
URAC STANDARDS HUM v8: UM 1-2; UM 2-1	NCQA STANDARDS UM 2		ADDITIONAL AREAS OF IMPACT	
CMS REQUIREMENTS	STATE/FEDERAL REQUIREMENTS		APPLICABLE LINES OF BUSINESS Commercial, Exchange, Medicaid	

I. PURPOSE

Indications for determining medical necessity for Carotid Duplex.

II. DEFINITIONS

Non-invasive extra cranial arterial studies involve the use of direct methods of ultrasound. The direct tests examine the anatomy and physiology of the carotid artery.

An appropriate diagnostic or therapeutic procedure is one in which the expected clinical benefit exceeds the risks or negative consequences of the procedure by a sufficiently wide margin such that the procedure is generally considered acceptable or reasonable care. The ultimate objective of AUC is to improve patient care and health outcomes in a cost–effective manner but is not intended to ignore ambiguity and nuance intrinsic to clinical decision making.

Appropriate Care- Median Score 7-9

May be Appropriate Care- Median Score 4-6

Rarely Appropriate Care- Median Score 1-3

III. POLICY

Indications for approving a request for medical necessity are:

A. Evaluation of a patient presenting with an asymptomatic carotid bruit(s) with no prior Carotid duplex done within the last 12 months **(AUC Score 7)**[1,2,3,4,5,6]

B. Monitoring of an asymptomatic patient with known carotid stenosis (greater than 30% narrowing). 30–50% percent stenosis followed on an annual basis **(AUC Score 5)**, greater than 50% stenosis, followed every six months **(AUC Score 8)**[1,2,3,4,5,6]

C. Evaluation of a patient with a recent stroke (less than 6 months) or with focal cerebral or ocular transient ischemic symptoms (does not include blurred vision or dizziness) with no prior Carotid Duplex since recent episode of stroke. **(AUC Score 9)**[1,2,3,4,5,6]

D. Evaluation of a patient with syncope that is strongly suggestive of vertebra-basilar or bilateral carotid artery disease in etiology with no prior carotid duplex within the last 6 months. **(AUC Score 7)**[1,2,3,4,5,6]

E. Evaluation of a patient with retinal arterial emboli or amaurosis fugax with no prior carotid duplex since onset of the symptoms. **(AUC Score 9)**[1,2,3,4,6]

F. Evaluation of a patient with signs/symptoms of subclavian steal syndrome with no prior carotid duplex performed within the last 6 months. **(AUC Score 7)**[1,2,3,4,5,6]

G. Evaluation of a patient with known carotid disease on medical management with recurrent cerebrovascular Symptoms with no prior carotid duplex within the last 3 months or since the last episode of CVA. **(AUC Score 9)**[1,2,3,4,5,6]

H. Evaluation of a patient presenting with an injury to the carotid artery or blunt neck trauma **(AUC Score 8)**[1,2,3,4,5,6]

I. Evaluation of a patient with vasculitis involving the extra cranial carotid arteries **(AUC Score 7)**[1,2,3,4,5,6]

J. Evaluation of a patient with suspected aneurysm of the carotid artery or suspected aortic dissection **(AUC Score 8)**[1,2,3,4,5,6]

K. Evaluation of a patient with pulsatile neck mass with no prior carotid duplex performed within the last 6 months. **(AUC Score 8)**[1,2,3,4,5,6]

L. Monitoring of the post carotid intervention patient is appropriate at 6 weeks, 6 months, 12 months, and 24 months post intervention. **(AUC Score 7)**[1,2,3,4,5,6]

M. Carotid duplex maybe appropriate for preoperative evaluation of patients scheduled for cardiac surgery (e.g., CABG, valve repair/replacement, heart transplantation) when there is evidence of systemic atherosclerosis, greater than 65 years, left main coronary stenosis, or history of smoking if no carotid duplex is performed within the last 6 months. **(AUC Score 6)**[2,3,4,5,6]

N. Carotid duplex is indicated in asymptomatic patient with no evidence of carotid bruit but has risk factors for Carotid Artery Disease i.e., atherosclerotic disease in other vascular beds (e.g., lower extremity PAD, coronary artery disease, abdominal aortic aneurysm) No previous carotid duplex performed. Once in a lifetime screening if GDMT for risk factors have been initiated. **(AUC Score 7)**[1,2,3,4,5,6]

O. Carotid Duplex is medically indicated in patients with no prior history of Carotid Artery Disease and is presenting with atypical neurological symptoms with evidence of recent cerebrovascular event on CT/MRI brain. NO previous carotid duplex in the last 12 months **(AUC Score 7)**[1,2,3,4,5,6]

Limitations:

A. Dizziness is not a typical indication unless associated with other localizing signs or symptoms. When reporting syncope as an indication for this service, it is necessary to document that other

more common causes have been ruled out. Carotid duplex studies are reasonable and necessary only if the outcome will potentially impact the clinical course of the patient.

B. The United States Preventative Services Task Forces (USPSTF) recommends against screening for carotid artery stenosis (CAS) among healthy adult patients with no prior history of transient ischemic attack or stroke and no symptoms of a blocked artery in the neck.

C. Requests for services that are part of a surveillance protocol for patients who are involved in a clinical trial are considered out of scope (OOS) for New Century Health and cannot be reviewed.

IV. PROCEDURE

A. To review a request for medical necessity, the following items must be submitted for review:

1. Cardiologist/Vascular Surgeon progress note that prompted request
2. All previous vascular studies performed

B. Primary codes appropriate for this service:

93880 – (Complete Bilateral)

93882 – (Unilateral or Limited Study)

V. APPROVAL AUTHORITY

A. Review – Utilization Management Department

B. Final Approval – Utilization Management Committee

VI. ATTACHMENTS

A. None

VII. REFERENCES

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4. Centers for Medicare and Medicaid Services. Illinois. Local Coverage Determination (LCD) (L33627). Non-invasive Extracranial Arterial Studies. Retrieved from https://www.cms.gov [Accessed December 19, 2023].
5. Heather L. Gornik MD, FACC, et al. ACCF/ACR/AIUM/ASE/ASN/ICAVL/SCAI/SCCT/SIR/SVM/SVS2012 Appropriate Use Criteria for Peripheral Vascular Ultrasound and Physiological Testing Part I: Arterial Ultrasound and Physiological Testing :A Report of the American College of Cardiology Foundation Appropriate Use Criteria Task Force, American College of Radiology, American Institute of Ultrasound in Medicine, American Society of Echocardiography, American Society of Nephrology, Inter-societal Commission for the Accreditation of Vascular Laboratories ,Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Computed Tomography, Society for

Interventional Radiology, Society for Vascular Medicine, and Society for Vascular Surgery. Journal of the American College of Cardiology. July 2012, Volume 60, Issue 3, Pages 242-276. https://www.sciencedirect.com/science/article/pii/S0735109712005049?via%3Dihub

6. Robert C. Hendel MD, FACC, FAHA, et al. Appropriate use of cardiovascular technology: 2013 ACCF appropriate use criteria methodology update: a report of the American College of Cardiology Foundation appropriate use criteria task force. Journal of the American College of Cardiology. March 2013, Volume 61, Issue 12, Pages 1305-1317.
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