



Cardio Policy:

Femoral Popliteal Bypass Surgery

POLICY NUMBER UM CARDIO_1164	SUBJECT Femoral Popliteal Bypass Surgery	DEPT/PROGRAM UM Dept	PAGE 1 OF 3
DATES COMMITTEE REVIEWED 09/09/11, 01/09/13, 08/22/13, 06/30/14, 08/12/15, 11/28/16, 12/21/16, 10/10/17, 03/02/18, 03/07/19, 08/14/19, 12/11/19, 08/12/20, 08/11/21, 03/09/22	APPROVAL DATE March 9, 2022	EFFECTIVE DATE March 25, 2022	COMMITTEE APPROVAL DATES 09/09/11, 01/09/13, 08/22/13, 06/30/14, 08/12/15, 11/28/16, 12/21/16, 10/10/17, 03/02/18, 03/07/19, 08/14/19, 12/11/19, 08/12/20, 08/11/21, 03/09/22
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 Femoral Popliteal Bypass Surgery.

II. DEFINITIONS

Femoral popliteal artery bypass, grafting is surgery utilizing a saphenous vein or synthetic or composite graft to bypass an occluded or narrowed section of the femoral artery and restore blood flow to the leg.

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:

- A. Surgical procedures are reasonable as a revascularization option for patients with lifestyle-limiting claudication with inadequate response to GDMT, acceptable perioperative risk, and technical factors suggesting advantages over endovascular procedures. **(AUC Score 6)**^{1,2,3}
- B. When surgical revascularization is performed, bypass to the popliteal artery with autogenous vein is recommended in preference to prosthetic graft material. **(AUC Score 9)**^{1,2,3}
- C. Thromboendarterectomy with or without patch graft if performed during bypass graft is done to remove plaque causing stenosis from artery if not amenable for percutaneous intervention. **(AUC Score 7)**^{1,2,3}

Technical Considerations:

- A. Bypasses to the popliteal artery above the knee should be constructed with autogenous vein when possible.
- B. Bypasses to the popliteal artery below the knee should be constructed with autogenous vein when possible.
- C. The use of synthetic grafts to the popliteal artery below the knee is reasonable only when no autogenous vein from ipsilateral or contralateral legs or arms is available.
- D. Femoral-tibial artery bypasses with prosthetic graft material should not be used for the treatment of claudication
- E. Surgical procedures should not be performed in patients with PAD solely to prevent progression to Chronic Limb Ischemia.

Limitations

- A. 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. Progress note from vascular surgeon that prompted the request
 2. Latest imaging report supporting request

Primary codes appropriate for this service are: Bypass graft using vein - 35539-35572. In situ Vein – 35583-35587. Bypass graft using other than vein - 35646-35671. Bypass graft using composite grafts - 35681-35683. Excision, Exploration, Repair, Revision - 35700-35721, 35741, 35860, 35879-35884, 35903. Thromboendarterectomy including patch graft - 35302, 35303, 35304, 35306, 35351, 35355, 35361, 35363, 35371, 35372. Open femoral artery exposure for delivery of endovascular prosthesis by groin incision, unilateral (add-on code to a primary procedure) – 38412

- B. Place/Site of Service: Inpatient hospital (21)

V. APPROVAL AUTHORITY

- A. Review – Utilization Management Department
- B. Final Approval – Utilization Management Committee

VI. ATTACHMENTS

A. None

VII. REFERENCES

1. Gerhard-Herman MD, et al. 2016 AHA/ACC Guideline on the Management of Patients with Lower Extremity Peripheral Artery Disease: Executive Summary. Journal of the American College of Cardiology. March 2017. Volume 69, Issue 11, Pages e71-e126.
2. Alan T. Hirsch, et al. ACC/AHA 2005 Guidelines for the Management of Patients With Peripheral Arterial Disease (Lower Extremity, Renal, Mesenteric, and Abdominal Aortic): Executive Summary A Collaborative Report From the American Association for Vascular Surgery/Society for Vascular Surgery,* Society for Cardiovascular Angiography and Interventions, Society for Vascular Medicine and Biology, Society of Interventional Radiology, and the ACC/AHA Task Force on Practice Guidelines (Writing Committee to Develop Guidelines for the Management of Patients With Peripheral Arterial Disease). Journal of the American College of Cardiology. March 2006. Volume 47, Issue 6. Pages 1239-1312.
3. 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.
4. NCQA UM 2022 Standards and Elements.