

MVP/Preferred Care BENEFIT INTERPRETATION

Cardiac Revascularization:
External Enhanced Counterpulsation,
Intravascular Brachytherapy,
Transmyocardial Laser Revascularization,
Drug Eluting Stents

Type of Policy

Medical

Codes

HCPCS Codes: G0290, G0291

Evidence Basis for Policy

Some Proven Benefit. This rating indicates that there are reasonably good data to support its use in the cited application(s). Further research is required to clarify clinical indications, contraindications, dosage/duration, comparison with alternative technologies, and/or impact on clinical outcomes.

Description

Catheter-based Intracoronary Brachytherapy has been approved by the FDA as a technique to reduce re-stenosis following transluminal intracoronary angioplasty (PTCA), primarily in those procedures with a stenosis occurring at the site of a prior stent placement (i.e., "in-stent restenosis"). The FDA has approved a number of intracoronary brachytherapy devices. This approval, however, limits the use of these devices to the treatment of in-stent restenosis in native coronary arteries and vein grafts. Intra-vascular brachytherapy requires the expertise of a multidisciplinary team that includes an in-plan interventional cardiologist, an in-plan radiation oncologist, and an in-plan radiation physicist.

External Counterpulsation (ECP) is a non-invasive outpatient procedure intended to relieve angina pectoris by improving perfusion of areas of the heart deprived of adequate blood supply. ECP involves sequential pneumatic compression of the legs that is coordinated with cardiac contractions, and is designed to increase aortic blood pressure, improve venous blood return, and decrease afterload on the left ventricle. The goal of ECP is to reduce the severity and frequency of angina pectoris. Members receive external counterpulsation for one or two 60-minute treatment sessions each day (usually five days per week) for a total of 35 hours. Treatment should be completed within two months of initiation of therapy.

Transmyocardial Laser Revascularization (TMLR) is a surgical technique which employs a laser to bore holes through the myocardium in an attempt to restore perfusion to areas of the heart not being adequately perfused by diseased or clogged coronaries for palliation of intractable angina.

Angioplasty plus stent implantation is a common treatment for angina. Angioplasty opens the partially blocked artery and the implanted stent keeps it open. Twenty percent of treated patients have growth of tissue within the stent causing re-stenosis of the artery. Individuals with co-morbid conditions, such as diabetes, have a higher risk of in-stent re-stenosis. After implantation, drug eluting stents allow a slow release of drug over a period of 15-45 days that prevents proliferation of tissue within the stent and prevents in-stent re-stenosis.

Indications/Criteria

Documentation Requirements

Documentation of the clinical severity of the member's coronary artery disease must be submitted upon request. Documentation, as appropriate, should include but is not limited to the following:

- clinical history of heart disease;
- medical therapies attempted and therapeutic results of such therapies;
- PTCA and/or drug eluting stents procedure indication/contraindications and clinical pertinent documentation;
- exercise testing results;
- imaging study results; and
- general medical condition and life expectancy.

In the case of ECP, the medical record must document the member's inability to undergo more traditional re-vascularization techniques (CABG, PTCA). External cardiac assist, electronic electrocardiography (EECG), pulse oximetry, and plethymography would be considered part of ECP.

Indications for Catheter-based Intracoronary Brachytherapy

- Intracoronary vascular brachytherapy is indicated as an adjunct to PTCA, atherectomy, or stent implantation in patients with an in-stent restenosis of a native coronary artery.

Indications for ECP

- Members who have been diagnosed with disabling angina (Canadian Cardiovascular Society Class III or IV) who, in the opinion of a cardiologist or cardiothoracic surgeon, are not readily amenable to surgical intervention, such as PTCA or cardiac bypass because:
 - their condition is inoperable, or they are at high-risk of operative complications or post-operative failure;

- their coronary anatomy is not readily amenable to such procedures; or
- they have co-morbid states that create excessive risk.

Indications for TMLR

- Members who have been diagnosed with disabling intractable, (Canadian Cardiovascular Society Class III or IV) stable or unstable angina which has been found refractory to standard medical therapy, including drug therapy at the maximum tolerated or maximum safe dosages in a hospital inpatient setting. In addition, the angina syndrome must be caused by areas of the heart not amenable to surgical therapies such as PTCA, stenting, coronary atherectomy, or coronary bypass.
- Coverage is further limited to those uses of the laser used in performing the procedure which have been approved by the FDA for the purpose for which they are being used.
- Members must meet additional selection guidelines such as:
 - ejection fraction $\geq 25\%$;
 - viable ischemic heart tissue as established by (unspecified) diagnostic study that cannot be re-vascularized by direct coronary vascularization; and
 - stable cardiovascular status with regard to severe ventricular arrhythmias, decompensated congestive heart failure or acute myocardial infarction.

Indications for Drug Eluting Stents

- Drug-eluting stents are indicated to improve luminal diameter in vessels and lesions in accordance with the FDA approved package labeling instructions.

Exclusions/Limitations

Catheter-based Intracoronary Brachytherapy

- Applications other than those listed in the indications/criteria section for intracoronary brachytherapy are considered INVESTIGATIONAL, including, but not limited to, the treatment of coronary stenoses unrelated to prior stent placement and the treatment of stenoses of non-native coronary vessels and, as such, are not covered under this policy.
- Recent evidence of a myocardial infarction within three (3) days prior to brachytherapy.
- History of prior radiotherapy to same arterial segment.
- Evidence of severe peripheral vascular disease.
- Child bearing potential.
- Left main coronary artery disease.
- Intraprocedural angiography shows evidence of thrombus, spasm or dissection;
- Use of radioactive stent for prevention of re-stenosis and treatment of de novo lesions.

- Inability to maintain member on antiplatelet and/or anticoagulant therapy.

ECP

- Member is a candidate for interventional procedures.
- Left main coronary artery disease.
- Cardiac catheterization within one to two weeks.
- Arrhythmia (e.g., atrial fibrillation, atrial flutter, ventricular tachycardia).
- Aortic insufficiency.
- Evidence of an abdominal aortic aneurysm or severe iliofemoral occlusive disease.
- Limiting peripheral vascular disease (PVD) and/or phlebitis.
- Severe hypertension $\geq 180/110$ mm Hg.
- Bleeding diathesis or coumadin therapy with an INR ≥ 1.8 .
- Pregnancy or possible pregnancy.
- There is insufficient evidence that member will benefit from a second or subsequent ECP procedure, therefore, the benefit is restricted to a single course of treatment.
- Canadian Cardiovascular Society Classification II angina.
- Heart failure:
 - NYHA Class II/III stable heart failure symptoms with an ejection fraction of $\leq 30\%$; or
 - NYHA Class IV.
- Cardiogenic shock.
- Acute myocardial infarction.

Transmyocardial Laser Revascularization (TMLR)

- Unstable angina
- Recent myocardial infarct
- Depressed left ventricular ejection fraction ($<25\%$)
- Pre-existing arrhythmias, CHF, bleeding tendencies

Drug Eluting Stents are not covered for the following:

- any indication not listed in the FDA approved package labeling instructions;
- use of multiple stents in quantities greater than that listed in the FDA approved package labeling instructions, have not been evaluated clinically and; therefore, will not be covered; or
- the use of different types of stents in combination has not been clinically evaluated and; therefore, will not be covered.

References

Literature Search (updated in 2008)

1. Centers for Medicare & Medicaid Services (CMS) 2006. Decision Memo for External Counterpulsation (ECP) Therapy (CAG-00002R2) Available on-line: www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=162.
2. HAYES Directory™. Drug Eluting Stents for Treatment of Coronary Artery Disease. Lansdale, PA: HAYES, Inc.; ©2007 Winifred S. Hayes, Inc. Sept. 12, 2007.
3. HAYES Directory™. External Counterpulsation. Lansdale, PA: HAYES, Inc.; ©2002 Winifred S. Hayes, Inc. Nov 7, 2002.
4. HAYES update search™. External Counterpulsation. Lansdale, PA: HAYES, Inc.; ©2008 Winifred S. Hayes, Inc. Aug. 19, 2007.
5. Cardiomedics. External counterpulsation [corporate website]. Available at URL address: www.cardiomedics.com/.
6. Vasomedical, Inc. EECP [corporate website]. Available at URL address: www.eecp.com.
7. HAYES Directory™. Myocardial Laser Revascularization. Lansdale, PA: HAYES, Inc.; ©2006 Winifred S. Hayes, Inc. Jan. 6, 2006.
8. HAYES update search™. Myocardial Laser Revascularization. Lansdale, PA: HAYES, Inc.; ©2008 Winifred S. Hayes, Inc. Jan. 25, 2008.
9. Eclipse Surgical Technologies, Inc. Eclipse TMR Holmium Laser System. Information for Use. Sunnyvale, California. 1999.
10. PLC Medical Systems, Inc. The Heart laser CO2™. Milford, MA. 1998.
11. Lemos, P., Saia, F., Hofman, S.H., et.al., Short- and Long-Term Clinical Benefits of
12. Sirolimus-Eluting Stents Compared to Conventional Bare Metal For Patients
13. With Acute Myocardial Infarction, Journal of The American College of
14. Cardiology. March 2004, Available: www.medscape.com.
15. Boston Scientific, Directions for use, TAXUS™ Express²™, Paclitaxel-Eluting Coronary
16. Stent System, Monorail® and Over the wire Coronary Stent Delivery System (2007).
17. Cordis®, Instructions for use. CYPHER® Sirolimus-eluting Coronary Stent on Raptor™ Over the Wire System and CYPHER® Sirolimus-eluting Coronary Stent on Raptorail™ Rapid Exchange Delivery System (2006).
18. Endeavor ABT-578 Eluting Coronary Stent System, Instructions for use. Medtronic, Inc. (2007).
19. Empire Medical Review Policy Issue, (February, 2002). Intravascular brachytherapy. The Medicare News Brief, MNB-Policy-2002-02, 18-21.

20. Centers for Medicare & Medicaid Services (CMS) [formerly HCFA]. (April, 2001). Medical policies: External counterpulsation (ESP). Medicare B, 14-17.
21. ACC/AHA Task Force Report, (1991). Guidelines and indications for coronary artery bypass graft surgery, Journal of the American College of Cardiology, 17(3), 534-589.
22. Centers for Medicare & Medicaid Services (CMS) [formerly HCFA]. (1999). Transmyocardial revascularization for severe angina-medicare coverage issues manual, [On-Line], 2000. Available: www.hcfa.gov.
23. AHA Medical/Scientific Statement Special Report, (1994). Optimal risk factor management in the patient after coronary revascularization, Circulation, 90, (6), 3125-3133.
24. A Consensus Development Conference Report to The National Advisory Committee on Core Health and Disability Support Services. (1993). Coronary artery bypass grafting and angioplasty, 1-27.
25. International Journal of Technology Assessment in Health Care, (1993). The appropriateness of the use of cardiovascular procedures: British versus U.S. perspectives, 9(1), 3-10.
26. ACC/AHA Task Force Report, (1993). Guidelines for percutaneous transluminal coronary artery angioplasty, Journal of the American College of Cardiology, 22(7), 2033-54.
27. Health Technology Assessment Information Service, (1998). Transmyocardial laser revascularization for intractable ischemic heart disease (8).
28. Fishman, R., Harvey, S., Zellner, J., Pinosky, M., & Handy, J. (1998). Reducing cardiac surgical trauma: The minimally invasive direct coronary artery bypass. The Journal of the American College of Cardiology, 31, 1234-1239.
29. Wait, M.A. (1998). Direct coronary artery bypass (midcabg). What is the role of minimally invasive surgery in re-vascularization of patients? Journal of the Southern Medical Association.
30. ACC Educational Highlights/Fall 1998. Changing the business of heart surgery: The economics and future of minimally invasive cardiac surgery.
31. Vassilios, G., Knaut, M., Wagner, M., & Schuler, S. (1998). Minimally invasive surgical technique for the treatment on multi-vessel coronary artery disease, Cardiology Management.
32. Centers for Medicare & Medicaid Services (CMS) [formerly HCFA]. (1999). Enhanced counterpulsation for severe angina, [On-Line], 2000. Available: www.hcfa.gov.
33. University of California at San Francisco, Division of Cardiology (1998). ECP – external counterpulsation, [On-Line], 2000 Available: www.ucsf.edu/cardiology.

Approvals & Review/Revisions

Medical

Reviewed:

Medical Advisory Team: 4/13/08

Approved:

Quality Improvement Committee: 6/9/08

Prior Approval Date: 7/17/06

Last Revision Date: 4/11/08

Origination Date: 6/96

Effective Date: 8/1/08

Note: For Preferred Care authorization requirements refer to Appendix A and Appendix B in the Referral/Prior Authorization/Notification Administrative Policy. You may also refer to the "Prior Authorization of Certain Prescription Drugs" for information on drugs that require prior authorization. Both policies are available on the *easyLink* for Providers at www.preferredcare.org.