



# Cardio Policy: Femoral Popliteal Bypass Surgery

<b>POLICY NUMBER</b> UM CARDIO_1164	<b>SUBJECT</b> Femoral Popliteal Bypass Surgery		<b>DEPT/PROGRAM</b> UM Dept	<b>PAGE 1 OF 4</b>
<b>DATES COMMITTEE REVIEWED</b> 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, 02/01/23	<b>APPROVAL DATE</b> February 1, 2023	<b>EFFECTIVE DATE</b> February 1, 2023	<b>COMMITTEE APPROVAL DATES</b> 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, 02/01/23	
<b>PRIMARY BUSINESS OWNER:</b> UM		<b>COMMITTEE/BOARD APPROVAL</b> Utilization Management Committee		
<b>URAC STANDARDS</b> HUM v8: UM 1-2; UM 2-1	<b>NCQA STANDARDS</b> UM 2		<b>ADDITIONAL AREAS OF IMPACT</b>	
<b>CMS REQUIREMENTS</b>	<b>STATE/FEDERAL REQUIREMENTS</b>		<b>APPLICABLE LINES OF BUSINESS</b> 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

Guideline directed medical therapy (GDMT) are outlined by joint American College of Cardiology (ACC)/American Heart Association (AHA) in cardiovascular clinical practice guidelines as Class I recommendation. These are maximally tolerated medications for a cardiovascular condition, when

prescribed, have shown to improve healthcare outcomes such as survival along with significant reduction in major adverse cardiovascular events and hospitalization. For all recommended drug treatment regimens, the prescriber should confirm the dosage with product insert material and carefully evaluate for contraindications and interactions<sup>1,2,4,6,7</sup>

### III. POLICY

**Patients should be on maximally tolerated GDMT.**

**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)**<sup>1,2,3,4,5,6,7,8,9,10</sup>
- 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)**<sup>1,2,3</sup>
- 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)**<sup>1,2,3</sup>

**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.
- B. Before proceeding with bypass surgery for a patient with symptomatic PAD the following must be considered: Predicted or observed lack of adequate response to maximally tolerated GDMT<sup>1,2,4,6,7</sup>.

### 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. Thromboendartectomy 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.
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4. Gerhard-Herman MD, et al. 2016 AHA/ACC Guideline on the Management of Patients with Lower Extremity Peripheral Artery Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *Circulation*. 2017 Mar 21;135(12):e726-e779.
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9. Fakhry F, et.al. Long-term clinical effectiveness of supervised exercise therapy versus endovascular revascularization for intermittent claudication from a randomized clinical trial. British Journal of Surgery 2013; 100: 1164–1171.
10. David L Dawson MD et.al. A comparison of cilostazol and pentoxifylline for treating intermittent claudication. The American Journal of Medicine. Volume 109, Issue 7, November 2000, Pages 523-530.
11. NCQA UM 2022 Standards and Elements.