

Lower Extremity Endovascular Procedures Medicare Coverage, Medicare Advantage and Commercial Payer Policies

Lower extremity endovascular procedures can be performed in the following settings:

- **Facility setting:** Hospital Inpatient, Hospital Outpatient, and Ambulatory Surgical Center (ASC)
- **Non-facility setting:** Physician office/ Office-Based Lab (OBL)

There is no Medicare national coverage determination for stenting or atherectomy. The following National Coverage Determination (NCD) is applicable to angioplasty (with or without stenting). National Coverage Determination (NCD) 20.7 and Local Coverage Determination (LCD) L35998 are applicable to lower extremity endovascular procedures. In the absence of an NCD or LCD, Medicare Advantage plans may defer to commercial payer coverage criteria. Commercial coverage criteria varies by payer.

Traditional Medicare does not require prior authorization.

Medicare Advantage plans are managed by commercial payers and may require prior authorization.

Most commercial plans also require prior authorization; please check with your payers for any requirements.

Additional materials are available for physicians when seeking prior authorization for lower extremity endovascular procedures. The materials can be accessed on Abbott, Vascular Division Reimbursement website:

[Vascular Reimbursement Resources](#)

The ultimate responsibility for coding and obtaining payment/reimbursement remains with the customer. This includes the responsibility for accuracy and veracity of all coding and claims submitted to third-party payers. In addition, the customer should note that laws, regulations, and coverage policies are complex and are updated frequently, and, therefore, the customer should check with its local carriers or intermediaries often and should consult with legal counsel or a financial, coding, or reimbursement specialist for any questions related to coding, billing, reimbursement, or any related issues.

MEDICARE COVERAGE DETERMINATIONS

1. National Coverage Determination

There is no Medicare National Coverage Determination for stenting or atherectomy. The following National Coverage Determination (NCD) is applicable to angioplasty (with or without stenting).

- **[National Coverage Determination \(NCD\) 20.7, section B1: Percutaneous Transluminal Angioplasty](#)**, covers percutaneous transluminal angioplasty (PTA) in the lower extremities (i.e., iliac, femoral, and popliteal arteries).

2. Local Coverage Determination

- **[Local Coverage Determination \(LCD\) L35998: Non-Coronary Vascular Stents](#)** is applicable to Wisconsin Physician Service Insurance Corporation (WPS), in jurisdictions J5 (Iowa, Kansas, Missouri, and Nebraska), and J8 (Indiana and Michigan).
 - PTA and stenting are considered medically necessary for patients with critical limb ischemia. Stent placement is covered by Medicare only when an FDA-approved stent is used for the FDA-approved indications OR supported by the peer medical literature.
 - PTA and stenting for claudication may be appropriate for patients who failed medical management and exercise program and continue to have lifestyle limiting disease.

CLINICAL GUIDELINES AND PAYER POLICIES

Clinical guidelines and medical policies determine medical necessity criteria for patients diagnosed with claudication and chronic limb-threatening ischemia (CLTI).

These links represent currently available clinical guidelines for national payers; guidelines vary by payer and are subject to change at any time. *

1. Aetna:

Commercial medical policies

Effective 11/12/24: [Peripheral Vascular Stents - Clinical Policy](#)

Effective 8/15/24: [Peripheral Atherectomy and Thrombectomy Devices - Clinical Policy](#)

Clinical guideline issued by eviCore, a Medical Benefits Management company. eviCore Peripheral Vascular Intervention Guideline, effective 1/24/25: [Peripheral Vascular Intervention Guidelines](#) (input “Aetna” in the “search by health plan...” window, select the current guideline for peripheral vascular intervention).

2. Anthem Blue Cross Blue Shield: clinical guideline issued by Carelon, a Medical Benefits Management Company.

Commercial policy, effective 10/20/24: [Carelon Appropriate Use Criteria for Endovascular Revascularization](#)

3. Cigna: co-branded clinical guideline issued by eviCore.

Commercial policy, effective 1/24/25: [Cigna eviCore Peripheral Intervention guideline](#)

4. Humana:

Commercial policy, effective 2/2/23 and Medicare Advantage policy effective 12/10/24:

[Peripheral Artery Revascularization of the Lower Extremities](#)

5. United Healthcare:

Commercial policy, effective 1/1/25: [Lower Extremity Endovascular Procedures](#)

PRIOR AUTHORIZATION

The links below represent the prior authorization requirements for the national payers.

Additional payers may require prior authorization requests before the procedure is performed; requirements vary by payer and are subject to change at any time. *

1. Aetna:

Prior authorization managed by eviCore.

[Aetna Provider Resources](#) | [EviCore by Evernorth](#)

2. Anthem Blue Cross Blue Shield:

Anthem BCBS operates in the following states: CA, CO, CT, GA, IN, KY, ME, MO, NV, NH, NY, OH, VA, WI

Select the applicable state to determine prior authorization requirements:

[Prior Authorization](#) | [Provider](#) | [Individual & Commercial Plans](#) | [Anthem](#)

3. Cigna:

Select the applicable plan type to determine prior authorization requirements:

Commercial policy, effective February 2025: [Commercial Prior Authorization Guideline](#)

Medicare Advantage policy, effective 10/1/24: [Medicare Advantage Prior Authorization Guideline](#)

4. Humana:

Prior authorization managed by Cohere Health, a Medical Benefit Management company.

[Authorization Submission Information - Humana](#)

Select the applicable plan type to determine prior authorization requirements:

Commercial policy, effective 7/1/24: [Commercial Prior Authorization Criteria](#)

Medicare Advantage policy, effective 7/1/24: [MA Prior Authorization Criteria](#)

5. United Healthcare:

Select the applicable plan type to determine prior authorization requirements:

Commercial policy, effective 1/1/25: [Prior Authorization for Commercial Plans](#)

Medicare Advantage policy, effective 2/1/25: [Prior Authorization for Medicare Advantage Plans](#)

* These prior authorization requirements and clinical guidelines are current as of **1/17/2025**. This document will be updated on a quarterly basis to reflect the most current payer requirements. Please check with your respective payers for the specific prior authorization requirements and medical necessity criteria.

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