MEDICAL POLICY – 2.02.16
Ultrasonographic Measurement of Carotid Intima-Medial Thickness as an Assessment of Subclinical Atherosclerosis

BCBSA Ref. Policy: 2.02.16
Effective Date: April 1, 2017
Last Revised: Oct. 24, 2017
Replaces: N/A

RELATED MEDICAL POLICIES:
N/A  Cardiovascular Risk Panels

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | CODING | RELATED INFORMATION
EVIDENCE REVIEW | REFERENCES | HISTORY

∞ Clicking this icon returns you to the hyperlinks menu above.

Introduction

Atherosclerosis is a condition in which plaque builds up on artery walls. Plaque is made up of fat, cholesterol and other substances in the blood. Over time, the plaque hardens and narrows the arteries. Narrowed arteries means less blood can flow to organs like the heart and brain. There are a number of well proven tests that doctors use to diagnose atherosclerosis. A newer test uses sound waves (ultrasound) to look at the two innermost layers of the carotid artery. (The carotid arteries are on both sides of the neck.) The goal of the ultrasound test is to try to see if plaque is building up in arteries before other tests are able identify it. Medical studies have found that this type of ultrasound test is uncertain in trying to predict who will develop atherosclerosis. Also, there are no studies showing how this testing leads to better health results compared to standard testing. For these reasons, ultrasound testing to try to identify atherosclerosis is considered investigational.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.
Policy Coverage Criteria

Service | Investigational
--- | ---
Ultrasonographic measurement of carotid artery intima-medial thickness (CIMT) | Ultrasonographic measurement of carotid artery intima-medial thickness (CIMT) as a technique for identifying subclinical atherosclerosis is considered investigational for use in the screening, diagnosis, or management of atherosclerotic disease.

Coding

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>CPT 0126T</td>
<td>Common carotid intima-media thickness (IMT) study for evaluation of atherosclerotic burden or coronary heart disease risk factor assessment</td>
</tr>
<tr>
<td>93895</td>
<td>Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral</td>
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Related Information

Benefit Application

Ultrasonographic measurement of the carotid intimal-medial thickness may be performed as a function of participation in some clinical trials.

Evidence Review
Description

Ultrasonographic measurement of carotid intima-medial (or intimal-media) thickness (CIMT) refers to the use of B-mode ultrasound to determine the thickness of the two innermost layers of the carotid artery wall, the intima and the media. Detection and monitoring of intima-medial thickening, which is a surrogate marker for atherosclerosis, may provide an opportunity to intervene earlier in atherogenic disease and/or monitor disease progression.

Background

Coronary heart disease (CHD) accounts for 27% of all deaths in the United States.\(^1\) Established major risk factors for CHD have been identified by the National Cholesterol Education Program (NCEP) Expert Panel. These risk factors include elevated serum levels of low-density lipoprotein cholesterol (LDL-C), total cholesterol, and reduced levels of high-density lipoprotein cholesterol. Other risk factors include a history of cigarette smoking, hypertension, family history of premature CHD, and age.

The third report of the NCEP Adult Treatment Panel (ATP III) establishes various treatment strategies to modify the risk of CHD, with emphasis on target goals of LDL-C. Pathology studies have demonstrated that levels of traditional risk factors are associated with the extent and severity of atherosclerosis. ATP III recommends use of the Framingham criteria to further stratify those patients with 2 or more risk factors for more intensive lipid management.\(^2\) However, at every level of risk factor exposure, there is substantial variation in the amount of atherosclerosis, presumably related to genetic susceptibility and the influence of other risk factors. Thus, there has been interest in identifying a technique that can improve the ability to diagnose those at risk of developing CHD, as well as to measure disease progression, particularly for those at intermediate risk.

The carotid arteries can be well visualized by ultrasonography, and ultrasonographic measurement of the carotid artery intima-medial thickness (CIMT) has been investigated as a technique to identify and monitor subclinical atherosclerosis. B-mode ultrasound is most commonly used to measure CIMT. The intima-medial thickness (IMT) is measured and averaged over several sites in each carotid artery. Imaging of the far wall of each common carotid artery yields more accurate and reproducible IMT measurements than imaging of the near wall. Two echogenic lines are produced, representing the lumen-intima interface and the media-adventitia interface. The distance between these two lines constitutes the IMT.
Summary of Evidence

For individuals who are undergoing cardiac risk assessment who receive ultrasonic measurement of carotid intima-media thickness (CIMT), the evidence includes large cohort studies and systematic reviews. Relevant outcomes are test accuracy and morbid events. Some studies correlate increased CIMT with many other commonly used markers for risk of coronary heart disease (CHD) and with risk for future cardiovascular events. A 2012 meta-analysis of individual participant data by Lorenz et al found that CIMT was associated with increased cardiovascular events although CIMT progression over time was not associated with increased cardiovascular event risk. In a 2012 systematic review by Peters et al, the added predictive value of CIMT was modest, and the ability to reclassify patients into clinically relevant categories was not demonstrated. The results from these reviews and other studies have demonstrated the predictive value of CIMT is uncertain, and that the predictive ability for any level of population risk cannot be determined with precision. In addition, available studies do not define how the use of CIMT in clinical practice improves outcomes. There is no scientific literature that directly tests the hypothesis that measurement of CIMT results in improved patient outcomes and no specific guidance on how measurements of CIMT should be incorporated into risk assessment and risk management. The evidence is insufficient to determine the effects of the technology on health outcomes.

Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this policy are listed in Table 1.

Table 1. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
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<tr>
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<td></td>
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<tr>
<td>NCT01849575</td>
<td>Direct VIsuAliZAtion of Asymptomatic Atherosclerotic Disease for Optimum Cardiovascular Prevention. A Population Based Pragmatic Randomised Controlled Trial Within Västerbotten Intervention Programme (VIP) and Ordinary Care</td>
<td>3200</td>
<td>Jun 2021</td>
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NCT: national clinical trial.
Practice Guidelines and Position Statements

*American College of Cardiology and American Heart Association*

A 2013 guideline on the assessment of cardiovascular risk from the American College of Cardiology and the American Heart Association (ACC/AHA) does not recommend CIMT for routine risk assessment of a first atherosclerotic cardiovascular disease event (ACC/AHA Class III: no benefit, level of evidence B).27 This differs from the previous 2010 version of the ACC/AHA guidelines for assessment of cardiovascular risk,28 which indicated CIMT might be reasonable for assessing cardiovascular risk in intermediate-risk asymptomatic adults.

*American Society of Echocardiography*

The American Society of Echocardiography Consensus Statement29 endorsed by the Society for Vascular Medicine, states that CIMT is a feature of arterial wall aging “that is not synonymous with atherosclerosis, particularly in the absence of plaque.” The statement recommends measurement of both CIMT and carotid plaque by ultrasound “for refining CVD [cardiovascular disease] risk assessment in patients at intermediate cardiovascular disease risk (Framingham Risk Score 6–20%) without established CHD, peripheral arterial disease, cerebrovascular disease, diabetes mellitus, or abdominal aortic aneurysm.” However, the authors acknowledge that “More research is needed to determine whether improved risk prediction observed with CIMT or carotid plaque imaging translates into improved patient outcomes.”

*NCEP Adult Treatment Panel*

The Third Report of National Cholesterol Education Program Adult Treatment Panel (2003) does not recommend using “emerging risk factors” in the assessment of persons for primary prevention. It does state that “emerging risk factors” may be useful in certain patient-centered circumstances.2

*U.S. Preventive Services Task Force Recommendations*

In October 2009, the U.S. Preventive Services Task Force (USPSTF) published a systematic review of CIMT within the scope of a larger recommendation statement entitled “Using Nontraditional Risk Factors in Coronary Heart Disease Risk Assessment.”30 On the basis of one fair- and 2 good-
quality studies, USPSTF states that CIMT, independent of Framingham risk factors, predicts CHD in asymptomatic patients. These studies were longitudinal, population-based studies conducted in the United States and the Netherlands. USPSTF reviewed the Atherosclerosis Risk in Communities (ARIC) study and concluded that CIMT measurement can result in risk prediction that is modestly improved, particularly in adult men. However, the review cautions that the studies that did show an association were all done in a research setting, and therefore one cannot draw conclusions on the applicability of CIMT to the intermediate-risk population at large. The studies that USPSTF referenced are further detailed within this policy.

The Summary of Recommendation specific to CIMT is stated as: “The U.S. Preventive Services Task Force (USPSTF) concludes that the current evidence is insufficient to assess the balance of benefits and harms of using ... [CIMT] ... to screen asymptomatic men and women with no history of CHD to prevent CHD events.” USPSTF identifies the following research need: “The predictive value ... of carotid IMT ... should be examined in conjunction with traditional Framingham risk factors for predicting CHD events and death.”

Medicare National Coverage

There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.

Regulatory Status

In February 2003, SonoCalc® (SonoSite) was cleared for marketing by the FDA through the 510(k) process. The FDA determined that this software was substantially equivalent to existing image display products for use in the automatic measurement of the IMT of the carotid artery from images obtained from ultrasound systems. Subsequently, several other devices have been approved through the 510(k) process.

Product code: LLZ.

References


**History**

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<td>10/24/17</td>
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Email AppealsDepartmentInquiries@Premera.com

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Getting Help in Other Languages

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)


Hmoob (Hmong): Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tej zaum tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb bxo koy daim ntawv thov kev pab los yoy kog chov kev pab cuam los ntawm Premera Blue Cross. Tej zaum muaj cov hnb tuem ceeb cuam sau rau hauv daim ntawm no. Tej zaum koj koy juvu tau uu qee yam uu peb kom koy ua tsis pub dhaa cov caji nyooj uas teev teev rau hauv daim ntawm no mas koj thaj yuvu tau baais kev pab cuam kho mob los yoy kev pab them tej nqi kho mob ntawv. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau mbau sau uu koj hom lub pub dawb rau koj. Hu rau 800-722-1471 (TTY: 800-842-5357).

Ilokano (Ilocano): Daytoy a Pakdaara kat nagliaon iti Napateg nga Impomarsa. Daytoy a pakdaara mabal in nga adda kat nagliaon iti napateg nga impomarsa maipangepp iti aplikasyon nga covering babaen iti Premera Blue Cross. Daytoy ket malabing dagiti importante a pelsa iti daytoy a pakdaara. Mabal in nga adda rumbeng nga aramidenyo nga addang saskay dagiti partikular a naitding nga adda aldaw tapno mapagatanliyo ti covering ti salun-atyo nga tungon kadagiti gastos. Adda karbenganyo a mangala i daytoy nga impomarsa ken tungon iti bukodyo a pagasasao nga awan ti bayadanyo. Tumawag ti numero nga 800-722-1471 (TTY: 800-842-5357).

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Fa’asamoa (Samoan): Atonu ua i a i le fia’asilasiaga ni fa’amatagala e sili ona tauta e fia’amatagala ona e malama. Ia. O le fia’asilasiaga o se fia’amatagala atena ona fa’amatagala ai la i le tulaga o le polokalame, Premera Blue Cross, te fia’amatagala ona fa’amatagala ai i le fia’asilasiaga tauta. Masolo o le a i ai fea i fia’amatagala ona fa’amatagala ai la i le aui a le aui ai i fia’asilasiaga ina i a i i peia ma fia’asilasiaga mai ai la le polokalame a le Malo olo’o i a i ai. Olo’o ia i ait i le aia tauta e fia’amatagala ona fia’asilasiaga ina i a i i le fia’asilasiaga atena o le fia’asilasiaga ina i a i ai i le fia’asilasiaga ina i a i ai i le fia’asilasiaga ina i a i ai i le fia’asilasiaga ina i a i ai.


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