PTA WITH CAS MEDICARE COVERAGE WORKSHEET

Complete this form to determine coverage per NCD 20.7 for patients with traditional Medicare fee for service as primary or secondary insurance coverage.

PATIENT INFORMATION

Last Name:	First Name:	DOB:
Reason/Diagnosis:		MR#:
Date of CAS Procedure:	Physician:	

DETERMINE MEDICARE COVERAGE per NCD 20.7 (Medicare requires this procedure be done in an inpatient setting only)

#	
1	Is the patient participating in an FDA-approved Category B IDE clinical trial? ❑ YES – Meets Medicare coverage – Go to #15 ❑ NO – Go to #2
2	Is the facility on the CMS list of certified facilities to perform CAS? ❑ YES – Go to #3 ❑ **NO - Does NOT meet Medicare coverage – Go to #15**
3	Is the patient at high-risk for CEA as evidenced by one or more of the following, or other comorbidity that makes the patient a poor candidate for CEA? **(Check all that apply)** ❑ Age ≥ 80 ❑ CHF (NYHA class III/IV) ❑ Previous neck radiation ❑ Recent MI (< 30 days) ❑ Unstable angina (CCS class III/IV) ❑ Restenosis of prior CEA ❑ LVEF < 30% ❑ Renal failure (ESRD on dialysis) ❑ Tracheostomy ❑ Contralateral carotid occlusion ❑ Severe pulmonary disease ❑ CCA lesion(s) below clavicle ❑ High cervical ICA lesion ❑ Clinically significant cardiac disease ❑ Contralateral laryngeal nerve palsy ❑ Other (specify): ____________________ ❑ YES – Go to #4 ❑ **NO – Does NOT meet Medicare coverage – Go to #15**
4	Is the patient's baseline modified Rankin score ≥ 3? ❑ **YES – Does NOT meet Medicare coverage – Go to #15** ❑ NO – Go to #5 **Baseline modified Rankin score:** ____________
5	Does the physician plan to use embolic protection? ❑ YES – Go to #6 ❑ **NO – Does NOT meet Medicare coverage – Go to #15**
6	Was a carotid artery ultrasound done? ❑ YES – Go to #7 ❑ NO – Go to #8
7	What was the degree of carotid artery stenosis indicated by ultrasound? **Stenosis %** ____________ **If stenosis < 70% the procedure may not be covered. Consider issuing a HINN if patient is not in a post-approval study. Go to #8**
8	Does the patient have symptoms of carotid artery stenosis as evidenced by one of the following? **(check symptom)** ❑ Carotid transient ischemic attack lasting < 24 hours ❑ Focal cerebral ischemia producing a non-disabling stroke (modified Rankin score < 3 with symptoms for 24 hours or more) ❑ Transient monocular blindness (amaurosis fugax) ❑ Other [specify carotid stenosis symptom(s)]:____________________ ❑ YES – Go to #9 ❑ **NO – If patient is asymptomatic the procedure may not be covered. Consider issuing a HINN if patient is not in a post-approval study. Go to #12**
	Clinical Reviewer initials indicating #1-#8 have been reviewed: ____________ **Date/Time:** ____________
	SYMPTOMATIC SYMPTOMATIC SYMPTOMATIC
9	Did the patient have carotid artery stenosis ≥ 70% **confirmed by angiography** prior to stenting? ❑ YES –Go to #14 ❑ NO – Go to #10 **Stenosis %** ____________
10	Is the patient in a post-approval study? ❑ YES – Go to #11 ❑ NO – **Does NOT meet Medicare coverage – Go to #15**
11	Did the patient have carotid artery stenosis of 50%-69% **confirmed by angiography** prior to stenting? ❑ YES – Go to #14 ❑ NO – **Does NOT meet Medicare coverage – Go to #15** **Stenosis %** ____________
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12	Is the patient in a post-approval study? ❑ YES – Go to #13 ❑ NO – **Does NOT meet Medicare coverage – Go to #15**
13	Did the patient have carotid artery stenosis ≥ 80% **confirmed by angiography** prior to stenting? ❑ YES – Go to #14 ❑ NO – **Does NOT meet Medicare coverage – Go to #15** **Stenosis %** ____________
14	Was embolic protection used? ❑ YES – Meets Medicare coverage – Go to #15 ❑ **NO – Does NOT meet Medicare coverage – Go to #15**
15	**FOR ALL PATIENTS: *Above results (i.e., angiography report, Rankin Score, stenosis %, embolic protection) must be documented in the medical record.** ***CMS required data must be collected for all CAS procedures performed, including non-Medicare fee for service patients.** **GO TO #16**
16	Please send this completed, signed and dated form to the facility Clinical Reviewer.

Physician Signature: ____________________ Date/Time: ____________________

FOR HOSPITAL USE ONLY

❑ Meets Medicare Coverage per NCD 20.7 ❑ Does NOT Meet Medicare Coverage per NCD 20.7 – Refer to Administration

Clinical Reviewer: ____________________ Date/Time: ____________________

Patient Label

CARD