

Policy: MP110

Section: Medical Benefit Policy

Subject: Uterine Artery Embolization for Treatment of Symptomatic Fibroids

Applicable Lines of Business

Commercial	X	CHIP	X
Medicare	X	ACA	X
Medicaid	X		

I. Policy: Uterine Artery Embolization for Treatment of Symptomatic Fibroids

II. Purpose/Objective:

To provide a policy of coverage regarding Uterine Artery Embolization for Treatment of Symptomatic Fibroids

III. Responsibility:

- A. Medical Directors
- B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

DESCRIPTION:

Uterine artery embolization is a treatment option used to promote shrinkage of symptomatic uterine fibroid tumors by blocking the blood supply to the fibroid, which causes infarction and atrophy.

INDICATIONS:

Treatment of symptomatic uterine fibroids manifested by:

- Fibroids considered to be the cause of excessive uterine bleeding; **or**
- Fibroids considered to be the cause of acute, severe low back or pelvic pain or pressure with urinary frequency; **or**
- Fibroids considered to be the cause of gastrointestinal symptoms related to compression of the bowel; **or**
- Dyspareunia; **or**
- Fibroids that are palpable abdominally and causing abdominal enlargement;

AND

Any of the following indications:

1. Poor surgical candidate for surgical treatment
2. Medical contraindication to hysterectomy
3. Contraindication to, intolerance to, or failure of hormonal therapy
4. Hydronephrosis
5. Desire to avoid hysterectomy
6. Desired fertility, but not a candidate for other treatment options such as myomectomy or hormonal therapy

Uterine artery embolization is considered medically necessary as a treatment for postpartum uterine hemorrhage.

CONTRAINDICATIONS: Any of the following:

Current pregnancy
 Active pelvic inflammatory disease
 Poorly controlled diabetes
 Severe renal insufficiency
 Uncorrected vascular or coagulatory disorders
 Arteriovenous malformation
 Ovarian, uterine, endometrial or cervical cancer
 Undiagnosed pelvic mass

Medicaid Business Segment:

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

CODING ASSOCIATED WITH: Uterine Artery Embolization for Treatment of Symptomatic Fibroids

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

- 36245 Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family
- 36246 initial second order abdominal, pelvic or lower extremity branch, within a vascular family
- 36247 initial third order or more selective abdominal, pelvic or lower extremity artery branch, within a vascular family
- 36248 additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family

- 37204 Transcatheter occlusion or embolization, percutaneous, any method, non-central nervous system, non-head or neck
- 37210 Uterine artery Embolization (UFE, Embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intra-procedural road-mapping, and imaging guidance necessary to complete the procedure.
- 37243 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction
- 37244 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation [when specified as embolization of uterine artery]
- 75736 Angiography, pelvic, selective, radiological supervision and interpretation
- 75894 Transcatheter therapy, embolization, any method, radiological supervision and interpretation
- 75898 Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion.

Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL

LINE OF BUSINESS:

Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supersede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:

Geisinger Clinic Technology Assessment Committee, TAC Triage Group, Uterine Artery Embolization. May 2003.

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American College of Obstetricians and Gynecologists (ACOG). Management of Symptomatic Uterine Leiomyomas: ACOG Practice Bulletin, Number 228. Obstet Gynecol. 2021 Jun 1; 137(6):e100-e115.

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This policy will be revised as necessary and reviewed no less than annually.

Devised: 7/03

Revised: 8/04(reference); 8/06 (reference); 5/22(add indication post-partum hemorrhage)

Reviewed: 8/05, 8/07, 8/08, 8/09, 6/10, 6/11, 6/12, 6/13, 6/14, 6/15, 6/16, 6/17, 5/18, 5/19, 5/20, 5/21, 5/23, 5/24

CMS UM Oversight Committee Approval: 12/23, 7/24

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.