Uterine Artery Embolization to Treat Fibroids

Policy Number: MM.03.004
Original Effective Date: 05/14/2002
Line(s) of Business: HMO; PPO: QUEST Integration
Current Effective Date: 3/25/2016
Section: OB/GYN & Reproduction
Place(s) of Service: Outpatient

I. Description

Uterine artery embolization (UAE) is a minimally invasive, therapeutic procedure performed by an interventional radiologist. UAE provides relief from symptoms directly attributed to uterine fibroids. Uterine fibroids are non-cancerous growths that develop in the muscular wall of the uterus that can cause dysmenorrhea, non-cyclic pelvic pain and abnormal uterine bleeding. This procedure stops the blood flow to the fibroid by injecting small synthetic substances (i.e., polyvinyl alcohol or gelatin sponge particles) into the artery that is supplying blood to the fibroids. As a result of the restricted blood flow, the fibroids begin to shrink.

II. Criteria/Guidelines

A. UAE is covered (subject to Limitations and Administrative Guidelines) for the treatment of uterine fibroids when recommended by a gynecologist when all of the following criteria are met:

1. An ultrasound or MRI performed within the past three months confirms the presence of fibroids.
2. One or more of the following symptoms must be present and directly attributable to uterine fibroids:
   a. Excessive uterine bleeding as evidenced by either profuse bleeding lasting more than 8 days or prolonged menstrual bleeding with or without anemia).
   b. Pelvic discomfort caused by myomata, either acute severe pain, chronic lower abdominal pain or low back pressure or bladder pressure with urinary frequency not due to urinary tract infection.
   c. Obstruction or compression on the bladder, ureters or kidneys.

B. The patient understands and is informed of the risks associated with future fertility/pregnancy.
III. Limitations

A. UAE is not covered for patients with any of the following:
   1. Pregnancy
   2. Myoma with narrow pedicle or intracavity mass
   3. A pedunculated (base <50% diameter) submucosal leiomyoma
   4. Pelvic inflammatory disease
   5. Suspicion of malignancy of uterus or cervix
   6. Infertility secondary to uterine fibroids
   7. The patient is hemodynamically unstable (e.g., congestive heart failure or renal insufficiency)
   8. Patient is on exogenous estrogen
   9. Coagulopathy
   10. Severe allergy to contrast material

B. UAE is not covered for patients with asymptomatic uterine fibroids.

C. Repeat uterine embolizations to treat persistent symptoms of uterine fibroids after an initial UAE are not covered

D. A routine MRI post embolization is not covered

E. MRA for UAE is not covered

IV. Administrative Guidelines

A. Precertification is not required. HMSA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination criteria. The following information should be kept in the patient’s medical record and be made available upon request:
   1. Supporting documentation that the procedure is medically necessary for the condition.
   2. Pelvic ultrasound or MRI report performed within the past three months.
   3. A current negative endometrial biopsy report for patients with a history of abnormal uterine bleeding or when endometrial cancer is suspected

B. The following evaluations (if applicable) must be performed prior to the procedure and documented in the patient's medical records:
   1. A current negative pregnancy test result for child-bearing age patients suspected of being pregnant.
   2. A current negative test for any sexually transmitted diseases (e.g., gonorrhea and chlamydia) for patients with a history of pelvic inflammatory disease or for patients at risk of or suspected of having a sexually transmitted disease.
C. Applicable codes:

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<tr>
<th>CPT Code</th>
<th>Description</th>
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<tr>
<td>37243</td>
<td>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 (new code effective 01/01/14).</td>
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V. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients' Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

VI. References