Transcatheter Uterine Artery Embolization

I. Policy

University Health Alliance (UHA) will reimburse for transcatheter uterine artery embolization (UAE) when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

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

1. An ultrasound performed within the past three months confirms the presence of fibroids. An MRI can be performed if the ultrasound is inconclusive.
2. The fibroids are unresponsive to alternative conservative medical treatment.
3. One or more of the following symptoms must be present and directly attributable to uterine fibroids:
   a. Menorrhagia (abnormally heavy or prolonged menstrual bleeding, with or without anemia).
   b. Chronic pelvic, back, or leg pain or discomfort.
   c. Obstruction or compression on the bladder, ureters, or kidneys.
   d. Constipation.
   e. Asymptomatic fibroids of such size that they are palpable abdominally and are a concern to the patient;
4. One repeat uterine artery embolization may be performed when there is documentation of continued symptoms such as bleeding or pain. Repeat procedures may be most appropriate when there are persistent symptoms in combination with findings on imaging of an incomplete initial procedure, as evidenced by continued blood flow to the treated regions. Limited data from case series have suggested a high rate of success following repeat procedures for this purpose, with most patients reporting relief of symptoms.
5. The patient understands and is informed of the risks associated with future fertility/pregnancy.

B. UAE as a treatment of postpartum uterine hemorrhage is covered (subject to Limitations/Exclusions and Administrative Guidelines) when recommended by a gynecologist

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may
request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

III. Limitations/Exclusions

A. Transcatheter embolization for the management of all other indications, including cervical ectopic pregnancy, uterine arteriovenous malformation, and adenomyosis is not covered.

B. A routine MRI post embolization is not covered

C. MRA for UAE is not covered

IV. Administrative Guidelines

A. Prior authorization is not required.

B. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record and must be made available to UHA upon request. UHA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination criteria and to ensure proper reimbursement is made. 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 (when applicable) 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
4. A current negative pregnancy test result for child-bearing age patients suspected of being pregnant.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<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</td>
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<tr>
<td>36245</td>
<td>Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family</td>
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<tr>
<td>36246</td>
<td>Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family</td>
</tr>
<tr>
<td>36247</td>
<td>Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family</td>
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V. Policy History

Policy Number: MPP-0010-120101
Current Effective Date: 11/27/2018
Original Document Effective Date: 01/01/2012
Previous Revision Dates: N/A
PAC Approved Date: 01/01/2012
Previous Policy Title: Uterine Artery Embolization to Treat Fibroids