



## Medical Policy

# Occlusion of Uterine Arteries Using Transcatheter Embolization

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### Policy Number: 242

BCBSA Reference Number: 4.01.11  
NCD/LCD: N/A

### Related Policies

- MRI-Guided Focused Ultrasound for the Treatment of Uterine Fibroids and Other Tumors, #[243](#)
- Laparoscopic and Percutaneous Techniques for the Myolysis of Uterine Fibroids, #[244](#)

### Policy

#### Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO Blue<sup>SM</sup> and Medicare PPO Blue<sup>SM</sup> Members

Transcatheter embolization of uterine arteries as a treatment of uterine fibroids or as a treatment of postpartum uterine hemorrhage may be considered [MEDICALLY NECESSARY](#).

One repeat transcatheter embolization of uterine arteries to treat persistent symptoms of uterine fibroids after an initial uterine artery embolization may be considered [MEDICALLY NECESSARY](#).

#### Initial Procedure

There are no specific criteria for uterine artery embolization regarding the size, location, or multiplicity of fibroid tumors. The American College of Obstetricians and Gynecologists has suggested the following general criteria for treatment of fibroid tumors:

- Asymptomatic fibroids of such size that they are palpable abdominally and are a concern to the patient; OR
- Excessive uterine bleeding as evidenced by either profuse bleeding lasting more than 8 days, or anemia due to acute or chronic blood loss; OR
- 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.

#### Repeat Procedure

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.

Transcatheter embolization for the management of all other indications, including cervical ectopic pregnancy, uterine arteriovenous malformation, and adenomyosis is considered **INVESTIGATIONAL**.

### Prior Authorization Information

#### Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

#### Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is <b>not required</b> .
Commercial PPO and Indemnity	Prior authorization is <b>not required</b> .
Medicare HMO Blue <sup>SM</sup>	Prior authorization is <b>not required</b> .
Medicare PPO Blue <sup>SM</sup>	Prior authorization is <b>not required</b> .

### CPT Codes / HCPCS Codes / ICD Codes

*Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.*

*Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.*

*The following codes are included below for informational purposes only; this is not an all-inclusive list.*

**The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:**

#### CPT Codes

CPT codes:	Code Description
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

### DESCRIPTION

#### UTERINE FIBROIDS

Uterine leiomyomata (ie, fibroids) are extremely common benign tumors that can be submucosal (located primarily within the uterine cavity below the endometrium), intramural (with the uterine wall or myometrium), or subserosal in location. Patient symptomatology, physical examination findings, and imaging results are related to the location of the fibroids. Individuals may have fibroids in any or all of these locations within the uterus.

#### Treatment

Treatment for uterine fibroids is typically recommended when accompanied by menorrhagia, pelvic pain, or urinary symptoms (ie, frequency), or when the fibroids are suspected to cause infertility. Treatment options include medical therapy with gonadotropin agonists or progestins or various types of surgical therapy. Hysterectomy is considered the definitive surgical treatment for those who no longer want to

maintain fertility. Various types of myomectomy (the removal of fibroids with retention of the uterus) are recommended to maintain fertility. Hysteroscopic myomectomy involves removal of submucosal fibroids using a resectoscope or a laser. Subserosal fibroids can be removed via an open abdominal or laparoscopic approach. Laparoscopic laser coagulation of uterine fibroids is a unique approach in which the fibroid is not physically removed; instead multiple (up to 75) laparoscopic laser punctures of the uterine fibroid are performed to devascularize the fibroid and induce atrophy.

## **ECTOPIC PREGNANCIES**

Ectopic pregnancies account for up to 2% of pregnancies and are the leading cause of first-trimester maternal mortality. Patients present with pelvic pain and vaginal bleeding.

### **Treatment**

First-line treatment for patients with minimal symptoms is systemic methotrexate. In patients with high  $\beta$ -human chorionic gonadotrophin, response to methotrexate may not be adequate, and the patient is susceptible to complications such as hemorrhaging, resulting in the need for a hysterectomy.

## **UTERINE ARTERIOVENOUS MALFORMATION**

Uterine arteriovenous malformations (AVMs) are rare but may cause severe genital hemorrhaging. There are 2 types: low-flow AVM is characterized by an abnormal vascular network without visible early venous drainage and high-flow AVM, which has early venous drainage. Uterine AVMs may be congenital or acquired. Risk factors for acquired AVMs are prior uterine surgery such as dilatation and curettage, myomectomy, and cesarean section.

### **Treatment**

Treatment options include hysterectomy, uterine artery ligation, and uterine artery embolization.

## **ADENOMYOSIS**

Adenomyosis is characterized by the diffuse or focal growth of endometrial glandular and stromal tissue in the muscular layer of the uterus. The etiology of adenomyosis is unknown. Symptoms include dysmenorrhea, menorrhagia, infertility, and an enlarged uterus may be found on physical examination.

### **Treatment**

Treatment options include surgery and hormone therapy.

## **UTERINE ARTERY EMBOLIZATION**

There is interest in techniques that directly devascularize the uterine fibroid by interrupting the uterine arteries. One technique, uterine artery embolization, involves selective catheterization of the uterine arteries with an injection of embolization material. Uterine artery embolization has also been used to control bleeding in situations such as severe postpartum hemorrhage, cervical ectopic pregnancy, bleeding uterine AVM, and adenomyosis.

## **Summary**

Transcatheter uterine artery embolization (UAE) is a minimally invasive technique that involves the injection of small particles, gelfoam, coils, or glue into the uterine arteries to block the blood supply to the uterus and uterine fibroids. It potentially serves as an alternative to hysterectomy. UAE has also been used to treat postpartum hemorrhage, cervical ectopic pregnancy, uterine arteriovenous malformations, and adenomyosis.

For individuals who have uterine fibroids who receive transcatheter UAE, the evidence includes randomized controlled trials and systematic reviews. Relevant outcomes are symptoms, quality of life, and treatment-related morbidity. The majority of studies have compared UAE with hysterectomy and myomectomy and found similar levels of symptoms and quality of life across all treatment groups. Benefits for women undergoing UAE included avoiding surgery and maintaining their uteruses, lower complication rates, and lower blood transfusion rates. However, patients undergoing UAE had higher reintervention rates compared with patients who had surgery. Smaller trials have compared UAE with laparoscopic occlusion and magnetic resonance image-guided focused ultrasound surgery. Additional

trials with larger sample sizes comparing UAE with these and other uterus-preserving procedures are needed. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have persistent uterine fibroids despite prior UAE who receive repeat transcatheter UAE, the evidence includes case series. Relevant outcomes are symptoms, quality of life, and treatment-related morbidity. Case series have shown that a high degree of symptom relief is possible after a repeat UAE for uterine fibroids. Moreover, evidence from randomized controlled trials on the safety and efficacy of UAE for initial treatment of uterine fibroids suggests a benefit for patients in need of repeat procedures for the same indication. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have postpartum uterine hemorrhage who receive transcatheter UAE, the evidence includes case series and a systematic review. Relevant outcomes are overall survival, symptoms, and treatment-related morbidity. The systematic review of case series assessing over 1400 women reported success rates of bleeding cessation that ranged from 58% to 98%. Postpartum uterine hemorrhage is an emergency situation with serious potential consequences (ie, maternal mortality). Conducting randomized controlled trials is particularly difficult in this setting and may be unnecessary when there are sufficient uncontrolled data. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have cervical ectopic pregnancy who receive transcatheter UAE, the evidence includes case series. Relevant outcomes are treatment-related morbidity. Only a few case series with a small number of patients have been published. Additional studies, especially controlled studies comparing UAE with medication or surgery, are needed to assess the safety and efficacy of UAE in patients with cervical ectopic pregnancy. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have uterine arteriovenous malformations who receive transcatheter UAE, the evidence includes case reports, case series, and a systematic review. Relevant outcomes are symptoms and treatment-related morbidity. Only case reports and case series with a small number of patients have been published. A systematic review identified 54 women in 40 studies with uterine arteriovenous malformations treated with UAE. Additional controlled studies comparing UAE with hysterectomy are needed to assess the safety and efficacy of UAE in patients with uterine arteriovenous malformations. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have adenomyosis who receive transcatheter UAE, the evidence includes case series and a systematic review. Relevant outcomes are symptoms and treatment-related morbidity. A systematic review of case series data found short-term improvement in 83% of patients and long-term improvement in 65% of patients, suggesting possible recurrence of symptoms over time. All studies were case series, which might have been subject to selection and/or observational biases. Additional case series published after the review have reported that patients with greater necrosis of adenomyosis and patients with higher vascularity of lesions may experience higher response rates to UAE. Controlled studies comparing UAE with medication or surgery and reporting long-term symptom recurrence rates are needed. The evidence is insufficient to determine the effects of the technology on health outcomes.

## Policy History

Date	Action
10/2018	BCBSA National medical policy review. Description, summary and references updated. Policy statements unchanged. 10/1/2018
9/2017	New references added from BCBSA National medical policy.
1/2017	BCBSA National medical policy review. Adenomyosis added to investigational policy statement. Effective 1/1/2017.
8/2015	New references from BCBSA National medical policy.

12/2014	BCBSA National medical policy review. New investigational indications described. Coding information clarified. Effective 12/1/2104.
6/2014	Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.
1/2014	Coding information clarified.
11/2013	Removed invalid diagnosis codes 666.0 and 666.1
10/2013	New references from BCBSA National medical policy.
2/2013	BCBSA National medical policy review. Changes to policy statement. Effective 2/4/2013.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
9/2011	Reviewed - Medical Policy Group – Urology, Obstetrics and Gynecology. No changes to policy statements.
10/2010	Reviewed - Medical Policy Group - Obstetrics and Gynecology. No changes to policy statements.
7/2010	Medical Policy 242 effective 7/201. Describing covered and non-covered indications.

## Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

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