Clinical Policy Title: Uterine artery embolization

Clinical Policy Number: 12.03.02

Effective Date: April 1, 2015
Initial Review Date: October 15, 2014
Most Recent Review Date: October 19, 2016
Next Review Date: October 2017

Policy contains:
- Uterine artery embolization.
- Leiomyoma.
- Fibroids.
- Adenomyosis.

Related policies:
CP# 12.03.03 Endometrial ablation
CP# 13.01.02 Transvaginal and transabdominal ultrasound

ABOUT THIS POLICY: Keystone First has developed clinical policies to assist with making coverage determinations. Keystone First’s clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of “medically necessary,” and the specific facts of the particular situation are considered by Keystone First when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. Keystone First’s clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. Keystone First’s clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, Keystone First will update its clinical policies as necessary. Keystone First’s clinical policies are not guarantees of payment.

Coverage policy

Keystone First considers the use of uterine artery embolization (UAE) for treatment of uterine fibroids to be clinically proven and, therefore, medically necessary when all of the following criteria are met:

- Presence of one or more persistent symptoms directly attributed to uterine fibroids, including, but not limited to: excessive menstrual bleeding (menorrhagia), bulk-related pelvic pain, pressure or discomfort, urinary symptoms referable to compression of the ureter or bladder, and dyspareunia.
- Any of the following criteria are met:
  - The use of anesthesia places the individual at high surgical risk.
  - The individual has medical contraindications to hysterectomy (e.g., morbid obesity).
  - The use of hormonal therapy is contraindicated, or the individual is intolerant to or has previously failed a course of hormone therapy.
  - The individual wishes to avoid a hysterectomy.
  - The individual has hydronephrosis.
- None of the following contraindications to UAE is present:
  - Viable pregnancy, active untreated infection, suspicion of leiomyosarcoma or adnexal malignancy (unless UAE is performed for palliation or with surgery), and severe vascular disease limiting access.
- Contraindications to angiographic procedures (e.g., coagulopathy, severe contrast allergy and renal impairment).
- Prior treatment or procedure that alters pelvic arterial anatomy, (e.g., salpingooophorectomy, resection of an ectopic pregnancy or pelvic irradiation), which may make selection and embolization of the uterine arteries difficult or impossible.
- Future pregnancy is planned, as its effectiveness in this population has not been determined.
- Compromised immune system, chronic endometritis or partially treated pelvic infection, extensive endometriosis or diffuse adenomyosis, markedly pedunculated subserosal fibroids (risk of detachment) or submucosal fibroids, and associated gynecological conditions requiring surgery (e.g., uterine prolapse or stress incontinence).
- Currently using a gonadotropin-releasing agonist, as it may cause diffuse vasospasm and impact the technical success of the procedure. UAE should be performed no earlier than six weeks after discontinuation of hormone therapy.

Keystone First considers the use of repeat UAE to be clinically proven and, therefore, medically necessary to treat symptoms of uterine fibroids that persist after an initial UAE.

Keystone First considers the use of UAE for treatment of adenomyosis to be investigational and, therefore, not medically necessary.

Limitations:

All other uses of UAE are not medically necessary.

Note: The following CPT/HCPCS codes are not listed in the Pennsylvania Medicaid fee schedule:

0336T - Laparoscopy, surgical, ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency

S2095 - Transcatheter occlusion or embolization for tumor destruction, percutaneous, any method, using yttrium-90 microspheres

Alternative covered services:

- Prescription drug therapy (e.g., gonadotropin-releasing hormone agonist).
- Hysterectomy.
- Myomectomy (via hysteroscopy, laparoscopy or laparotomy).

Background
Uterine fibroids (also known as leiomyomas or myomas) are benign growths that attach to the muscle tissue of the uterus. They are the most common tumor in women of reproductive age, affecting more than 66 percent of women by age 50 years, and the leading cause of hysterectomy in the United States (Whiteman 2008). The clinical presentation of uterine fibroids can vary greatly in number, size, growth rate, and symptoms (American College of Obstetricians and Gynecologists [ACOG] 2014). They may be present inside the uterus, on its outer surface or within its wall, or attached by a stem-like structure.

Adenomyosis (also known as adenomyoma or endometriosis interna) is a benign condition in which the endometrium breaks through the outer muscular wall of the uterus (National Library of Medicine 2014). The condition may be localized or diffusely spread throughout the uterus, and may coincide with endometriosis or leiomyomas. Adenomyosis is diagnosed with increasing frequency in women attending infertility clinics, but its role in infertility independent of these other conditions is not well understood.

Symptoms associated with uterine fibroids and adenomyosis include changes in menstruation, abnormal bleeding, anemia from blood loss, abdominal or lower back pain, difficulty urinating or frequent urination, difficult bowel movements, and abdominal cramps. They may cause an enlarged uterus and abdomen, miscarriages, and infertility. Rarely are they cancerous. Asymptomatic growths may be found incidentally during a routine pelvic exam or testing for other problems. The differential work up includes laboratory testing, ultrasonography, hysteroscopy, hysterosalpingography, sonohysterography, and laparoscopy. Imaging tests, such as magnetic resonance imaging (MRI) and computed tomography, may be used to further differentiate these conditions. Some of these tests may be used to track their growth over time (ACOG 2014).

**Treatment options:**

Uterine fibroids that are asymptomatic or small, or occur in a woman who is nearing menopause, often do not require treatment. Symptomatic growths may signal the need for treatment. For some women, drug therapy is an option to reduce heavy bleeding and painful periods. Drug treatment includes hormonal birth control methods, gonadotropin-releasing hormone (GnRH) agonists, and a progestin-releasing intrauterine device. However, these agents have several drawbacks. Once the agent is discontinued, the growths quickly return to their previous volume and symptoms typically recur. In addition, chronic use of GnRH agonists results in trabecular bone loss. Drug treatment may not prevent new tumors. Therefore, these agents are typically used for temporary situations (e.g., to reduce tumor size prior to surgery) (ACOG 2014).

The need for surgical treatment is based on the clinical stability of the patient, the severity of bleeding, contraindications to medical management, the patient’s lack of response to medical management, the underlying medical condition of the patient, and the patient’s desire for future fertility (ACOG 2013). Fertility-preserving surgical options include dilation and curettage, myomectomy, hysteroscopy, endometrial ablation, and UAE. These options remove the tumor(s) while leaving the uterus in place, enabling women to bear children, but they do not prevent new tumors from developing (Stokes 2010). If new growths appear, more surgery may be needed. A hysterectomy removes the entire uterus and is performed when other treatments have not worked, are not possible or the tumors are very large. The
effectiveness of other techniques, such as MRI-guided ultrasound, is being studied (ACOG 2014, Burke 2012).

**UAE:**

According to the Society of Interventional Radiology (SIR) Standards of Practice Committee, UAE is defined as the delivery of an embolic agent, typically tris-acryl gelatin microspheres or spherical polyvinyl alcohol, via a catheter or microcatheter placed in both uterine arteries (Stokes 2010). The United States Food and Drug Administration (FDA) has approved a number of embolic agents specifically for UAE (FDA 2014).

The goal of UAE is to occlude or markedly reduce the arterial blood flow of all distal uterine artery branches feeding the tumor(s), producing irreversible ischemic injury to the tumor while avoiding permanent damage to the uterus. Clinical success is defined as the significant improvement or resolution of presenting symptoms, such as menorrhagia or bulk-related pain, bloating, urinary frequency or constipation, without additional therapy (Stokes 2010).

The procedure is performed typically under conscious sedation using either a unilateral or bilateral common femoral artery approach, depending on operator preference. The patient is followed closely for the first 24 to 48 hours after discharge for adequacy of pain and nausea control and to assess for potential complications. At three to six months following the procedure, the patient is re-evaluated for treatment efficacy (Stokes 2010). Since the 1990s, UAE has seen rapid adoption into the standard practice of interventional radiology (Burke 2012).

**Searches**

Keystone First searched PubMed and the databases of:
- UK National Health Services Centre for Reviews and Dissemination.
- Agency for Healthcare Research and Quality’s National Guideline Clearinghouse and other evidence-based practice centers.
- The Centers for Medicare & Medicaid Services (CMS).

We conducted searches on September 16, 2016. Search terms were: “uterine artery embolization” [MeSH] and "Leiomyoma" [MeSH] or "fibroma" [MeSH] or “adenomyosis” [MeSH], and also free text terms for “uterine artery embolization” limited to human studies published in English.

We included:
- Systematic reviews, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.
- Guidelines based on systematic reviews.
Economic analyses, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

**Findings**

For this policy, we identified seven systematic reviews (Mohan 2013, Martin 2013, Toor 2012, Gupta 2012, Maheshwari 2012, Popovic 2011 and Hayes 2009) and five evidence-based guidelines (ACOG 2013, ACOG 2008, ACOG 2004, Burke 2012 and Stokes 2010). For treatment of uterine fibroids with UAE, the evidence consists of randomized controlled trials (RCTs), other randomized comparative studies and observational studies of low to moderate quality. For adenomyosis, the evidence is of lower quality, consisting of uncontrolled studies, case-control studies, case reports, and expert opinion.

Patients represented in these studies had confirmed uterine fibroids or adenomyosis that caused a variety of problems, including anemia, menorrhagia, pain, and bulk-related symptoms. Some patients had elected to undergo UAE in an attempt to preserve fertility, but most studies excluded patients seeking to become pregnant. Outcome measured were symptom relief, resumption of normal menses, resolution of anemia, changes in growth volume, complications, pregnancy and patient satisfaction. Control groups generally consisted of patients who underwent hysterectomy and myomectomy. None of the studies compared UAE with pharmaceutical therapies.

**Symptomatic uterine fibroids:**

There is sufficient evidence to support UAE as an alternative to hysterectomy or myomectomy in women with symptomatic uterine fibroids who wish to avoid surgical therapies or who are not good surgical candidates, and who are not concerned about preserving their fertility (Martin 2013, Toor 2012, Gupta 2012, Hayes 2009; Table 1). UAE is a safe procedure and provides significant symptomatic relief associated with uterine fibroids comparable to surgery, although some patients who undergo UAE may require subsequent hysterectomy. Major complications are uncommon and occur at a rate of approximately 3 percent in observational studies and 7 percent in RCTs for the initial few years after UAE, with this value tapering off over time.

When reported, patient satisfaction with UAE was high or very high. Hospital length of stay, recovery time and time to return to work or normal activities were significantly shorter for patients who underwent UAE than for those who underwent hysterectomy or myomectomy. Limited evidence suggests UAE is more cost-effective than hysterectomy in the short term, but hysterectomy becomes more cost-effective in the long term when factoring in the increased risk of reintervention after UAE. Evidence-based guidance recommends consideration of UAE in patients who are not good candidates for myomectomy and in patients who refuse surgery (ACOG 2008, Stokes 2010).

**Adenomyosis:**
There is insufficient evidence to support UAE as an alternative to hysterectomy or myomectomy in women with adenomyosis outside of a research setting, although both systematic reviews acknowledge an increasing interest in using UAE for adenomyosis (Maheshwari 2012, Popovic 2011). While there are a growing number of small case studies on the use of UAE for treatment of adenomyosis, there are no meta-analyses to date (December 6, 2014) demonstrating effectiveness of this modality. The SIR Standards of Practice Committee considered the available uncontrolled studies and expert opinion in their recommendation — UAE is a conservative alternative for patients who desire fertility, are at increased surgical risk, or absolutely desire uterine preservation (Stokes 2010). ACOG (2013) lists UAE as having a series of case reports only for support. Keystone First considers this level of evidence of interest, but not sufficient proof to demonstrate clinical utility.

Women who desire future fertility:

There is insufficient evidence to support the use of UAE as a first-line treatment in women who desire future fertility (Mohan 2013, Gupta 2012, Maheshwari 2012, Popovic 2011). The minimally invasive nature of the procedure is attractive to the increasing numbers of women with symptomatic fibroid tumors or adenomyosis during childbearing age, but lack of good-quality prospective controlled studies and a strong likelihood of publication bias in existing research prevent firm conclusions about the safety and efficacy of UAE in this population. The issue of fertility following UAE remains controversial and has been inadequately studied. Advanced age and presence of these growths may affect fertility and complicate assessment of fertility following UAE. For now, myomectomy may be superior to UAE in women planning future pregnancy. Evidence-based guidelines list the desire for future fertility as a relative contraindication to UAE (Burke 2012, Stokes 2010, ACOG 2008).

Contraindications:

Absolute contraindications to UAE include patients with viable pregnancy, active untreated infection, suspicion of leiomyosarcoma or adnexal malignancy (unless UAE is performed for palliation or with surgery) and severe vascular disease limiting access (ACOG 2008, Stokes 2010, Burke 2012). Relative contraindications to UAE similar to those for other angiographic procedures include coagulopathy, severe contrast allergy and renal impairment. Other relative contraindications more specific to UAE include (Stokes 2010, Hayes 2009):

- Any prior treatment or procedure that could alter pelvic arterial anatomy, such as salpingo-oophorectomy, resection of an ectopic pregnancy, or pelvic irradiation, which may make selection and embolization of the uterine arteries difficult or impossible.
- A desire to maintain childbearing potential.
- Concurrent use of a gonadotropin-releasing agonist, as it may cause diffuse vasospasm and impact the technical success of the procedure.
- Patients with diffuse endometriosis or adenomyosis, markedly pedunculated subserosal fibroids (risk of detachment) or submucosal fibroids, and associated gynecological conditions requiring surgery (e.g., adnexal disease, uterine prolapse or stress incontinence).
Appropriate patient selection and management are integral to successful outcomes with UAE. Presenting symptoms, clinical history, physical examination, imaging findings, and patient preferences influence candidacy for UAE. However, identification of appropriate candidates for UAE often relies on ill-defined objective criteria (e.g., tumor size) or subjective criteria (e.g., perceived symptom severity). Evidence-based recommendations are needed to assess effectiveness of, and guide appropriate patient selection for, UAE.

### Table 1. Outcomes of UAE vs. surgery (hysterectomy and/or myomectomy)

<table>
<thead>
<tr>
<th>Citation</th>
<th>Minor complications (number of studies)</th>
<th>Major complications (number of studies)</th>
<th>Fertility rates (number of studies)</th>
<th>Reintervention rates (number of studies)</th>
<th>Patient satisfaction rates (number of studies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Martin 2013</td>
<td>NS (5)</td>
<td>Favors UAE (2)</td>
<td>NR</td>
<td>Favors surgery (3)</td>
<td>NR</td>
</tr>
<tr>
<td>Gupta 2012</td>
<td>Favors surgery (7)</td>
<td>NS (1)</td>
<td>Favors myomectomy (1)</td>
<td>Favors surgery within 2 years follow up (4) and 5 years follow up (2)</td>
<td>NS within 2 years follow up (5) or 5 years follow up (2)</td>
</tr>
</tbody>
</table>

NS, no statistically significant difference.
NR, not reported.

**Policy updates:**

In 2016, we found one update of a previously included Cochrane review (Gupta 2014) for this policy. The update included two new RCTs comparing UAE to myomectomy. Limited findings from a subgroup of a single, small RCT suggested less favorable fertility outcomes with UAE than myomectomy, but these results should be interpreted cautiously. Both procedures have similar patient satisfaction rates and major complication rates, but UAE is associated with higher rates of minor complications and surgical reintervention. These results confirm earlier findings that UAE is a safe, minimally invasive alternative to surgery in appropriately selected patients. Therefore, no changes to the policy are warranted.

**Summary of clinical evidence:**

<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gupta (2012, updated 2014)</td>
<td><strong>Key points:</strong></td>
</tr>
<tr>
<td>Cochrane review UAE vs. surgical alternatives</td>
<td>- Systematic review of seven RCTs (793 total patients): UAE vs. hysterectomy only (three RCTs); UAE vs. hysterectomy or myomectomy (two RCTs); UAE vs. myomectomy only (two RCTs).</td>
</tr>
<tr>
<td></td>
<td>- Overall quality: Low to moderate.</td>
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<tr>
<td></td>
<td>- UAE vs. myomectomy (66 total patients, low quality evidence): Improved fertility outcomes with myomectomy in women wishing to preserve fertility (odds ratio [OR], 95% confidence interval [CI]):</td>
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<tr>
<td></td>
<td>- Live birth: (0.33, 0.11 to 1.00).</td>
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<tr>
<td></td>
<td>- Pregnancy: (0.29, 0.10 to 0.85).</td>
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<tr>
<td></td>
<td>- No significant difference in major complication rate.</td>
</tr>
<tr>
<td></td>
<td>- UAE vs. either surgery: Similar patient satisfaction rates and ovarian failure rates at long-term</td>
</tr>
<tr>
<td>Citation</td>
<td>Content, Methods, Recommendations</td>
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</tbody>
</table>
| Mohan (2013) | **UAE and fertility outcomes** **Key points:**  
  - Systematic review of one RCT, six nonrandomized cohort or follow-up studies, and five cohort or case-control studies and case series.  
  - Overall quality: Low.  
  - Cumulative pregnancy rate (58.6%, mean age 35.9 years), miscarriage rate (28%), and preterm delivery rate (7.3%) following UAE of included study populations were comparable to general population.  
  - Confounders of fertility assessment following UAE for fibroids are advanced age and presence of the leiomyoma.  
  - Large, well-designed RCTs comparing UAE to other fertility-preserving options and large registries for observational data are needed to confirm findings. |
| Martin (2013) | **UAE versus surgical alternatives** **Key points:**  
  - Systematic review of five RCTs, 76 nonrandomized studies.  
  - Overall quality assessment: Not reported.  
  - UAE vs. alternatives: Decreased risk for major complications and similar risk for minor complications. Common complications: discharge and fever (4.00%), bilateral UAE failure (4.00%), and postembolization syndrome (2.86%), amenorrhea (4.26%), pain (3.59 %), and fibroid expulsion (five cases).  
  - UAE had significantly increased risk for reintervention. |
| Toor (2012) | **UAE for symptomatic leiomyomas** **Key points:**  
  - Systematic review of seven RCTs and 47 observational studies (8,159 total patients).  
  - Overall quality: Low to moderate.  
  - No reported deaths.  
  - Major complication rate 2.9% (95% CI 2.2% to 3.8%), reintervention hysterectomy rate after UAE 0.7% (0.5% to 0.9%), readmission rate 2.7% (1.9% to 3.7%), leiomyoma tissue passage 4.7% (3.9% to 5.7%), deep venous thrombosis or pulmonary embolism 0.2% (0.2% to 0.4%), and permanent amenorrhea 3.9% (2.7% to 5.3%).  
  - Reintervention rates (repeat UAE, myomectomy or hysterectomy) 5.3% (4.2% to 6.4%) per patient-year with 0.25 to 5 years follow up.  
  - Clinical symptomatic improvement 78% to 90%, with 0.25 to two years follow up.  
  - Conclusion: UAE is an acceptable alternative to hysterectomy. |
| Hayes (2009) | **UAE for symptomatic uterine fibroids** **Key points:**  
  - Systematic review of 10 randomized comparative studies; 21 prospective uncontrolled studies, case series, or registry studies; four prospective controlled or comparative studies; and five retrospective or case control studies.  
  - Overall quality: Low to moderate. Substantial overlap in populations.  
  - UAE offers short-term relief comparable to myomectomy or hysterectomy.  
  - Reintervention rate up to 20%.  
  - High early patient satisfaction rates for UAE, with significant improvements in several health-related quality of life (HRQOL) measures, shorter hospital stays and faster recovery times compared with surgery.  
  - No comparisons with medical therapy.  
  - Limited evidence of UAE effect on ovarian and uterine function, fertility and pregnancy outcomes in women with fibroids who wish to retain childbearing potential. Age may contribute.  
  - UAE is safe with minimal complications. Adequate pain management is essential. Serious adverse events, including infection (sepsis) and pulmonary embolus, have been reported. |
<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenomyosis</td>
<td></td>
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<tr>
<td>Maheshwari (2012)</td>
<td>Key points:</td>
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<tr>
<td>UAE and fertility</td>
<td></td>
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<tr>
<td>outcomes</td>
<td></td>
</tr>
<tr>
<td>Key points:</td>
<td>Systematic review of one case series.</td>
</tr>
<tr>
<td></td>
<td>Overall quality: Low with high risk of bias.</td>
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<tr>
<td></td>
<td>At 35 months follow up, live birth rate 83.3% (five of six patients).</td>
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<tr>
<td></td>
<td>Insufficient evidence.</td>
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<tr>
<td>Popovic (2011)</td>
<td>Key points:</td>
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<tr>
<td>Symptomatic outcomes</td>
<td></td>
</tr>
<tr>
<td>Key points:</td>
<td>Systematic review of 15 primarily case series, case reports and uncontrolled studies (511 total studies), including patients with pure adenomyosis or mixed adenomyosis and fibroids.</td>
</tr>
<tr>
<td></td>
<td>Overall quality: Low with high risk of bias.</td>
</tr>
<tr>
<td></td>
<td>No deaths or serious adverse events reported.</td>
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<tr>
<td></td>
<td>Symptom relief rate for pure adenomyosis and mixed populations: 64.9% to 92.9%.</td>
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<tr>
<td></td>
<td>Reintervention rate 13.2% (37 hysterectomies in 280 patients) at 12 months.</td>
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<tr>
<td></td>
<td>Significant short term improvements on MRI diminished over time.</td>
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<td></td>
<td>Insufficient evidence for UAE as a first-line treatment. Larger-scale, RCTs needed.</td>
</tr>
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</table>

**Glossary**

**Adenomyosis** — A condition in which the tissue that normally lines the uterus begins to grow in the muscle wall of the uterus.

**Fibroids** — See leiomyoma.

**Hysterosalpingography** — A special radiologic procedure in which a small amount of fluid is injected into the uterus and fallopian tubes to detect abnormal changes in their size and shape or to determine whether the tubes are blocked.

**Hysteroscopy** — A surgical procedure in which a slender, light-transmitting telescope, the hysteroscope, is used to view the inside of the uterus or perform surgery.

**Leiomyoma** — A benign smooth muscle tumor that is very rarely (0.1 percent) premalignant. The most common forms occur in the uterus, where the growth develops from the muscular tissue of the uterus.

**Myoma** — See leiomyoma.

**Myomectomy** — Surgical removal of fibroids while leaving the uterus in place and preserving fertility. Surgical methods for myomectomy include hysteroscopy, laparoscopy, or laparotomy.

**Sonohysterography** — A procedure in which fluid is put into the uterus and ultrasonography is used to view the inside of the uterus.

**Uterine artery embolization (UAE)** — Partial blockage of the uterine arteries with microparticles, which decreases blood flow to fibroids.
Uterine artery occlusion — Doppler-guided procedure in which the uterine arteries are temporarily clamped (approximately six hours), which stops the flow of blood to the fibroids. The procedure is supposed to cause the excess fibroid tissue to slough off.

References

Professional society guidelines/other:


Peer-reviewed references:


**Clinical trials:**

Searched clinicaltrials.gov on September 19, 2016 using terms "uterine artery embolization" OR fibroid OR leiomyoma OR adenomyosis | Open Studies | United States . 23 studies found, two relevant.


**CMS National Coverage Determinations (NCDs):**

No NCDs identified as of the writing of this policy.
Local Coverage Determinations (LCDs):

No LCDs identified as of the writing of this policy.

**Commonly submitted codes**

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Comment</th>
</tr>
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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>
<td></td>
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<tr>
<td>0336T</td>
<td>Laparoscopy, surgical, ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
<tr>
<td>D25.0</td>
<td>Submucous leiomyoma of uterus</td>
<td></td>
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<tr>
<td>D25.1</td>
<td>Intramural leiomyoma of uterus</td>
<td></td>
</tr>
<tr>
<td>D25.2</td>
<td>Subserosal leiomyoma of uterus</td>
<td></td>
</tr>
<tr>
<td>D25.9</td>
<td>Leiomyoma of uterus, unspecified</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>HCPCS Level II</th>
<th>Description</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>S2095</td>
<td>Transcatheter occlusion or embolization for tumor destruction, percutaneous, any method, using yttrium-90 microspheres</td>
<td></td>
</tr>
</tbody>
</table>