



Therapeutic Treatments for Uterine and Pelvic Conditions

LOB(s): <input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicare	State(s): <input checked="" type="checkbox"/> Idaho <input checked="" type="checkbox"/> Montana <input checked="" type="checkbox"/> Oregon <input checked="" type="checkbox"/> Washington <input type="checkbox"/> Other:
<input checked="" type="checkbox"/> Medicaid	<input checked="" type="checkbox"/> Oregon

Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

Radiofrequency ablation (RFA) is a minimally invasive treatment used to destroy uterine fibroid tissue by delivering targeted thermal energy, resulting in fibroid necrosis that is gradually replaced by fibrosis and scar tissue. RFA may be performed using laparoscopic or transcervical approaches with imaging guidance and is intended to reduce fibroid-related symptoms such as abnormal uterine bleeding, pelvic pain, pressure, or urinary complaints while preserving the uterus.

Uterine artery embolization is a minimally invasive endovascular treatment for symptomatic uterine fibroids that reduces uterine blood flow to relieve bleeding and bulk-related symptoms while preserving the uterus in patients who meet clinical and imaging criteria after failure of conservative management.

Pelvic venous insufficiency causes chronic, non-cyclical pelvic pain related to ovarian or internal iliac vein reflux and may be treated with minimally invasive transcatheter embolization in patients who fail conservative or pharmacologic therapy.

Vulvar and labial varicosities may result from pelvic venous insufficiency and, when persistently symptomatic despite conservative management, may be treated with minimally invasive procedures such as stab phlebectomy.

Criteria

Commercial

Prior Authorization is Required.

I. Radiofrequency Ablation for Uterine Fibroids (Leiomyomas)

- A. PacificSource considers the use of laparoscopic (e.g., Acessa®) or transcervical (e.g., Sonata®) radiofrequency ablation as a treatment for uterine fibroids (leiomyomas) to be medically necessary when **ALL** of the following criteria are met:
1. Persistence of one or more symptoms directly attributed to uterine fibroids (e.g., excessive menstrual bleeding unresponsive to conservative management (menorrhagia), bulk-related pelvic pain, pressure or discomfort, urinary symptoms referable to compression of the ureter or bladder, and/or dyspareunia)
 2. Uterine preservation is desired
 3. Fibroids are less than 10 cm in any diameter
 4. Other potential causes for symptoms (e.g., infection, malignancy) have been ruled out

II. Uterine Artery Embolization

- A. PacificSource considers uterine artery embolization medically necessary when all of the MCG A-0287 (AC) is met.

III. Ovarian or Iliac Vein Embolization for Pelvic Venous Disorders

- A. PacificSource considers embolization (e.g., using metallic coils or foam/gel sclerotherapy) of the ovarian veins, with or without the internal iliac veins, medically necessary as a treatment for clinically significant pelvic venous disorders/venous-origin chronic pelvis pain when **ALL** of the following criteria are met:
1. Imaging-confirmed pelvic congestion insufficiency consistent with the member's symptoms (e.g., Diagnostic venography, Computed tomography (CT), Magnetic resonance imaging (MRI))
 2. Chronic pelvic pain present for greater than 6 months
 - a. Pain is persistent and clinically significant, interfering with activities of daily living (ADLs) or quality of life (i.e., worsening with prolonged standing or sitting; evening exacerbation, relief with recumbency or leg elevation, visible pelvic or vulvar varicosities)
 3. Documented failure of an adequate trial (greater than or equal to 6 months) of appropriate pharmacologic therapy such as analgesics, anti-inflammatory medications, or hormonal therapy (e.g., ovarian suppression, progestins, or equivalent)

IV. Vulvar/Labial Varicosities

- A. PacificSource may consider stab phlebectomy medically necessary as a treatment for vulvar/labial varicosities (e.g., pelvic vein incompetence) when **ALL** of the following conditions are present:
1. Member has persistent symptoms/signs of discomfort, aching, throbbing, heaviness and/or dull pain which has been present for a least 6 months

Medicaid

PacificSource Community Solutions (PCS) follows the general coverage, limitations, and exclusions outlined in OARs 410-141-3820, 410-141-3825, and 410-120-1200. Relevant coverage guidance on the Health Evidence Review Commission (HERC) Prioritized List of Health Services; as well as any applicable Oregon Administrative Rules (OARs) may be used to determine coverage of therapeutic treatments for uterine and pelvic conditions.

PacificSource Community Solutions (PCS) follows the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage requirements in OAR 410-151-0000 through 410-151-0003 for EPSDT beneficiaries. Relevant coverage guidance may be used to assist in informing a determination of medical necessity and medical appropriateness during the individual case review. A case-by-case review for EPSDT Medical Necessity and EPSDT Medical Appropriateness as defined in OAR 410-151-0001 is required prior to denying. Refer to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) policy for details.

Medicare

PacificSource Medicare follows CMS guidelines and criteria. In the absence of CMS guidelines and criteria, PacificSource Medicare will follow the PacificSource commercial criteria above for determination of coverage and medical necessity coverage of therapeutic treatments for uterine and pelvic conditions.

Experimental/Investigational/Unproven

PacificSource considers the following treatments for uterine fibroids (leiomyomas) to be experimental, investigational, or unproven:

- Acupuncture
- Cryomyolysis
- Cryotherapy
- Electrical ablation
- Interstitial thermotherapy
- Lasers
- Ultrasound ablation, with or without magnetic resonance imaging (MRI) guidance

PacificSource considers ovarian vein embolization for the treatment of pelvic venous disorders/venous-origin chronic pelvis pain experimental, investigational, or unproven for other indications not included above.

Note: * indicates the item remains E/I/U but will not be reviewed annually by the NTOC Committee, unless requested.

Note: PacificSource Community Solutions (PCS) and PacificSource Medicare require items listed on this policy's E/I/U list, to be reviewed by medical necessity review guidelines. Please see related policy, "Clinical Criteria Used in UM Decisions" to review criteria hierarchy and "Medical Necessity Reviews" for determination of coverage and medical necessity guidelines.

Coding Information

The following list of codes are for informational purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

- 37241 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)
- 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
- 37765 Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions
- 37766 Stab phlebectomy of varicose veins, one extremity; more than 20 incisions
- 37799 Unlisted procedure, vascular surgery (is utilized for phlebectomy “less than 10 incisions”)
- 58580 Transcervical ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency
- 58674 Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency
- 58578 Unlisted laparoscopy procedure, uterus
- 58579 Unlisted hysteroscopy procedure, uterus
- 58999 Unlisted procedure, female genital system (non-obstetrical)
- 0071T Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue
- 0072T Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue

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HCPCS® codes, descriptions and materials are copyrighted by Centers for Medicare and Medicaid Services (CMS).

Definitions

Fibroids - Fibrous tissue collected in the uterine wall; also referred to as leiomyomas or myomas.

Laparoscopic - A surgical procedure performed using a laparoscope, a thin fiberoptic scope introduced into a body cavity for diagnostic and surgical purposes.

Transcervical - A medical procedure performed through the cervical opening of the uterus.

Transcatheter Embolization - A minimally invasive endovascular technique in which embolic materials are delivered through a catheter to intentionally occlude targeted blood vessels to reduce abnormal blood flow or venous reflux.

Stab Phlebectomy - A surgical procedure involving small skin incisions to remove superficial varicose veins, typically performed for persistently symptomatic varicosities when conservative management has failed.

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Appendix

Policy Number:

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Policy type: Enterprise

Author(s):

Depts.: Health Services

Applicable regulation(s): OARs 410-120-1200, 410-141-3820, 410-141-3825, 410-151-0000 through 410-151-0003 and Medicare is 42 CFR § 422.101(b-c).

External entities affected:

OPs Approval: 4/2026