BLUE CROSS OF NORTHEASTERN PA "BCNEPA" MEDICAL POLICY BULLETIN	**MANUAL:** MEDICAL POLICY
	REFERENCE NO.: MPO-490-0126
EFFECTIVE DATE October 1, 2014	**SUBJECT:** Transcatheter Embolization

Blue Cross of Northeastern Pennsylvania ("BCNEPA") Medical Policy

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical policy and claims payment policy are applied. Policies are provided for informational purposes only and are developed to assist in administering plan benefits and do not constitute medical advice. Treating providers are solely responsible for medical advice and treatment. Policies are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and information are constantly changing and BCNEPA may review and revise its medical policies periodically. Also, due to the rapid pace of changing technology and the advent of new medical procedures, BCNEPA may not have a policy to address every procedure. In those cases, BCNEPA may review other sources of information including, but not limited to, current medical literature and other medical resources, such as Technology Evaluation Center Assessments (TEC) published by the Blue Cross Blue Shield Association. BCNEPA may also consult with health care providers possessing particular expertise in the services at issue.

I. DESCRIPTION:

Uterine Artery Embolization is a technique used to control bleeding in obstetric and/or gynecologic disorders (e.g., postpartum hemorrhage, cut off blood supply of fibroids, etc.).

Transcatheter arterial chemoembolization (TACE) of the liver is a procedure in which the blood supply to a tumor of the liver is blocked and chemotherapy is administered directly to the tumor.

II. BENEFIT POLICY STATEMENT:

BCNEPA makes decisions on coverage based on Policy Bulletins, benefit plan documents, and the member's medical history and condition. Benefits may vary based on product line, group or contract, therefore, Member benefits must be verified. In the event of a conflict between the Member's benefit plan document and topics addressed in Medical Policy Bulletins (i.e., specific contract exclusions), the Member's benefit plan document always supersedes the information in the Medical Policy Bulletins. BCNEPA determines medical necessity only if the benefit exists and no contract exclusions are applicable.

Benefits are determined by the terms of the Member's specific benefit plan document [i.e., the Fully Insured policy, the Administrative Services Only (ASO) agreement applicable to the Self-Funded Plan Participant, or the Individual Policy] that is in effect at the time services are rendered.

III. MEDICAL POLICY STATEMENT:

Coverage is subject to the terms, conditions, and limitations of the member's contract.

Occlusion of Uterine Arteries Using Transcatheter Embolization

A. BCNEPA will provide coverage for uterine artery embolization when medically necessary.

1. Uterine artery embolization may be considered medically necessary for the following indications, such as, but not limited to:

a) Postpartum hemorrhage (that is not controlled by conservative measures i.e., uterotomes, D&C, and packing);

b) Cervical ectopic pregnancy;

c) Severe vaginal lacerations;

d) Post surgical (gynecologic) bleeding; and

e) May also be used in the treatment of symptomatic uterine fibroids (i.e., bleeding or pain).

- Bulk-related symptoms (pressure, urinary frequency, constipation, dysmenorrhea, dyspareunia) of pain indication must meet all of the same criteria used for treatment of fibroids by hysterectomy or myomectomy (laparotomy or laparoscopic).

- Bleeding indication (menorrhagia) must meet criteria for myomectomy, hysterectomy and have been uncontrolled by hormonal therapy, D&C, and hysteroscopic resection.

2. BCNEPA will not provide coverage for the following contraindications of UAE procedures:

a) Currently pregnant, and/or desires future pregnancy;

b) Active pelvic infection (pelvic inflammatory disease);

c) Contrast allergy;

d) Arteriovenous fistula;

e) Undiagnosed pelvic masses or bleeding;

f) History of pelvic radiation (i.e., radiation induced vasculitis which causes ischemic necrosis of uterus and adjacent organs);

g) Women with uterine size greater than 20 weeks;

h) Presence of an IUD (can be removed prior to procedure); or

i) Presence of gynecological malignancies.

3. 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.

4. Transcatheter embolization of uterine arteries is considered not medically necessary when the above criteria have not been met.

Ovarian and Internal Iliac Vein Embolization

B. BCNEPA will not provide coverage for embolization of the ovarian vein and internal iliac veins as a treatment of pelvic congestion syndrome as this is considered investigational.

Radioembolization for Primary and Metastatic Tumors of the Liver

C. BCNEPA will provide coverage for radioembolization, also referred to as selective internal radiation therapy or SIRT, when medically necessary.

1. Radioembolization or SIRT may be considered medically necessary for the following indications:

a) To treat primary hepatocellular carcinoma that is unresectable and limited to the liver.

- Radioembolization is used for unresectable HCC that is > 3cm.
- Radioembolization should be reserved for patients with adequate functional status (ECOG 0-2), adequate liver function and reserve, Child Pugh score A or B, and liver-dominant metastases.

b) In primary hepatocellular carcinoma as a bridge to liver transplantation.

c) To treat hepatic metastases from neuroendocrine tumors (carcinoid and noncarcinoid) with diffuse and symptomatic disease when systemic therapy has failed to control symptoms.

2. Radioembolization may be considered medically necessary to treat unresectable hepatic metastases from colorectal carcinoma that are both progressive and diffuse, in patients with liver-dominant disease who are refractory to chemotherapy or are not candidates for chemotherapy.

3. Radioembolization is considered investigational for all other hepatic metastases except for metastatic neuroendocrine tumors as noted above.

D. BCNEPA will not provide coverage for radioembolization to treat primary intrahepatic cholangiocarcinoma as it is considered investigational.

Transcatheter Arterial Chemoembolization (TACE)

E. BCNEPA will provide coverage for transcatheter arterial chemoembolization (TACE) when medically necessary.

1. Transcatheter hepatic arterial chemoembolization may be considered medically necessary for the following indications:

a) To treat hepatocellular cancer that is unresectable but confined to the liver and not associated with portal vein thrombosis.

b) To treat liver metastasis in symptomatic patients with metastatic neuroendocrine tumors whose symptoms persist despite systemic therapy and who are not candidates for surgical resection.

c) To treat liver metastasis in patients with liver-dominant metastatic uveal melanoma.

d) As a bridge to transplant in patients with hepatocellular cancer where the intent is to prevent further tumor growth and to maintain a patient's candidacy for liver transplant. The following patient characteristics apply:

- Single tumor less than 5cm or no more than three (3) tumors less than 3cm in size.
- Absence of extra hepatic disease or vascular invasion.
- Child-Pugh score of either A or B.

F. BCNEPA will not provide coverage for transcatheter hepatic arterial chemoembolization for the following indications as they are considered investigational and, therefore, not covered because the safety and effectiveness of these services cannot be established by review of the available published peer-reviewed literature:

1. As neoadjuvant or adjuvant therapy in hepatocellular cancer that is considered resectable.

2. To treat liver metastases from any other tumors or to treat hepatocellular cancer that does not meet criteria noted above, including recurrent hepatocellular carcinoma.

3. To treat hepatocellular tumors prior to liver transplantation except as noted above.

4. To treat unresectable cholangiocarcinoma.

5. All other indications not identified above as medically necessary.

IV. DEFINITIONS:

TACE: Transarterial chemoembolization, a procedure in which the blood supply to a tumor is blocked (embolized) and chemotherapy is administered directly into the tumor.

Child-Pugh Score: Sometimes called the Child-Turcotte-Pugh Score, is used to assess the prognosis of chronic liver disease, mainly cirrhosis. Although it was originally used to predict mortality during surgery, it is now used to determine the prognosis, as well as the required strength of treatment and the necessity of liver transplantation.

CODING:

- **The identification of a code in this section does not denote coverage or separate reimbursement.**
- Covered procedure codes are dependent upon meeting criteria of the policy and appropriate diagnosis code.
- The following list of codes may not be all-inclusive, and are subject to change at any time.
- Benefits are determined by the terms of the Member's specific benefit plan document [i.e., the Fully Insured policy, the Administrative Services Only (ASO) agreement applicable to the Self-Funded Plan Participant, or the Individual Policy] that is in effect at the time services are rendered.

PROCEDURE CODES

37241	37242	37243	37244	Q0083	S2095