MASSACHUSETTS

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Medical Policy

Ovarian and Internal Iliac Vein Endovascular Occlusion as a Treatment of Pelvic Congestion Syndrome

Table of Contents

Policy Number: 266

BCBSA Reference Number: 4.01.18 (For Plans internal use only)
NCD/LCD: NA

Related Policies

Treatment of Varicose Veins/Venous Insufficiency, #238

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO Blue℠ and Medicare PPO Blue℠ Members

Endovascular occlusion of the ovarian vein and internal iliac veins is considered **INVESTIGATIONAL** as a treatment of pelvic congestion syndrome.

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)	This is **not** a covered service.
Commercial PPO and Indemnity	This is **not** a covered service.
Medicare HMO Blue℠	This is **not** a covered service.
Medicare PPO Blue℠	This is **not** a covered service.

CPT Codes / HCPCS Codes / ICD Codes

The following codes are included below for informational purposes. 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.

CPT Codes

CPT codes:	Code Description
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)
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation

ICD-10 Diagnosis Codes

ICD-10-CM Diagnosis codes:	Code Description
N94.89	Other specified conditions associated with female genital organs and menstrual cycle

Description

Pelvic Venous Disorder-associated Chronic Pelvic Pain

Pelvic congestion syndrome is a chronic pelvic pain syndrome of variable location and intensity, which is associated with dyspareunia (which may be aggravated by standing) and symptoms suggestive of a venous origin, such as postcoital ache and tenderness over the ovarian point. The syndrome usually occurs before menopause, and pain is often greater before or during menses. The underlying etiology is thought to be related to varices of the pelvic veins, leading to pelvic vascular congestion. The lack of clear diagnostic criteria and overlapping clinical presentation of pelvic congestion syndrome with other potentially related pelvic venous disorders has hindered research progress and contributed to underdiagnosis of these disorders as causes of chronic pelvic pain.[1] In 2021, a multidisciplinary, intersociety working group convened by the American Vein and Lymphatic Society published the Symptoms-Varices-Pathophysiology (SVP) classification of pelvic venous disorders which, in conjunction with the established Clinical-Etiologic-Anatomic-Physiologic classification for lower extremity venous disorders when applicable, places patients in homogeneous populations based on standardized definitions of presenting symptoms, involved variceal reservoirs, and underlying pathophysiology (including anatomic, hemodynamic, and etiologic disease features).[2] The term pelvic venous disorder, accompanied by the patient-specific SVP classification, has been proposed to replace pelvic congestion syndrome and other historical nomenclature for related diseases (such as May-Thurner syndrome and nutcracker syndrome). As diagnostic criteria remain lacking, pelvic venous disorder as a cause of chronic pelvic pain amounts to a diagnosis of exclusion; evaluation may involve a variety of physical assessments, laboratory measurements, and/or imaging studies to eliminate other etiologies of chronic pelvic pain, such as cystitis or gynecologic malignancy.

Treatment

An initial conservative approach to the treatment of pelvic congestion syndrome may involve analgesics (eg, short-term use of nonsteroidal anti-inflammatory drugs) and hormonal therapy, with or without psychotherapy.[3,4] The evidence base for medical management consists primarily of 5 clinical trials of hormonal therapy (sample sizes ranging from 22 to 102) in which medroxyprogesterone (in combination

with psychotherapy), goserelin, and etonogestrel demonstrated significant improvements in pain scores with up to 13 months of follow-up.[4,5] Longer-term efficacy of these treatments has not been demonstrated, and the largest trial of medroxyprogesterone indicated rapid recurrence of symptoms with discontinuation.[6] Surgical ligation of pelvic veins may be considered, but is also supported by limited evidence and further limited by need for general anesthesia, duration of hospitalization, recovery time, and associated morbidity.[7] Embolization therapy and/or sclerotherapy of the ovarian and internal iliac veins has been proposed as an alternative to surgical vein ligation. Endovascular occlusion can be performed using a variety of materials including coils, vascular plugs, glue, liquid embolic agents, and gelatin sponge or powder (Gelfoam).

Summary

Description

Pelvic congestion syndrome is characterized by chronic pelvic pain that is often aggravated by standing; diagnostic criteria for this condition are not clearly definedwell-defined. Endovascular occlusion (eg, embolization, sclerotherapy) of the ovarian and internal iliac veins has been proposed as a treatment for patients who fail medical therapy.

Summary of Evidence

For individuals who have pelvic congestion syndrome who receive ovarian and/or internal iliac vein endovascular occlusion, the evidence includes randomized studies, comparative cohort studies, non-comparative cohort studies, case series, and systematic reviews. Relevant outcomes are symptoms, quality of life, and treatment-related morbidity. Systematic reviews of prospective and retrospective data, as well as more recently published retrospective cohort studies, indicate consistently high clinical success rates (primarily in the form of significant pain reduction) ranging from 63.7% to 100% after ovarian and/or internal iliac vein endovascular occlusion at short-term, long-term, or overall follow-up. These data support guideline and international consensus recommendations for endovascular occlusion in this setting. In a randomized trial of embolization with vascular plugs or coils in patients with pelvic congestion syndrome, adverse events were reported in 22% and 10% of patients, respectively. A retrospective analysis comparing coil embolization to endoscopic resection indicated significantly greater improvement in pain 1-month post-procedure with resection, but similar improvements in pain between the procedures at 5-year follow-up. Differences between these procedures, particularly the need for general anesthesia with resection versus local anesthesia with embolization, suggest the possibility of selection bias in this study. Randomized controlled trials using well-defined eligibility criteria and relevant comparators are needed. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Policy History

Date	Action
11/2023	Annual policy review. Policy updated with literature review through June 29, 2023; references added. Policy statement unchanged.
10/2022	Annual policy review. Description and summary updated. No references added. Policy statement(s) unchanged.
9/2021	Annual policy review. Policy statements unchanged.
10/2020	Annual policy review. Description, summary, and references updated. Policy statement(s) unchanged.
10/2019	Annual policy review. Policy title and language revised from embolization to endovascular occlusion to clarify policy inclusion of both embolization and sclerotherapy treatment strategies. Policy statement otherwise unchanged.
10/2018	Annual policy review. No change to policy statement. New references added.
10/2016	Annual policy review. New references added.
9/2014	Annual policy review. New references added.
6/2014	Updated Coding section with ICD10 procedure and diagnosis codes. Effective 10/2015.
1/2014	Updated to add new CPT codes 37241 and 37242 and remove deleted code 37204.
6/2013	Annual policy review. New references added.

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.
9/1/2010	Medical policy 266 created.

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

References

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