



# CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all plans administered by CIGNA Companies including plans administered by Great-West Healthcare, which is now a part of CIGNA.

**Subject Embolization for Pelvic Congestion**

**Effective Date ..... 10/15/2010**  
**Next Review Date ..... 10/15/2011**  
**Coverage Policy Number ..... 0213**

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## Hyperlink to Related Coverage Policies

Hysterectomy

### INSTRUCTIONS FOR USE

Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans as well as benefit plans formerly administered by Great-West Healthcare. Please note, the terms of a participant's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a participant's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a participant's benefit plan document **always supercedes** the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable group benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. Proprietary information of CIGNA. Copyright ©2010 CIGNA

## Coverage Policy

**CIGNA does not cover percutaneous transcatheter embolization for the treatment of pelvic congestion syndrome (PCS) because it is considered experimental, investigational or unproven.**

## General Background

Pelvic congestion syndrome (PCS), also known as chronic pelvic pain (CPP) syndrome or pelvic venous incompetence, is caused by utero-ovarian varices. PCS is defined by engorged pelvic veins of more than 10 mm diameter on selective transuterine venography in multiparous, premenopausal women with a history of chronic, noncyclic pelvic pain for more than six months (Halligan, et al., 2000). Nulliparous women may also be affected, although this is uncommon. Patients may report pelvic pain in the following situations: 1) when standing or in the upright position (relieved in the supine position); 2) during or after intercourse; 3) in association with varices in the thigh, buttock, perineum, vulva, or vagina; and 4) in association with bladder urgency (Society of Interventional Radiology [SIR], 2004).

Partial suppression of ovarian function with medroxyprogesterone acetate may relieve symptoms in some patients with PCS (Stones and Mountfield, 2000; Chung and Huh, 2003). As with other chronic pain situations, there may also be psychological overlay to the symptoms, and psychotherapy is sometimes used as an adjunct treatment. Patients who do not respond to pharmacological treatment and/or psychotherapy, or who experience recurrence of symptoms, may be referred for surgical therapies, including ovarian vein ligation or hysterectomy

with removal of one or both ovaries. Surgical therapies are associated with significant morbidity, however, and hysterectomy may be undesirable, especially in younger women who desire children.

Percutaneous transcatheter coil embolization or embolotherapy has been proposed as an alternative treatment strategy to surgery and as an adjunct procedure to embolization with detachable balloons, sclerosing agents or glue (e.g., enbucrilate). Percutaneous access to the ovarian vein is generally gained via the femoral venous approach. Several coils are inserted into the affected ovarian vein under fluoroscopic guidance, using contrast media to locate the varices. The ovarian and internal iliac veins are in close communication; therefore, in some cases, embolization of the iliac veins may also be required. Embolization of the iliac vein is usually performed after treatment of the ovarian vein. Rare complications of embolization include pulmonary embolus and recurrence of varices.

### **Literature Review**

The peer-reviewed medical literature investigating the safety and effectiveness of coil embolization of the ovarian vein for treatment of PCS primarily consists of case series and cohort studies. A systematic review by Tu et al (2010) evaluated the evidence on the treatment of PCS. Treatment in studies (n=22) included gonadal hormonal suppression, vagomimetic agents; ovarian and pelvic vein embolization percutaneously with coils, glue, or sclerosants; placement of renal vein stents; or operative pelvic vein ligation (including hysterectomy with salpingo-oophorectomy). A total of 12 studies (n=469 women) evaluated percutaneous vascular approaches, with coils being the most commonly used material. The rate of clinical success was found to range from 58%–100%. However the quality of the studies supporting transcatheter embolization was found to be very poor, with pelvic pain definitions varying widely and inconsistent follow-up of outcomes.

A randomized trial by Chung and Huh (2003) compared the efficacy of coil embolization (n=52) to that of hysterectomy and bilateral oophorectomy (n=27) or hysterectomy and unilateral oophorectomy (n=27). A significant improvement in pain symptoms versus baseline values was observed for patients in all three groups. The treatment effect was maintained for 12 months in all patients (Chung and Huh, 2003). Additional randomized controlled trials with long-term follow-up are needed to support these findings.

Sample sizes in the available case series and cohort studies (Asciutto, et al., 2009; Kwon, et al., 2007; Creton, et al., 2006; Kim, et al., 2006; Bachar, et al., 2003; Venbrux, et al., 2002; Maleux, et al., 2000) have ranged from 6–131. Relief of symptoms was the most common outcome measure and was assessed using standardized questionnaires or a visual analogue scale (VAS). Patients were followed for between three months and five years. Initial technical success rates were determined using repeat angiography and ranged from 88.9–100%. The treatment effect varied considerably among and within studies, and symptom relief ranged from 40–100%. Small sample sizes, lack of control groups, insufficiently defined patient selection criteria, nonstandardized procedures and the use of subjective outcome measures compromised the quality of the studies.

### **Professional Societies**

The American College of Obstetricians and Gynecologists (ACOG) guideline for chronic pelvic pain does not discuss the use of embolization as a treatment for PCS (ACOG, 2004).

The Society of Interventional Radiology (SIR) endorses coil embolization as an effective treatment option for PCS (SIR, 2004).

### **Summary**

Evidence in the published peer-reviewed medical literature investigating the use of embolization for pelvic congestion syndrome (PCS) exists primarily in the form of small case series and cohort studies with mixed results. Results from a single randomized trial suggest that coil embolization may provide an alternative to surgery in patients diagnosed with who do not respond to pharmacological and/or psychotherapeutic treatment. However, additional well-designed randomized controlled trials are needed to evaluate the safety and effectiveness of embolization therapy as a treatment for PCS.

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## **Coding/Billing Information**

**Note:** This list of codes may not be all-inclusive.

**Experimental/Investigational/Unproven/Not Covered:**

CPT* Codes	Description
37204 <sup>†</sup>	Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck

<sup>†</sup>**Note: Experimental, investigational, unproven, and not covered when used to report percutaneous transcatheter embolization for the treatment of pelvic congestion syndrome.**

ICD-9-CM Diagnosis Codes	Description
625.5	Pelvic congestion syndrome

\*Current Procedural Terminology (CPT®) ©2010 American Medical Association: Chicago, IL.

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## Policy History

<b>Pre-Merger Organizations</b>	<b>Last Review Date</b>	<b>Policy Number</b>	<b>Title</b>
CIGNA HealthCare	10/15/2008	0213	Embolization for Pelvic Congestion

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