# Reimbursement Rules:

## Can Payment Barriers for Uterine Artery and Pelvic Congestion Embolization Be Overcome?

Why reimbursement is limited for these procedures and what can be done to change the payment landscape.

**BY THERESA CARIDI, MD, FSIR**

Interventional radiologists sometimes experience difficulties with payment regarding desirable women's health procedures such as uterine artery embolization (UAE) and pelvic congestion embolization. These challenges, as well as current and future payment strategies, are worthy of review.

### BACKGROUND

#### Uterine Artery Embolization

There are over 2 decades of support in the literature for UAE for control of symptoms related to leiomyoma (fibroids). The current American College of Obstetricians and Gynecologists (ACOG) guidelines support the utilization of uterine fibroid embolization (UFE) in women who wish to maintain their uteri and are either not good candidates for surgical myomectomy or prefer to avoid surgery altogether.[1,2] Nevertheless, hysterectomy remains the gold standard from a payer's perspective, probably due to its easy-to-conceptualize, definitive management of fibroids. Minimally invasive procedures to eliminate fibroid-related symptoms have certainly threatened this gold standard because they offer potential patient and cost benefits. The greatest overall cost savings seem to be associated with hysteroscopic myomectomy.[3] However, this procedure is limited in scope because it is not useful for treating fibroids in all locations within the uterus—unlike hysterectomy or UAE, for instance.

Surprisingly, when overall costs are considered, some studies suggest that UAE does not provide cost savings when compared to outpatient hysterectomy, taking into consideration all obstetrics/gynecology–related health care costs in the 1-year follow-up period after intervention.[3,4] Although UAE does not appear to provide cost savings over the standard inpatient hysterectomy,[4] there is a trend away from inpatient to outpatient hysterectomy, where costs are much lower. Therefore, cost is not a motivator on the part of payers that have failed to support coverage for UFE.

Various other gynecologic conditions are also sometimes treated via UAE, including adenomyosis, postpartum hemorrhage, and uterine arteriovenous malformations. However, it is the elective UAE performed for adenomyosis that really ignites the same, or perhaps more, scrutiny from payers as UFE.

#### Pelvic Congestion Syndrome

As we best understand it, pelvic congestion syndrome (PCS) is a constellation of symptoms, most notably pelvic pain that is thought to be a result of venous enlargement and reflux in a woman's pelvis. The syndrome is hard to define because there are no widely accepted standard criteria to outline the condition. Finding dilated pelvic veins and pelvic congestion on imaging does not necessarily equate to symptoms or the syndrome.[5] Further, imaging techniques are limited in that cross-sectional modalities such as CT and MRI are performed in the supine position, which potentially limits visualization of the venous reflux.[6] Nevertheless, women who have pelvic pain for > 6 months and who have findings of venous reflux on imaging are often considered for venography and ovarian vein and/or internal iliac vein embolization. Although robust clinical data are lacking, there are reasonably sized studies to date that show treatment efficacy of ≥ 90% and even durable symptom relief at 1 year.[7]

### CURRENT STATE OF REIMBURSEMENT

#### Uterine Artery Embolization

Fortunately, UAE has been recognized by most payers as a conceivable choice for a woman seeking a nonsurgical option for fibroid treatment. This allows a physician, whether gynecologist or interventional radiologist, to decide when a woman is a candidate for a procedure and what, if any, additional workup is needed. However, there remains at least one insurance company that has a policy requiring unnecessary testing for many women prior to having UAE covered. To impose the same requirements on all women, regardless of what the physician expert believes is neces-

sary, can be likened to the insurance company practicing medicine, which they are not equipped to do. Some of these implausible requirements include the following: (1) all women ≥ 40 years must undergo an endometrial biopsy; (2) women must state that they do not desire future fertility; and (3) there must be proof that medical therapy failed. These are not in keeping with any accepted medical specialty guidelines, including the ACOG guidelines.

Payers also often deny UAE for other pelvic conditions, such as adenomyosis, even though it serves as a minimally invasive approach and allows for more than two-thirds of women who undergo this procedure to maintain their uteri and experience long-term symptom relief.[8]

### Pelvic Congestion Syndrome

The explanation for payment limitations in PCS is for altogether different reasons. PCS tends to be a less well-understood entity and is often a diagnosis made late in the evaluation of a woman's pelvic pain. The condition is also less tangible to define. There are no definitive criteria to follow for the diagnosis nor is there a noninvasive gold standard for imaging the condition. Additionally, the symptoms widely vary among women. Therefore, it is sometimes overlooked, limiting referrals to interventional radiology (IR). Further, the data are not as robust as those for UAE. PCS is poorly understood and identified by physicians, and it is also poorly understood by payers. This rightfully, to some degree, leads to questions about coverage.

## WHEN EMBOLIZATION IS DENIED

When a denial is made for either UAE or pelvic venous embolization, it often prompts a physician to draft a letter to the payer or request a peer-to-peer phone consultation. Although these are sometimes successful, they only allow for a change in that single case or possibly a regional policy adjustment and will not result in a global change. At most, a policy change may occur for that particular geographic territory, but the change will not affect what happens with the same scenario in a different region. This is even true for Medicare—policy changes related to procedure coverage are made regionally but not nationally. This means that a significant amount of physician time can be spent on solving these same issues on a repeated basis.

Unfortunately, there is also the reality that embolization is frequently denied despite a peer-to-peer discussion, which is not surprising given the lack of interventional radiologists serving in an advisory capacity for these large organizations. We recognize that IR is poorly understood by those who do not specialize in the field. As a result, the Society of Interventional Radiology (SIR) has developed materials to make appeals standardized and available for easy use by members.[9] This allows for previously successful wording and strategies to be easily applied to a new case or territory.

## FUTURE STRATEGIES

### Uterine Artery Embolization

In general, the reimbursement landscape for UAE is mostly positive. However, it is not without continued challenges with well-known entities that have been less accepting of UAE. The most fruitful strategy will likely involve customers of payers (ie, patients and large employers of these patients), as they will be the most powerful agents for change with insurers. For this to be true, women must know their options. SIR sponsored a Fibroid Fix survey, which showed that 44% of women who are diagnosed with fibroids are not aware of UFE as a treatment choice.[10] It will take continued improvement in awareness of UFE as the first step to increase patient demand on insurance companies. From a societal standpoint, we need to continue to advocate for face time with these organizations so that we can provide current data in support of UAE. The formation of the women's health service line of the SIR in the fall of 2018 will help to maintain a focus on these issues and initiatives.

### Pelvic Congestion Syndrome

Tactics for obtaining reimbursement for PCS may lie within the name of the condition itself. In other words, there may be a strategy in referring to PCS as "pelvic venous disease," an entity that may be clearer to payers. This is essentially a play on words in order to be more consistent with similar disease processes in other areas of the body that are covered.

Pelvic venous disease is an area of interest for data collection given the limited quality data in the existing literature. This will go a long way to garner successful payments, particularly because there is no good alternative to embolization. In other words, there should be no need for proof of failed therapy because there is no other gold standard. This is an opportunity for IR to be at the forefront in establishing embolization as the gold standard therapy for treating pelvic venous disease.

### Strategies of the Society of Interventional Radiology

For both UAE and pelvic venous disease, the women's health service line of the SIR has made the following goals for this year's agenda regarding awareness and reimbursement, which will aid in positive change for the payment landscape.

1. Appeal to a large insurer of patients who are being denied the coverage they need.
2. Engage with women's advocacy groups to expand education and patient awareness, specifically noting individual payers' failure to provide coverage for IR therapies.

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3. Leverage the current SIR awareness campaign, which is in the process of being launched. Women's health related to overall pelvic pain will be a key topic, focusing on referrers and patients, and will include an expanded web presence and streamlined processes to find IR providers.
4. Continue to make the economic argument of more rapid recovery with minimally invasive procedures such as UAE and pelvic venous embolization.
5. Request that standard procedure is followed when guidelines are made for coverage so that payers do not impose unnecessary requirements on a woman before she can choose a minimally invasive option. Taking that a step further, some would argue for restrictions on unnecessary surgeries—for example, it should be mandatory that a woman see an interventional radiologist in consultation to discuss the minimally invasive option prior to having a surgical procedure.

## CONCLUSION

Although there are various challenges with the current payment landscape for UAE and pelvic congestion embolization, the future is not bleak. UAE and pelvic congestion embolization continue to show steadfast efficacy for the treatment of their respective conditions. This, coupled with many IR initiatives, will only enhance the current landscape and further solidify access to outstanding treatment options for women seeking nonsurgical procedures. ■

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