Physician Coding Fact Sheet

Uterine Fibroid Embolization

Effective January 1, 2013

Impact of Sequestration on Medicare Payments:

Per the Centers for Medicare and Medicaid Services, Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payment. Claims for durable medical equipment (DME), prosthetics, orthotics, and supplies, including claims under the DME Competitive Bidding Program, will be reduced by 2 percent based upon whether the date-of-service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013.

The claims payment adjustment shall be applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments.

Uterine fibroids (leiomyomas) are common non-cancerous (benign) tumors of the uterus, which may cause heavy bleeding, pelvic discomfort, pain, pressure on other organs, infertility and urinary complications. Uterine fibroids occur in 20-70% of women between the ages of 30 and 50.3 In the United States, there are approximately 400,000 new cases diagnosed each year.[4]

The Uterine Fibroid Embolization (UFE) procedure typically involves bilateral selective catheterization services from femoral access through which embolic material is injected to occlude the blood flow to the fibroid(s), resulting in infarction and shrinkage of the fibroids. Intra-procedural angiography is used to map the procedure, guide the intervention, and perform post-procedure angiographic assessment.

Physicians that report and bill for UFE procedures should review and include on claim forms all the diagnosis codes (ICD-9 code), CPT procedure codes and HCPCS product codes that accurately reflect the patient's condition, the procedures performed, and the products used during a UFE procedure. This needs to be consistent with the patient's insurance company's reimbursement requirements. Observed codes are listed to the right.

Reporting UFE procedures:

ICD-9 Coding

The most common diagnosis codes for the UFE Procedure are as follows:

Primary ICD-9 codes[3]:	
218.0 - 218.9	Uterine leiomyoma
617.0	Adenomyosis
Related ICD-9 codes[3]:	
593.3	Stricture or kinking of ureter [with urinary symptoms referable to compression of the ureter or bladder]
593.4	Other ureteric obstruction [with urinary symptoms referable to compression of the ureter or bladder]
625.0	Dyspareunia
625.8 - 625.9	Other and unspecified symptoms associated with female genital organs [bulk-related pelvic pain, pressure or discomfort]
626.2	Excessive or frequent menstruation [menorrhagia]
788.0 - 788.9	Symptoms involving urinary system

CPT Coding

Effective January 1, 2007, the new CPT Code 37210 was added to report embolization of uterine fibroids. The new code is a single all-inclusive code which has been valued to include embolization, selective catheterization, and radiological supervision and interpretation services required for the UFE procedure. **CPT code 37210 should only be billed once per procedure.**

CPT Code[1]	Description[1]	Physician Payment in a Facility - Medicare[2]	Physician Payment in the office - Medicare[2]
99213	Established Patient - Level lll Ofice Visit	$49.67	$72.81
72197	MRI,pelvis; without contrast material(s) followed by contrast material(s) and further sequences	$108.53	$585.88
37210	Uterine fibroid embolization, percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intra-procedural road mapping, and imaging guidance necessary to compete the procedure	$526.34	$3,787.10

Evaluation and Management Services Coding

CPT code 37210 – Uterine fibroid embolization, has a global period of "000" days. Generally, this means that visits by the same physician on the same day as the procedure are included in the payment for the procedure and should not be coded separately. However, there are exceptions when a significant, separately identifiable E/M service is performed.

With a global period of "000", postoperative visits beyond the day of the procedure are not included in the payment amount for the procedure. They may be coded and paid separately.

To bill for E/M services to new patients, use CPT Codes 99201 to 99205, selecting the appropriate level (1-5) based on what was performed by the physician or an ancillary staff under the "incident to" Medicare requirements or other insurer guidelines.

To bill for E/M services to established patients, use CPT Codes 99211 to 99215, selecting the appropriate level (1-5) based on what was performed by the physician or an ancillary staff under the "incident to" Medicare requirements of other insurer guidelines.

Coverage and payment for E/M services (e.g. visits) must meet the criteria established by the patient's insurer, which may include:

1. The service must be medically necessary.
2. The service must be properly documented.
3. The service must be consistent with "incident to" billing guidelines (Medicare).
4. The level of E/M service billed must be appropriate for the care rendered.
5. The service must be "above and beyond the other service(s) provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed."

In selecting the E/M level of service that is most appropriate for the care rendered, you need to follow two sets of criteria:

The level of E/M service provided can be determined by meeting the criteria for the three key components of documentation. They are:

- Patient History
- Patient Examination
- Level of Medical Decision Making

Coding E/M Services Based on Time

	New Patient Office Visits 99201 to 99205	Established Patient Office Visits 99211 to 99215
Level 1	10 minutes	5 minutes
Level 2	20 minutes	10 minutes
Level 3	30 minutes	15 minutes
Level 4	45 minutes	25 minutes
Level 5	60 minutes	40 minutes

Additional information regarding appropriate E/M coding guidelines may be found in the1997 Documentation Guidelines for Evaluation and Management Services as published in partnership with CMS and the American Medical Association.

Coverage

Medicare:

The typical UFE patient is a premenopausal woman between 25 and 50 years of age. UFE is rarely performed on the Medicare (> age 65) population therefore there is not a national or local coverage determination for UFE. Local carriers may cover on a case-by-case basis and it is suggested that you contact your local carrier prior for determination criteria.

Non-Medicare:

Most non-Medicare insurance plans now provide at least conditional coverage for Uterine Fibroid Embolization. Private payers typically determine coverage for procedures based on prior authorization. With UFE patients, unless you are aware of the payer's coverage policy for a specific patient population, we recommend that you contact the payer to seek prior authorization. If you ask about coverage after procedure, it may result in unpaid claims, leaving both the hospital and the physician without compensation. Be sure to allow sufficient time to obtain prior authorization.

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[2] Source: November 16, 2012 Federal Register. MD payments calculated using the 2013 conversion factor of $34.0230. MD rates are effective from January 1 – December 31, 2013. When an Angiography procedure is performed in the office-based setting, the physician would bill for a global (professional +technical payment). When a procedure is performed in a hospital- based or ambulatory surgical center, the physician would bill the professional payment. If the physician is only performing the interpretation of the study, the physician would bill the professional payment and the fee-standing center (non-hospital or ASC-based) that performed the study would bill the technical component fee, only. http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage

[3] Source: The Educational Annotation of ICD-9-CM, Reno, NV; Channel Publishing Ltd. Copyright 2011 Craig D. Puckett, Fifth Edition

[4] Mude-Nochumson H, Goldberg J. Fertility-sparing treatment options for women with symptomatic fibroids. The Female Patient. 2003; 28(11):21-26.

[5] Hartmann KE, Birnbaun H, Ben-Hamadi R, et al. Annual Costs Associated with Diagnosis of Uterine Leiomyomata. Obstetrics and Gynecology, Vol. 108, No. 4, October 2006.

Below is a listing of insurance companies reportedly covering UFE:

- AETNA U.S. HealthCare
- Aetna Medicare/Medicaid - NY
- Alliance Mega Life & Health (CT)
- AmeriHealth
- Anthem BCBS Ohio
- Kaiser Permanente
- Personal Choice - PA
- Personal Choice - NJ
- BCBS CA Managed Care
- BCBS Michigan
- BCBS Central NY
- BCBS Tennessee
- BCBS Texas
- BCBS Western
- Blue Cross - CA
- Blue Cross - DE
- Blue Cross - Federal
- Blue Cross - IL
- Blue Cross - MI
- Blue Cross - NJ
- Blue Cross - NY
- Blue Cross - OR
- Blue Cross - PA
- Blue Shield - California
- Blue Shield - PA
- ChampVA - Virginia
- Cigna (plan dependent)
- Conrail Metro Health
- Corporate Health Administrators (ND)
- Empire BC/BCBS New York
- Empire Metro Life & Health (NY)
- Golden Rule (IL)
- Great West Care (NJ)
- Greater Atlantic/Qual-Med (will approve on case-by-case basis if patient is enrolled in a study)
- Guardian PHCS - PPO
- GW Health Plan [Virginia, Maryland, Washington, DC]
- Kaiser Permanente (OR)
- Keystone Health Plan East (PA)
- Keystone Mercy Health Plan
- LabCore Benefits (CA)
- Medical Service Bureau (Blue Shield) - Washington
- MAMSI (MDIPA; Optimum Choice; MAMSI; Alliance PPO)
- National Assoc. of Letter Carriers
- New York Now Care
- Oaktree
- Oxford Health Plans CT, NY, NJ
- Postmasters Benefit Plans
- Prudential (plan dependent)
- Screen Actors' Guild
- Travelers Oxford Liberty
- Vytra
- United Healthcare
- United Health Care Administrators (FL)
- US HealthCare
- US HealthCare HMO PA/NJ

* See Hospital

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