Uterine Fibroid Embolization (UFE)

Coverage, coding and payment for medical procedures and devices can be confusing. This guide was developed to assist with Medicare reporting and reimbursement when performing transcatheter peripheral embolization or occlusion procedures. If you have any questions, please contact our reimbursement team at 800.468.1379 or by e-mail at Reimbursement@cookmedical.com.

**Coverage**

Medicare carriers may issue local coverage decisions (LCDs) listing criteria that must be met prior to coverage. Physicians are urged to review these policies (http://www.cms.hhs.gov/mcd/search.asp) and contact their carriers’ medical directors (www.cms.hhs.gov/apps/contacts) or commercial insurers to determine if a procedure is covered.

**Coding**

The following Current Procedural Terminology (CPT®) code is a bundled code, which includes all radiological supervision and interpretation; intra-procedural guidance and roadmapping; and imaging to document the completion of the procedure.

The CPT® code used to describe uterine fibroid embolization is:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>37243</td>
<td>Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation; intra-procedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction</td>
</tr>
</tbody>
</table>

37243 does not include vessel selection and catheter placement(s); ultrasound guidance for vascular access; diagnostic studies (eg, diagnostic angiography or venography); chemotherapy administration (eg, 96420); or injection of a radioisotope (eg, 79445).¹

Do not report 37243 in conjunction with 75894, 75898 in the same surgical field.

For embolization procedures of the central nervous system or head and neck, see 61624, 61626, 61710.¹

## 2019 Medicare Reimbursement for Uterine Fibroid Embolization

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure Description</th>
<th>Ambulatory Surgery Center</th>
<th>Outpatient Hospital</th>
<th>Physician Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>37243</td>
<td>Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction</td>
<td>$4,056.12</td>
<td>5193</td>
<td>$9,669.04</td>
</tr>
</tbody>
</table>

Fee When Procedure Is Performed in Hospital or ASC (National Medicare Avg3)

Fee When Procedure Is Performed in Office (National Medicare Avg4)

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2019 physician fees for your local area can be found at the following CMS links:


or

[https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html)

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Disclaimer: The information provided herein reflects Cook’s understanding of the procedure(s) and/or device(s) from sources that may include, but are not limited to, the CPT coding system; Medicare payment systems; commercially available coding guides; professional societies; and research conducted by independent coding and reimbursement consultants. This information should not be construed as authoritative. The entity billing Medicare and/or third party payers is solely responsible for the accuracy of the codes assigned to the services and items in the medical record. Cook does not, and should not, have access to medical records, and therefore cannot recommend codes for specific cases. When you are making coding decisions, we encourage you to seek input from the AMA, relevant medical societies, CMS, your local Medicare Administrative Contractor and other health plans to which you submit claims. Cook does not promote the off-label use of its devices.