Sentara Health Plans

Medicaid

Genicular Artery Embolization (GAE)

Table of Content

Effective Date	8/2023
Next Review Date	8/15/2024
Coverage Policy	Medical 342
Version	1

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Purpose:

This policy addresses Genicular Artery Embolization (GAE).

Description & Definitions:

Genicular artery embolization (GAE) is a minimally invasive procedure by reducing the blood flow and inflammation to the areas around the knee.

Criteria:

Genicular artery embolization is medically necessary for **1 or more** of the following:

- Knee hemarthrosis following total knee arthroplasty for **ALL** of the following:
  - Failed Conservative Therapy and **1 or more** of the following:
    - Ice
    - Immobilization
    - Compression
    - saline lavage
    - corticosteroid instillation
    - selective COX-2 inhibitors
    - demonstrated synovial hyper-vascularity on angiography
  - Reduce tumor vascularity about the knee preoperatively in preparation for tumor resection about the knee;
  - Reduce tumor bulk in inoperable cases of tumors around the knee;

Genicular artery embolization is considered **not medically necessary** for uses other than those listed in the clinical criteria.

Coding:

Medically necessary with criteria:

Coding	Description
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)
37244	Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 2023: February
- 2022: August
- 2021: February
- 2020: March
- 2019: November
- 2015: July, August
- 2013: August
- 2012: August
- 2008: August
- 2003: January
- 2001: July
- 1998: December
- 1994: February

Reviewed Dates:

- 2022: February
- 2018: April, November
- 2017: January
- 2016: June
- 2014: August
- 2011: August
- 2010: August
- 2009: August
- 2007: August, September
- 2005: February, November
- 2004: April, July
- 2003: October, November
- 2002: October
- 2000: July, December
- 1999: July, December
- 1996: August

Effective Date:

- February 1992

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

(2023). Retrieved Apr 25, 2023, from EncoderPro: https://www.encoderpro.com/epro/index.jsp

(2023). Retrieved Apr 25, 2023, from MCG 26th Edition: https://careweb.careguidelines.com/ed26/index.html

(2023). Retrieved Apr 25, 2023, from UpToDate: https://www.uptodate.com/contents/overview-of-dermoscopy?search=Dermoscopy&source=search_result&selectedTitle=1~94&usage_type=default&display_rank=1

(2023). Retrieved Apr 25, 2023, from Carelon Medical Benefits Management: https://guidelines.carelonmedicalbenefitsmanagement.com/no-search-results-found/

Genicular artery embolisation for pain from knee osteoarthritis. (2021, Oct 27). Retrieved Apr 25, 2023, from National Institute for Health And Care Excellence (NICE) Guidelines: https://www.nice.org.uk/guidance/IPG708/chapter/1-Recommendations

Genicular Artery Embolization with Embozene Microspheres for Symptomatic Knee Osteoarthritis - Emerging Technology Report - Dec 6, 2021. (n.d.). Retrieved Apr 25, 2023, from HAYES: https://evidence.hayesinc.com/report/pg.embozene

National Coverage Determination (NCD) Therapeutic Embolization (20.28). (1978, Dec 15). Retrieved Apr 25, 2023, from Centers for Medicare & Medicaid Services NCD: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=52&ncdver=1&bc=0

Percutaneous Management of Osteoarthritis in the Knee. (2021, Jun). Retrieved Apr 25, 2023, from Society of Interventional Radiology Research: https://www.jvir.org/article/S1051-0443(21)00798-3/fulltext

Procedure Fee Files & CPT Codes. (2023). Retrieved Apr 25, 2023, from Department of Medical Assistance Services: https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/procedure-fee-files-cpt-codes/ & https://www.dmas.virginia.gov/for-providers/cardinal-care-transition/

Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect,

physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

Genicular Artery Ablation, Geniculate artery embolization, Embozene, (GAE)