GUIDELINES
This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder contract. Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards. This guideline is solely for explaining correct procedure reporting and does not imply coverage and reimbursement.

DESCRIPTION
Menorrhagia, heavy bleeding during the menstrual period, is a relatively benign condition that is common among women of reproductive age. Although menorrhagia is usually idiopathic, it may also be associated with underlying uterine lesions, an anatomical abnormality, systemic illnesses, hormonal imbalances, or the use of certain medications. If diagnostic tests, imaging studies, and pelvic and physical examinations rule out serious causes of menorrhagia, conservative treatments such as nonsteroidal anti-inflammatory drugs, hormonal therapy, or dilation and curettage may stabilize bleeding. These approaches represent viable options for patients who wish to avoid surgery or maintain their fertility; however, the effects of conservative medical therapy are not always durable. If nonsurgical medical therapies fail, are contraindicated, or cause intolerable side effects, correction of menorrhagia may require a hysterectomy or endometrial ablation. Although hysterectomy cures menorrhagia, its invasive nature, potential morbidity and mortality, and long recovery period have prompted the development of minimally invasive treatments for menorrhagia.

Endometrial ablation (ELA) involves removal or destruction of the inner lining of the uterus with electrosurgery, cryoprobes, heated fluid, or laser light. During ELA, thermal energy generated by neodymium-ytrrium-aluminum-garnet (Nd:YAG) laser light destroys the endometrium after it has been made thin by medication, curettage, or during the early proliferative stage of the menstrual cycle. The goal of this procedure is to induce thermal destruction of the endometrium and thereby reduce or eliminate menstrual blood loss.

POLICY
Endometrial ablation does not require prior authorization when criteria below is met.

Photodynamic endometrial ablation is non-covered.

HMO, PPO, Individual Marketplace, Elite, Advantage
Endometrial ablation is considered medically necessary for women who meet ALL of the following selection criteria:

1. Menorrhagia or excessive anovulatory bleeding (N92.0 - N92.6, D25.0, D25.1, D25.2, D25.9, N93.8, N93.9) unresponsive to (or with a contraindication to) either:
   - Dilation and curettage
   - Hormonal therapy or other pharmacotherapy

   (Note: The degree of severity and persistence of the menorrhagia and the failure of prior treatment should be such that the member would otherwise be a candidate for a hysterectomy; these alternative less invasive approaches should have been attempted in the past year)

2. Endometrial sampling or D&C (58100-58146, 58558) has been performed within the year prior to the procedure to exclude cancer, pre-cancer or hyperplasia, and the results of the histopathological report have been reviewed before the ablation procedure is scheduled (should be done in the past year)

3. Pap smear and gynecologic examination have excluded significant cervical disease. (Note: The Pap smear should be up to date so not necessarily within the past year)

4. Uterus size is less than 12 weeks’ gestation (i.e., uterine length is less than 13 centimeters [cm] and anterior-posterior width is less than 7 cm)

5. The woman is premenopausal and has no desire for future childbearing

Radiofrequency endometrial ablation (58353, 58563) is considered experimental and investigational when performed at the same time as hysteroscopic sterilization (58565), as ablation has been shown to decrease the success rate of sterilization.
Endometrial ablation is considered experimental and investigational for all other indications because its effectiveness for other indications has not been established.

The following are endometrial ablation approaches to be established for treatment of women who meet the selection criteria set forth above:

- Chemical ablation with trichloroacetic acid
- Cryoablation (freezing) (Her Option Cryoablation Therapy)
- Electrosurgical ablation (e.g., electric rollerball, resecting loop with electric current, triangular mesh with electrical current)
- Laser
- Microwave endometrial ablation (Microsulis Microwave Endometrial Ablation (MEA) System)
- Radiofrequency ablation (The NovaSure Procedure)
- Thermoablation (e.g., heated saline (Genesys HydroThermAblator), thermal fluid-filled balloon (GynecareThermachoice)).

Photodynamic endometrial ablation is considered experimental and investigational because there is insufficient scientific evidence to support its effectiveness.

**CODING/BILLING INFORMATION**
The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

<table>
<thead>
<tr>
<th>CPT CODES</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>58100-58146</td>
<td>Corpus uteri excision</td>
</tr>
<tr>
<td>58353</td>
<td>Endometrial ablation, thermal, without hysteroscopic guidance</td>
</tr>
<tr>
<td>58356</td>
<td>Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed</td>
</tr>
<tr>
<td>58558</td>
<td>Hysteroscopy, surgical; with sampling(biopsy) of endometrium and/or polypectomy, with or without D&amp;C</td>
</tr>
<tr>
<td>58563</td>
<td>Hysteroscopy, surgical; with endometrial ablation (e.g., endometrial resection, electrosurgical ablation, thermoablation)</td>
</tr>
<tr>
<td>58565</td>
<td>Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>ICD-10-CM CODES</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N92.0 - N92.6</td>
<td>Excessive, frequent and irregular menstruation</td>
</tr>
<tr>
<td>D25.0</td>
<td>Submucous leiomyoma of uterus</td>
</tr>
<tr>
<td>D25.1</td>
<td>Intramural leiomyoma of uterus</td>
</tr>
<tr>
<td>D25.2</td>
<td>Subserosal leiomyoma of uterus</td>
</tr>
<tr>
<td>D25.9</td>
<td>Leiomyoma of uterus, unspecified</td>
</tr>
<tr>
<td>N93.8</td>
<td>Other specified abnormal uterine and vaginal bleeding</td>
</tr>
<tr>
<td>N93.9</td>
<td>Abnormal uterine and vaginal bleeding, unspecified</td>
</tr>
</tbody>
</table>

**REVISION HISTORY EXPLANATION**
03/14/17: Policy created to reflect most current clinical evidence per Medical Policy Steering Committee.

**REFERENCES/RESOURCES**
Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
Ohio Department of Medicaid http://jfs.ohio.gov/
Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
Industry Standard Review
Hayes, Inc.