GUIDELINES
This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder terms, conditions, exclusions and limitations contract. It does not constitute a contract or guarantee regarding coverage or reimbursement/payment. Self-Insured group specific policy will supersede this general policy when group supplementary plan document or individual plan decision directs otherwise.
Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards.
This medical policy is solely for guiding medical necessity and explaining correct procedure reporting used to assist in making coverage decisions and administering benefits.

SCOPE
X Professional
_ Facility

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.

There are various first and second generations of Endometrial Ablation techniques that all result in destruction of the endometrial lining. Ablation examples include, Endometrial Laser Ablation (ELA), Resectoscopic, Cryotherapy, Heated Free Fluid, Microwave, Radiofrequency Electricity, and Thermal Balloon. Physician preference and patient history and exam, influence the provider to decide which method is best for the patient. The goal of these procedures is to induce destruction of the endometrium and thereby reduce or eliminate menstrual blood loss.

POLICY

<table>
<thead>
<tr>
<th>HMO, PPO, Individual Marketplace, Advantage, Elite/ProMedica Medicare Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Procedure 58563 – Hysteroscopy, surgical; with endometrial ablation (e.g., endometrial resection, electrosurgical ablation, thermoablation), does require prior authorization.</td>
</tr>
<tr>
<td>- Procedures 58353 - Endometrial ablation, thermal, without hysteroscopic guidance and 58356 - Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed, do not require a prior authorization when the coverage criteria documented below is met supporting one of the following diagnosis – D25.0, D25.1, D25.2, D25.9, F64.1-F64.9, N92.0, N92.1, N92.2, N92.3, N92.4, N92.5, N92.6, N93.8, N93.9</td>
</tr>
</tbody>
</table>

Photodynamic endometrial ablation is non-covered for all product lines.
COVERAGE CRITERIA
HMO, PPO, Individual Marketplace, Elite/ProMedica Medicare Plan, Advantage
Endometrial ablation is considered medically necessary for women who meet ALL of the following selection criteria:

1. Abnormal menorrhagia or excessive anovulatory bleeding resulting in anemia or interferes with ADLs

2. Abnormal menorrhagia or excessive anovulatory bleeding unresponsive to (or with a contraindication to) one of the following:
   - Dilation and curettage
   - Hormonal therapy or other pharmacotherapy
   - Tranexamic acid x 3 consecutive cycles.

   (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)

3. 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)

4. 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)
   a. Most recent cervical cytology normal OR treated per guidelines
   b. Thyroid disease excluded by history or physical examination or testing

5. Vagina and cervix normal by physical examinations.
   a. 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 or as described by the particular manufacturer’s specifications.)

6. Sonohysterogram or ultrasound within last year negative for endometrial lesion.

7. One of the following:
   a. Human chorionic gonadotropin (HCG) negative or HCG planned prior to procedure
   b. Sterilization by history
   c. Patient not sexually active by history

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 (ELA)
- 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.

Paramount utilizes InterQual® criteria sets for medical necessity determinations.

CODING/BILLING INFORMATION
The inclusion or exclusion of a code in this section does not necessarily indicate coverage. Codes referenced in this clinical policy are for informational purposes only. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

**CPT CODES**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<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>58563</td>
<td>Hysteroscopy, surgical; with endometrial ablation (e.g., endometrial resection, electrosurgical ablation, thermoablation)</td>
</tr>
</tbody>
</table>

**ICD-10-CM CODES**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<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>F64.1- F64.9</td>
<td>Gender identity disorders [to stop residual menstrual bleeding after androgen treatment]</td>
</tr>
<tr>
<td>N92.0</td>
<td>Excessive and frequent menstruation with regular cycle</td>
</tr>
<tr>
<td>N92.1</td>
<td>Excessive and frequent menstruation with irregular cycle</td>
</tr>
<tr>
<td>N92.2</td>
<td>Excessive menstruation at puberty</td>
</tr>
<tr>
<td>N92.3</td>
<td>Ovulation bleeding</td>
</tr>
<tr>
<td>N92.4</td>
<td>Excessive bleeding in the premenopausal period</td>
</tr>
<tr>
<td>N92.5</td>
<td>Other specified irregular menstruation</td>
</tr>
<tr>
<td>N92.6</td>
<td>Irregular menstruation, 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>

Paramount reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to [https://www.paramounthealthcare.com/services/providers/medical-policies/](https://www.paramounthealthcare.com/services/providers/medical-policies/).

**REVISION HISTORY EXPLANATION**
**ORIGINAL EFFECTIVE DATE: 03/14/2017**

<table>
<thead>
<tr>
<th>Date</th>
<th>Explanation &amp; Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/14/17</td>
<td>• Policy created to reflect most current clinical evidence per Medical Policy Steering Committee</td>
</tr>
<tr>
<td>10/01/19</td>
<td>• Policy updated to establish prior authorization criteria for procedure 58563</td>
</tr>
<tr>
<td>12/01/19</td>
<td>• Medical Policy revised to include the Elite Product requiring a prior authorization as of 1/1/2020</td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>09/10/20</td>
<td>Corrected a mistype. In the green box above, under the Elite Product line, documentation</td>
</tr>
<tr>
<td></td>
<td>corrected “Procedures 58563 58353 and 58356 do not require a prior authorization when</td>
</tr>
<tr>
<td></td>
<td>the coverage criteria documented below is met.”</td>
</tr>
<tr>
<td>12/28/2020</td>
<td>Medical policy placed on the new Paramount Medical policy format</td>
</tr>
<tr>
<td>03/17/2021</td>
<td>- Policy updated to clarify coverage criteria to include listed diagnosis</td>
</tr>
<tr>
<td></td>
<td>- Removed procedures 58100-58146, 58558, and 58565 as they are not addressed within</td>
</tr>
<tr>
<td></td>
<td>the medical policy coverage</td>
</tr>
<tr>
<td></td>
<td>- Added diagnosis D25.0, D25.1, D25.2, D25.9, N92.2, N92.3, N93.8, N93.9 for medical</td>
</tr>
<tr>
<td></td>
<td>necessity coverage of procedures 58353 and 58356.</td>
</tr>
</tbody>
</table>

**REFERENCES/RESOURCES**

- Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
- Ohio Department of Medicaid
- Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
- Hayes, Inc.
- Industry Standard Review