MEDICAL MUTUAL®

Medical Policy

Policy:	**200302**	**Initial Effective Date:**	**01/15/2003**
SUBJECT:	**Endometrial Ablation**	**Annual Review Date:**	**01/06/2023**
		Last Revised Date:	**01/06/2023**

Some or all procedure codes listed in this Corporate Medical Policy may be considered experimental/investigational.

Definition: : Endometrial ablation is a surgical procedure utilized for the treatment of menorrhagia (prolonged, excessive uterine bleeding or heavy menstrual bleeding) that is refractory to conventional medical therapy, such as hormonal therapy and/or dilation and curettage. The procedure involves removal or destruction of uterine endometrial lining by electrosurgery, cryoablation, radiofrequency ablation, microwave ablation, or thermal ablation, aiming to reduce or eliminate menstrual blood loss. Endometrial ablation may be performed as an alternative to hysterectomy when other medical causes for menorrhagia, such as cancer or fibroids, have been excluded.

Medical Necessity: The Company considers endometrial ablation **(CPT Codes 58353, 58356, 58563, ICD-10 Procedure Codes 0U5B0ZZ, 0U5B3ZZ, 0U5B4ZZ, 0U5B7ZZ, 0U5B8ZZ, 0UDB7ZZ and 0UDB8ZZ) medically necessary** and eligible for reimbursement providing that ***all*** of the following medical criteria are met:

- Premenopausal; and
- No longer desires fertility; and
- History of excessive uterine bleeding determined by ***at least one*** of the following:
    - Profuse bleeding or repetitive periods; or
    - Anemia due to uterine blood loss; and
- Physical examination and either sonohysterogram or hysteroscopy within the past 12 months that fails to identify cervical or other uterine pathology that would explain abnormal uterine bleeding; and
- Endometrial sampling biopsy within the past 12 months that excludes cancer, pre-cancer or structural abnormalities (e.g., polyps, fibroids) that would require surgery; and
- Uterine cavity length ≤12 cm; and
- Other conditions that may be associated with excessive bleeding (e.g., coagulopathy, hypothyroidism, hyperthyroidism, medication) have been excluded; and
- Failure of, intolerance to or unable to receive >3 months hormonal therapy; and
- Performed by one of the following techniques:
    - Thermal balloon endometrial ablation; or
    - Hydrothermal endometrial ablation; or
    - Radiofrequency endometrial ablation; or

- Cryoablation; or
- Electrosurgical ablation (e.g., electric rollerball, resecting loop with electric current); or
- Microwave endometrial ablation;

AND

At least one of the following clinical conditions is present:

- Excessive and frequent menstruation with regular cycle
- Excessive and frequent menstruation with irregular cycle
- Hematocolpos
- Other specified irregular menstruation
- Other specified abnormal uterine and vaginal bleeding
- Irregular menstruation, unspecified
- Abnormal uterine and vaginal bleeding, unspecified
- Excessive bleeding in the premenopausal period

NOTE: Endometrial ablation is considered **medically necessary** for residual menstrual bleeding after androgen treatment.

*Current certificate books exclude coverage for surgical and non-surgical management of gender dysphoria. To verify coverage, refer to member mailings and updated certificate books as they become available.

Endometrial ablation is considered investigational and **not** eligible for reimbursement for **any** indication other than those listed above.

Photodynamic endometrial ablation: Based upon our findings, the Company has determined photodynamic endometrial ablation has not demonstrated equivalence or superiority to currently accepted standard means of treatment. The Company considers photodynamic endometrial ablation **(CPT Code 58999[†]) investigational** and **not** eligible for reimbursement.

[†]When *unlisted procedure, female genital system nonobstetrical* (58999) is determined to be photodynamic endometrial ablation

Benefits for investigational services are subject to each specific benefit plan.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member, and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may

include patient records, test results, and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply, and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

NOTE: After reviewing the relevant documentation, the Company reserves the right to apply this policy to the service, or procedure, supply, product, or accommodation performed or furnished regardless of how the service, or procedure, supply, product, or accommodation was coded by the Provider.

Approval or clearance by the U.S. Food and Drug Administration alone is not a basis for coverage.

Coverage may differ for Medicare Advantage plan members; please see any applicable national and/or local coverage determinations for details. This information may be available at the Centers for Medicare & Medicaid Services (CMS) website.

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Sources of Information:

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- Practice Committee of American Society for Reproductive Medicine. Indications and options for endometrial ablation. *Fertil Steril*. 2008;90(5 Suppl):S236-S240.
- Sharp HT. (2019, October 17). An overview of endometrial ablation. In: UpToDate, Falcone T (Ed), UpToDate, Waltham, MA.

Applicable Code(s):	
CPT:	**58353, 58356, 58563, 58999**
HCPCS:	**N/A**
ICD10 Procedure Codes:	**0U5B0ZZ, 0U5B3ZZ, 0U5B4ZZ, 0U5B7ZZ, 0U5B8ZZ, 0UDB7ZZ, 0UDB8ZZ**