MASSACHUSETTS

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Medical Policy

Endometrial Ablation

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Policy Number: 331

BCBSA Reference Number: 4.01.04

Related Policies

- None

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO Blue[SM] and Medicare PPO Blue[SM] Members

Endometrial ablation, with or without hysteroscopic guidance, using an FDA-approved device may be considered **MEDICALLY NECESSARY** in women with menorrhagia who are not candidates for, or who are unresponsive to, hormone therapy and would otherwise be considered candidates for hysterectomy.

Endometrial ablation is **INVESTIGATIONAL** for all other indications.

Intrauterine ablation or resection of the endometrium should not be confused with laparoscopic laser ablation of intraperitoneal endometriosis. This policy does not address laparoscopic intraperitoneal ablation.

Contraindications for intrauterine ablation or resection of the endometrium include:

- Patient who is pregnant or desires pregnancy
- History of endometrial cancer or precancerous histology
- Patient with an active genital or urinary tract infection at the time of the procedure
- Patient with active pelvic inflammatory disease
- Patient with an intrauterine device currently in place
- Patient with any anatomic or pathologic condition in which weakness of the myometrium could exist, such as history of previous classical cesarean sections or transmural myomectomy.

Other contraindications for microwave ablation include myometrial thickness less than 10 mm, and uterine sounding length less than 6 cm.

In February 2013, FDA downgraded its contraindication of NovaSure for women with Essure® contraceptive micro-inserts to a warning. The warning states that a health hazard may exist when a

NovaSure procedure is performed in women with improperly positioned Essure® microinserts. To verify proper placement, a report of the Essure Confirmation Test should be obtained prior to performing the NovaSure procedure. The labeling change also includes the requirement for a postapproval study. (1)

Prior Authorization Information

Pre-service approval is required for all inpatient services for all products.
See below for situations where prior authorization may be required or may not be required.
Yes indicates that prior authorization is required.
No indicates that prior authorization is not required.

	Outpatient
Commercial Managed Care (HMO and POS)	No
Commercial PPO and Indemnity	No
Medicare HMO Blue℠	No
Medicare PPO Blue℠	No

CPT Codes / HCPCS Codes / ICD-9 Codes

The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

CPT Codes

CPT codes:	Code Description
58353	Endometrial ablation, without hysteroscopic guidance
58356	Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed
58563	Hysteroscopy, surgical, with endometrial ablation (e.g., endometrial resection, electrosurgical ablation, thermoablation)

ICD-9 Procedure Codes

ICD-9 procedure codes	Code Description
68.23	Endometrial ablation

ICD-9-CM Diagnosis Codes

ICD-9-CM diagnosis codes	Code Description
626.2	Excessive or frequent menstruation (menorrhagia)
627.0	Premenopausal menorrhagia

Description

Endometrial ablation is a potential alternative to hysterectomy for menorrhagia. A variety of approaches are available; these are generally classified into hysteroscopic techniques (eg, Nd-YAG laser, electrosurgical rollerball) and nonhysteroscopic techniques (eg, cryosurgical, radiofrequency [RF] ablation).

Background
Ablation or destruction of the endometrium is used to treat menorrhagia in women who failed standard therapy. It is considered a less invasive alternative to hysterectomy; however, as with hysterectomy, the procedure is not recommended for women who wish to preserve their fertility.

Multiple energy sources have been used. These include: Nd-YAG laser, a resecting loop using electric current, electric rollerball, and thermal ablation devices. Endometrial ablation is typically preceded by hormonal treatment to thin the endometrium.

Techniques for endometrial ablation are generally divided into 2 categories: those that do and do not require hysteroscopic procedures. (Other terminology for these categories of techniques include first-generation versus second-generation procedures and resectoscopic versus nonresectoscopic endometrial ablation methods). Hysteroscopic techniques were developed first; the initial technique was photovaporization of the endometrium using an Nd-YAG laser, and this was followed by electrosurgical ablation using an electrical rollerball or electrical wire loop. (The latter technique is also known as transcervical resection of the endometrium). Hydrothermal ablation also involves hysteroscopy. Hysteroscopic techniques require skilled surgeons and, due to the requirement for cervical dilation, use of general or regional anesthesia. In addition, the need for the instillation of hypotonic distension media creates a risk of pulmonary edema and hyponatremia such that very accurate monitoring of fluids is required.

Nonhysteroscopic techniques can be performed without general anesthesia and do not involve use of a fluid distention medium. Techniques include thermal fluid-filled balloon, cryosurgical endometrial ablation, instillation of heated saline, and RF ablation.

There are concerns about maternal and fetal morbidity and mortality associated with pregnancy after endometrial ablation. Thus, U.S. Food and Drug Administration (FDA) approval of endometrial ablation devices includes only women for whom childbearing is complete.

Summary
There is evidence from multiple randomized controlled trials that endometrial ablation improves the net health outcome in women who have failed prior treatment for menorrhagia and are otherwise eligible for hysterectomy. Moreover, meta-analyses of randomized controlled trials suggest similar benefits with first-generation (hysteroscopic) techniques and second-generation (mainly nonhysteroscopic) techniques. There is a lack of consistent evidence that any 1 ablation technique is superior to another. Thus, endometrial ablation using a Food and Drug Administration–approved device may be considered medically necessary in women with menorrhagia who have failed hormonal treatment and would be considered candidates for hysterectomy.

Policy History
Date	Action
10/2014	Policy statements aligned with BCBSA National medical policy.
10/2013	Policy statements clarified. Effective 10/8/2013.
3/2012	Added ICD-9 procedure code 68.23, endometrial ablation. Effective 3/2012.
9/2011	Reviewed - Medical Policy Group - Urology, Obstetrics and Gynecology, no changes in coverage.
12/2010	o Removed coverage statements and coding information for robotic-assisted myomectomy o Removed endometrial ablation coverage statement as follows: endometrial sampling prior to the ablation has excluded cancer, pre-cancer, or structural abnormalities that require surgery o Added endometrial ablation coverage statement: women who otherwise are considered a candidate for hysterectomy o Removed endometrial ablation coverage exclusion: enlarged uterus (greater than 10 cm or equivalent to 12 weeks gestation)

	o Excluded coverage of endometrial ablation when the patient has one of the following situations (a.-g.): a. an active genital or urinary tract infection at the time of the procedure, b. active pelvic inflammatory disease, c. an intrauterine device currently in place, d. any anatomic or pathologic condition in which weakness of the myometrium could exist, such as history of previous classical cesarean section or transmural myomectomy, e. Essure contraceptive micro-inserts in place, f. myometrial thickness less than 10mm and g. uterine sounding length less than 6 cm. All updates effective 12/1/10.
10/2010	Reviewed - Medical Policy Group - Obstetrics and Gynecology no changes in coverage.
7/2010	Language related to occlusion of uterine arteries using transcatheter embolization and laparoscopic occlusion to treat uterine arteries transferred to Medical Policy # 242, Occlusion of Uterine Arteries Using Transcatheter Embolization.
7/2010	Language related to laparoscopic and percutaneous techniques for the myolysis of uterine fibroids transferred to Medical Policy #244, Laparoscopic and Percutaneous Techniques for the Myolysis of Uterine Fibroids.
7/2010	Language related to MRI-guided focused ultrasound for the treatment of uterine fibroids and other tumors transferred to Medical Policy #243, MRI-Guided Focused Ultrasound - MRgFUS.
6/2010	Clarified coverage criteria for endometrial ablation.
10/2009	Reviewed - Medical Policy Group - Obstetrics and Gynecology, no changes in coverage.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:
Medical Policy Terms of Use
Managed Care Guidelines
Indemnity/PPO Guidelines
Clinical Exception Process
Medical Technology Assessment Guidelines

References

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