BLUE CROSS OF NORTHEASTERN PA "BCNEPA" MEDICAL POLICY BULLETIN	**MANUAL:** MEDICAL POLICY
	REFERENCE NO.: MPO-490-0077
EFFECTIVE DATE April 1, 2014	**SUBJECT:** Endometrial Ablation

Blue Cross of Northeastern Pennsylvania ("BCNEPA") Medical Policy

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical policy and claims payment policy are applied. Policies are provided for informational purposes only and are developed to assist in administering plan benefits and do not constitute medical advice. Treating providers are solely responsible for medical advice and treatment. Policies are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and information are constantly changing and BCNEPA may review and revise its medical policies periodically. Also, due to the rapid pace of changing technology and the advent of new medical procedures, BCNEPA may not have a policy to address every procedure. In those cases, BCNEPA may review other sources of information including, but not limited to, current medical literature and other medical resources, such as Technology Evaluation Center Assessments (TEC) published by the Blue Cross Blue Shield Association. BCNEPA may also consult with health care providers possessing particular expertise in the services at issue.

I. DESCRIPTION:

Endometrial ablation is the ablation or destruction of the endometrium. It is used to treat menorrhagia in women who failed hormone therapy or dilation and curettage. The procedure uses either a hysterscope or resectoscope to view the endometrium during treatment. Multiple energy sources have been used: (1) the neodymium-yttrium aluminum garnet (Nd-YAG) laser; (2) a resecting loop using electric current; (3) electric roller ball; and (4) thermal ablation devices, including high-frequency radio frequency (RF) probes, cryoprobes, liquid filled balloons, multi-electrode balloons, and microwave energy.

II. BENEFIT POLICY STATEMENT:

BCNEPA makes decisions on coverage based on Policy Bulletins, benefit plan documents, and the member's medical history and condition. Benefits may vary based on product line, group or contract, therefore, Member benefits must be verified. In the event of a conflict between the Member's benefit plan document and topics addressed in Medical Policy Bulletins (i.e., specific contract exclusions), the Member's benefit plan document always supersedes the information in the Medical Policy Bulletins. BCNEPA determines medical necessity only if the benefit exists and no contract exclusions are applicable.

Benefits are determined by the terms of the Member's specific benefit plan document [i.e., the Fully Insured policy, the Administrative Services Only (ASO) agreement applicable to the Self-Funded Plan Participant, or the Individual Policy] that is in effect at the time services are rendered.

III. MEDICAL POLICY STATEMENT:

Coverage is subject to the terms, conditions, and limitations of the member's contract.

A. BCNEPA will provide coverage for intrauterine ablation or resection of the endometrium when medically necessary.

1. Intrauterine ablation or resection of the endometrium may be considered medically necessary after other pathologic etiologies for menorrhagia have been ruled out, for the following indications, such as, but not limited to:

a) For women with menorrhagia that is unresponsive to medical management, hormonal therapy and/or dilation and curettage; and

b) When the menorrhagia is of a degree of severity and persistence that the failure of prior treatment will be such that the Member would otherwise be a candidate for hysterectomy.

B. BCNEPA will provide coverage of endometrial ablation using an FDA approved device, such as, but not limited to laser therapy, resecting loop roller ball using electric current, or thermal ablation using a liquid-filled balloon, microwave, electrode array or a cryosurgical device.

C. BCNEPA will not provide coverage for intrauterine ablation or resection of the endometrium for all other indications as this is considered investigational.

D. Contraindications for intrauterine ablation or resection of the endometrium include, but are not limited to:

1. Unexplained vaginal uterine bleeding;

2. Members who would like to maintain fertility;

3. Past history of endometrial cancer or pre-cancerous histology;

4. Active genital or urinary tract infection;

5. Intrauterine Device (IUD) in place;

6. Presence of an enlarged uterus (e.g., greater than 10 cm in length or comparable to 14 weeks gestation or more);

7. Uterine prolapse of marked degree;

8. Women who are less than 35 years of age without Medical Director approval; and

9. 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.

IV. DEFINITIONS:

N/A

-PLEASE SEE CODING ON NEXT PAGE-

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BCNEPA CODING

Covered procedure codes are dependent upon meeting criteria of the policy and appropriate diagnosis code.
Benefits are determined by the Member's fully insured policy or the administrative services only agreement applicable to the Self-Funded plan Participant that is in effect at the time services are rendered.

PROCEDURE CODES

58353 58356 58563

ICD-9 DIAGNOSIS CODES

626.2 627.0

ICD-9 PROCEDURE CODES

68.23

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ICD-10 DIAGNOSIS CODES
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N92.0 N92.4

ICD-10 PROCEDURE CODES
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0U5B0ZZ 0U5B3ZZ 0U5B4ZZ 0U5B7ZZ 0U5B8ZZ

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