Medical Policy
Endometrial Ablation

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Policy Number: 331
BCBSA Reference Number: 4.01.04
NCD/LCD: N/A

Related Policies
Occlusion of Uterine Arteries Using Transcatheter Embolization, #242

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

Endometrial ablation, with or without hysteroscopic guidance, using an FDA-approved device may be considered MEDICALLY NECESSARY in women with abnormal uterine bleeding 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.
Prior Authorization Information

Inpatient
- For services described in this policy, precertification/preauthorization is required for all products if the procedure is performed inpatient.

Outpatient
- For services described in this policy, see below for products where prior authorization might be required if the procedure is performed outpatient.

<table>
<thead>
<tr>
<th>Product</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
<td>Prior authorization is not required.</td>
</tr>
<tr>
<td>Commercial PPO and Indemnity</td>
<td>Prior authorization is not required.</td>
</tr>
<tr>
<td>Medicare HMO BlueSM</td>
<td>Prior authorization is not required.</td>
</tr>
<tr>
<td>Medicare PPO BlueSM</td>
<td>Prior authorization is not required.</td>
</tr>
</tbody>
</table>

CPT Codes / HCPCS Codes / ICD Codes

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.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria must be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

CPT Codes

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>58353</td>
<td>Endometrial ablation, 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>

Description

ABNORMAL UTERINE BLEEDING
A number of conditions cause abnormal uterine bleeding, including fibroids, polyps, and endometrial hyperplasia. Prevalence estimates for abnormal uterine bleeding range between 10% and 30%, varying by population and condition definition.

Treatment
Ablation or destruction of the endometrium is used to treat abnormal uterine bleeding in women who have failed standard therapy. It is considered a less invasive alternative than hysterectomy; however, as with hysterectomy, the procedure is not recommended for women who want to preserve 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 radiofrequency ablation.

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

Summary

For individuals who have abnormal uterine bleeding and have failed hormonal therapy who receive endometrial ablation, the evidence includes randomized controlled trials (RCTs) and systematic reviews. Relevant outcomes are symptoms, quality of life, resource utilization, and treatment-related morbidity. RCTs and systematic reviews of RCT data have found that hysterectomy resulted in greater symptom relief and fewer reoperations than endometrial ablation, but endometrial ablation resulted in a reasonable level of symptom control and the procedure has some advantages over hysterectomy (e.g., women retain their uterus and avoid a more invasive procedure). A meta-analysis of RCTs suggested similar benefits with first-generation (hysteroscopic) techniques and second-generation (mainly nonhysteroscopic) techniques. The evidence is sufficient to determine qualitatively that the technology results in a meaningful improvement in the net health outcome.

Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/2016</td>
<td>BCBSA National medical policy review. Terminology in first policy statement updated to abnormal uterine bleeding from menorrhagia; intent of policy statement unchanged. 10/1/2016</td>
</tr>
<tr>
<td>8/2015</td>
<td>New references added from BCBSA National medical policy.</td>
</tr>
<tr>
<td>8/2015</td>
<td>Clarified coding information.</td>
</tr>
<tr>
<td>10/2014</td>
<td>Policy statements aligned with BCBSA National medical policy.</td>
</tr>
<tr>
<td>12/2010</td>
<td>o Removed coverage statements and coding information for robotic-assisted myomectomy</td>
</tr>
<tr>
<td></td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>o Added endometrial ablation coverage statement: women who otherwise are considered a candidate for hysterectomy</td>
</tr>
<tr>
<td></td>
<td>o Removed endometrial ablation coverage exclusion: enlarged uterus (greater than 10 cm or equivalent to 12 weeks gestation)</td>
</tr>
</tbody>
</table>
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 microinserts in place, f. myometrial thickness less than 10mm and g. uterine sounding length less than 6 cm. All updates effective 12/1/10.


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.


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


9. Sambrook A, Elders A, Cooper K. Microwave endometrial ablation versus thermal balloon endometrial ablation (MEATBall): 5-year follow up of a randomised controlled trial. BJOG. May 2014;121(6):747-753. PMID 24506529


