

# Clinical Policy: Endometrial Ablation

Reference Number: CP.MP.106

Last Review Date: 07/18

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## Description

This policy describes the medical necessity guidelines for an endometrial ablation. Endometrial ablation is a minimally invasive surgical procedure used to treat premenopausal abnormal uterine bleeding. Although this procedure preserves the uterus, endometrial ablation is indicated for those who have no desire for future fertility. The two major classifications of endometrial ablation procedures are first generation resectoscopic techniques and second generation non-resectoscopic methods. Quality of life may improve following endometrial ablation procedures.

## Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation® that endometrial ablation using an FDA approved device is **medically necessary** when all the following criteria are met:
  - A. One of the following indications:
    1. Menorrhagia unresponsive to at least 3 months of hormonal or medical therapy (unless contraindicated to such therapy); or
    2. To stop residual menstrual bleeding after at least 6 months of androgen therapy in a female to male transgender person who meets the gender dysphoria and eligibility criteria in CP.MP.95 Gender Reassignment Surgery policy;
  - B. Cervical cytology and gynecological exam excludes significant cervical disease;
  - C. Endometrial sampling prior to the procedure has excluded malignancy or hyperplasia;
  - D. No structural anomalies, such as fibroids or polyps that require surgery or represent a contraindication to an ablation procedure, or previous transmyometrial uterine surgery (including classical cesarean);
  - E. If anatomic or pathologic conditions exist that may result in a weakened myometrium, only a resectoscopic endometrial ablation is appropriate;
  - F. Does not have any of the following contraindications:
    1. Premenopausal with future desire for fertility;
    2. Untreated disorders of hemostasis;
    3. Pregnancy at time of procedure;
    4. Intrauterine device at time of procedure;
    5. Active pelvic infection.
- II. It is the policy of health plans affiliated with Centene Corporation that endometrial ablation is **experimental/investigational** as follows:
  - A. Photodynamic endometrial ablation procedures;
  - B. For the treatment of all other conditions than those specified above.

## Background

Menstrual disorders are among the most prevalent gynecological health problems in the United States, and abnormal menstrual bleeding affects up to 30% of people at some time during their

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reproductive years.<sup>5</sup> Endometrial ablation is a minimally invasive surgical procedure used to treat premenopausal, abnormal uterine bleeding.

Endometrial ablation can also be used to treat residual menstrual bleeding in transgender men. Generally, masculinizing hormones cause cessation of menses within 2 – 6 months of initiation. Addition of a progestational agent or endometrial ablation may be considered for those wishing to completely cease menses.

Endometrial ablation encompasses several techniques of targeted destruction of the endothelial surface of the uterine cavity through a vast array of energy sources. While hysterectomies provide permanent relief from abnormal uterine bleeding, they are also associated with longer recovery times, higher rates of postoperative complications, substantial convalescent time and morbidity.<sup>9,10</sup> Although endometrial ablation has a high success rate, there are specific cases of endometrial ablation failures in which the patient will return for repeat care, often for a hysterectomy.<sup>10</sup> Among patients who return for hysterectomy after failure of endometrial ablation, endometriosis is the most common contributing diagnosis.<sup>21</sup>

Pregnancy following endometrial ablation can occur, and premenopausal patients should be counseled that an appropriate contraception method should be used.<sup>1</sup> However endometrial ablation is predominately indicated for patients who have no desire for future fertility.<sup>1</sup> Post-operative complications from endometrial ablation include: (1) pregnancy after endometrial ablation; (2) pain-related to obstructed menses (hematomata, post ablation tubal sterilization syndrome); (3) failure to control menses; (4) risk from preexisting conditions (endometrial neoplasia, cesarean section; and (5) infection.<sup>14</sup>

**Table 1: FDA-Approved Techniques Approved For Endometrial Ablation**

Procedure <sup>1,2,3</sup>	System <sup>1,2</sup>	Device Size <sup>1</sup> (mm)	Treatment Time <sup>1</sup> (min)	Amenorrhea Rate <sup>2</sup>
<b>Resectoscopic Ablation</b>				
Laser Vaporization				37%
Electrosurgical Rollerball				25-60%
Transcervical resection of endometrium				26-40%
Radiofrequency Vaporization				N/A
<b>Non-Resectoscopic Ablation</b>				
Cryotherapy	Her Option	4.5	10–18	53%
Heated Free Fluid	Hydro ThermAblator	7.8	~ 14 *	71%
Microwave		8.5	2.5–4.5	61%
Radiofrequency Electricity	NovaSure	7.2	1.5	41%

\* 3 minutes to heat the fluid to 90°C, 10 minutes to maintain that temperature to ablate the endometrium, and approximately 1 minute for the fluid to cool down allowing the device to be removed.

**Coding Implications**

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included for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
58353	Endometrial ablation, thermal, without hysteroscopic guidance
58356	Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed
58563	Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)

**ICD-10-CM Diagnosis Codes that Support Coverage Criteria**

ICD-10-CM Code	Description
N92.0	Excessive and frequent menstruation with regular cycle
N92.1	Excessive and frequent menstruation with irregular cycle
N92.4	Excessive bleeding in the premenopausal period

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed, reviewed by specialist	12/15	01/16
Language clarifications d/t confusion in criteria, no specific criteria change: I.C clarified that structural anomalies be limited to those requiring surgery or are otherwise a contraindication to EA I.E language clarified I.F removed anatomic or pathologic conditions affecting the myometrium as this is similar to I.C. I.F.2 added “untreated” for disorders of hemostasis	06/16	
Changed active pelvic inflammatory disease to active pelvic infection Removed postmenopausal women from contraindications as this is a relative, not absolute, contraindication.	08/16	9/16
Added indication for residual menstrual bleeding in female to male transgender persons after androgen therapy, no codes added as ICD-10 codes would still be applicable for new indication.	09/16	10/16
References reviewed and updated	08/17	09/17
Added “previous transmyometrial uterine surgery” in I.D. References reviewed and updated.	06/18	07/18

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**Important reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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