Sentara Health Plans

Medicaid

# Endometrial Ablation, Surgical 15

**Table of Content**



| | |
|---|---|
| Effective Date | 2/1992 |
| Next Review Date | 2/2026 |
| Coverage Policy | Surgical 15 |
| Version | 7 |

**All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.**

## Description & Definitions:

Endometrial Ablation is the surgical destruction of the innermost uterine lining called the endometrium using electrical, thermal or laser energy.

**Other common names:** hydrothermal endometrial ablation (HTEA), Thermal balloon endometrial ablation (TBEA), Microwave Endometrial Ablation (MEA), cryoablation, electrosurgical ablation, laser, ThermaChoice, Hydro ThermAblator, Uterine Cryoblation Therapy, Sonata Sonography-Guided, Endometrial Ablation (ELA), Photodynamic endometrial ablation

## Criteria:

**Endometrial ablation** is considered medically necessary with **1 or more** of the following:

- Individual with indications of **ALL** of the following:
  - Endometrial Ablation Procedure of **1 or more** of the following:
    - Chemical ablation with trichloroacetic acid
    - Cryoablation (freezing)
    - Electrosurgical ablation/electrocautery ablation (e.g., electric rollerball, resecting loop with electric current, triangular mesh with electrical current)
    - Laser
    - Microwave endometrial ablation ((MEA)
    - Radiofrequency ablation (The NovaSure Procedure, and the Minerva Endometrial Ablation System)
    - Thermoablation/hydrothermal ablation/balloon therapy ablation, thermal fluid-filled balloon
  - Diagnosis of **1 or more** of the following:
    - Heavy menstrual bleeding (HMB)
    - Chronic menorrhagia
    - Recurrent abnormal uterine bleeding

    - Menorrhagia unresponsive to/or with contraindication to **1 or more** of the following:
        - Failure of hormonal treatment
        - Intolerance to hormonal treatment
        - Contraindication to hormonal treatment
        - Refusal to take hormonal treatment
    - Endometrial sampling or D&C has been performed within the year prior to the procedure or is being planned at the time of procedure
    - Pap smear and gynecologic examination prior to the procedure have excluded significant cervical disease and infection
    - Individual no longer desires future fertility
- For individual with residual menstrual bleeding after androgen treatment in an individual with confirmed gender dysphoria and/or undergoing female to male hormonalgender reassignment therapy

**Endometrial ablation** procedure is considered **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- Photodynamic endometrial ablation.

## Document History:

Revised Dates:

- 2024: February
- 2023: February
- 2022: August
- 2021: February
- 2020: March
- 2019: November
- 2015: July, August
- 2013: August
- 2012: August
- 2008: August
- 2003: January
- 2001: July
- 1998: December
- 1994: February

Reviewed Dates:

- 2025: February
- 2022: February
- 2018: April, November
- 2017: January
- 2016: June
- 2014: August
- 2011: August
- 2010: August
- 2009: August
- 2007: August, September
- 2005: February, November
- 2004: April, July
- 2003: October, November
- 2002: October
- 2000: July, December
- 1999: July, December
- 1996: August

Effective Date:

- February 1992

## Coding:

Medically necessary with criteria:

| Coding | 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). |

Considered Not Medically Necessary:

| Coding | Description |
|---|---|
| 58579 | Unlisted hysteroscopy procedure, uterus |
| 58999 | Unlisted procedure, female genital system (nonobstetrical) |

U.S. Food and Drug Administration (FDA) - approved only products only.

*The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device-code(s) does not constitute or imply member coverage or provider reimbursement.*

## Special Notes: *

- Coverage
  - See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products
  - Policy is applicable to Sentara Health Plan Virginia Medicaid products.
- Authorization requirements
  - Pre-certification by the Plan is required.
- Special Notes:
  - Medicaid
    - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
    - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.

## References:


Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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## Keywords:

Endometrial Ablation, SHP Surgical 15, uterine bleeding, Menorrhagia, Hormonal therapy, Dilation and curettage, D&C, Pap smear, gynecologic examination, cervical disease, endometrial resection, electrosurgical ablation, thermoablation, hydrothermal endometrial ablation (HTEA), Thermal balloon endometrial ablation (TBEA), Microwave Endometrial Ablation (MEA), cryoablation, electrosurgical ablation, laser