Sentara® Health Plans

Commercial

Endometrial Ablation

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Effective Date	2/1992
Next Review Date	2/2025
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Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details *.

Purpose:

This policy addresses surgical necessity of Endometrial ablation.

Description & Definitions:

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

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 hormonal gender 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.
- Endometrial ablation for any other indication.

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.

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:

- 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

References:

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

(2024). Retrieved Jan 2024, from CMS: https://www.cms.gov/medicare-coverage-database/search-results.aspx?keyword=endometrial&keywordType=starts&areaId=all&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all

(2024). Retrieved Jan 2024, from MCG 27th Edition: https://careweb.careguidelines.com/ed27/index.html

(2024). Retrieved Jan 2024, from DMAS Provider Manual: https://vamedicaid.dmas.virginia.gov/pdf_chapter/practitioner#gsc.tab=0

(2024). Retrieved Jan 2024, from Hayes: https://evidence.hayesinc.com/search?q=%257B%2522text%2522:%2522Endometrial%2520ablation%2522,%2522title%2522:null,%2522termsource%2522:%2522searchbar%2522,%2522page%2522:%257B%2522page%2522:0,%2522size%2522:50%257D,%2522type%2522:%2522all%2522,%2522sourc

Endometrial Ablation. (2021). Retrieved Jan 2024, from National Institute for Clinical Excellence (NICE): https://www.nice.org.uk/search?q=endometrial%20ablation

Endometrial Ablation Guidelines. (2024). Retrieved Jan 2024, from American Society for Reproductive Medicine (ASRM): https://www.reproductivefacts.org/news-and-publications/fact-sheets-and-infographics/endometrial-ablation/?_t_id=F5YQrH9_208ajG2FY_60_A==&_t_uuid=yt30yxN8SSeSm1d04STLOg&_t_q=Endometrial%20Ablation&_t_tags=siteid:01216f06-3dc9-4ac9-96da-555740dd020c,langua

Management of Abnormal Uterine Bleeding Associated With Ovulatory Dysfunction. (2013). Retrieved Jan 2024, from American College of Obstetricians and Gynecologists (ACOG): https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2013/07/management-of-abnormal-uterine-bleeding-associated-with-ovulatory-dysfunction

Special Notes: *

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.

Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We

sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

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