

Endometrial Ablation, Surgical 15

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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 ^{*}.

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, ThermoChoice, Hydro ThermoAblator, Uterine Cryoablation 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:
 - o 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
 - o Diagnosis of **1 or more** of the following:
 - Heavy menstrual bleeding (HMB)
 - Chronic menorrhagia
 - Recurrent abnormal uterine bleeding
 - o 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.

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. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

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 Commercial products.
- Authorization requirements
 - Pre-certification by the Plan is required.
- Special Notes:
 - Commercial
 - 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.

References:

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

28th Edition. (2025). Retrieved 1 2025, from MCG: <https://careweb.careguidelines.com/ed28/index.html>

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Management of Acute Abnormal Uterine Bleeding in Nonpregnant Reproductive-Aged Women. (2024). Retrieved 1 2025, from American College of Obstetricians and Gynecologists (ACOG): <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/04/management-of-acute-abnormal-uterine-bleeding-in-nonpregnant-reproductive-aged-women>

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