Clinical Policy: Endometrial Ablation

Reference Number: CP.MP.106 Revision Log
Last Review Date: 07/19 Coding Implications

See Important Reminder at the end of this policy for important regulatory and legal information.

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);
  2. Abnormal uterine bleeding, including residual menstrual bleeding after at least 6 months of androgen therapy in a female to male transgender person;
- **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

reproductive years.[5] 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 associated with longer recovery times, higher rates of postoperative complications, substantial convalescent time and morbidity.[9,10] 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.[10] Among patients who return for hysterectomy after failure of endometrial ablation, endometriosis is the most common contributing diagnosis.[21]

Pregnancy following endometrial ablation can occur, and premenopausal patients should be counseled that an appropriate contraception method should be used.[1] Endometrial ablation is predominately indicated for patients who have no desire for future fertility.[1] Post-operative complications from endometrial ablation include: (1) pregnancy after endometrial ablation; (2) pain-related to obstructed menses (hematometra, post ablation tubal sterilization syndrome); (3) failure to control menses; (4) risk from preexisting conditions (endometrial neoplasia, cesarean section; and (5) infection.[14] Uterine perforation has been reported in 0.3 percent of non-resectoscopic endometrial ablation procedures and 1.3 percent of resectoscopic ablations or resections.[22]

Table 1: FDA-Approved Techniques Approved For Endometrial Ablation

Procedure[1,2,3]	System[1,2,13]	Device Size[1] (mm)	Treatment Time[1,13] (min)	Amenorrhea Rate[2]
Resectoscopic Ablation				
Laser Vaporization				37%
Electrosurgical Rollerball				25-60%
Transcervical resection of endometrium				26-40%
Radiofrequency Vaporization				N/A
Non-Resectoscopic Ablation				
Cryotherapy	Her Option	4.5	10–18	53%
Heated Free Fluid	Hydro ThermAblator	7.8	~ 14 *	71%
Microwave (no longer available in U.S.)		8.5	2.5–4.5	61%
Vapor ablation	Mara		2.0	
Radiofrequency Electricity	NovaSure	7.2	1.5	41%
Combined thermal and bipolar radiofrequency ablation device	Minerva		2.0	

* 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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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
N92.5	Other specified irregular menstruation
N92.6	Irregular menstruation, unspecified
N93.8	Other specified abnormal uterine and vaginal bleeding
N93.9	Abnormal uterine and vaginal bleeding, unspecified

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

Reviews, Revisions, and Approvals	Date	Approval Date
Added "previous transmyometrial uterine surgery" in I.D. References reviewed and updated.	06/18	07/18
Added additional FDA approved devices (i.e., Mara, Minerva) to table 1. References reviewed and updated. Specialist review.	06/19	07/19
Added "abnormal uterine bleeding" as an indication and combined this with the residual menstrual bleeding after androgen therapy in a female to male transgender person indication. Removed reference to criteria in CP.MP.95 Gender Affirming Procedures. Added the following codes as medically necessary: N92.5, N92.6, N93.8, N93.9.	10/19	11/19

References

1. Munro, M. G. " ACOG Practice Bulletin: endometrial ablation." Obstet Gynecol 109 (2007): 1233. Reaffirmed 2018.
2. Apgar BS, Kaufman AH, George-Nwogu U, Kittendorf A. et al. Treatment of menorrhagia. Am Fam Physician 2007 Jun 15;75(12): 1813-9
3. Sharp HT. Endometrial ablation or resection: Resectoscopic techniques. In: UpToDate, Falcone T (Ed), UpToDate, Waltham, MA. Accessed May31, 2019.
4. American College of Obstetricians and Gynecologists. ACOG committee opinion no. 557: Management of acute abnormal uterine bleeding in nonpregnant reproductive-aged women. Obstet Gynecol. 2013 Apr;121(4):891-6. Reaffirmed 2017
5. Matteson KA, Boardman LA, Munro MG, Clark MA et al. Abnormal uterine bleeding: a review of patient-based outcome measures. Fertil Steril. 2009 Jul;92(1):205-16..
6. Frick KD, Clark MA, Steinwachs DM, et al. Financial and quality-of-life burden of dysfunctional uterine bleeding among women agreeing to obtain surgical treatment. Women's Health Issues 2009 Jan-Feb;19(1):70-8 .
7. American College of Obstetricians and Gynecologists. Committee on Practice Bulletins—Obstetrics. ACOG Practice Bulletin No. 128. Diagnosis of Abnormal Uterine Bleeding: in Reproductive-Aged Women. Clinical Management Guidelines. Obstetrics and Gynecology 120 (2012): 197. Reaffirmed 2016
8. Munro MG, Critchley HO, Broder MS, et al. FIGO classification system (PALM-COEIN) for causes of abnormal uterine bleeding in non-gravid women of reproductive age. Int J Gynaecol Obstet. 2011 Apr;113(1):3-13
9. Sowter MC .New surgical treatments for menorrhagia. Lancet 2003 Apr 26;361(9367):1456-8
10. Fergusson RJ, Lethaby A, Shepperd S, Farquhar C. Endometrial resection and ablation versus hysterectomy for heavy menstrual bleeding. Cochrane Database Syst Rev. 2013 Nov 29;(11):CD000329
11. Laberge P, Leyland N, Murji A,et al. Endometrial ablation in the management of abnormal uterine bleeding. J Obstet Gynaecol Can. 2015 Apr;37(4):362-79.
12. Lethaby A, Penninx J, Hickey M, et al. Endometrial resection and ablation techniques for heavy menstrual bleeding. Cochrane Database Syst Rev. 2013 Aug 30;(8):CD001501..
13. Sharp, H.T. Endometrial ablation: Non-resectoscopic techniques. In: UpToDate, Falcone T (Ed), UpToDate, Waltham, MA. Accessed May 31, 2019.

14. Sharp HT. Endometrial ablation: postoperative complications. Am J Obstet Gynecol. 2012 Oct;207(4):242-7
15. El-Nashar SA, Hopkins MR, Creedon DJ et al. Prediction of treatment outcomes after global endometrial ablation. Obstet Gynecol. 2009 Jan;113(1):97-106
16. Normedi Nordic. Discontinuation of Gynecare Thermachoice. Normedi Nordics. March 1, 2016. Accessed October 3, 2016.
17. Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA et al. Endocrine Treatment of Transsexual Person: An Endocrine Society Clinical Practice Guideline. Endocr Pract. 2017 Dec;23(12):1437. doi: 10.4158/1934-2403-23.12.1437.
18. The World Professional Association for Transgender Health Inc (WPATH). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th version. https://www.wpath.org/publications/soc
19. Kalampokas E, McRobbie S, Payne F, Parkin DE**.** Long-term incidence of hysterectomy following endometrial resection or endometrial ablation for heavy menstrual bleeding. Int J Gynaecol Obstet. 2017 Jul 11.
20. Al-Shaikh G, Almalki G, Bukhari M, et al.Effectiveness and outcomes of thermablate endometrial ablation system in women with heavy menstrual bleeding. Obstet Gynaecol. 2017 Aug;37(6):770-774
21. Riley KA, Davies MF, Harkins GJ. Characteristics of patients undergoing hysterectomy for failed endometrial ablation. JSLS. 2013 Oct-Dec;17(4):503-7.
22. Sharp HT. An overview of Endometrial Ablation. In: UpToDate. Falcone T (Ed). UpToDate, Waltham, MA. Accessed May 31, 2019.
23. Bofill Rodriguez M, Lethaby A, Grigore M, et al.Endometrial resection and ablation techniques for heavy menstrual bleeding. Cochrane Database Syst Rev. 2019 Jan 22;1:CD001501. doi: 10.1002/14651858.CD001501.pub5.

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.