Clinical Policy: Endometrial Ablation
Reference Number: CP.MP.106
Last Review Date: 07/19

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. 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. 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. Among patients who return for hysterectomy after failure of endometrial ablation, endometriosis is the most common contributing diagnosis.

Pregnancy following endometrial ablation can occur, and premenopausal patients should be counseled that an appropriate contraception method should be used. Endometrial ablation is predominately indicated for patients who have no desire for future fertility. 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. Uterine perforation has been reported in 0.3 percent of non-resectoscopic endometrial ablation procedures and 1.3 percent of resectoscopic ablations or resections.

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

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

*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
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019 American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are 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.

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>58353</td>
<td>Endometrial ablation, thermal, without hysteroscopic guidance</td>
</tr>
<tr>
<td>58356</td>
<td>Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed</td>
</tr>
<tr>
<td>58563</td>
<td>Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)</td>
</tr>
</tbody>
</table>

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N92.0</td>
<td>Excessive and frequent menstruation with regular cycle</td>
</tr>
<tr>
<td>N92.1</td>
<td>Excessive and frequent menstruation with irregular cycle</td>
</tr>
<tr>
<td>N92.4</td>
<td>Excessive bleeding in the premenopausal period</td>
</tr>
<tr>
<td>N92.5</td>
<td>Other specified irregular menstruation</td>
</tr>
<tr>
<td>N92.6</td>
<td>Irregular menstruation, unspecified</td>
</tr>
<tr>
<td>N93.8</td>
<td>Other specified abnormal uterine and vaginal bleeding</td>
</tr>
<tr>
<td>N93.9</td>
<td>Abnormal uterine and vaginal bleeding, unspecified</td>
</tr>
</tbody>
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Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Date</th>
<th>Approval Date</th>
</tr>
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<tbody>
<tr>
<td>12/15</td>
<td>01/16</td>
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</tbody>
</table>

- Policy developed, reviewed by specialist
- 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
- Changed active pelvic inflammatory disease to active pelvic infection
- Removed postmenopausal women from contraindications as this is a relative, not absolute, contraindication.
- 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.
- References reviewed and updated
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Reviews, Revisions, and Approvals

| 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

**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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.
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This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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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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