Clinical Policy: Endometrial Ablation

Reference Number: WNC.CP.120 Coding Implications
Last Review Date: 04/22 Revision Log

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

Note: 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.

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 nonresectoscopic methods. Quality of life may improve following endometrial ablation procedures.

Policy/Criteria

I. It is the policy of WellCare of North Carolina® that Endometrial Ablation 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 or HPV testing 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 WellCare of North Carolina® that there is insufficient scientific evidence to support effectiveness for the following:

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 nonresectoscopic 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%
Thermal Balloon	ThermaChoice	5.5	8.0	
Combined thermal and bipolar radiofrequency ablation device	Minerva		2.0	

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. Codes referenced in this clinical policy are 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.

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)

HCPCS ®* Codes	Description
No applicable codes.	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

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
Original approval date	02/21	05/21
Added “HPV testing” to Section I.B. Updated investigational verbiage in Section II. Revised Table 1 to add ThermaChoice. References reviewed and updated.	04/22	

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North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise); or
   2. the NC Health Choice (NCHC is NC Health Choice program, unless context clearly indicates otherwise) Program on the date of service and shall meet the criteria in this policy.

b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.

c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.

2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

EPSDT does not apply to NCHC beneficiaries.

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the, NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer

to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan
   For NCHC refer to NCHC State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan
g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

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.

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

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This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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