Application Statement

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

Disclaimer

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member’s particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member’s benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any. All links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change prior to the annual review date. Lines of business (LOB) are subject to change without notice; current LOBs can be found at www.wellcare.com. All guidelines can be found at this site as well but selecting the Provider tab, then “Tools” and “Clinical Guidelines”.

Background

Sterilization is a popular, permanent method of birth control for women. In tubal sterilization, the fallopian tubes are cut and tied with special thread, closed shut with bands or clips, sealed with an electric current, or blocked with scar tissue formed by small implants. Tubal sterilization prevents the sperm from reaching the egg. Tubal sterilization can be performed with a minilaparotomy, with laparoscopy, or with hysteroscopy.

Sterilization by laparoscopy has a low risk of complications. The most common complications are those related to general anesthesia. There is a risk of injury to the bowel, bladder, or a major blood vessel. If an electric current is used to seal the fallopian tubes, there is a risk of burn injury to the skin or bowel. Other risks include bleeding from the incisions made in the skin and infection.
Postpartum sterilization (or tubal ligation) is performed following the birth of a baby. For women who have had a vaginal delivery, a small incision is made in the abdomen (minilaparotomy). For women who have had a cesarean delivery, postpartum tubal ligation can be done through the same abdominal incision that was made for delivery.²

Pregnancy is rare after sterilization. If pregnancy does occur, the risk of an ectopic pregnancy is higher than in women who did not have sterilization.¹ The American College of Obstetricians and Gynecologists (ACOG) affirmed their position for the use of hysterosalpingography (HSG) after tubal sterilization, emphasizing approval by the United States Food and Drug Administration of two devices for hysteroscopic tubal sterilization. ACOG emphasizes the necessity of performing HSG 3 months after hysteroscopic tubal sterilization to identify factors that may interfere with performance of an adequate HSG assessment.³

In addition to the items noted above, ACOG also supports salpingectomy for ovarian cancer prevention. Committee Opinion No. 620 underscores the high mortality rate of ovarian cancer (the fifth leading cause of cancer deaths in women) and the lack of effective diagnostics for the disease. Researchers theorize that retrograde menses may cause endometriosis and clear cell carcinomas of the ovary, hence the potentially protective effects of salpingectomy. The authors of the Committee Opinion note the safety of salpingectomy, the lack of impact of the procedure on ovarian function, and the value of discussing bilateral salpingectomy as a method of contraception.⁵

**POSITION STATEMENT**

**Applicable To:**
- ☑ Medicare
- ☑ Medicaid

**Exclusions**

Hysteroscopic tubal sterilization is contraindicated in any woman who:
- Cannot have occlusive device placed OR,
- Has previously undergone a tubal ligation; OR,
- Is uncertain about her desire to end fertility; OR,
- Has an active or recent upper or lower pelvic infection; OR,
- Delivery or termination of a pregnancy less than 6 weeks before occlusion device placement; OR,
- Known allergy to contrast media; OR,
- Pregnancy or suspected pregnancy; OR,
- ESSURE micro-insert is contraindicated in women who have just given birth either by vaginal delivery or cesarean section.

**Coverage**

1. Tubal sterilization (e.g., laparoscopic or open sterilization procedure) is **considered medically necessary** for women who:
   A. Desire permanent birth control by bilateral occlusion or removal of the fallopian tubes or ovaries; OR,
   B. Sterilization is a necessary part of the treatment of an illness or injury (court ordered sterilization; an illness or injury where getting pregnant may put member’s life at risk) or the member’s life is at risk.⁴

   NOTE: The following procedures **are considered medically necessary** for tubal ligation sterilization: Essure micro-insert, Falope ring, Filshie clip, Hulka-Clemens clip, Pomeroy technique (tubal ligation), salpingectomy

2. Hysterosalpingogram (HSG) is **considered medically necessary**:
   A. Three months after surgery to verify insert placement and tubal occlusion. (ESSURE micro-insert procedure only)
Covered CPT® Codes

58565  Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants (Code covers both the procedure and the implants.)

58600  Ligation or transection of fallopian tube (s), abdominal or vaginal approach, unilateral or bilateral

58605  Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)

58611  Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)

58615  Oclusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach

58670  Laparoscopy, surgical; with fulguration of oviducts (with or without transection)

58671  Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, or Falope ring)

58700  Removal of fallopian tube

58661  Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)

HCPCS®* Codes- No applicable codes.

Covered ICD-10-CM Diagnosis Codes

Z30.2  Encounter for sterilization

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES


MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

<table>
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<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>4/6/2017</td>
<td>• Approved by MPC. Changes made to include laparoscopic and open procedures.</td>
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<tr>
<td>12/3/2015</td>
<td>• Approved by MPC. Updated codes.</td>
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<tr>
<td>7/9/2015</td>
<td>• Approved by MPC. No changes.</td>
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<td>9/7/2014</td>
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