Clinical Policy: Endometrial Ablation

Reference Number: CP.MP.106
Date of Last Revision: 09/22

Revision Log
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 preserve the uterus, endometrial ablation is indicated for those who have no desire for future fertility.[12] 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 member/enrollee with a female reproductive system undergoing treatment for gender affirmation;
- **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 transmural surgery or represent a contraindication to an ablation procedure;
- **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;
  6. Previous classical cesarean or other transmural surgery.

II. It is the policy of health plans affiliated with Centene Corporation that there is insufficient scientific evidence to support effectiveness for the following:

- **A.** Photodynamic endometrial ablation procedures;
- **B.** Endometrial ablation 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] Traditionally, medication therapy has been the initial treatment of choice, followed by hysterectomy, when medication does not provide the desired outcome. The levonorgestrel (LNG)-releasing intrauterine device (e.g., Mirena or Liletta; referred to as LNG 52) is an option in patients who do not desire pregnancy. Both the LNG 52 IUD and endometrial ablation are effective in reducing menstrual blood loss. The decision to use the LNG 52 or endometrial ablation depends on a patient's preferences regarding treatment factors, such as plans for fertility and contraception, convenience, and risks of anesthesia.[22,25] Endometrial ablation can offer an alternative to the more invasive hysterectomy treatment option.[10] 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.[24] Generally, masculinizing hormones cause cessation of menses within 2 – 6 months of initiation.[18] The addition of a progestational agent or endometrial ablation may be considered for those wishing to completely cease menses.[18]

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	Treatment
Resectoscopic Ablation			
Laser Vaporization			37%
Electrosurgical Rollerball			25-60%
Transcervical resection of endometrium			26-40%
Radiofrequency Vaporization			N/A
Non-Resectoscopic Ablation			

Procedure[1,2,3]	System[1,2,13]	Device	Treatment	Amenorrhea
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	

* 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 2020 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.

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	Revision Date	Approval Date
Policy developed, reviewed by specialist	12/15	01/16

Reviews, Revisions, and Approvals	Revision Date	Approval Date
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
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 reviewed and updated.	07/20	07/20
Annual review completed. References reviewed and updated and reformatted for AMA style. Changed "members" to "members/enrollees." Removed "experimental and investigation" from II, changing to "insufficient evidence." Changed "review date" in the header to "date of last revision" and "date" in the revision log header to "revision date." Specialty review completed. Added ThermaChoice to Table 1 per UpToDate reference "3".	07/21	07/21
Annual review completed. Added "or HPV testing" to I.B. References reviewed and updated. Background updated with no impact to criteria.	03/22	03/22
Changed criteria I.D. from "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)" to "no structural anomalies, such as fibroids or polyps that require transmural surgery or represent a contraindication to an ablation procedure." Added contraindication criteria I.F.6. "Previous classical cesarean or other transmural surgery."	04/22	04/22
In I.A.2, reworded portion pertaining to abnormal bleeding in transgender members from "female to male transgender person" to	09/22	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
"member/enrollee with a female reproductive system undergoing treatment for gender affirmation."		

References

1. Munro, MG. *ACOG Practice Bulletin: Endometrial Ablation Number 81*. American College of Obstetricians and Gynecologists. Published May 2007 (reaffirmed 2019). www.acog.org. Accessed February 1, 2022.
2. Apgar BS, Kaufman AH, George-Nwogu U, Kittendorf A. Treatment of menorrhagia. *Am Fam Physician.* 2007;75(12):1813-1819.
3. Sharp HT. Endometrial ablation or resection: resectoscopic techniques. UpToDate. www.uptodate.com. Updated June 23, 2021. Accessed February 1, 2022.
4. American College of Obstetricians and Gynecologists. ACOG Committee Opinion No. 557: Management of Acute Abnormal Uterine Bleeding in Nonpregnant Reproductive-Aged Women. https://www.acog.org. Published April 2013 (reaffirmed 2020). Accessed February 1, 2022.
5. Matteson KA, Boardman LA, Munro MG, Clark MA. Abnormal uterine bleeding: a review of patient-based outcome measures. *Fertil Steril*. 2009;92(1):205-216. doi:10.1016/j.fertnstert.2008.04.023
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. *Womens Health Issues*. 2009;19(1):70-78. doi:10.1016/j.whi.2008.07.002
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. www.acog.org. Published July 2012 (reaffirmed 2021). Accessed February 1, 2022.
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;361(9367):1456-1458. doi:10.1016/S0140-6736(03)13140-6
10. Bofill Rodriguez M, Lethaby A, Fergusson RJ. Endometrial resection and ablation versus hysterectomy for heavy menstrual bleeding. *Cochrane Database Syst Rev*. 2021;2(2):CD000329. Published February 23, 2021. doi:10.1002/14651858.CD000329.pub4
11. Laberge P, Leyland N, Murji A, et al. Endometrial ablation in the management of abnormal uterine bleeding. *J Obstet Gynaecol Can*. 2015;37(4):362-379. doi:10.1016/s1701-2163(15)30288-7
12. Bofill Rodriguez M, Lethaby A, Grigore M, Brown J, Hickey M, Farquhar C. Endometrial resection and ablation techniques for heavy menstrual bleeding. *Cochrane Database Syst Rev*. 2019;1(1):CD001501. Published 2019 Jan 22. doi:10.1002/14651858.CD001501.pub5
13. Sharp HT. Endometrial ablation: non-resectoscopic techniques. UpToDate. www.uptodate.com. Updated September 28, 2021. Accessed February 1, 2022.
14. Sharp HT. Endometrial ablation: postoperative complications. *Am J Obstet Gynecol*. 2012;207(4):242-247. doi:10.1016/j.ajog.2012.04.011

15. El-Nashar SA, Hopkins MR, Creedon DJ, St Sauver JL, Weaver AL, McGree ME, Cliby WA, Famuyide AO. Prediction of treatment outcomes after global endometrial ablation. Obstet Gynecol. 2009 Jan;113(1):97-106. doi: 10.1097/AOG.0b013e31818f5a8d. Erratum in: Obstet Gynecol. 2010 Mar;115(3):663. PMID: 19104365; PMCID: PMC2977517.
16. Food and Drug Administration. Class 2 Device Recall Gynecare Thermachoice III. www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfRes/res.cfm?ID=142341 Accessed February 1, 2022.
17. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline [published correction appears in J Clin Endocrinol Metab. 2018 Feb 1;103(2):699] [published correction appears in J Clin Endocrinol Metab. 2018 Jul 1;103(7):2758-2759]. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903. doi:10.1210/jc.2017-01658
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. www.wpath.org/publications/soc. Accessed February 1, 2022.
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;139(1):61-64. doi:10.1002/ijgo.12259.
20. Al-Shaikh G, Almalki G, Bukhari M, Fayed A, Al-Mandeel H. Effectiveness and outcomes of thermablate endometrial ablation system in women with heavy menstrual bleeding. *J Obstet Gynaecol*. 2017;37(6):770-774. doi:10.1080/01443615.2017.1292228.
21. Riley KA, Davies MF, Harkins GJ. Characteristics of patients undergoing hysterectomy for failed endometrial ablation. *JSLS*. 2013;17(4):503-507. doi:10.4293/108680813X13693422520602.
22. Sharp HT. An overview of Endometrial Ablation. UpToDate. www.uptodate.com. Updated January 12, 2022. Accessed February 1, 2022.
23. National Institute for Clinical Excellence (NICE). Photodynamic endometrial ablation. Interventional Procedure Guidance 47. London, UK: NICE; 2004.
24. Obedin-Maliver J. Pelvic pain and persistent menses in transgender men. UCSF Transgender Care. https://transcare.ucsf.edu/guidelines/pain-transmen. Published June 17, 2016. Accessed February 11, 2022.
25. Kaunitz AM. Abnormal uterine bleeding: Management in premenopausal patients. UpToDate. www.uptodate.com. Published June 10, 2021. Accessed March 29, 2022.

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 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.

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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, 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/enrollees, 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.