Geisinger

Geisinger Health Plan Policies and Procedure Manual

Policy: MP210

Section: Medical Benefit Policy

Subject: Endometrial Ablation

Applicable Lines of Business

Commercial	**X**	**CHIP**	**X**
Medicare	**X**	**ACA**	**X**
Medicaid	**X**		

I. Policy: Endometrial Ablation

II. Purpose/Objective:

To provide a policy of coverage regarding Endometrial Ablation

III. Responsibility:

A. Medical Directors
B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

DESCRIPTION:
Endometrial ablation is the removal or destruction of the endometrium (lining of the uterus). Endometrial ablation is an alternative to hysterectomy for members with heavy uterine bleeding who wish to avoid hysterectomy.

INDICATIONS:
Endometrial ablation with or without hysteroscopic guidance may be considered medically necessary in members who meet the following criteria:

- Profuse menorrhagia such that the individual would be a candidate for hysterectomy, that is unresponsive to (or a contraindication/intolerance exists for) either:
    - Hormonal or other pharmacotherapy for a minimum of 3 months; or
    - Dilation and curettage
      and
- Precancerous lesions, cancerous lesions or structural abnormalities of the endometrium or cervix that require surgical treatment have been ruled out; and
- Gynecological exam and cervical cytology have excluded significant cervical disease; and
- Childbearing has been completed
- The endometrial ablation is accomplished using any of the following FDA approved technologies:
    - laser ablation using a neodymium-yttrium aluminum garnet (Nd-YAG) laser
    - electrosurgical ablation (rollerball)
    - transcervical resection of the endometrium
    - thermal ablation (cryoablation, thermal fluid-filled balloon, heated saline, radiofrequency, microwave)
- Endometrial ablation, using an FDA approved device, for treatment of residual menstrual bleeding after androgen therapy in a female to male gender reassignment.

EXCLUSIONS:
There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of photodynamic ablation of the endometrium when compared to established technologies. It is considered experimental, investigational or unproven and is **NOT COVERED**.

There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of chemoablation of the endometrium when compared to established technologies. It is considered experimental, investigational or unproven and is **NOT COVERED**.

Medicaid Business Segment:
Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

CODING ASSOCIATED WITH: Endometrial ablation
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements

HCPCS/CPT Coding
58353 Endometrial ablation, thermal, without hysteroscopic guidance
58356 Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed
58563 Hysteroscopy, surgical, with endometrial ablation (e.g. endometrial resection, electrosurgical ablation, thermoablation)
C1886 Catheter, extravascular tissue ablation, any modality (insertable)

LINE OF BUSINESS:
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

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This policy will be revised as necessary and reviewed no less than annually.

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