# Uterine Services and Procedures

**Policy Number**: MMP098.07
**Last Committee Approval Date**: July 10, 2024
**Effective Date**: September 1, 2024

➲ Instructions for Use

**Table of Contents** **Page**



| Related Policies |
| --- |
| None |

## Coverage Rationale

### Uterine Artery Embolization (UAE) for Treatment of Uterine Fibroids

Medicare has a general NCD for Therapeutic Embolization (20.28), but does not have a specific NCD for UAE for treatment of uterine fibroids. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

**For coverage guidelines,** in addition to the general Medicare guidelines in the NCD referenced above, refer to the UnitedHealthcare Commercial Medical Policy titled Abnormal Uterine Bleeding and Uterine Fibroids.

UnitedHealthcare uses the criteria in the Commercial Medical Policy referenced above to supplement the general Medicare criteria within the NCD for Therapeutic Embolization (20.28) regarding when uterine artery embolization (UAE) for treatment of uterine fibroids or severe dysfunctional uterine bleeding is reasonable and necessary. UnitedHealthcare uses the criteria noted above in order to ensure consistency in reviewing the conditions to be met for coverage of UAE, as well as reviewing when such services may be reasonable and necessary. Use of this criteria to supplement the general provisions noted above provides clinical benefits by helping ensure UAE is not incorrectly denied when medically appropriate for a particular patient nor incorrectly approved when not reasonable and necessary for a patient. The potential clinical harms of using these criteria may include inappropriately denying an UAE when it is otherwise indicated, which could lead to persistent anemia related to continued blood loss, abdominal pain and swelling, and possible bowel or bladder compression and dysfunction including incontinence or urine leakage. This may impact their functional independence, activities of daily living, and overall quality of life. The benefits to using these criteria include the criteria may decrease inappropriate denials by creating a consistent set of review criteria and will provide clinical benefits in helping ensure that the patient obtains an appropriate surgical procedure for the requested indication. Further, use of the criteria should limit the circumstances where UAE is incorrectly approved, which itself provides benefits because it prevents unnecessary development of adverse events (e.g., abnormal bleeding (hemorrhage), injury to the uterus, infection of the uterus, necrosis of infarcted tissue, including non- fibroid uterine tissue, or the puncture site in the groin, injury to the artery being used or nearby structure, and blood clots). Additionally, patients undergoing UAE may be at risk of developing post embolization syndrome. Symptoms include pelvic pain, cramping, vaginal discharge, nausea, vomiting, fatigue, and discomfort. Overall, based on the information above, the clinical benefits of using these criteria are highly likely to outweigh any clinical harms, including from delayed or decreased access to services.

### Magnetic Resonance Imaging (MRI) - Guided Focused Ultrasound Ablation

Medicare does not have National Coverage Determination (NCD) for magnetic resonance imaging (MRI) - guided cryoablation. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

**For coverage guidelines,** refer to the UnitedHealthcare Commercial Medical Policy titled Abnormal Uterine Bleeding and Uterine Fibroids.

## Hysterectomy

Medicare does not have National Coverage Determination (NCD) for hysterectomy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

**For coverage guidelines,** refer to the UnitedHealthcare Commercial Medical Policy titled Hysterectomy.

## Transvaginal Biomechanical Mapping

Medicare does not have National Coverage Determination (NCD) for transvaginal biomechanical mapping. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

**For coverage guidelines,** refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

# Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service; however, language may be included in the listing below to indicate if a code is non-covered. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

| CPT Code | Description |
|---|---|
| **UAE for Uterine Fibroids** | |
| 37243 | Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction |
| **MRI Guided Focused Ultrasound Ablation** | |
| 0071T | Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue |
| 0072T | Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue |
| **Hysterectomy** | |
| 58150 | Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); |
| 58152 | Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocystopexy (e.g., Marshall-Marchetti-Krantz, Burch) |
| 58180 | Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s) |
| 58260 | Vaginal hysterectomy, for uterus 250 g or less; |
| 58262 | Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s) |
| 58263 | Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele |
| 58267 | Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control |
| 58270 | Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele |
| 58290 | Vaginal hysterectomy, for uterus greater than 250 g; |
| 58291 | Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s) |
| 58292 | Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele |
| 58294 | Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele |
| 58541 | Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; |
| 58542 | Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s) |

| CPT Code | Description |
|---|---|
| **Hysterectomy** | |
| 58543 | Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; |
| 58544 | Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s) |
| 58550 | Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; |
| 58552 | Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s) |
| 58553 | Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; |
| 58554 | Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s) |
| 58570 | Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; |
| 58571 | Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s) |
| 58572 | Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; |
| 58573 | Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s) |
| **Transvaginal Biomechanical Mapping** | |
| 58999 | Unlisted procedure, female genital system (nonobstetrical) [when used to report Transvaginal biomechanical mapping] |



# Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the Medicare Coverage Database, if no NCD, LCD or LCA is found refer to the criteria as noted in the Coverage Rationale section above.

| Medicare Administrative Contractor (MAC) With Corresponding States/Territories | |
|---|---|
| **MAC Name (Abbreviation)** | **States/Territories** |
| CGS Administrators, LLC (CGS) | KY, OH |
| First Coast Service Options, Inc. (First Coast) | FL, PR, VI |
| National Government Services, Inc. (NGS) | CT, IL, ME, MA, MN, NH, NY, RI, VT, WI |
| Noridian Healthcare Solutions, LLC (Noridian) | AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY |
| Novitas Solutions, Inc. (Novitas) | AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, VA** |
| Palmetto GBA (Palmetto) | AL, GA, NC, SC, TN, VA**, WV |
| Wisconsin Physicians Service Insurance Corporation (WPS)* | IA, IN, KS, MI, MO, NE |
| **Notes** | |
| *Wisconsin Physicians Service Insurance Corporation: Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers.<br>**For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction. | |

# Policy History/Revision Information

| Date | Summary of Changes |
|---|---|
| 10/01/2024 | **Centers for Medicare & Medicaid (CMS) Related Documents**<br>• Added notation for the state of Virginia to indicate “Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction” |

| Date | Summary of Changes |
|---|---|
| 09/01/2024 | **Template Update**<br>• Reformatted and reorganized policy; transferred content to new template<br>• Changed policy type classification from “Coverage Summary” to “Medical Policy”<br>• Updated *Instructions for Use*<br>**Coverage Rationale**<br>• Removed content/language addressing:<br>  ○ Hysterectomy for purpose of sterilization<br>  ○ Use of intrauterine devices (IUD) for treatment of endometrial hyperplasia<br>• Removed language indicating:<br>  ○ Uterine services and procedures are covered when Medicare coverage criteria are met<br>  ○ The guidelines in this Medicare Advantage Coverage Summary are for specific procedures only; for procedures not addressed in this Medicare Advantage Coverage Summary, refer to the *Medicare Coverage Database* to search for applicable coverage policies [National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs)]<br>***Uterine Artery Embolization (UAE) for Treatment of Uterine Fibroids***<br>• Revised language to indicate:<br>  ○ Medicare has a general NCD for therapeutic embolization (NCD 20.28), but does not have a specific NCD for uterine artery embolization (UAE) for treatment of uterine fibroids; LCDs/LCAs do not exist<br>  ○ For coverage guidelines in addition to the general Medicare guidelines in the NCD referenced above, refer to the UnitedHealthcare Commercial Medical Policy titled *Abnormal Uterine Bleeding and Uterine Fibroids*<br>  ○ UnitedHealthcare uses the criteria in the Commercial Medical Policy referenced above to supplement the general Medicare criteria within the NCD for therapeutic embolization (NCD 20.28) regarding when uterine artery embolization (UAE) for treatment of uterine fibroids or severe dysfunctional uterine bleeding is reasonable and necessary<br>  ○ UnitedHealthcare uses the criteria noted above in order to ensure consistency in reviewing the conditions to be met for coverage of UAE, as well as reviewing when such services may be reasonable and necessary<br>  ▪ Use of this criteria to supplement the general provisions noted above provides clinical benefits by helping ensure UAE is not incorrectly denied when medically appropriate for a particular patient or incorrectly approved when not reasonable and necessary for a patient<br>  ▪ The potential clinical harms of using these criteria may include inappropriately denying an UAE when it is otherwise indicated, which could lead to persistent anemia related to continued blood loss, abdominal pain and swelling, and possible bowel or bladder compression and dysfunction including incontinence or urine leakage; this may impact their functional independence, activities of daily living, and overall quality of life<br>  ▪ The benefits to using these criteria include the criteria may decrease inappropriate denials by creating a consistent set of review criteria and will provide clinical benefits in helping ensure that the patient obtains an appropriate surgical procedure for the requested indication<br>  ▪ Further, use of the criteria should limit the circumstances where UAE is incorrectly approved, which itself provides benefits because it prevents unnecessary development of adverse events [e.g., abnormal bleeding (hemorrhage), injury to the uterus, infection of the uterus, necrosis of infarcted tissue including non-fibroid uterine tissue, or the puncture site in the groin, injury to the artery being used or nearby structure, and blood clots)]<br>  ▪ Additionally, patients undergoing UAE may be at risk of developing post embolization syndrome; symptoms include:<br>  – Pelvic pain<br>  – Cramping<br>  – Vaginal discharge<br>  – Nausea<br>  – Vomiting<br>  – Fatigue<br>  – Discomfort |

| Date | Summary of Changes |
|---|---|
| | ○ Overall, based on the information above, the clinical benefits of using these criteria are highly likely to outweigh any clinical harms, including from delayed or decreased access to services<br>***Magnetic Resonance Imaging (MRI)-Guided Focused Ultrasound Ablation***<br>• Removed reference link to the *Medicare Coverage Database*<br>***Hysterectomy***<br>• Removed reference link to the *Medicare Coverage Database*<br>**Applicable Codes**<br>• Updated list of applicable CPT/HCPCS codes (previously located in the *Coverage Guidelines* section):<br>○ Added 37243, 0071T, 0072T, 58150, 58152, 58180, 58260, 58262, 58263, 58267, 58270, 58290, 58291, 58292, 58294, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, and 58999<br>○ Removed 37244<br>**Centers for Medicare and Medicaid Services (CMS) Related Documents**<br>• Updated list of documents available in the *Medicare Coverage Database* to reflect the most current information<br>**Supporting Information**<br>• Archived previous policy version MCS098.06 |

# Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

- Medical necessity coverage guidelines; including documentation requirements, and/or
- Medicare coding or billing requirements.

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a

result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Providers are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate's requirements need to be followed.