MEDICAL POLICY

POLICY TITLE	ENDOMETRIAL ABLATION
POLICY NUMBER	MP 7.013

CLINICAL BENEFIT	☐ MINIMIZE SAFETY RISK OR CONCERN. ☐ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. ☒ ASSURE APPROPRIATE LEVEL OF CARE. ☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. ☐ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. ☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective Date:	**9/1/2024**

I. POLICY

Endometrial ablation, with or without hysteroscopic guidance, using an FDA-approved device may be considered **medically necessary** in premenopausal members (including transgender men and non-binary members) with abnormal uterine bleeding who are not candidates for, or who are unresponsive to, or decline hormone therapy and would otherwise be considered candidates for hysterectomy.

Contraindications for intrauterine ablation or resection of the endometrium include:

- Patient who is pregnant or desires pregnancy
- History of endometrial cancer or pre-cancerous histology
- Patient with an active genital or urinary tract infection at the time of the procedure
- Patient with active pelvic inflammatory disease
- Patient with an intrauterine device (IUD) currently in place
- Patient with any anatomic or pathologic condition in which weakness of the myometrium could exist, such as history of previous classical cesarean sections or transmural myomectomy
- Endometrial cavity size which exceeds size limitations defined for each device
- Structural uterine abnormality (e.g., congenital anomaly), that interferes with device access to the endometrium

Other contraindications for microwave ablation include myometrial thickness less than 10 mm, and uterine sounding length less than 6 cm.

Endometrial ablation is considered **not medically necessary** for other indications, including postmenopausal bleeding. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

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Policy Guidelines

Intrauterine ablation or resection of the endometrium should not be confused with laparoscopic laser ablation of intraperitoneal endometriosis. This policy does not address laparoscopic intraperitoneal ablation.

The American College of Obstetricians and Gynecologists states "The use of endometrial ablation in postmenopausal women or in women with disorders of hemostasis has not been rigorously studied" (2007).

Cross-reference:

MP 7.026 Noncontraceptive use of Intrauterine Devices (IUDs)
MP 7.027 Laparoscopic and Percutaneous Techniques for the Myolysis of Uterine Fibroids

II. PRODUCT VARIATIONS TOP

This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations as discussed in Section VI. Please see additional information below.

FEP PPO - Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at:
https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies

III. DESCRIPTION/BACKGROUND TOP

Endometrial ablation is a potential alternative to hysterectomy for abnormal uterine bleeding. A variety of approaches are available; these are generally classified into hysteroscopic techniques (e.g., Nd-YAG laser and electrosurgical rollerball) and non-hysteroscopic techniques (e.g., cryosurgical and radiofrequency [RF] ablation).

Ablation or destruction of the endometrium is used to treat abnormal uterine bleeding in women who have failed standard therapy. It is considered a less invasive alternative than hysterectomy; however, as with hysterectomy, the procedure is not recommended for women who want to preserve fertility.

Multiple energy sources have been used. These include Nd-YAG laser, a resecting loop using electric current, electric rollerball, and thermal ablation devices. Endometrial ablation is typically preceded by hormonal treatment to thin the endometrium.

Techniques for endometrial ablation are generally divided into 2 categories: those that do and do not require hysteroscopic procedures. (Other terminology for these categories of techniques include first-generation versus second-generation procedures and resectoscopic versus nonresectoscopic endometrial ablation methods.) Hysteroscopic techniques were developed first; the initial technique was photovaporization of the endometrium using an Nd-YAG laser,

and this was followed by electrosurgical ablation using an electrical rollerball or electrical wire loop. (The latter technique is also known as transcervical resection of the endometrium.) Hydrothermal ablation also involves hysteroscopy. Hysteroscopic techniques require skilled surgeons and, due to the requirement for cervical dilation, use of general or regional anesthesia. In addition, the need for the instillation of hypotonic distension media creates a risk of pulmonary edema and hyponatremia such that very accurate monitoring of fluids is required.

Nonhysteroscopic techniques can be performed without general anesthesia and do not involve use of a fluid distention medium. Techniques include thermal fluid-filled balloon, cryosurgical endometrial ablation, instillation of heated saline, and radiofrequency ablation.

There are concerns about maternal and fetal morbidity and mortality associated with pregnancy after endometrial ablation. Thus, Food and Drug Administration approval of endometrial ablation devices includes only women for whom childbearing is complete.

Regulatory Status

The FDA indicates that endometrial devices are for use in premenopausal women with menorrhagia due to benign causes for whom childbearing is complete. FDA-approved devices for endometrial ablation include, but may not be limited to, laser therapy, electrical wire loop, rollerball using electric current, and thermal ablation using a liquid-filled balloon, microwave, electrode array, or a cryosurgical device.

IV. RATIONALE

TOP

Summary of Evidence

For individuals who have abnormal uterine bleeding and have failed hormonal therapy who receive endometrial ablation, the evidence includes RCTs and systematic reviews. Relevant outcomes are symptoms, quality of life, resource utilization, and treatment-related morbidity. RCTs and systematic reviews of RCT data have found that hysterectomy provided greater symptom relief and fewer reoperations than endometrial ablation, but that endometrial ablation resulted in a reasonable level of symptom control and the procedure has some advantages over hysterectomy (e.g., women retain their uterus and avoid a more invasive procedure). A meta-analysis of RCTs has suggested similar benefits with first-generation (hysteroscopic) techniques and second-generation (mainly nonhysteroscopic) techniques. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

V. DEFINITIONS

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ADENOMYOSIS is the benign invasive growth of the endometrium into the muscular layer of the uterus.

DILATION AND CURETTAGE is a surgical procedure that expands the cervical canal of the uterus (dilation) so that the surface of the lining of the uterus can be scraped (curettage).

HYSTERECTOMY is the surgical removal of the uterus.

MYOMECTOMY is the removal of a portion of muscle or muscular tissue.

NULLIPARITY refers to the condition of not having given birth.

SUBMUCOSAL refers to the layer of connective tissue below the mucosa.

TRANSMURAL refers to a condition affecting the entire thickness of the wall of an organ or cavity.

VI. BENEFIT VARIATIONS

TOP

The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member's health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits, and which require preauthorization. There are different benefit plan designs in each product administered by Capital Blue Cross. Members and providers should consult the member's health benefit plan for information or contact Capital Blue Cross for benefit information.

VII. DISCLAIMER

TOP

Capital Blue Cross' medical policies are developed to assist in administering a member's benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital Blue Cross' Provider Services or Member Services. Capital Blue Cross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

TOP

Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Covered when medically necessary:

Procedure Codes								
58353	58356	58563	C1886					

ICD-10-CM Diagnosis 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

IX. REFERENCES

TOP

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X. POLICY HISTORY

TOP

MP 7.013	**02/18/2020 Consensus Review.** No changes to the policy statements. Coding and references reviewed.
	02/16/2021 Minor Review. Changed women to members and added "premenopausal". Added that members could decline hormone therapy. Under contraindications, added last two bullet points. Placed all contraindications that were listed in the policy guidelines into the actual policy statement. Included two cross-references. Added HCPCS code

	C1886 and deleted Dx codes N93.0 (stated abnormal uterine and vaginal bleeding, which is a duplicate of N93.9) & N95.0 (postmenopausal bleeding). References updated.
	03/23/2021: Minor Review. Per discussion in CAC, added postmenopausal members to investigational statement. Gave reasoning behind not covering postmenopausal members in Policy Guidelines section.
	02/28/2022: Minor Review. Added clarification for coverage of ablation for transgender men and non-binary members. Changed ablation for postmenopausal members from investigational to not medical necessary.
	06/29/2023 Consensus Review. No changes to the policy statements. Coding and references reviewed.
	01/19/2024 Administrative Update. Clinical benefit added.
	06/05/2024 Consensus Review. No changes to the policy statement. Updated background information. Reviewed and updated references.

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