Regence

Medical Policy Manual Surgery, Policy No. 218

Hysterectomy

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IMPORTANT REMINDER

Medical Policies are developed to provide guidance for members and providers regarding coverage in accordance with contract terms. Benefit determinations are based in all cases on the applicable contract language. To the extent there may be any conflict between the Medical Policy and contract language, the contract language takes precedence.

PLEASE NOTE: Contracts exclude from coverage, among other things, services or procedures that are considered investigational or cosmetic. Providers may bill members for services or procedures that are considered investigational or cosmetic. Providers are encouraged to inform members before rendering such services that the members are likely to be financially responsible for the cost of these services.

DESCRIPTION

Hysterectomy (surgical removal of the uterus) may be performed for a variety of indications, including abnormal uterine bleeding, fibroids, and pelvic pain.

MEDICAL POLICY CRITERIA

Notes:

- This policy only applies to certain member contracts. Please check the preauthorization website for the member contract to confirm requirements.
- This policy only addresses abnormal uterine bleeding, pelvic pain, endometriosis, chronic pelvic inflammatory disease, pelvic adhesive disease, pelvic venous congestion, adenomyosis, cervical intraepithelial neoplasia, and leiomyoma.

I. Hysterectomy surgery may be considered **medically necessary** when any of the following criteria are met:

A. Abnormal uterine bleeding when the clinical records document all of the following criteria are met (1. – 4.):

1. Hysteroscopy, sonohysterography (SIS), or pelvic ultrasound has been performed; and
2. No specific etiology of abnormal uterine bleeding (e.g., endometrial hyperplasia, leiomyoma, polyps) has been identified; and
3. Hormonal treatment options (intrauterine delivery system or systemic hormonal therapy, e.g., oral contraceptive pills or progestins) cannot be used because of one or more of the following:
    a. They are contraindicated; or
    b. They are not tolerated; or
    c. Symptoms are ongoing despite treatment; or
    d. They are not appropriate for severity of patient's condition (e.g., severe persistent bleeding, acute anemia, postmenopausal age) or clinical scenario.
4. Conservative surgery (e.g., endometrial ablation, endometrial polypectomy, D&C) cannot be used because of one or more of the following:
    a. Procedure is contraindicated (extreme uterine flexion or version, extremely thin myometrium); or
    b. Procedure was tried but did not adequately treat patient's condition; or
    c. Procedure is not appropriate for severity of patient's condition or clinical scenario; or
    d. Hysterectomy is preferred (e.g., patient concern about recurrence after conservative surgery).

B. Adenomyosis when the clinical records document all of the following criteria are met (1. – 2.):
1. Adenomyosis is suspected on ultrasound or MRI; and
2. Patients have been counseled with their alternative options (e.g., medical therapy).

C. Cervical intraepithelial neoplasia (CIN) and one or more of the following:
1. Both of the following (a. – b.):
    a. Recurrent biopsy-confirmed CIN-2,3 after ablative or excisional procedure; and
    b. Repeat excisional procedure or ablative procedures is not feasible.
2. CIN III with negative margins on a cone, but with glandular involvement; or
3. Spontaneous CIN III or carcinoma in situ (CIS) with rapid development (no other recent history); or
4. Any CIN II or III (after cone or LEEP rules out invasion) on an immunocompromised (e.g.; HIV) patient; or
5. Persistent high-risk HPV (especially 16/18) in a patient over the age of 40; or

6. Glandular dysplasias (as opposed to squamous) due to the skip nature of the lesions.

D. Chronic pelvic inflammatory disease (PID) persisting after treatment and diagnosed by one of more of the following:
   1. Endometrial biopsy with histopathologic evidence of endometritis; or
   2. Ultrasound, computed tomography (CT), or magnetic resonance imaging techniques showing thickened, fluid-filled tubes with or without free pelvic fluid or tubo-ovarian complex; or
   3. Abnormalities on laparoscopic exam consistent with PID such as tubal wall edema, visible hyperemia, or exudate.

E. Endometriosis when the clinical records document all of the following criteria are met (1. – 3.):
   1. One or more of the following has been used to confirm a diagnosis of endometriosis:
      a. Histology on biopsy
      b. Laparoscopic visualization
      c. Identification of endometrioma on ultrasound or MRI
   2. Pelvic pain is associated with endometriosis; and
   3. Symptoms are ongoing or recurrent despite treatment with conservative surgery (e.g., destruction of implants, removal of endometrioma, lysis of adhesions).

F. Leiomyoma ("fibroid") when the clinical records document all of the following criteria are met (1. – 3.):
   1. Significant clinical manifestations or findings attributable to leiomyoma, including one or more of the following:
      a. Abnormal uterine bleeding
      b. Iron-deficiency anemia
      c. Dyspareunia
      d. Malignancy suspected
      e. Pelvic pain or pressure
      f. Urinary or bowel dysfunction
   2. Imaging (e.g., ultrasound, CT, MRI) has ruled out other significant abnormalities and is consistent with a diagnosis of leiomyoma; and
   3. Conservative surgery or medical therapy has been unsuccessful or is not desired.

G. Pelvic pain associated with any of the following:
   1. Unknown etiology when the clinical records document all of the following criteria are met (a. – d.):

a. Comprehensive evaluation (e.g., pain specialist, mental health evaluation) has been performed or clinical documentation for why it is not indicated is provided; and

b. No specific etiology of symptoms (e.g., interstitial cystitis, inflammatory bowel disease) has been identified via appropriate investigations (e.g., laparoscopy, endoscopy, imaging); and

c. Pain is ongoing for at least 6 months; and

d. Conservative treatments (e.g., oral contraceptives, progestins, gonadotropin-releasing hormone analogues, analgesics, antidepressants, physical therapy) have been unsuccessful.

2. Essure placement when pelvic pain did not exist prior to Essure placement; or

3. Refractory cervical stenosis; or

4. Prior endometrial ablation (EA), with or without abnormal uterine bleeding; or

5. Vaginal agenesis (also known as Mullerian agnesis, Mayer-Rokitansky Kuster Hauser syndrome, or obstructed uterine rudimentary horn).

H. Pelvic adhesive disease resulting from prior multiple gynecological/abdominal surgeries and one or more of the following:

1. Adhesiolysis failure; or

2. Adhesiolysis contraindicated or relatively contraindicated because of the presence of one or more other conditions; or

3. Frozen pelvis (scarred down pelvis) documented by laparoscopy or laparotomy.

I. Pelvic Venous Congestion (PVC) syndrome when diagnosis of PVC is documented, including all of the following (1. – 3.):

1. Documentation of characteristic symptoms is submitted, including but not limited to one or more of the following:

a. Chronic pelvic discomfort, exacerbated by increased abdominal pressure

b. Sharp pelvic pains

c. Dysmenorrhea

d. Deep dyspareunia

e. Urinary urgency

f. Dilated pelvic veins

g. Gluteal, vulvar and/or thigh varices

2. Tenderness on physical exam (ovarian, cervical motion, and uterine tenderness with direct palpation); and

3. Imaging or laparoscopy/laparotomy identifies pelvic venous changes.

II. Hysterectomy surgery for the treatment of abnormal uterine bleeding, pelvic pain, endometriosis, chronic pelvic inflammatory disease, pelvic adhesive disease, pelvic

venous congestion, adenomyosis, cervical intraepithelial neoplasia, or leiomyoma is considered **not medically necessary** when Criterion I. is not met.

NOTE: A summary of the supporting rationale for the policy criteria is at the end of the policy.

POLICY GUIDELINES

RECURRENT ENDOMETRIOSIS

- Recurrent endometriosis symptoms (pelvic pain) do not require another diagnostic workup, medical management, or other uterine sparing procedure if tried in the past.
- For recurrent endometriosis, diagnosis and/or treatment during previous exacerbations of endometriosis may be considered in determining whether criteria are met.

MULTIPLE CONDITIONS

- It should be reasonable to expect that hysterectomy would resolve the dominant condition or related symptoms.
- If there is more than one dominant condition for which the clinical information submitted may meet guideline criteria, also apply criteria for those other conditions, if appropriate.
- Patient only needs to meet criteria for the dominant condition to qualify for a hysterectomy.

HORMONE THERAPY

Possible relative contraindications for hormonal therapy include a 3 or greater per the CDC Medical Eligibility Criteria for Contraceptive Use.

LIST OF INFORMATION NEEDED FOR REVIEW

REQUIRED DOCUMENTATION:

The information below **must** be submitted for review to determine whether policy criteria are met. If any of these items are not submitted, it could impact our review and decision outcome.

- History and physical/chart notes
- Conservative treatment provided, if any
    - o If options for more conservative management are relatively or absolutely contraindicated, those contraindications should be specified.
    - o If options for more conservative management previously have been tried and have been ineffective or not tolerated, clinical information regarding those previous treatments should be provided.
    - o If an option or options for conservative management is/are felt to be unlikely to be successful, reasons should be specified.
    - o If options for more conservative management are declined based on choice in the absence of clinical reasons such as contraindication(s) or a history of ineffectiveness or intolerance, those reasons for choosing to decline more conservative management should be specified.

- Relevant imaging (ultrasound, CT, hysteroscopy etc) reports
- Lab/pathology reports

CROSS REFERENCES

1. Gender Affirming Interventions for Gender Dysphoria, Medicine, Policy No. 153
2. Endometrial Ablation, Surgery, Policy No. 01

BACKGROUND

HYSTERECTOMY

An assessment of hysterectomies performed in the United States found that in 2013, 35 out of every 10,000 women underwent a hysterectomy (surgical removal of the uterus).[1] According to the same study, also in 2013, just over 43% of hysterectomies were performed laparoscopically. Other surgical approaches for hysterectomy are abdominal, laparoscopic assisted vaginal, and vaginal. According to the American College of Obstetricians and Gynecologists, when hysterectomy is used for the treatment of benign indications, the choice of approach depends on anatomical features as well as, “extent of extrauterine disease; the need for concurrent procedures; surgeon training and experience; average case volume; available hospital technology, devices, and support; whether the case is emergent or scheduled; and preference of the informed patient.”

Laparoscopic and vaginal hysterectomies generally require shorter hospital stays and shorter postoperative recovery times than open abdominal hysterectomies. Vaginal hysterectomies are associated with better outcomes than laparoscopic and abdominal hysterectomies. In cases where extrauterine disease prevents the use of a vaginal approach, another minimally invasive approach is preferred.

INDICATIONS FOR HYSTERECTOMY

Hysterectomies are commonly performed for abnormal uterine bleeding, fibroids, endometriosis, and pelvic pain. Other indications not reviewed here include cancer, uterine prolapse, and high risk of cancer based on genetic testing or family or personal history. For some conditions, hysterectomy is the definitive treatment. For others, due to the nature of the condition, the safety and efficacy of alternative options must be weighed against hysterectomy.

Alternative treatments vary by condition. For the treatment of fibroids, treatment options include myomectomy, uterine artery embolization or occlusion (UAE or UAO), myolysis, and endometrial ablation. Alternatives for abnormal uterine bleeding include endometrial ablation, levonorgestrel intrauterine system (LNG-IUS), and medications. Utero-sacral nerve ablation, presacral neurectomy, lysis of adhesions, utero-sacral ligament resection, and a variety of medications have been used for the treatment of pelvic pain. Hysterectomy is considered the most invasive of these options.

EVIDENCE SUMMARY

Systematic Reviews

Systematic reviews (SRs) have evaluated the accumulated evidence for hysterectomy for a number of indications. Key outcomes following therapy depend on the indication for the intervention, but include bleeding, pain, quality of life, sexual health, and re-intervention.

A 2022 meta-analysis of Cochrane reviews was completed to evaluate medical and surgical treatments for heavy menstrual bleeding.[2] A total of nine systematic reviews were included from the Cochrane Library up to July 2021. Hysterectomy was evaluated as a second-line intervention. The analysis, performed either with or without imputed data, suggested that hysterectomy results in a large reduction of menstrual blood loss (low certainty of evidence). Additionally, analysis of evidence from 27 trials with 4,284 participants suggested that minimally invasive hysterectomy results in a large increase in satisfaction (low certainty of evidence). Other interventions suggested by the analysis to result in a large reduction in menstrual blood loss were levonorgestrel-releasing intrauterine system (LNG-IUS; first-line treatment) and resectoscopic endometrial ablation (REA) and microwave non-resectoscopic endometrial ablation (NREA; second-line treatments).

A 2019 Cochrane SR by Fergusson compared the safety and effectiveness of hysterectomy versus endometrial ablation or resection for heavy menstrual bleeding.[3] A total of nine RCTs met inclusion criteria. Bleeding outcomes were assessed differently in the different trials, but generally hysterectomy was associated with better bleeding outcomes. Adverse events were more common in patients who underwent hysterectomy. During the hospital stay, those in the endometrial ablation group were less likely to experience sepsis (RR 0.19, 95% CI 0.12 to 0.31; participants = 621; studies = 4; I^2 = 62%), blood transfusion (RR 0.20, 95% CI 0.07 to 0.59; 791 women; 5 studies; I^2 = 0%), pyrexia (RR 0.17, 95% CI 0.09 to 0.35; 605 women; three studies; I^2 = 66%), vault hematoma (RR 0.11, 95% CI 0.04 to 0.34; 858 women; five studies; I^2 = 0%) and wound hematoma (RR 0.03, 95% CI 0.00 to 0.53; 202 women; one study). The SR authors concluded that the benefits of hysterectomy are permanent and immediate relief from heavy menstrual bleeding and the benefits of endometrial resection/ablation are shorter operating and recovery time and lower postoperative complications.

In 2017, Hartmann published a Comparative Effectiveness review for the Agency for Healthcare Research and Quality (AHRQ) on the management of uterine fibroids.[4] For hysterectomy, the authors identified 14 studies reported in 23 publications. Comparators were most often different approaches to hysterectomy; however, some studies did report alternative treatments as comparators. One randomized controlled trial (RCT) compared GnRH agonist (n=59) to hysterectomy (n=13). Individuals in the GnRH group could opt for hysterectomy at any time. In the GnRH group, 23 patients assigned to medication continued to hysterectomy by the end of the third year of follow-up. Three randomized studies compared UAE with hysterectomy, with a total of 291 women ages 33 to 57 years who had symptomatic uterine fibroids and were eligible for hysterectomy. Follow-up was six months to five years. Length of hospital stay and time to usual activities was significantly shorter in the UAE group ($p<0.001$ for both). Re-admission rates were the same in one study (5%) and higher after UAE (11% vs. 0%, $p<0.003$) in another. Relief from pain was not significantly different between groups, but improvement in pressure symptoms was significantly greater in the UAE group ($p=0.03$) and urinary bladder symptoms were greater in the hysterectomy group ($p=0.03$). There was no difference in one study in overall health-related quality of life or sexual function at 24 months or later. In all three studies, subsequent treatment was higher in those treated with UAE at each time point in follow-up. The review concluded that although subsequent intervention is more common after UAW than hysterectomy, the majority of women in the UAE group avoided hysterectomy for the duration of follow-up. They additionally concluded that the evidence is currently insufficiently to shape clinical decisions.

Marjoribanks published a 2016 Cochrane SR that evaluated surgery versus medical therapy for heavy menstrual bleeding in patients with no abnormal endometrial pathology or other uterine abnormalities such as polyps or fibroids.[5] Medical therapy included use of LNG-IUS and oral medication. A total of 15 parallel-group RCTs including 1,289 women met inclusion criteria. Of these, one RCT compared hysterectomy with oral medication and two with LNG-IUS. Results from the one RCT that reported objective assessment of bleeding indicated that hysterectomy was more likely to have objective control of bleeding at one year than medical therapy. In one RCT, women in the hysterectomy group reported statistically significantly higher levels of satisfaction with symptom resolution and overall health than women in the medical group at the six-month follow-up, but not at the two-year follow-up. With respect to complications, one RCT reported 35 operative and postoperative complications in the 107 hysterectomy patients and failure of the insertion in three LNG-IUS patients (unable to insert in two and removal in one). The other RCT comparing the same interventions reported that there were no postoperative complications in either group that necessitated readmission, blood transfusion or repeat surgery. The SR authors concluded that surgery, particularly hysterectomy, reduces menstrual bleeding more than medical treatment at one year but that there is no conclusive evidence of a difference in satisfaction rates between surgery and LNG-IUS. They stated that overall, oral medication suits a minority of women in the long term, and that for most women, the LNG-IUS device provides a better alternative to surgery.

A Cochrane SR published by Lethaby in 2015 compared the safety and effectiveness of progesterone or progestogen-releasing intrauterine devices versus other treatments for heavy menstrual bleeding, with hysterectomy as a comparator.[6] Only RCTs of women of reproductive age were included. A total of 21 RCTs met inclusion criteria, three of which compared progestogen-releasing intrauterine devices with hysterectomy. Evidence from these studies was rated as high quality. One study reported that progestogen-releasing intrauterine devices were not as successful as hysterectomy at reducing heavy menstrual bleeding long-term (24 months), though the 12-month outcomes were similar. Two of the three RCTs reported equivalent improvements in quality of life between the groups while the third reported different outcomes for different quality of life measures.

Chen published a 2016 Canadian Agency for Drugs and Technology in Health (CADTH) SR that compared uterine-preserving interventions for symptomatic uterine fibroids to each other and to hysterectomy.[7] A total of 26 studies were included on the safety and efficacy of uterine-preserving interventions. One nonrandomized study reported that compared with myomectomy, patients treated with hysterectomy reported statistically significant improvements in symptom severity/quality of life measures. In the four studies that evaluated complications from myomectomy versus hysterectomy (one three-arm prospective cohort study and three retrospective cohort studies), overall, open abdominal hysterectomy was related to more peri-procedural complications (blood loss and organ injury) than abdominal myomectomy whereas laparoscopic myomectomy was related to fewer organ injuries but higher risk of converting to the open surgery, compared to laparoscopic hysterectomy. Hysterectomy and uterine artery ablation were both reported to ease pelvic pressure and increase health-related quality of life, though whether one procedure did to a greater degree was inconsistent between two RCTs. On the other hand, uterine artery ablation was reported to result in statistically significantly less blood loss and severe pain compared to hysterectomy, according to the six studies that reported on complications, and shorter hospital stays according to the five studies that reported on this outcome. One multi-center prospective study compared magnetic resonance-guided focused ultrasound (MRgFUS) with hysterectomy. The difference in the number of adverse events experienced was significantly significant, with fewer

patients in the MRgFUS group reporting adverse events. Overall, the authors concluded that the quality of the available studies was low due to small sample sizes and study design and inconsistent results were reported across the included studies.

In 2012, the AHRQ published a Comparative Effectiveness review of therapies for noncyclic chronic pelvic pain.[8] A total of 18 randomized controlled trials (RCTs) (2 good, 3 fair, and 13 poor quality); three cohort studies (three poor quality); and 15 cross-sectional studies addressing the prevalence of comorbidities (quality varied by comorbidity) met inclusion criteria and were included in the review. Only one study compared hysterectomy with nonsurgical therapy, and it was determined to be of poor quality. This study reported 12-month outcomes for 380 patients in the nonsurgical group and 311 in the hysterectomy group. All patients were being treated for chronic pelvic pain. Significant improvements in mean number of days with pain per month (determined via interview) were reported for both groups. The mean reduction in days with pain per month was 7 ($p<0.001$) and 18 ($p<0.001$) for the nonsurgical and hysterectomy groups, respectively. Statistically significant improvements in all quality of life measures were reported for the hysterectomy group ($p<0.001$) while statistically significant improvements in only two quality of life measures were reported for the nonsurgical management group ($p<0.001$ for both). Overall, the authors of the SR concluded that the strength of the evidence for the surgical approaches, including hysterectomy, was low, and that the evidence was insufficient to comment on relief of pain after hysterectomy.

A 2012 SR by Matteson compared hysterectomy with less-invasive alternatives for the treatment of abnormal uterine bleeding.[9] Only RCTs were included in the SR, and nine RCTs described in 18 articles met inclusion criteria. Of the nine RCTs, seven (one rated as “A” quality and the rest as “B”) compared hysterectomy to endometrial ablation, one (“A” quality) compared hysterectomy to LNG-IUS, and one (“A” or “B” quality for different outcomes) compared hysterectomy to medication. In the comparisons with endometrial ablation, follow-up was between 4 and 48 months. All seven RCTs reported bleeding control. Bleeding control was implied to be 100% in most studies (although one did report a woman with post-hysterectomy bleeding). In comparison, there was a 13 to 64% rate of amenorrhea following endometrial ablation. Generally, quality of life measures were not different between groups. Although a few studies did report statistically significant differences in some measures, the SR concluded that moderate strength of evidence indicated no difference between hysterectomy and ablation in quality of life. Of the five trials that assessed pain beyond the immediate post-operative period, all but one reported some measure of pain as superior in the hysterectomy group, although statistical testing was not always done. The SR concluded that based on low strength of evidence, pain beyond the post-operative period favored hysterectomy. Based on quality evidence from five trials, there was no difference in sexual health between groups. Five trials assessed general satisfaction, and overall, based on very low quality of evidence, reported no differences between groups. The need for additional treatment was reported in seven studies. Moderate quality of evidence favored hysterectomy over ablation, with 10 to 29% of endometrial ablation patients undergoing hysterectomy within one to four years post-ablation. The one “A” quality RCT that compared hysterectomy to LNG-IUS included 263 patients with six-month to 10-year follow-up. No differences were reported between groups for quality of life, pain, sexual health, or satisfaction. Hysterectomy was favored over LNG-IUS for bleeding control and need for additional treatments. The one RCT that compared hysterectomy to medical therapy included 63 patients with two-year follow-up. Based on low or very low quality of evidence, no differences were reported between groups for any measure. Overall, the SR authors concluded that hysterectomy had superior long-term bleeding control compared to ablation and LNG-IUS and additionally better long-term pain control than ablation.

Society of Gynecologic Surgeons

The Society of Gynecologic Surgeons published an evidence-based clinical practice guideline in 2012 regarding the use of hysterectomy versus alternative therapy for abnormal uterine bleeding caused by ovulatory disorders (AUB-O) or by endometrial hemostatic disorders (AUB-E).[10] These guidelines make the following recommendations:

- In women with AUB presumed caused by predominately AUB-O or AUB-E, we suggest that any of the following treatment options may be chosen on the basis of patient values and preferences: hysterectomy, endometrial ablation, systemically administered medical therapies, or LNG IUS. (Weak)
- If the patient's main preference is for amenorrhea or avoiding additional therapy or experiencing less pain, we suggest hysterectomy rather than endometrial ablation (Weak).
- If the patient's main preference is for shorter hospitalization and for lower operative and postoperative procedural risk, we suggest endometrial ablation rather than hysterectomy (Weak)
- If the patient's main preference is for improvement in overall quality of life or sexual health, we suggest that either hysterectomy or endometrial ablation may be chosen and that the selection of treatment be based on additional patient preferences (Weak).
- If the patient's main preference is for amenorrhea or avoiding additional therapy, we suggest hysterectomy rather than systemically administered medications (Weak).
- If the patient's main preference is to avoid adverse events, we suggest systemically administered medications rather than hysterectomy (Weak).
- If the patient's main preference is long-term improvement in QOL, pain or sexual health, we suggest that either hysterectomy or systemically administered medications is appropriate and that the choice of treatment be based on additional patient preferences (Weak).

The American College of Obstetricians and Gynecologists

The American College of Obstetricians and Gynecologists (ACOG) published a Practice Bulletin on "Alternatives to Hysterectomy in the Management of Leiomyomas".[11] This bulletin makes the following recommendations:

> The following recommendations and conclusions are based on good and consistent scientific evidence (Level A):
>
> - Abdominal myomectomy is a safe and effective alternative to hysterectomy for treatment of women with symptomatic leiomyomas.
> - Based on long- and short-term outcomes, uterine artery embolization is a safe and effective option for appropriately selected women who wish to retain their uteri.
> - Gonadotropin-releasing hormone agonists have been shown to improve hematologic parameters, shorten hospital stay, and decrease blood loss, operating time, and postoperative pain when given for 2–3 months preoperatively. Benefits of preoperative use of GnRH agonists should be weighed against their cost and side effects for individual patients. Several studies

suggest that the infiltration of vasopressin into the myometrium decreases blood loss at the time of myomectomy.

The following recommendations are based on limited or inconsistent scientific evidence (Level B):

- The clinical diagnosis of rapidly growing leiomyomas should not be used as an indication for myomectomy or hysterectomy.
- Hysteroscopic myomectomy is an accepted method for the management of abnormal uterine bleeding caused by submucosal leiomyomas.

The following recommendations and conclusions are based primarily on consensus and expert opinion (Level C):

- There is insufficient evidence to support hysterectomy for asymptomatic leiomyomas solely to improve detection of adnexal masses, to prevent impairment of renal function, or to rule out malignancy.
- Leiomyomas should not be considered the cause of infertility, or significant component of infertility, without completing a basic fertility evaluation to assess the woman and her partner.
- Hormone therapy may cause some modest increase in uterine leiomyoma size but does not appear to have an impact on clinical symptoms. Therefore, this treatment option should not be withheld from women who desire or need such therapy.
- The effect of uterine artery embolization on pregnancy remains understudied.

SUMMARY

There is enough research to show that when policy criteria are met, hysterectomy for the treatment of abnormal uterine bleeding, pelvic pain, chronic pelvic inflammatory disease, pelvic adhesive disease, pelvic venous congestion, adenomyosis, cervical intraepithelial neoplasia, and leiomyoma improves health outcomes. Clinical guidelines based on research recommend hysterectomy in these clinical scenarios. Therefore, hysterectomy may be considered medically necessary when policy criteria are met.

For abnormal uterine bleeding, pelvic pain, chronic pelvic inflammatory disease, pelvic adhesive disease, pelvic venous congestion, adenomyosis, cervical intraepithelial neoplasia, and leiomyoma, evidence and guidelines do not support the use of endometrial ablation when policy criteria are not met. Therefore, hysterectomy for the treatment of these indications is considered not medically necessary when policy criteria are not met.

REFERENCES

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CODES

Codes	Number	Description
CPT	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 (eg, 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)
	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
	58275	Vaginal hysterectomy, with total or partial vaginectomy;
	58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele
	58290	Vaginal hysterectomy, for uterus greater than 250 g

Codes	Number	Description
	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)
	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)
HCPCS	None	
ICD-10	A18.17	Tuberculous female pelvic inflammatory disease
	A54.24	Gonococcal female pelvic inflammatory disease
	A54.85	Gonococcal peritonitis
	A56.11	Chlamydial female pelvic inflammatory disease
	A74.81	Chlamydial peritonitis
	D06.0	Carcinoma in situ of endocervix
	D06.1	Carcinoma in situ of exocervix
	D06.7	Carcinoma in situ of other parts of cervix
	D06.9	Carcinoma in situ of cervix, unspecified
	D21.9	Benign neoplasm of connective and other soft tissue, unspecified
	D25.0	Submucous leiomyoma of uterus
	D25.1	Intramural leiomyoma of uterus
	D25.2	Subserosal leiomyoma of uterus
	D25.9	Leiomyoma of uterus, unspecified
	G89.29	Other chronic pain
	K66.0	Peritoneal adhesions (postprocedural) (postinfection)
	N70.01	Acute salpingitis
	N70.02	Acute oophoritis
	N70.03	Acute salpingitis and oophoritis
	N70.11	Chronic salpingitis
	N70.12	Chronic oophoritis

Codes	Number	Description
	N70.13	Chronic salpingitis and oophoritis
	N70.91	Salpingitis, unspecified
	N70.92	Oophoritis, unspecified
	N70.93	Salpingitis and oophoritis, unspecified
	N71.0	Acute inflammatory disease of uterus
	N71.1	Chronic inflammatory disease of uterus
	N71.9	Inflammatory disease of uterus, unspecified
	N72	Inflammatory disease of cervix uteri
	N73.0	Acute parametritis and pelvic cellulitis
	N73.1	Chronic parametritis and pelvic cellulitis
	N73.2	Unspecified parametritis and pelvic cellulitis
	N73.3	Female acute pelvic peritonitis
	N73.4	Female chronic pelvic peritonitis
	N73.5	Female pelvic peritonitis, unspecified
	N73.6	Female pelvic peritoneal adhesions (postinfective)
	N73.8	Other specified female pelvic inflammatory diseases
	N73.9	Female pelvic inflammatory disease, unspecified
	N74	Female pelvic inflammatory disorders in diseases classified elsewhere
	N80.00	Endometriosis of the uterus, unspecified
	N80.01	Superficial endometriosis of the uterus
	N80.02	Deep endometriosis of the uterus
	N80.03	Adenomyosis of the uterus
	N80.101	Endometriosis of right ovary, unspecified depth
	N80.102	Endometriosis of left ovary, unspecified depth
	N80.103	Endometriosis of bilateral ovaries, unspecified depth
	N80.109	Endometriosis of ovary, unspecified side, unspecified depth
	N80.111	Superficial endometriosis of right ovary
	N80.112	Superficial endometriosis of left ovary
	N80.113	Superficial endometriosis of bilateral ovaries
	N80.119	Superficial endometriosis of ovary, unspecified ovary
	N80.121	Deep endometriosis of right ovary
	N80.122	Deep endometriosis of left ovary
	N80.123	Deep endometriosis of bilateral ovaries
	N80.129	Deep endometriosis of ovary, unspecified ovary
	N80.201	Endometriosis of right fallopian tube, unspecified depth
	N80.202	Endometriosis of left fallopian tube, unspecified depth
	N80.203	Endometriosis of bilateral fallopian tubes, unspecified depth
	N80.209	Endometriosis of unspecified fallopian tube, unspecified depth
	N80.211	Superficial endometriosis of right fallopian tube
	N80.212	Superficial endometriosis of left fallopian tube
	N80.213	Superficial endometriosis of bilateral fallopian tubes
	N80.219	Superficial endometriosis of unspecified fallopian tube

Codes	Number	Description
	N80.221	Deep endometriosis of right fallopian tube
	N80.222	Deep endometriosis of left fallopian tube
	N80.223	Deep endometriosis of bilateral fallopian tubes
	N80.229	Deep endometriosis of unspecified fallopian tube
	N80.30	Endometriosis of pelvic peritoneum, unspecified
	N80.311	Superficial endometriosis of the anterior cul-de-sac
	N80.312	Deep endometriosis of the anterior cul-de-sac
	N80.319	Endometriosis of the anterior cul-de-sac, unspecified depth
	N80.321	Superficial endometriosis of the posterior cul-de-sac
	N80.322	Deep endometriosis of the posterior cul-de-sac
	N80.329	Endometriosis of the posterior cul-de-sac, unspecified depth
	N80.331	Superficial endometriosis of the right pelvic sidewall
	N80.332	Superficial endometriosis of the left pelvic sidewall
	N80.333	Superficial endometriosis of bilateral pelvic sidewall
	N80.339	Superficial endometriosis of pelvic sidewall, unspecified side
	N80.341	Deep endometriosis of the right pelvic sidewall
	N80.342	Deep endometriosis of the left pelvic sidewall
	N80.343	Deep endometriosis of the bilateral pelvic sidewall
	N80.349	Deep endometriosis of the pelvic sidewall, unspecified side
	N80.351	Endometriosis of the right pelvic sidewall, unspecified depth
	N80.352	Endometriosis of the left pelvic sidewall, unspecified depth
	N80.353	Endometriosis of bilateral pelvic sidewall, unspecified depth
	N80.359	Endometriosis of pelvic sidewall, unspecified side, unspecified depth
	N80.361	Superficial endometriosis of the right pelvic brim
	N80.362	Superficial endometriosis of the left pelvic brim
	N80.363	Superficial endometriosis of bilateral pelvic brim
	N80.369	Superficial endometriosis of the pelvic brim, unspecified side
	N80.371	Deep endometriosis of the right pelvic brim
	N80.372	Deep endometriosis of the left pelvic brim
	N80.373	Deep endometriosis of bilateral pelvic brim
	N80.379	Deep endometriosis of the pelvic brim, unspecified side
	N80.381	Endometriosis of the right pelvic brim, unspecified depth
	N80.382	Endometriosis of the left pelvic brim, unspecified depth
	N80.383	Endometriosis of bilateral pelvic brim, unspecified depth
	N80.389	Endometriosis of the pelvic brim, unspecified side, unspecified depth
	N80.3A1	Superficial endometriosis of the right uterosacral ligament
	N80.3A2	Superficial endometriosis of the left uterosacral ligament
	N80.3A3	Superficial endometriosis of the bilateral uterosacral ligament(s)
	N80.3A9	Superficial endometriosis of the uterosacral ligament(s), unspecified side
	N80.3B1	Deep endometriosis of the right uterosacral ligament
	N80.3B2	Deep endometriosis of the left uterosacral ligament

Codes	Number	Description
	N80.3B3	Deep endometriosis of bilateral uterosacral ligament(s)
	N80.3B9	Deep endometriosis of the uterosacral ligament(s), unspecified side
	N80.3C1	Endometriosis of the right uterosacral ligament, unspecified depth
	N80.3C2	Endometriosis of the left uterosacral ligament, unspecified depth
	N80.3C3	Endometriosis of bilateral uterosacral ligament(s), unspecified depth
	N80.3C9	Endometriosis of the uterosacral ligament(s), unspecified side, unspecified depth
	N80.391	Superficial endometriosis of the pelvic peritoneum, other specified sites
	N80.392	Deep endometriosis of the pelvic peritoneum, other specified sites
	N80.399	Endometriosis of the pelvic peritoneum, other specified sites, unspecified depth
	N80.40	Endometriosis of rectovaginal septum, unspecified involvement of vagina
	N80.41	Endometriosis of rectovaginal septum without involvement of vagina
	N80.42	Endometriosis of rectovaginal septum with involvement of vagina
	N80.50	Endometriosis of intestine, unspecified
	N80.511	Superficial endometriosis of the rectum
	N80.512	Deep endometriosis of the rectum
	N80.519	Endometriosis of the rectum, unspecified depth
	N80.521	Superficial endometriosis of the sigmoid colon
	N80.522	Deep endometriosis of the sigmoid colon
	N80.529	Endometriosis of the sigmoid colon, unspecified depth
	N80.531	Superficial endometriosis of the cecum
	N80.532	Deep endometriosis of the cecum
	N80.539	Endometriosis of the cecum, unspecified depth
	N80.541	Superficial endometriosis of the appendix
	N80.542	Deep endometriosis of the appendix
	N80.549	Endometriosis of the appendix, unspecified depth
	N80.551	Superficial endometriosis of other parts of the colon
	N80.552	Deep endometriosis of other parts of the colon
	N80.559	Endometriosis of other parts of the colon, unspecified depth
	N80.561	Superficial endometriosis of the small intestine
	N80.562	Deep endometriosis of the small intestine
	N80.569	Endometriosis of the small intestine, unspecified depth
	N80.6	Endometriosis in cutaneous scar
	N80.A0	Endometriosis of bladder, unspecified depth
	N80.A1	Superficial endometriosis of bladder
	N80.A2	Deep endometriosis of bladder
	N80.A41	Superficial endometriosis of right ureter
	N80.A42	Superficial endometriosis of left ureter
	N80.A43	Superficial endometriosis of bilateral ureters

Codes	Number	Description
	N80.A49	Superficial endometriosis of unspecified ureter
	N80.A51	Deep endometriosis of right ureter
	N80.A52	Deep endometriosis of left ureter
	N80.A53	Deep endometriosis of bilateral ureters
	N80.A59	Deep endometriosis of unspecified ureter
	N80.A61	Endometriosis of right ureter, unspecified dept
	N80.A62	Endometriosis of left ureter, unspecified depth
	N80.A63	Endometriosis of bilateral ureters, unspecified depth
	N80.A69	Endometriosis of unspecified ureter, unspecified depth
	N80.B1	Endometriosis of pleura
	N80.B2	Endometriosis of lung
	N80.B31	Superficial endometriosis of diaphragm
	N80.B32	Deep endometriosis of diaphragm
	N80.B39	Endometriosis of diaphragm, unspecified depth
	N80.B4	Endometriosis of the pericardial space
	N80.B5	Endometriosis of the mediastinal space
	N80.B6	Endometriosis of cardiothoracic space
	N80.C0	Endometriosis of the abdomen, unspecified
	N80.C10	Endometriosis of the anterior abdominal wall, subcutaneous tissue
	N80.C11	Endometriosis of the anterior abdominal wall, fascia and muscular layers
	N80.C19	Endometriosis of the anterior abdominal wall, unspecified depth
	N80.C2	Endometriosis of the umbilicus
	N80.C3	Endometriosis of the inguinal canal
	N80.C4	Endometriosis of extra-pelvic abdominal peritoneum
	N80.C9	Endometriosis of other site of abdomen
	N80.D0	Endometriosis of the pelvic nerves, unspecified
	N80.D1	Endometriosis of the sacral splanchnic nerves
	N80.D2	Endometriosis of the sacral nerve roots
	N80.D3	Endometriosis of the obturator nerve
	N80.D4	Endometriosis of the sciatic nerve
	N80.D5	Endometriosis of the pudendal nerve
	N80.D6	Endometriosis of the femoral nerve
	N80.D9	Endometriosis of other pelvic nerve
	N80.8	Other endometriosis
	N80.9	Endometriosis, unspecified
	N83.6	Hematosalpinx
	N83.7	Hematoma of broad ligament
	N87.0	Mild cervical dysplasia
	N87.1	Moderate cervical dysplasia
	N87.9	Dysplasia of cervix uteri, unspecified
	N92.0	Excessive and frequent menstruation with regular cycle

Codes	Number	Description
	N92.1	Excessive and frequent menstruation with irregular cycle
	N92.3	Ovulation bleeding
	N92.4	Excessive bleeding in the premenopausal period
	N92.5	Other specified irregular menstruation
	N92.6	Irregular menstruation, unspecified
	N93.0	Postcoital and contact bleeding
	N93.8	Other specified abnormal uterine and vaginal bleeding
	N93.9	Abnormal uterine and vaginal bleeding, unspecified
	N94.0	Mittelschmerz
	N94.10	Unspecified dyspareunia
	N94.11	Superficial (introital) dyspareunia
	N94.12	Deep dyspareunia
	N94.19	Other specified dyspareunia
	N94.4	Primary dysmenorrhea
	N94.5	Secondary dysmenorrhea
	N94.6	Dysmenorrhea, unspecified
	N94.89	Other specified conditions associated with female genital organs and menstrual cycle
	N94.9	Unspecified condition associated with female genital organs and menstrual cycle
	N95.0	Postmenopausal bleeding
	N99.4	Postprocedural pelvic peritoneal adhesions
	R10.2	Pelvic and perineal pain
	R87.610	Atypical squamous cells of undetermined significance on cytologic smear of cervix (ASC-US)
	R87.611	Atypical squamous cells cannot exclude high grade squamous intraepithelial lesion on cytologic smear of cervix (ASC-H)
	R87.612	Low grade squamous intraepithelial lesion on cytologic smear of cervix (LGSIL)
	R87.613	High grade squamous intraepithelial lesion on cytologic smear of cervix (HGSIL)
	R87.619	Unspecified abnormal cytological findings in specimens from cervix uteri
	R87.810	Cervical high risk human papillomavirus (HPV) DNA test positive

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