

**Subject: Hysterectomy**

**Background:** Harvard Pilgrim Health Care (HPHC) authorizes elective hysterectomy procedures (e.g., vaginal hysterectomy, radical hysterectomy, hysterectomy with or without bilateral salpingo-oophorectomy, as appropriate) that are reasonable and medically necessary for members who meet condition-specific criteria outlined below.

The vaginal route should be considered as a first choice for all benign indications. Alternative hysterectomy routes choice (e.g. AH, LH, TLH) can be individualized by the surgeon based on the indication for surgery, pelvic anatomy, relative risk and benefit of each hysterectomy type, patient preference, surgeon's competence and preference, and support facility.

**Authorization:** Prior authorization is required for all hysterectomy procedures requested for members enrolled in commercial (HMO, POS, PPO) products

**Policy and Coverage Criteria:**

Harvard Pilgrim Health Care (HPHC) considers hysterectomy procedures as reasonable and medically necessary when medical record documentation confirms that a female member has been diagnosed with ANY of the following:

- Cervical cancer stages I through IIA
- Upper vaginal carcinoma
- Uterine or cervical sarcomas
- Endometrial Cancer
- Lynch Syndrome (confirmed by genetic testing)
- Suspected ovarian or tubal cancer (based on imaging)
- Endocervical adenocarcinoma in situ (confirmed by biopsy)

Hysterectomy is also authorized when medical record documentation confirms a member will be undergoing authorized female-to-male Gender Reassignment Surgery.

For other conditions, hysterectomy may be authorized when medical record documentation confirms ALL the following:

1. The member is not pregnant, and has been diagnosed (by physical exam and/or other appropriate diagnostic modalities) with a condition listed below; AND
2. The member has normal vagina and cervix (on physical examination), and normal cervical cytology; AND
3. The member has been educated regarding risks (e.g. fertility desires and effect of hysterectomy) and potential alternative treatments (e.g., conservative pharmacologic and surgical management), and wishes to proceed with hysterectomy; AND
4. Relevant condition-specific criteria are met.

**I. Abnormal Uterine Bleeding**

**For pre-menopausal women** Documentation confirms ALL the following:

1. Normal endometrium (e.g., no endometrial lesions) confirmed by ANY of the following within past 3 months:
  - Endometrial biopsy and ultrasound

**HPHC Medical Policy****Hysterectomy****Page 1 of 7**

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- Hysteroscopy with directed biopsy
  - Dilation and Curettage (D&C)
2. No active or untreated thyroid disease'
  3. EITHER of the following (criteria a or b):
    - a. Bleeding that interferes with ADL; OR
    - b. ALL the following:
      - Anemia that has not responded to at least 12 weeks of treatment with Iron;
      - Treatment with EITHER\*:
        - 3 cycles of Progestin, oral contraceptives, or Tranexamic Acid; OR
        - Use of Levonorgestrel-releasing intrauterine system (LNG-IUS); OR
        - Endometrial ablation or resection or D&C

**For post-menopausal women** Documentation confirms ALL the following:

1. Normal endometrium (e.g., no endometrial lesions) confirmed by ANY of the following within past 3 months:
  - Endometrial biopsy and ultrasound
  - Hysteroscopy with directed biopsy
  - Dilation and Curettage (D&C)
2. Hormone treatment (e.g. three months of hormone replacement therapy for atrophy, or progestin for hypertrophy) unless contraindicated
  - If pharmacologic therapies are contraindicated, documentation of the contraindication(s) is required.

**II. Adenomyosis** Ultrasound imaging suggests Adenomyosis (endometrial tissue extending into the muscular wall of the uterus), and documentation confirms BOTH (criteria 1 AND 2):

1. Member is experiencing ANY of the following:
  - Abnormal bleeding that interferes with ADL (other etiologies for bleeding must have been excluded); OR
  - Anemia unresponsive to at least 12 weeks of treatment with Iron; OR
  - Significant pelvic pain/discomfort that interferes with ADL (other etiologies excluded); OR
  - Deep dyspareunia
2. A 3-month (12 week) trial of pharmacologic therapies including NSAIDs, and hormonal treatment (i.e., GnRH agonist, oral contraceptives, Depo-Provera) has failed to relieve symptoms/findings.
  - If pharmacologic therapies are contraindicated, documentation of the contraindication(s) is required.

**III. Cervical Intra-Epithelial Neoplasia (CIN) 2 or 3** Documentation confirms BOTH:

1. Endocervical curettage (ECC) or biopsy confirmation of abnormal or severely abnormal cells on cervical surface at least 4 months after initial procedure (e.g., loop electrosurgical excision, cone biopsy, laser therapy/ablation, cryotherapy); AND
2. Abnormal cells cannot be safely removed with a second conservative excision.

**IV. Chronic Pelvic Pain** Unable to diagnose source/cause of pain after history, comprehensive physical exam, ultrasound, and ALL the following:

1. Unable to diagnose source/cause of pain by:
  - Diagnostic laparoscopy, operative hysteroscopy and endometrial sampling/biopsy; AND
  - Evaluation of bladder (e.g. urinalysis or cystoscopy); AND
  - Evaluation of potential gastrointestinal etiology; AND
  - Evaluation of potential psychological and musculoskeletal etiology
2. Normal lab findings (i.e., urinalysis, urine culture, CBC with differential);
3. Patient is counselled on chances of pain improvement post-surgery

## HPHC Medical Policy

### Hysterectomy

Page 2 of 7

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4. A 3-month (12 week) trial of pharmacologic therapies including NSAIDs, and hormonal treatment (i.e., GnRH agonist, oral contraceptives, Depo-Provera) has failed to relieve pain.
    - If pharmacologic therapies are contraindicated, documentation of the contraindication(s) is required.
- V. Endometrial Hyperplasia with Cellular Atypia** Diagnosis confirmed by biopsy or Dilation and Curettage (D&C).
- Documentation must include evidence of discussion of conservative treatment options (e.g., hormone therapy), history of failed hormone treatment, or contraindication to anti-estrogen treatment.
- VI. Endometriosis** Documentation confirms the member has remained symptomatic following BOTH:
1. Conservative surgery attempted (e.g., prior laparoscopy with or without implant ablation and lysis of adhesions) unless contraindicated; AND
  2. At least 12 weeks of hormone therapy with GnRH agonist, oral contraceptives, Depo-Provera, or Danazol
    - If pharmacologic therapies are contraindicated or intolerance to their side effects, documentation of the contraindication(s)/intolerance(s) is required.
- VII. Pelvic Inflammatory Disease (PID)** Documentation confirms BOTH:
1. Member with deep pelvic pain with either cervical motion tenderness or deep adnexal tenderness on examination; AND ANY of the following:
    - Positive culture; OR
    - Abnormal CBC with differential; OR
    - High fever; OR
    - Ultrasound shows adnexal mass or tubo-ovarian abscess
  2. Failed to respond after at least 1 course of antibiotic treatment.
- VIII. Uterine Fibroids** Ultrasound confirms presence of uterine fibroids, and documentation confirms ANY of the following:
1. For pre-menopausal women only: Bleeding that interferes with ADL (other etiologies of bleeding excluded);
  2. For pre-menopausal women only: Anemia unresponsive to at least 12 weeks of treatment with Iron;
  3. Significant pain/pressure unresponsive to pharmacologic management with both NSAIDs and hormone treatment (e.g., Danazol, Provera, oral contraceptives);
    - If pharmacologic therapies are contraindicated or intolerance to their side effects, documentation of the contraindication(s)/intolerance(s) is required.
  4. Ureteral compression (from the uterus) at the pelvic rim on imaging OR Uterine size at least 12 weeks' gestation (ultrasound confirmation required);
  5. Urinary frequency or urgency without other etiologies;
  6. Deep dyspareunia without other etiology;
  7. For post-menopausal women only: uterine growth when not on HRT, or after HRT is discontinued
- IX. Uterine Prolapse** Documentation confirms second or third degree uterine prolapse, discussion of conservative treatment options (e.g., use of pessary), and ANY of the following:
1. History of pelvic pain/pressure, or stress incontinence
  2. Cervical or vaginal ulceration with bleeding or spotting
  3. Vaginal splinting

## HPHC Medical Policy

### Hysterectomy

Page 3 of 7

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- X. Oophorectomy** Harvard Pilgrim Health Care (HPHC) considers prophylactic hysterectomy as reasonable and medically necessary in conjunction with bilateral salpingo-oophorectomy when criteria for prophylactic bilateral salpingo-oophorectomy are met.

**Exclusions:** Harvard Pilgrim Health Care (HPHC) considers hysterectomy procedures experimental/investigational for all other indications. In addition, HPHC does not cover:

- Single port laparoscopic hysterectomy
- Robotic hysterectomy
- Prophylactic hysterectomy for indications other than Lynch syndrome

### **Supporting information:**

Hysterectomy is one of the most commonly used gynecological procedures. About 30% of the women in USA have had hysterectomy by the age of 60. There are several approaches to hysterectomy: Abdominal hysterectomy which is removal of the uterus through a lower abdomen incision, Vaginal hysterectomy which involves removal of the uterus via vagina; and Laparoscopic hysterectomy. In general, vaginal hysterectomy appears to be superior to other two approaches as it is associated with faster recovery and fewer postoperative infections. Among the laparoscopic and abdominal approach, laparoscopic approach is associated with faster recovery and lower post-operative infection rates but a longer operating time. There is no documented advantage of laparoscopic approach over vaginal approach. Single-port laparoscopic hysterectomy and Robotic Hysterectomy have not been shown to be superior to laparoscopic hysterectomy.

The most common indication for hysterectomy in premenopausal women is menorrhagia. Hysterectomy appears to be more cost-effective approach for menorrhagia when compared with alternative conservative therapies (endometrial resection and ablation and pharmacologic therapy) in long-term follow-up studies because of the relative high probability of the need for future surgery following a conservative approach. Fibroids and adenomyosis are other two major indications. However most premenopausal women with fibroids are likely to be asymptomatic and a more conservative myomectomy should be considered in women before hysterectomy, especially for women who haven't completed their families yet. If there is no desire for further fertility than hysterectomy can be considered a definitive solution, unless other non-surgical conservative treatments (e.g. levonorgestrel intrauterine device) can be offered. Pelvic pain, most likely caused by endometriosis and/or adenomyosis, is another indication for hysterectomy. Analgesics (e.g., NSAIDs or paracetamol) and other conservative treatments should be tried before surgery of the adnexa (endometrioma) is considered. However, hysterectomy may be proposed when more than one pathological conditions are present. Uterine prolapse is another common indication for hysterectomy, as it cannot be managed conservatively. Vaginal approach is the choice when there is a prolapse, although it may also be managed laparoscopically. Other infrequent indication for hysterectomy is malignancy.

ACOG: A recent Journal of the American Medical Association found that the percentage of hysterectomies performed robotically has jumped from less than 0.5% to nearly 10% over the past 3 years. The ACOG statement based on the article states that, expertise with robotic hysterectomy is limited and varies widely among both hospitals and surgeons. While there may be some advantages to the use of robotics in complex hysterectomies, especially for cancer operations, studies have shown that adding this expensive technology for routine surgical care does not improve patient outcomes. Consequently, there is no good data proving that robotic hysterectomy is even as good as, let alone better than, existing, and far less costly, minimally invasive alternatives.

AAGL: The available evidence indicates that robotic-assisted and conventional laparoscopic techniques for benign gynecologic surgery are comparable regarding perioperative outcomes, intraoperative complications, length of hospital stay, and rate of conversion to open surgery. However, published reports demonstrate that robotic assisted laparoscopic surgery has similar or longer operating times and higher associated costs. Efforts should be focused on the proper credentialing and privileging of surgeons to utilize robotic surgical systems as a means to minimize cases otherwise performed by laparotomy. Robotic-assisted laparoscopic surgery should not replace conventional laparoscopic or vaginal procedures for women who

### **HPHC Medical Policy**

#### **Hysterectomy**

**Page 4 of 7**

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could otherwise undergo conventional laparoscopic or vaginal surgery for benign gynecologic diseases. This is congruent with the findings of a 2012 Cochrane Review. Additional research comparing conventional laparoscopic and robotic-assisted laparoscopic surgery is needed to help characterize the advantages and disadvantages of robotic-assisted surgery and concurrently determine patient groups who would benefit from robotic-assisted laparoscopy over other methods. Pertinent research topics include the role of simulation, comparison of learning curves of robotic-assisted and conventional laparoscopic surgery, further cost analyses, practice trends, and additional studies focusing on short-term and long-term clinical outcomes for patients and surgeons.

### Coding:

**Codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible.**

CPT® Codes	Description
<b>Abdominal</b>	
<b>58150</b>	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
<b>58152</b>	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)
<b>58180</b>	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
<b>Vaginal</b>	
<b>58260</b>	Vaginal hysterectomy, for uterus 250 g or less;
<b>58262</b>	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
<b>58263</b>	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
<b>58267</b>	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
<b>58270</b>	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
<b>58275</b>	Vaginal hysterectomy, with total or partial vaginectomy;
<b>58280</b>	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele
<b>58285</b>	Vaginal hysterectomy, radical (Schauta type operation)
<b>58290</b>	Vaginal hysterectomy, for uterus greater than 250 g;
<b>58291</b>	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
<b>58292</b>	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele
<b>58293</b>	Vaginal hysterectomy, for uterus greater than 250 g; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
<b>58294</b>	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele
<b>Laparoscopic</b>	
<b>58541</b>	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;
<b>58542</b>	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
<b>58543</b>	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;
<b>58544</b>	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
<b>58570</b>	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less

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#### Hysterectomy

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<b>58571</b>	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
<b>58572</b>	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;
<b>58573</b>	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
<b>58575</b>	Laparoscopy, surgical, total hysterectomy for resection of malignancy (tumor debulking), with omentectomy including salpingo-oophorectomy, unilateral or bilateral, when performed
<b>Laparoscopic-Assisted Vaginal</b>	
<b>58550</b>	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;
<b>58552</b>	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
<b>58553</b>	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;
<b>58554</b>	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

### Related Policies:

For full coverage and indications for oophorectomy, please refer to Harvard Pilgrim Health Care's prophylactic procedures associated with hereditary breast and ovarian cancer syndrome policy.

### Billing Guidelines:

Member's medical records must document that services are medically necessary for the care provided. Harvard Pilgrim Health Care maintains the right to audit the services provided to our members, regardless of the participation status of the provider. All documentation must be available to HPHC upon request. Failure to produce the requested information may result in denial or retraction of payment.

### References:

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### HPHC Medical Policy

#### Hysterectomy

Page 6 of 7

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16. Pelvic Inflammatory Disease (PID). 2015 Sexually Transmitted Disease Treatment Guidelines. CDC. Updated June 4, 2015. Accessed January 8, 2018.
17. Uterine Adenomyosis. UpToDate.com/login [via subscription only]. Updated February 9, 2017. Accessed January 5, 2018.

### Summary of Changes

Date	Change
1/19	Reference to new policy regulating prophylactic oophorectomy added
01/18	Minor revisions in criteria under indications but no indication changes, supporting info added, references updated, one CPT code added 58575
2/17	Formatting updated
2/24/16	Differentiated pre- and post-menopausal criteria for AUB, removed TOA criteria, clarified PID criteria
7/28/15	Minor language edit (pgs. 2-3).

**Approved by Clinical Medical Advisory Committee: 1/8/19**

**Approved by Clinical Policy Operations Committee: 1/23/19**

**Policy Effective Date: 1/24/19**

**Revised: 1/15; 7/15; 2/16; 2/17; 10/17; 1/18; 1/19**

**Initiated: 7/1/15**

## HPHC Medical Policy

### Hysterectomy

Page 7 of 7

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