MEDICAL POLICY
No. 91575-R1

MENORRHAGIA TREATMENT

Effective Date: October 1, 2015
Review Dates: 8/10, 8/11, 8/12, 8/13, 8/14, 8/15, 8/16, 8/17
Date Of Origin: August 11, 2010
Status: Current

*Note this policy incorporates previously separate policies for Endometrial Ablation Procedures for Menorrhagia #91539 and Levongestrel-Releasing IUD (Mirena®) for Menorrhagia # 91487.

I. POLICY/Criteria

A. Hormonal therapy including levonorgestrel-releasing intrauterine systems (eg, Mirena®) or other pharmacotherapy as determined by member’s specific plan; or
B. Dilation and curettage; or
C. Endometrial ablation* is considered medically indicated when all of the following are present:
   1. Symptomatic menorrhagia (blood loss >80 mL per cycle, bleeding for >8 days, blood loss sufficient to cause anemia or blood loss or symptoms that significantly interfere with normal activities)
   2. Underlying anatomic or pathologic medical conditions have been ruled out (eg. Active infectious process or pelvic inflammatory disease, uterine polyps or other surgically correctable source of bleeding)
   3. Cervical cytology is negative
   4. Endometrial cancer or precancer is not present
   5. Adnexal tumors are not present
   6. Desire for childbearing completed

*The following endometrial ablation procedures are a covered benefit:
   • Hysteroscopic-assisted electrocautery utilizing a resectoscope with a wire loop
   • Thermal Balloon
   • Cryoablation
   • Hydrothermal
   • Radiofrequency (for example-NovaSure™ Impedence Controlled)

In addition to the above, the device utilized for endometrial ablation must be an FDA approved device and utilized as labeled.

Note: Coverage for the use of IUDs (including the levonorgestrel-releasing intrauterine system (Mirena®)) for contraception are a covered benefit for Medicaid, Healthy Michigan and MIChild members and for plans that fall under
the Women’s Preventive Health provisions of the Affordable Care Act. IUD’s may also be covered for commercial groups who have purchased a contraceptive management rider.

II. LIMITATIONS AND EXCLUSIONS

Coverage is not provided for:
- Diode laser (ELITT/GyneLase)
- Microwave

III. MEDICAL NECESSITY REVIEW

☐ Required     ☒ Not Required     ☐ Not Applicable

IV. APPLICATION TO PRODUCTS

Coverage is subject to member’s specific benefits. Group specific policy will supersede this policy when applicable.

❖ HMO/EPO: This policy applies to insured HMO/EPO plans.
❖ POS: This policy applies to insured POS plans.
❖ PPO: This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
❖ ASO: For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
❖ INDIVIDUAL: For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.
❖ MEDICARE: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
❖ MEDICAID/HEALTHY MICHIGAN PLAN: For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--00.html, the Michigan Medicaid Provider Manual will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.
V. DESCRIPTION

**Background:** Abnormal uterine bleeding is defined as a change in the frequency of menses, the duration of flow, or the amount of blood loss. The most common presenting complaint is excessive or prolonged bleeding, also referred to as menorrhagia.

Radiofrequency endometrial ablation (RFEA) has been introduced for the treatment of menorrhagia secondary to dysfunctional uterine bleeding (DUB). The procedure uses a radiofrequency-controlled probe that generates heat in the uterus to destroy the endometrial lining.

Other treatments for DUB include watchful waiting; pharmacological therapy using iron supplements, nonsteroidal anti-inflammatory drugs, oral contraceptives, and oral and intrauterine progestins; dilation and curettage; and hysterectomy. If optimal nonsurgical medical therapies fail, are contraindicated or cause intolerable side effects, then endometrial ablation or hysterectomy are options in women who have no wish for future pregnancies. Patients should however be informed that endometrial ablation is not an adequate form of contraception and pregnancy protection is still necessary.

VI. CODING INFORMATION

**Endometrial Procedures:**

**ICD-10 Codes** that may apply:
- N80.0 Endometriosis of uterus
- N85.9 Noninflammatory disorder of uterus, unspecified
- 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
- N92.6 Irregular menstruation, unspecified
- N93.8 Other specified abnormal uterine and vaginal bleeding
- N93.9 Abnormal uterine and vaginal bleeding, unspecified

**CPT/HCPCS Codes**
- 58353 Endometrial ablation, thermal, without hysteroscopic guidance
- 58356 Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed
- 58563 Hysteroscopy, surgical; with endometrial ablation (e.g., endometrial resection, electrosurgical ablation, thermoablation)

**Levonorgestrel-Releasing Intrauterine Device:**
*These procedures are covered regardless of diagnosis if the plan falls under the Women’s Preventive Health provisions of the Affordable Care Act. If a plan excludes*
coverage of contraceptive devices, the following procedures are covered as a medical benefit for these diagnoses only:

**ICD-10 Codes** that support medical necessity for the following procedures:
N92.0 Excessive and frequent menstruation with regular cycle
N92.1 Excessive and frequent menstruation with irregular cycle
N93.8 Other specified abnormal uterine and vaginal bleeding

* *CPT/HCPCS Codes
J7298 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg,
58300 Insertion of intrauterine device (IUD)
58301 Removal of intrauterine device (IUD)

*(This benefit does not apply to codes J7297, J7300 or J7301 -- contraception only)*

**VII. REFERENCES**


14. “Endometrial Cryoaurbation of the Uterus” Blue Cross Blue Shield Blue Care Network of Michigan Joint Medical Policy.  


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