UnitedHealthcare

UnitedHealthcare® Commercial
Medical Policy

Hysterectomy

Policy Number: 2022T0572Q
Effective Date: May 1, 2022

Instructions for Use

Table of Contents | Page

Coverage Rationale 1
Documentation Requirements 1
Applicable Codes 2
Description of Services 3
U.S. Food and Drug Administration 3
Policy History/Revision Information 4
Instructions for Use 4

Related Commercial Policies

- Abnormal Uterine Bleeding and Uterine Fibroids
- Outpatient Surgical Procedures – Site of Service
- Robotic Assisted Surgery

Community Plan Policy

- Hysterectomy

Coverage Rationale

Hysterectomy is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® Client Defined 2022, CP: Procedures, Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy (Custom) - UHG.

Click here to view the InterQual® criteria.

Documentation Requirements

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 documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

CPT Codes*	Required Clinical Information
Hysterectomy	

58150, 58152, 58180, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58290, 58291, 58292, 58294, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573	Medical notes documenting the following, when applicable:
	• Primary indication for the hysterectomy
	• Physician office notes which includes the following:
	  ○ Complete history and physical exam including OB/GYN, surgical and co-morbid medical condition(s), including thyroid disease
	  ○ Symptoms attributable to pelvic disease, including:
	    ▪ Duration
	    ▪ Severity
	    ▪ Relation to menstrual cycle
	    ▪ Impact on activities of daily living (ADL)
	  ○ Reports of relevant diagnostic evaluations, including:
	    ▪ Laboratory (including genetic testing results)
	    ▪ Pathology (including biopsy results)
	    ▪ Imaging includes Ultrasound, MRI, CT, etc.
	    ▪ Prior procedure/operative reports

Proprietary Information of UnitedHealthcare. Copyright 2022 United HealthCare Services, Inc.

CPT Codes*	Required Clinical Information
Hysterectomy	
	○ Diagnostic procedures (e.g., endometrial sampling, PAP, laboratory studies, hysteroscopy or D&C) ○ Reports of all attempted treatments attempted, declined, contraindicated or failed or including dates and clinical response • Identify if use of laparoscopic power morcellation is planned • For CPT codes 58260, 58262, 58290, and 58291, refer to the Medical Policy titled Gender Dysphoria Treatment • For CPT code 58263, refer to the Utilization Review Guideline Outpatient Surgical Procedures – Site of Service.

*For code descriptions, refer to the Applicable Codes section.

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. 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
Abdominal	
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)
Laparoscopic	
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)
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)
Vaginal	
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

Proprietary Information of UnitedHealthcare. Copyright 2022 United HealthCare Services, Inc.

CPT Code	Description
Vaginal	
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
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
Laparoscopic-Assisted Vaginal	
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)

CPT® is a registered trademark of the American Medical Association

Description of Services

A hysterectomy is a surgical procedure to remove the uterus, and in some cases, the ovaries and fallopian tubes as well. In a total hysterectomy, the entire uterus, including the cervix, is removed. In a supracervical or partial hysterectomy, the upper part of the uterus is removed, but the cervix is left in place. Benign conditions that might be treated with a hysterectomy include uterine fibroids, endometriosis, pelvic organ prolapse and abnormal uterine bleeding.

Hysterectomies can be performed vaginally, abdominally or with laparoscopic or robotic assistance. In a vaginal hysterectomy (VH), the uterus is removed through the vagina. In an abdominal hysterectomy (AH), the uterus is removed through an incision in the lower abdomen. A laparoscopic approach uses a laparoscope to guide the surgery. A laparoscope is a thin, lighted tube that is inserted into the abdomen through a small incision in or around the navel. The scope has a small camera that projects images onto a monitor. Additional small incisions are made in the abdomen for other surgical instruments used during the surgery. In a total laparoscopic hysterectomy (LH), the uterus is removed in small pieces through the incisions or through the vagina. In a laparoscopic-assisted VH, the uterus is removed through the vagina, and the laparoscope is used to guide the surgery. In a robotic-assisted LH, the surgeon uses a robot attached to the instruments to assist in the surgery (ACOG, 2015).

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

The interventions described in this policy are surgical procedures and are not subject to FDA approval. There are many surgical instruments approved for use in pelvic and abdominal surgery. See the following website to search for specific products. Available at: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed December 23, 2021)

A November 24, 2014 FDA Safety Communication recommends that manufacturers of laparoscopic power morcellators with a general indication or a specific gynecologic indication prominently include the following black box warning and contraindications in their product labeling:

- Warning:
  - Uterine tissue may contain unsuspected cancer. The use of laparoscopic power morcellators during fibroid surgery may spread cancer, and decrease the long-term survival of patients. This information should be shared with patients when considering surgery with the use of these devices.

Proprietary Information of UnitedHealthcare. Copyright 2022 United HealthCare Services, Inc.

- Contraindications:
  - Laparoscopic power morcellators are contraindicated in gynecologic surgery in which the tissue to be morcellated is known or suspected to contain malignancy.
  - Laparoscopic power morcellators are contraindicated for removal of uterine tissue containing suspected fibroids in patients who are peri- or post-menopausal, or are candidates for en bloc tissue removal, for example through the vagina or via a mini-laparotomy incision.

Refer to the following website for additional information: http://www.fda.gov/downloads/MedicalDevices/Safety/AlertsandNotices/UCM424444.pdf. (Accessed December 23, 2021)

Policy History/Revision Information

Date	Summary of Changes
05/01/2022	**Coverage Rationale** • Replaced reference to "InterQual® Client Defined *2021*" with "InterQual® Client Defined *2022*" **Supporting Information** • Archived previous policy version 2022T0572P

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Proprietary Information of UnitedHealthcare. Copyright 2022 United HealthCare Services, Inc.