Coverage Summary

Uterine Services and Procedures

Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee  Last Review Date: 09/18/2018

Related Medicare Advantage Policy Guidelines:
- Diagnostic Pap Smears (NCD 190.2)
- Gravlee Jet Washer (NCD 230.5)
- Therapeutic Embolization (NCD 20.28)
- Vabra Aspirator (NCD 230.6)

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member’s Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member’s EOC/SB, the member’s EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy, however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). 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).

<table>
<thead>
<tr>
<th>INDEX TO COVERAGE SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. COVERAGE</td>
</tr>
<tr>
<td>1. Diagnostic Pap Smear</td>
</tr>
<tr>
<td>2. Gravlee Jet Washer</td>
</tr>
<tr>
<td>3. Vabra Aspirator</td>
</tr>
<tr>
<td>4. Therapeutic Embolization</td>
</tr>
<tr>
<td>5. Uterine Artery Embolization</td>
</tr>
<tr>
<td>6. Magnetic Resonance Imaging (MRI)-guided Focused Ultrasound Ablation</td>
</tr>
<tr>
<td>7. Hysterectomy for Benign Conditions</td>
</tr>
<tr>
<td>8. Use of Intrauterine Devices (IUD) for Treatment of Endometrial Hyperplasia</td>
</tr>
<tr>
<td>II. DEFINITIONS</td>
</tr>
<tr>
<td>III. REFERENCES</td>
</tr>
<tr>
<td>IV. REFERENCES</td>
</tr>
<tr>
<td>V. REVISION HISTORY</td>
</tr>
<tr>
<td>V. ATTACHMENTS</td>
</tr>
</tbody>
</table>

I. COVERAGE

Coverage Statement: Uterine services and procedures are covered when Medicare coverage criteria are met.
Guidelines/Notes:

1. **Diagnostic Pap Smear**
   A diagnostic Pap smear and related medically necessary services are covered when ordered by a physician under one of the following conditions:
   - Previous cancer of the cervix, uterus, or vagina that has been or is presently being treated;
   - Previous abnormal pap smear;
   - Any abnormal findings of the vagina, cervix, uterus, ovaries, or adnexa;
   - Any significant complaint by the patient referable to the female reproductive system; or
   - Any signs or symptoms that might in the physician's judgment reasonably be related to a gynecologic disorder.

   See the [NCD for Diagnostic Pap Smears (190.2)](Accessed September 5, 2018)

   For screening Pap smears and pelvic examination for early detection of cervical or vaginal cancer, see the [Coverage Summary for Preventive Health Services and Procedures](#).

2. **Gravlee Jet Washer**
   Gravlee Jet Washer is covered for diagnosis of a patient with heavy uterine bleeding for detection of endometrial cancer. See the [NCD for Gravlee Jet Washer (230.5)](Accessed September 5, 2018)

3. **Vabra Aspirator**
   Vabra Aspirator is covered for use with patients who exhibit clinical symptoms of endometrial disease (irregular or heavy bleeding). The device is used to in the collection of uterine tissue for study for possible endometrial cancer. See the [NCD for Vabra Aspirator (230.6)](Accessed September 5, 2018)

4. **Therapeutic Embolization**
   Therapeutic embolization is covered for hemorrhage and other conditions amenable to this treatment. See the [NCD for Therapeutic Embolization (20.28)](Accessed September 5, 2018)

5. **Uterine Artery Embolization for Treatment of Uterine Fibroids (CPT code 37243)**
   - Medicare has a general [NCD for Therapeutic Embolization (20.28)](Accessed September 5, 2018), but does not have a specific NCD for uterine artery embolization (UAE) for treatment of uterine fibroids.
   - Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.
   - For coverage guidelines, refer to the [UnitedHealthcare Commercial Medical Policy for Abnormal Uterine Bleeding and Uterine Fibroids](#). (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
   - Committee approval date: September 18, 2018
   - Accessed September 5, 2018

6. **Magnetic Resonance Imaging (MRI)-guided Focused Ultrasound Ablation (CPT codes 0071T and 0072T)**
   - Medicare does not have National Coverage Determination (NCD) for magnetic resonance Imaging (MRI)-guided cryoabl abation.
   - Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the [LCD Availability Grid (Attachment A)](#).
7. **Hysterectomy for Benign Conditions**
   - Medicare does not have National Coverage Determination (NCD) for hysterectomy for benign conditions.
   - Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.
   - For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy for Hysterectomy for Benign Conditions. (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
   - Committee approval date: September 18, 2018
   - Accessed January 24, 2019

8. **Use of Intrauterine Devices (IUD) for Treatment of Endometrial Hyperplasia (CPT code 58999)**
   - Medicare does not have National Coverage Determination (NCD) for use of intrauterine devices (IUD) used in the treatment of endometrial hyperplasia.
   - Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, refer to the LCD Availability Grid (Attachment B).
   - For states with no LCDs/LCAs, see the UnitedHealthcare Commercial Medical Policy for Abnormal Uterine Bleeding and Uterine Fibroids for coverage guideline. (IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)
   - Committee approval date: September 18, 2018
   - Accessed January 24, 2019

**Note**: To avoid unnecessary claim denials use CPT® code 58999 Unlisted procedure, female genital system instead of CPT® code 58300. Use ICD-10 codes N85.00-N85.02 and enter “hormone IUD” in the comment/narrative field. See the Palmetto LCAs for Endometrial Hyperplasia Treatment (A53043). (Accessed January 24, 2019)

<table>
<thead>
<tr>
<th>II. DEFINITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III. REFERENCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>See above</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IV. REVISION HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/01/2019 • Updated policy introduction; added language to clarify: o There are instances where [the Coverage Summary] may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG) o In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or Local Coverage Article (LCA) for Endometrial Hyperplasia Treatment, use the above referenced policy.</td>
</tr>
</tbody>
</table>

© UnitedHealthcare. All rights reserved.
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)

- Retitled reference links that direct users to UnitedHealthcare Commercial policies

09/18/2018  Annual review with the following updates:
Updated Local Coverage Determination (LCD) Availability Grids; removed instruction to “use the applicable LCD based on member’s residence/place and type of service” (this note only applies when selecting the appropriate DME LCD Policy

Guideline 5 (Uterine Embolization)
Update guideline title to “Uterine Artery Embolization for Treatment of Uterine Fibroids”

Added a statement that there is a general NCD for therapeutic embolization.

01/16/2018  Re-review with the following update:
Guideline 6 [Magnetic Resonance Imaging (MRI)-guided Focused Ultrasound Ablation (CPT codes 0071T and 0072T)] - Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.

10/17/2017  Re-review; added Guideline 1 (Diagnostic Pap Smear); moved from retired Diagnostic Pap Smear Coverage Summary.

09/19/2017  Annual review; Guideline 4 (Uterine Artery Embolization) was updated to include CPT code 37243.

09/20/2016  Annual review; no updates.

01/19/2016  Updated reference link(s) of the applicable LCDs to reflect the new condensed LCD link(s).

11/17/2015  Guideline #7 [Use of Intrauterine Devices (IUD) for Treatment of Endometrial Hyperplasia (CPT® code 58999)] – Added applicable guidelines (new to coverage summary).

03/12/2015  Formatting change only.

12/16/2014  Guideline 6 (Hysterectomy for Benign Conditions) – added guideline; new to the policy

10/21/2014  Annual review with the following updates:
Guideline # 4 (Uterine Artery Embolization) – Updated to state that there are no available LCDs at this time as the only available First Coast Local Articles were retired on June 30, 2014.


03/18/2014  Guideline #4 Uterine Artery Embolization – CPT code 37210 deleted; no longer valid as of 1/1/2014.
Guideline #5 Endometrial Ablation – Deleted; prior authorization no longer required for this procedure.

Guideline #6 Magnetic Resonance Imaging (MRI)-guided Focused Ultrasound
   Renamed section from Magnetic Resonance Imaging (MRI)-guided Cryoablation to Magnetic Resonance Imaging (MRI)-guided Focused Ultrasound Focused Ultrasound
   Revised guideline for states with no LCDs; replaced NHIC LCD for Category III CPT Codes (L18917) to Noridian LCD for Non-Covered Services (L24473)

10/24/2013  Annual review; no updates
10/31/2012  Annual review with the addition of the following guidelines:
   • Guidelines #4 - Uterine Artery Embolization (CPT code 37210)
   • Guidelines #5 - Endometrial Ablation
   • Guidelines #6 - Magnetic Resonance Imaging (MRI)-guided Cryoablation

10/13/2011  Annual review; no updates

V. ATTACHMENT(S)

Attachment A - LCD Availability Grid

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>L35008</td>
<td>Non-Covered Services</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY</td>
</tr>
<tr>
<td>L35094</td>
<td>Services That Are Not Reasonable and Necessary</td>
<td>A and B MAC</td>
<td>Novitas Solutions, Inc.</td>
<td>AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX</td>
</tr>
<tr>
<td>L34555</td>
<td>Non-Covered Category III CPT Codes</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>NC, SC, VA, WV, AL, GA, TN</td>
</tr>
<tr>
<td>L33392</td>
<td>Category III CPT Codes</td>
<td>A and B MAC</td>
<td>National Government Services, Inc.</td>
<td>IL, MA, ME, MN, NH, NY, RI, VT, WI</td>
</tr>
<tr>
<td>L36219</td>
<td>Non Covered Services</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AS, CA, GU, HI, MP, NV</td>
</tr>
</tbody>
</table>

End of Attachment A

Attachment B - LCD Availability Grid

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>A53043</td>
<td>Endometrial Hyperplasia Treatment</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>NC, SC, VA, WV</td>
</tr>
<tr>
<td>A55061</td>
<td>IUD (Hormone-Eluting) for Endometrial Hyperplasia - CPT 58999</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>CA, HI, NV</td>
</tr>
<tr>
<td>A55062</td>
<td>IUD (Hormone-Eluting) for Endometrial Hyperplasia - CPT 58999</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, MT, ND, OR, SD, WA, UT, WY</td>
</tr>
</tbody>
</table>

Page 5 of 6
UHC MA Coverage Summary: Uterine Services and Procedures
Proprietary Information of UnitedHealthcare. Copyright 2018 United HealthCare Services, Inc.
### Attachment B - LCD Availability Grid

**Treatment of Endometrial Hyperplasia with IUD**

CMS website accessed January 24, 2019

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>A55951</td>
<td><strong>Endometrial Hyperplasia Treatment with Intrauterine Device (Hormone-Eluting)</strong></td>
<td>MAC – Part A &amp; Part B</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>AK, AL, AR, AZ, CT, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, OH, OR, RI, SC, SD, TN, UT, VA, VI, VT, WA, WI, WV, WY</td>
</tr>
</tbody>
</table>

End of Attachment B