Uterine Services and Procedures

Coverage Guidelines

Uterine services and procedures are covered when Medicare coverage criteria are met.

Note: The guidelines in this Coverage Summary are for specific procedures only. For procedures not addressed in this Coverage Summary, refer to the Medicare Coverage Database to search for applicable coverage policies (National Coverage Determination, Local Coverage Determinations and Local Coverage Articles).

Uterine Artery Embolization for Treatment of Uterine Fibroids (CPT code 37243)

Medicare has a general NCD for Therapeutic Embolization (20.28), 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.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Abnormal Uterine Bleeding and Uterine Fibroids.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.
(Accessed September 18, 2023)

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 cryoablation. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Abnormal Uterine Bleeding and Uterine Fibroids.
Magnetic resonance-guided focused ultrasound ablation (MRgFUS) is unproven and not medically necessary for treating uterine fibroids due to insufficient evidence of efficacy.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed September 18, 2023)

**Hysterectomy**

Medicare does not have National Coverage Determination (NCD) for hysterectomy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Hysterectomy.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed September 18, 2023)

**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 specific LCDs/LCAs, refer to the table for Treatment of Endometrial Hyperplasia with IUD.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Abnormal Uterine Bleeding and Uterine Fibroids.

Note: After checking the Treatment of Endometrial Hyperplasia with IUD table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

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. Refer to the Palmetto LCA for Billing and Coding: Endometrial Hyperplasia Treatment (A53043). (Accessed September 18, 2023)

### Supporting Information

#### Treatment of Endometrial Hyperplasia with IUD

Accessed September 18, 2023

<table>
<thead>
<tr>
<th>LCD/LCA ID</th>
<th>LCD/LCA Title</th>
<th>Contractor Type</th>
<th>Contractor Name</th>
<th>Applicable States/Territories</th>
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<tr>
<td>A58649</td>
<td>Billing and Coding: IUD (Hormone-Eluting) for Endometrial Hyperplasia - CPT 58999</td>
<td>Part A and B MAC</td>
<td>National Government Services, Inc.</td>
<td>CT, IL, MN, NY, ME, MA, NH, RI, WI, VT</td>
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<td>A55061</td>
<td>Billing and Coding: IUD (Hormone-Eluting) for Endometrial Hyperplasia - CPT 58999</td>
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<td>Noridian Healthcare Solutions, LLC</td>
<td>CA, HI, NV, AS, GU, MP</td>
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<td>A55062</td>
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<td>Part A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, MT, ND, OR, SD, WA, UT, WY</td>
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# Treatment of Endometrial Hyperplasia with IUD

Accessed September 18, 2023

<table>
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<tr>
<th>LCD/LCA ID</th>
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<th>Contractor Name</th>
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</thead>
<tbody>
<tr>
<td>A53043</td>
<td>Billing and Coding: Endometrial Hyperplasia Treatment</td>
<td>Part A and B MAC</td>
<td>Palmetto GBA</td>
<td>NC, SC, VA, WV</td>
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<tr>
<td>A55951</td>
<td>Billing and Coding: Endometrial Hyperplasia Treatment with Intrauterine Device (Hormone-Eluting)</td>
<td>Part B MAC</td>
<td>Wisconsin Physicians Service Insurance Corporation</td>
<td>IA, IN, KS, MI, MO, NE</td>
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## Policy History/Revision Information

<table>
<thead>
<tr>
<th>Date</th>
<th>Summary of Changes</th>
</tr>
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</table>
| 10/11/2023 | **Template Update**  
  - Updated Instructions for Use  
  **Supporting Information**  
  - Updated list of available Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) to reflect the most current information  
  - Archived previous policy version MCS098.03 |

## Instructions for Use

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 should not rely on this information in making health care decisions. 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.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing the items or services in this coverage summary have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, UnitedHealthcare applies internal coverage criteria in the UnitedHealthcare commercial policies referenced in this coverage summary. The coverage criteria in these commercial policies was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

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