

Hysterectomy (for Indiana Only)

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[Instructions for Use](#)

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Related Policy
<ul style="list-style-type: none"> Abnormal Uterine Bleeding and Uterine Fibroids

Application

This Medical Policy only applies to the state of Indiana.

Coverage Rationale

For medical necessity clinical coverage criteria, refer to the [Indiana Health Coverage Programs Bulletin, BT201976, December 26, 2019](#).

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 federal, state, or contractual requirements 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-urethrocytostomy (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

CPT Code	Description
Laparoscopic	
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-urethrocytopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
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
58285	Vaginal hysterectomy, radical (Schauta type operation)
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)

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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 July 23, 2020)

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.
- 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.

See the following website for additional information:

<http://www.fda.gov/downloads/MedicalDevices/Safety/AlertsandNotices/UCM424444.pdf>. (Accessed July 23, 2020)

Policy History/Revision Information

Date	Summary of Changes
04/01/2021	<ul style="list-style-type: none"> • New Medical Policy

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. 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.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual[®] criteria, to assist us in administering health benefits. The 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.