HYSTERECTOMY FOR BENIGN CONDITIONS

Guideline Number: MMG144.I **Effective Date**: April 1, 2019

Instructions for Use

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Related Medical Management Guideline

- Abnormal Uterine Bleeding and Uterine Fibroids

COVERAGE RATIONALE

Hysterectomy is proven and medically necessary in certain circumstances.
For medical necessity clinical coverage criteria, see the following MCG™ Care Guidelines, 23rd edition, 2019:

- Hysterectomy, Abdominal, ORG: S-650 (ISC)
- Hysterectomy, Vaginal, ORG: S-660 (ISC)
- Hysterectomy, Laparoscopic, ORG: S-665 (ISC)

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.

Required Clinical Information

Hysterectomy for Benign Conditions

Medical notes documenting **all** of the following:

- Primary indication for the hysterectomy
- Physician office notes which includes the following:
  - Complete history including OB/GYN, surgical and co-morbid medical condition(s)
  - Symptoms attributable to pelvic disease
    - Duration
    - Severity
    - Relation to menstrual cycle
  - Reports of all relevant diagnostic evaluations
    - Laboratory
    - Pathology
    - Imaging includes Ultrasound, MRI, CT, etc.
    - Prior procedure/operative reports
  - Reports of all attempted treatments (offered, attempted or declined), including dates and clinical response.
  - Investigational procedures (e.g., endometrial sampling, PAP, laboratory studies, hysteroscopy or D&C within ACOG guidelines)

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 guideline 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 250g or less;
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250g
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250g or less
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)
Vaginal	
58260	Vaginal hysterectomy, for uterus 250g or less
58262	Vaginal hysterectomy, for uterus 250g or less; with removal of tube(s), and/or ovary(s)
58263	Vaginal hysterectomy, for uterus 250g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
58267	Vaginal hysterectomy, for uterus 250g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58270	Vaginal hysterectomy, for uterus 250g 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
58293	Vaginal hysterectomy, for uterus greater than 250 g; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
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)

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).

CLINICAL EVIDENCE

Studies have shown that a vaginal approach to hysterectomy has fewer complications, requires a shorter hospital stay and is associated with better outcomes than a laparoscopic or abdominal approach.

A Cochrane review of 47 randomized controlled trials (RCTs) (n=5102) evaluating the abdominal, laparoscopic, and vaginal approach concluded that VH appears to be superior to LH and AH. VH is preferred to AH when possible, citing the advantages of a more rapid recovery and fewer postoperative complications of fever and/or infection. Where VH is not possible, a laparoscopic approach is preferred over AH with the same advantages as the vaginal approach, but requires a longer operating time and had more urinary tract injuries (Aarts et al., 2015).

A meta-analysis of five randomized studies comparing total LH and VH for benign disease reported no differences in perioperative complications between the two procedures. LH was associated with reduced postoperative pain scores and reduced hospital stay but took longer to perform. No differences in blood loss, rate of conversion to laparotomy or urinary tract injury were identified (Gendy et al., 2011).

A Cochrane review of 34 RCTs (n=4495) of AH, TLH, and VH concluded that VH should be performed in preference to AH where possible. The authors found that VH meant a quicker return to normal activities, fewer infections and episodes of raised temperature after surgery and a shorter hospital stay compared to AH. When a vaginal approach is not possible, a laparoscopic approach may avoid the need for an AH. LH meant a quicker return to normal activities, less blood loss and a smaller drop in blood count, a shorter hospital stay and fewer wound infections and episodes of raised temperature after surgery compared to AH; however, laparoscopic surgery is associated with longer operating times and higher rates of urinary tract injury. More research is needed, particularly to examine the long-term effects of the different types of surgery (Nieboer et al., 2009).

Walsh et al. (2009) performed a meta-analysis of RCTs to compare outcomes in total AH and total LH for benign disease in women who were not candidates for a vaginal approach. Results indicated that LH is associated with reduced overall peri-operative complications and reduced estimated blood loss. Additionally, there are trends towards shorter hospital stay and postoperative hematoma formation compared to AH. However, there were longer operating times in the LH group. Although the rates of major complication were not statistically different, the authors note that this analysis is likely underpowered to detect many major complications. Larger studies are needed to assess the impact on major complications and long-term clinical outcomes.

Professional Societies

American Association of Gynecologic Laparoscopists (AAGL)

An AAGL position statement concludes that most hysterectomies for benign disease should be performed either vaginally or laparoscopically. These approaches are associated with low surgical risks and can be performed with a short hospital stay. AH should be reserved for the minority of women for whom a laparoscopic or vaginal approach is not appropriate (2011).

American College of Obstetricians and Gynecologists (ACOG)

An ACOG committee opinion states that VH is the approach of choice whenever feasible. Evidence demonstrates that, in general, VH is associated with better outcomes and fewer complications than LH or AH. LH is an alternative to AH when a VH is not indicated or feasible (ACOG, 2017).

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

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 January 9, 2019)

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 January 9, 2019)

REFERENCES

Aarts JW, Nieboer TE, Johnson N, et al; Surgical approach to hysterectomy for benign gynaecological disease; Cochrane Database Syst Rev; 2015 Aug 12; 8: CD003677.

American Association of Gynecologic Laparoscopists (AAGL); Position statement: route of hysterectomy to treat benign uterine disease; J Minim Invasive Gynecol; 2011 Jan-Feb; 18 (1): 1-3.

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Falcone T, Walters MD; Hysterectomy for benign disease; Obstet Gynecol; 2008 Mar; 111 (3): 753-67.

Gendy R, Walsh CA, Walsh SR, et al; Vaginal hysterectomy versus total laparoscopic hysterectomy for benign disease: a meta-analysis of randomized controlled trials; Am J Obstet Gynecol; 2011 May; 204 (5): 388.e1-8.

Nieboer TE, Johnson N, Lethaby A, et al; Surgical approach to hysterectomy for benign gynaecological disease; Cochrane Database Syst Rev; 2009 Jul 8; (3): CD003677.

Walsh CA, Walsh SR, Tang TY, et al; Total abdominal hysterectomy versus total laparoscopic hysterectomy for benign disease: a meta-analysis; Eur J Obstet Gynecol Reprod Biol; 2009 May; 144 (1): 3-7.

GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
08/01/2019	**Template Update** • Added *Documentation Requirements* section

04/01/2019	• Reorganized policy template:
	  ○ Simplified and relocated *Instructions for Use*
	  ○ Removed *Benefit Considerations* section
	• Revised coverage rationale:
	  ○ Replaced reference to "MCG™ Care Guidelines, *22nd* edition*, 2018*" with "MCG™ Care Guidelines, *23rd* edition*, 2019*"; refer to 23rd edition for complete details on applicable updates to the MCG™ Care Guidelines
	• Archived previous policy version MMG144.H

INSTRUCTIONS FOR USE

This Medical Management Guideline 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 benefit plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, 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 Management Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare West Medical Management Guidelines 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.

Member benefit coverage and limitations may vary based on the member's benefit plan Health Plan coverage provided by or through UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare Benefits of Texas, Inc., or UnitedHealthcare of Washington, Inc.