Uterine Services and Procedures

Policy Number: MCS098.06
Approval Date: March 13, 2024
Effective Date: May 1, 2024

Instructions for Use

Table of Contents **Page**

Related Policies
None

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 Codes 37243 and 37244)

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.

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 (CPT Codes 58150, 58152, 58180, 58260, 58262, 58263, 58267, 58270, 58290, 58291, 58292, 58294, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, 58572, and 58573)

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 January 4, 2024)

Hysterectomy for Purpose of Sterilization

Refer to the Coverage Summary titled Reproductive Services: Infertility, Family Planning, and Maternity Care.

Use of Intrauterine Devices (IUD) for Treatment of Endometrial Hyperplasia

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 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.

Transvaginal Biomechanical Mapping (CPT Code 58999)

Medicare does not not have National Coverage Determination (NCD) for transvaginal biomechanical mapping. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.

For coverage guidelines, refer to the UnitedHealthcare Medical Policy titled Omnibus Codes.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed March 14, 2024)

Supporting Information

Treatment of Endometrial Hyperplasia with IUD Accessed January 11, 2024				
LCD/LCA ID	**LCD/LCA Title**	**Contractor Type**	**Contractor Name**	**Applicable States/Territories**
A59619	Billing and Coding: Treatment of Abnormal Uterine Bleeding with Intrauterine Device (Hormone-Eluting)	Part A and B MAC	First Coast	FL, PR, VI

Treatment of Endometrial Hyperplasia with IUD Accessed January 11, 2024				
LCD/LCA ID	**LCD/LCA Title**	**Contractor Type**	**Contractor Name**	**Applicable States/Territories**
A58649	Billing and Coding: IUD (Hormone-Eluting) for Endometrial Hyperplasia - CPT 58999	Part A and B MAC	National Government Services, Inc.	CT, IL, MA, ME, MN, NH, NY, RI, WI, VT
A55061	Billing and Coding: IUD (Hormone-Eluting) for Endometrial Hyperplasia - CPT 58999	Part A and B MAC	Noridian Healthcare Solutions, LLC	AS, GU, HI, MP, NV
A55062	Billing and Coding: IUD (Hormone-Eluting) for Endometrial Hyperplasia - CPT 58999	Part A and B MAC	Noridian Healthcare Solutions, LLC	AK, AZ, ID, MT, ND, OR, SD, WA, UT, WY
A59620	Article - Billing and Coding: Treatment of Abnormal Uterine Bleeding with Intrauterine Device (Hormone-Eluting)	Part A and B MAC	Novitas Solutions, Inc.	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
A53043	Billing and Coding: Endometrial Hyperplasia Treatment	Part A and B MAC	Palmetto GBA	NC, SC, VA, WV
A55951	Billing and Coding: Endometrial Hyperplasia Treatment with Intrauterine Device (Hormone-Eluting)	Part A and B MAC	Wisconsin Physicians Service Insurance Corporation*	IA, IN, KS, MI, MO, NE
Back to Guidelines				

MACs with Corresponding States/Territories	
MACs	**States/Territories**
CGS	KY, OH
First Coast	FL, PR, VI
NGS	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian	AK, AS, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
Palmetto	AL, GA, NC, SC, TN, VA, WV
WPS*	IA, IN, KS, MI, MO, NE
*__Note__: Wisconsin Physicians Service Insurance Corporation Contract Number 05901 - applies only to WPS Legacy Mutual of Omaha MAC A Providers	

Policy History/Revision Information

Date	Summary of Changes
03/13/2024	**Coverage Guidelines** • Removed content/language addressing: ○ Radical hysterectomy (CPT codes 58210, 58285, 58548, 58952, 58953, and 58954)

Date	Summary of Changes
	○ Hysteroscopy, diagnostic (CPT codes 58120, 58555, 58558, 59160, 59812, 59820, 59821, 59830, 59840, 59841, 59851, and 59870) ○ Hysteroscopy, dilation, and curettage (D&C) (CPT codes 58558, 58559, 58560, 58561, 58562, 58563, and 58565) ○ Endometriosis surgery (CPT code 58662) ***Hysterectomy for Purpose of Sterilization*** (new to policy) • Added instruction to refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Reproductive Services: Infertility, Family Planning, and Maternity Care* ***Use of Intrauterine Devices (IUD) for Treatment of Endometrial Hyperplasia*** • Removed list of applicable CPT codes from service heading • Removed notation pertaining to appropriate billing and coding ***Transvaginal Biochemical Mapping (CPT Code 58999)*** (new to policy) • Added language to indicate: ○ Medicare does not have National Coverage Determination (NCD) for transvaginal biomechanical mapping; Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines **Supporting Information** • Added list of applicable *Medicare Administrative Contractors (MACs) with Corresponding States/Territories* • Updated list of applicable LCDs/LCAs to reflect the most current information; added notation to indicate the Wisconsin Physicians Service Insurance Corporation (WPS) Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers **Administrative** • Archived previous policy version MCS098.05

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 NCDs or 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.

CPT® is a registered trademark of the American Medical Association.