

## Evidence Based Guideline

# Intrauterine Ablation or Resection of the Endometrium

**File Name:** intrauterine\_ablation\_or\_resection\_of\_the\_endometrium  
**Guideline Number:** EBG.OBGYN3030  
**Origination:** 4/1993  
**Last Review:** 12/2006

**Active guideline, no longer scheduled for routine literature review.**

### Description of Procedure or Service

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Intrauterine [ablation](#) or resection of the [endometrium](#) is used to treat excessive uterine bleeding (menorrhagia) in women for whom hormone therapy or dilatation and curettage (D & C) has been unsuccessful. In endometrial [ablation](#), physicians ablate (destroy) the [endometrium](#), (the lining of the uterus), to reduce or stop menorrhagia. Endometrial [ablation](#) was developed as a less radical alternative to hysterectomy, (the surgical removal of the uterus), to treat excessive uterine bleeding. The following multiple energy sources have been developed to perform endometrial [ablation](#):

1. the neodymium- yttrium aluminum garnet (Nd-YAG) laser;
2. a resecting loop using electric current;
3. electric rollerball;
4. thermal [ablation](#) devices using thermal energy (heat or cold), including high frequency radio frequency (RF) probes, cryoprobes, liquid filled balloons, multi-electrode balloons, hydrothermal [ablation](#)/circulating heated saline, and microwave energy.

Intrauterine [ablation](#) or resection may be performed on an outpatient basis, or with an overnight hospital stay or in a physician's office depending on the method used. Some [ablation](#) methods require general or spinal anesthesia, but others may be performed using local anesthesia. Thermal fluid-filled balloon, cryosurgical endometrial [ablation](#), instillation of heated saline or radiofrequency [ablation](#) can be performed without general anesthesia and can be performed in a physician's office.

After treatment, scarring of the uterine cavity occurs and the [endometrium](#) is not expected to regenerate. Pregnancies that occur after [ablation](#) can be dangerous for both the fetus and the mother. Although women undergoing endometrial [ablation](#) or resection must be finished with childbearing, intrauterine [ablation](#) or resection should not be considered a means of sterilization. Sterility may occur after [ablation](#) or resection, but cannot be guaranteed.

**Intrauterine [ablation](#) or resection of the [endometrium](#) should not be confused with laparoscopic laser [ablation](#) of intraperitoneal endometriosis. This policy does not address laparoscopic intraperitoneal [ablation](#).**

### Evidence Based Guideline for Intrauterine Ablation or Resection of the Endometrium

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Intrauterine ablation or resection of the endometrium may be appropriate when **all** of the following criteria are met:

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1. The [menometrorrhagia](#) is a high degree of severity and persistence, creating significant signs and symptoms for the patient and the failure of prior treatment should be such that the patient would otherwise be a candidate for [hysterectomy](#) (surgical removal of the uterus); **and**
2. The menorrhagia is not responsive to at least 3 months of hormone therapy (unless contraindicated) or D & C; **and**
3. **One** of the following techniques are used:
  - Nd-YAG laser; **or**
  - Resecting loop; **or**
  - Roller ball using electric current; **or**
  - Liquid filled balloons that are approved by the Food and Drug Administration (FDA) such as ThermoChoice®; **or**
  - Cryosurgical devices that are approved by the FDA such as HerOption™ Uterine Cryoablation Therapy™ System; **or**
  - Hydrothermal devices that are approved by the FDA such as HydroThermAblator® (HTA) Endometrial [Ablation](#) System; **or**
  - Microwave energy devices that are approved by the FDA such as the MEA System; **or**
  - Radiofrequency energy devices that are approved by the FDA such as the NovaSure™ impedance-controlled system.

### Medical Evidence regarding Intrauterine Ablation or Resection of the Endometrium indicates it is not recommended in the following situations:

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Intrauterine ablation or resection of the endometrium is not recommended when any **one** of the following techniques is used:

- ♦ Any other thermal [ablation](#) devices (heat or cold); **or**
- ♦ Multi-electrode balloons such as VestaBlate with 12 RF electrodes; **or**
- ♦ Photodynamic Endometrial [Ablation](#).

When **any** of the following medical contraindications are present:

- ♦ A patient who is pregnant or desires pregnancy; **or**
- ♦ History of endometrial cancer or pre-cancerous histology; **or**
- ♦ Patient with an active genital or urinary tract infection at the time of the procedure; **or**
- ♦ Patient with active pelvic inflammatory disease; **or**
- ♦ Patient with an intrauterine device (IUD) currently in place; **or**
- ♦ Patient with any anatomic or pathologic condition in which weakness of the myometrium could text goes here exist, such as history of previous classical cesarean sections or transmural myomec-tomy.

Other contraindications for [microwave ablation](#) include:

- ♦ Essure contraceptive micro-inserts are in place in the fallopian tubes;
- ♦ Myometrial thickness less than 10 mm;
- ♦ Uterine sounding length less than 6 cm.

## Policy: Intrauterine Ablation or Resection of the Endometrium

### Benefits Application

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Please refer to certificate for availability of benefit. This guideline relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore certificate language should be reviewed before applying the terms of the policy.

### Billing/Coding/Physician Documentation Information

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This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at [www.bcbsnc.com](http://www.bcbsnc.com). They are listed in the Category Search on the Medical Policy search page.

*Applicable codes: 58353, 58356, 58563*

### Medical Term Definitions

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#### **Ablation**

the removal of tissue or an abnormal growth, usually by cutting; may also refer to a very high dose of treatment that is calculated to kill a tumor.

#### **Endometrium**

the tissue lining the uterus.

#### **Hysterectomy**

surgical removal of the uterus, either through the abdominal wall or through the vagina.

#### **Menometrorrhagia**

excessive uterine bleeding occurring both during the menses and at irregular intervals.

### Scientific Background and Reference Sources

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BCBSA - 12/95

BCBSA - 7/31/97

Meyer WR, Walsh BW, Grainger DA. Thermal balloon and rollerball ablation to treat menorrhagia: a multi-center comparison. *Obstetrics & Gynecology*. 1998;92(1):98-103.

Amso NN, Stabinski SA, McFaul P. Uterine thermal balloon therapy for the treatment of menorrhagia: the first 300 patients from a multi-centre study. *British Journal of Obstetrics & Gynaecology*. 1998;105:517-523.

Specialty Matched Consultant Advisory Panel - 11/99

Medical Policy Advisory Group - 12/2/99

Specialty Matched Consultant Advisory Panel - 9/2001

ECRI Hotline Response: Cryosurgical Endometrial Ablation for Menorrhagia, Updated on 5/23/02

ECRI Hotline Response: Hydrothermal Endometrial Ablation for Menorrhagia, Updated on 6/3/02

BCBSA Medical Policy Reference Manual - Policy 4.01.04 - Review date: 07/12/02

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FDA New Device Approval: Hydro ThermAblator®, referenced 9/6/02

Specialty Matched Consultant Advisory Panel - 12/2002

BCBSA Medical Policy Reference Manual - Policy 4.01.04 - Review date: 12/18/02

BCBSA Medical Policy Reference Manual [Electronic Version]. 4.01.04, 2/25/04.

National Institute for Clinical Excellence. Interventional Procedure Guidance 47 - Photodynamic endometrial ablation. Accessed on 10/14/2004 at <http://www.nice.org.uk/pdf/IPG047guidance.pdf>.

Specialty Matched Consultant Advisory Panel - 12/2004

BCBSA Medical Policy Reference Manual [Electronic Version]. 4.01.04, 12/14/05.

Specialty Matched Consultant Advisory Panel - 12/13/2006

### Policy Implementation/Update Information

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- 10/89 Evaluated: Investigational for laser ablation
- 11/91 Evaluated: Eligible for coverage for laser ablation, rollerball ablation and loop resection
- 6/96 Reaffirmed: National Association reviewed 12/95. No changes.
- 7/99 Added liquid-filled balloon devices that have been FDA approved to covered indications.
- 7/99 Reformatted, Medical Term Definitions added.
- 12/99 Reaffirmed, Medical Policy Advisory Group
- 12/00 58563 added as replacement code for 56356 which is a deleted code (CPT 1999). New 2001 CPT code added; 58353. System coding changes.
- 9/01 Specialty Matched Consultant Advisory Panel review. No changes in criteria.
- 4/02 Policy revised under when it is covered to include liquid-filled balloons that are FDA approved such as ThermaChoice®. Revised under when it is not covered to clarify other thermal ablation devices that are not covered. Clarified contraindications to include women that have not finished with childbearing. Format changes. Billing/Coding Section updated with revised coding language.
- 8/02 Implementation section for 4/02 clarified for system coding changes.
- 01/03 Specialty Matched Consultant Advisory Panel review 12/02/2002. Description of procedure section revised for clarity. Under "When Covered" section - #3 added two bullets. One for Cryosurgical devices that are approved by the FDA such as HerOption Uterine Cryoablation Therapy System and another for Hydrothermal devices that are approved by the FDA such as Hydro ThermAblator Endometrial Ablation System. Under "When Not Covered" section re: techniques, first bullet, removed (except FDA approved thermal devices for.....). 0009T added to Billing/Coding Section. System coding changes.
- 7/03 Corrected dates of last review and next review to 12/2002 and 12/2004 respectively (Specialty Matched Consultant Advisory Panel review was 12/2002, not 10/2002.) Benefits Application section revised.
- 4/04 Billing/Coding section updated for consistency.
- 12/23/04 Specialty Matched Consultant Advisory Panel review 12/9/2004. Added microwave energy devices (such as MEA system) and radiofrequency energy devices (such as NovaSure system) that are approved by the FDA as covered. Under "When not covered" section: Added photodynamic endometrial ablation as non-covered (investigational); Listed VestaBlate with 12 RF electrodes as a multi-electrode balloon under second bullet; Removed "including high frequency radiofrequency

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(RF) probes" and "microwave energy"; Contraindications updated. CPT Code 0009T removed from Billing/Coding section-code will be deleted as of 12/31/04. To report 0009T effective 1/1/05 providers should use CPT code 58356. CPT code 58356 added. Sources added. Notice given 12/23/04. Effective 3/3/05.

8/21/06 Medical Policy changed to Evidence Based Guideline.

1/17/2007 Specialty Matched Consultant Advisory Panel - 12/12/2006. No changes to criteria. Billing/Coding section revised. Reference sources added.

10/20/08 Evidence Based Guideline status changed to "Active guideline, no longer scheduled for routine literature review."

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