



CIGNA MEDICAL COVERAGE POLICY

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Subject Hysterectomy

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- Magnetic Resonance (MR)-Guided Thermal Ablation of Uterine Fibroids
- Prophylactic Oophorectomy or Salpingo-oophorectomy With or Without Hysterectomy
- Transvaginal Ultrasound for Ovarian and Endometrial Cancer Screening or Surveillance
- Uterine Artery Embolization

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Coverage Policy

CIGNA covers hysterectomy, with or without salpingo-oophorectomy, as medically necessary for the following indications/conditions:

- uterine leiomyomata (fibroids) when **ALL** of the following medical necessity criteria are met:
 - significant size (i.e., fibroids that have enlarged the uterus to \geq 12 weeks' gestational size (i.e., at least 14 cm in one dimension as measured by transvaginal ultrasound [US])
 - significant symptoms, as indicated by **ANY ONE** of the following:
 - recurrent profuse bleeding lasting longer than seven days or repetitive periods at less than 21-day intervals, in the absence of other remediable pathology after completion of an appropriate evaluation (e.g., ultrasound, endometrial biopsy, sonohysterogram, hysteroscopy, hysterosalpingogram, or dilation and curettage [D&C])
 - anemia due to chronic uterine bleeding
 - failure of symptoms to respond to uterine artery embolization (UAE), hysteroscopic resection of submucosal fibroid or endometrial ablation
 - chronic lower abdominal or pelvic pain, low back pressure, rectal pressure or bowel dysfunction for which no other cause can be found

- urinary symptoms (e.g., frequent urination) found on evaluation to be due to mass pressure effect and not to intercurrent infection or other etiology
- abnormal (premenopausal) uterine bleeding with **ALL** of the following:
 - bleeding is recurrent (i.e., lasting longer than seven days or repetitive periods at less than 21-day intervals) and unresponsive to medical management, including at least a three-month trial of hormonal manipulation unless contraindicated or not tolerated
 - no evidence of other remediable pathology on diagnostic evaluation of the endometrium completed within the last 24 months by endometrial biopsy or D&C
 - no evidence of other remediable pathology on diagnostic imaging of uterine cavity by US, sonohysterogram, hysteroscopy, hysterosalpingogram
 - alternative therapeutic approaches (e.g., endometrial ablation) have been given careful consideration
- chronic pelvic pain when **ALL** of the following criteria have been met:
 - persistent pain for more than six months that impairs the individual's ability to complete her usual daily activities and is unresponsive to oral contraceptives, analgesics, anti-inflammatory agents, or amenorrheic agents (e.g., gonadotropin-releasing hormone (GnRH) analogs, danazol, Depo-Provera), unless these medications are contraindicated or not tolerated
 - nongynecological sources of pelvic pain (e.g., gastrointestinal, musculoskeletal, psychological, psychosexual and/or urinary) have been excluded
 - no gynecological cause for the pain has been determined after careful evaluation, including a laparoscopic evaluation performed within the past 24 months
- chronic pelvic inflammatory disease that is unresponsive to appropriate medical management
- recurrent, high-grade squamous intraepithelial neoplasia (HGSIL), following failure of conservative surgical therapy (e.g., loop electrosurgical excision procedure [LEEP] or cold knife cone)
- symptomatic pelvic relaxation when **BOTH** of the following are present:
 - second-degree or greater uterine prolapse
 - failure, intolerance, contraindication to, or individual non-acceptance of available nonsurgical options such as the use of a pessary
- when performed in conjunction with laparotomy for adnexal pathology when malignancy is suspected
- cervical, ovarian, fallopian tube, or endometrial cancer
- endometrial hyperplasia with atypia, as demonstrated on endometrial biopsy or D&C, **WITH** failure, contraindication or intolerance (includes individual non-acceptance) of hormonal manipulation
- endometriosis, when **ALL** of the following medical necessity criteria are met:
 - a histological or surgical diagnosis of endometriosis made within the past five years
 - persistent pain for more than six months causing impairment of the individual's ability to participate in her normal daily activities
 - failure, contraindication or intolerance of medical management, including danazol, lupron or other GnRH agonist, oral contraceptives or progestin therapy
 - where applicable, the failure of other appropriate surgical measures to control symptoms
- Postpartum hemorrhage that cannot be controlled by conservative therapy (e.g., uterine atony, placenta accreta)

CIGNA covers prophylactic hysterectomy for hereditary nonpolyposis colorectal cancer (HNPCC), as it is considered medically necessary after appropriate counseling.

General Background

Hysterectomy, the removal of the uterus, is one of the most commonly performed surgical procedures in the United States. A hysterectomy may be performed with or without an oophorectomy, and is most often done electively for abnormal uterine bleeding or other non-life-threatening indications. For women who require the procedure, the appropriate surgical approach (i.e., abdominal, vaginal, laparoscopic) is determined by anatomical factors, the type of pathology expected, patient preference and physician experience and training (Parker, 2004).

Surgical Techniques

Total Abdominal Hysterectomy (TAH): TAH (with or without salpingo-oophorectomy) is the most commonly performed hysterectomy. Both the uterine fundus and the cervix are removed at the cervico-vaginal junction. The entire uterus, ovaries and fallopian tubes are removed. It may be performed through either a transverse or a vertical abdominal incision, depending on the indications for the procedure and the size of the uterus. This is the procedure of choice for most uterine and ovarian cancers, endometriosis, pelvic pain, large fibroid uteri in which conservation of the cervix is not desired and conditions in which evaluation of the full pelvis and abdomen is required (e.g., pelvic masses or adnexal masses of unknown diagnosis).

Radical Hysterectomy: Radical hysterectomy is a procedure in which the parametrial tissue and the upper vagina are removed in conjunction with the fundus and the cervix. It is primarily indicated in the treatment of early-stage cervical cancer. It carries with it a greater risk for bowel and bladder dysfunction, ureteral injury and subsequent urinary fistula.

Supracervical Hysterectomy: Supracervical hysterectomy can be performed either abdominally or laparoscopically so that conservation of the cervix may be assured. The fundus of the uterus is removed to the level below the uterine vessels, and the cervix is conserved. This procedure is indicated for the patient who desires to keep her cervix for its potential role in sexual function, and who does not have a contraindication (e.g., history of cervical dysplasia, cancer) that would preclude retention of the cervix. It is also indicated for the patient in whom the surgical procedure would be made safer by conservation of the cervix (e.g., obliteration of the cul-de-sac because of advanced endometriosis) and in whom there is no contraindication to its retention. Advantages of this procedure include the greater ease and shorter time required. It is often the preferred surgery for emergency and Cesarean hysterectomies. Retention of the cervix may also result in less vaginal prolapse because of better vaginal support.

The American College of Obstetricians and Gynecologists (ACOG) committee opinion on supracervical hysterectomy states that patients electing this procedure should be carefully screened preoperatively to exclude cervical or uterine neoplasm. These patients should be counseled about the need for long-term follow-up, the possibility of future trachelectomy or removal of the cervical stump, and the lack of data demonstrating clear benefits over total hysterectomy (ACOG, 2007).

Vaginal Hysterectomy: Vaginal hysterectomy is performed entirely through the vagina. The most common indications include uterine prolapse or benign or premalignant conditions (e.g., endometrial hyperplasia or cervical dysplasia) that do not result in unusually large uteri and are not likely to result in significant intra-abdominal adhesions and in which exploration of the upper abdomen is nonessential. Advantages of this procedure are the absence of an abdominal scar, the tendency for a quicker recovery, and a shorter hospital stay. Physical requirements for the procedure include the ability to lie on one's back with legs in stirrups for a prolonged time, a relatively small and mobile uterus and adequate room in the vagina in which to operate. Thus, for women who have never had children or who are virginal, this option may not be possible. Experienced surgeons can sometimes remove larger uteri with this approach through coring or by removing the uterus in parts.

Laparoscopy-Assisted Vaginal Hysterectomy (LAVH): LAVH combines a vaginal approach with a laparoscopic abdominal approach. This may be appropriate for patients in whom evaluation of the abdomen is

indicated (for instance, for grade 1 endometrial cancer), or in whom removal of the ovaries is desired. Although this procedure has the advantages of smaller abdominal scars and shorter hospital stays, it has been shown to have higher rates of complication, and longer operative times than simple abdominal or simple vaginal hysterectomy. Appropriate case selection and high surgical volume are probably the two leading means of ensuring good outcomes. In general, patients should meet the same physical requirements as for simple vaginal hysterectomy, and they should be at low-risk for laparoscopic complication (no history suggestive of the formation of abdominal adhesions, normal weight range and no large pelvic masses). If there is uncertainty about a patient, but upper abdominal access is necessary, laparotomy with abdominal hysterectomy may be the procedure of choice.

According to the ACOG committee opinion on the use of LAVH, prospective randomized trials demonstrate that LAVH is associated with faster recovery, less postoperative pain and similar complication rates when compared to TAH. The position further states that the technique used for hysterectomy should be dictated by the indication for the surgery, patient characteristics, and patient preference. However, most patients requiring hysterectomy should be offered the vaginal approach when technically feasible and medically appropriate (ACOG, 2005).

Total Laparoscopic Hysterectomy (TLH): TLH involves the removal of the entire uterus and cervix through a small abdominal incision under laparoscopic guidance. The indications for TLH include benign gynecological conditions such as fibroids, endometriosis and abnormal uterine bleeding. The procedure may also be performed for malignant indications such as early endometrial cancer (Mettler, et al., 2005). TLH requires a high degree of surgical skill and is done by a limited proportion of gynecologists. In general, it has been reported that minimally invasive procedures take longer to perform; however, estimated blood loss and patient recovery time are typically less.

A number of studies in the literature have compared TLH to various hysterectomy procedures for the treatment of benign and malignant gynecological conditions (Ghezzi, et al., 2005; Garry, et al., 2004; Riberio, et al., 2003), and provided supportive evidence that TLH is technically feasible and can be performed safely in the hands of surgeons who are experienced in operative laparoscopy (Ramirez, et al., 2006; Obermair, et al., 2005; O'Hanlan, et al., 2005; Hoffman, et al., 2005; Seracchioli, et al., 2002).

Guidelines from the National Institute for Clinical Excellence (NICE) state that the current evidence on the safety and efficacy of laparoscopic techniques for hysterectomy appear adequate to support the use of LAVH, TLH, and laparoscopic supracervical hysterectomy. It is further stated that women should be advised of the higher risk of urinary tract injury and bleeding associated with these procedures compared to open surgery (NICE, 2007).

In an update of a Cochrane review, Nieboer et al. (2009) analyzed 34 comparative, parallel-group trials (n=4495) to assess the most beneficial and least harmful surgical approach to hysterectomy for women with benign gynecological conditions. Vaginal hysterectomy was found to have equal or significantly better outcomes on all parameters, including speedier return to normal activities, and fewer febrile episodes or unspecified infections. It was summarized that if vaginal hysterectomy is not possible, laparoscopic hysterectomy may avoid the need for an abdominal procedure. However the length of the surgery increases as the extent of the surgery performed laparoscopically increases (Nieboer, et al. 2009).

Conclusions drawn by ACOG in their committee opinion on the route of hysterectomy for benign disease include the following (No authors listed, 2009):

- Vaginal hysterectomy is the approach of choice whenever feasible, based on its well-documented advantages and lower complication rates.
- The choice of whether to perform prophylactic oophorectomy at the time of hysterectomy is based on the patient's age, risk factors, and informed wishes, but not on the route of hysterectomy.
- Laparoscopic hysterectomy is an alternative to abdominal hysterectomy for those patients in whom a vaginal hysterectomy is not indicated or feasible.

Indications for Hysterectomy

Leiomyoma (Fibroids): The most common indication for hysterectomy remains uterine leiomyoma. Uterine fibroids or leiomyomata are benign tumors of muscle and connective tissue that develop within the wall of the uterus. The size of fibroid tumors varies significantly (e.g., from as small as 1 mm to over 20 cm or eight inches

in diameter), and can increase uterine measurements. It is generally accepted that the size of a non-pregnant uterus ranges from 8 cm x 4 cm x 4 cm to 12 cm. A 10-week gestational size uterus measures 12 cm in length, and a 12-week size uterus measures approximately 14 cm or greater in length (Margulies and Miller, 2001). Fibroids can contribute to symptoms related to an enlarging pelvic mass (e.g., urinary frequency or constipation). Although many women do not feel any symptoms with uterine fibroids, they may cause symptoms such as heavy bleeding or painful periods, noncyclic pelvic pain, lower back pain, and pain during sex. A transvaginal or pelvic ultrasound may be performed to confirm the findings of uterine fibroids. In addition, dilatation and curettage or pelvic laparoscopy may be necessary to rule out other potentially malignant conditions.

Abnormal Uterine Bleeding: Abnormal or dysfunctional uterine bleeding (DUB) is another common indication for a hysterectomy. In women of childbearing age, abnormal uterine bleeding includes any change in menstrual period frequency or duration or amount of flow, as well as bleeding between cycles. In postmenopausal women, abnormal uterine bleeding includes vaginal bleeding 12 months or more after the cessation of menses, or unpredictable bleeding in postmenopausal women who have been receiving hormone therapy for 12 months or more. DUB (i.e., anovulatory and ovulatory) is diagnosed by exclusion of these causes.

Medical management of anovulatory DUB may include oral contraceptives and cyclic progestins, as well as a combination of various oral and injectable estrogens and progestins. Surgical management may include hysterectomy or less invasive, uterus-sparing procedures, such as endometrial ablation. A curettage or thorough endometrial aspiration is indicated for women over the age of 35 who have persistent abnormal bleeding or for women with bleeding that is sufficiently severe to produce anemia.

The most difficult management of DUB is treatment of ovulatory women with chronic menorrhagia. For these women, nonsteroidal anti-inflammatory drugs (NSAIDs), progestins, oral contraceptives, danazol, and gonadotropin-releasing hormone (GnRH) analogues are all useful therapeutic modalities. A combination of two or more of these agents is often required to obviate the need for endometrial ablation or hysterectomy.

Pelvic Pain: Chronic pelvic pain (CPP) accounts for approximately 9% of all hysterectomies performed. Dysmenorrhea is perhaps the most common example of recurrent pelvic pain and is defined as a painful cramping sensation in the lower abdomen, often accompanied by other symptoms, such as sweating, tachycardia, headaches, nausea, vomiting, diarrhea, and tremulousness. All these symptoms can occur just before or during the menses. Primary dysmenorrhea begins at or shortly after menarche, and is usually not accompanied by pelvic pathologic conditions. Secondary dysmenorrhea arises later and usually is associated with other pelvic conditions.

In addition, the following may be responsible for recurrent or persistent pelvic pain: incompletely treated pelvic infections, recurrent pelvic infections, endometriosis, and possibly postoperative pelvic adhesions, as well as diseases of the urinary tract and bowel.

According to the American College of Obstetricians and Gynecologists (ACOG), combined oral contraceptives should be considered as a treatment option to decrease pain from primary dysmenorrhea. Gonadotropin-releasing hormone (GnRH) agonists are effective in relieving pelvic pain associated with endometriosis and irritable bowel syndrome, as well as in women with symptoms consistent with endometriosis who do not have endometriosis. Progestins in daily, high doses should be considered as an effective treatment of CPP associated with endometriosis and pelvic congestion syndrome. Nonsteroidal antiinflammatory drugs, including COX-2 inhibitors, should be considered for moderate pain and are particularly effective for dysmenorrhea (ACOG, 2004). Hysterectomy should be reserved for patients who have failed conservative therapy

Some women with CPP also have associated psychosocial problems such as depression, somatization, narcotic dependency, or a history of physical and sexual abuse (Lifford and Barbieri, 2002). Published evidence suggests a significant association of physical and sexual abuse with various chronic pain disorders. Studies have reported that 40–50% of women with CPP have a history of abuse.

The ACOG guidelines for CPP state that the addition of psychotherapy to medical treatment of CPP should be considered, as the combination appears to improve response over that of medical treatment alone. The guidelines also state that hysterectomy can be considered an effective treatment that results in pain relief for 75–95% of women who have CPP associated with reproductive tract symptoms (ACOG, 2004).

Cervical Dysplasia: Dysplasia is a traditional term used to describe varying degrees of cervical intraepithelial neoplasia. The Pap smear has been widely used to screen women for malignant and premalignant cervical dysplasia or disease. Pap smear results may be mild (low-grade), involving approximately one-third of the epithelium (cervical intraepithelial neoplasia [CIN] I); moderate, involving approximately two-thirds of the epithelium (CIN II); or severe (high-grade), involving the full thickness of the epithelium (CIN III). When untreated, high grade cervical dysplasia may progress to cervical cancer over time. Hysterectomy is indicated for high-grade (CIN III) squamous intraepithelial neoplasia (HGSIL), following failure of conservative surgical therapy in conjunction with no desire for childbearing.

Uterine Prolapse (Descensus, Procidencia): Descensus of the uterus and cervix into or through the barrel of the vagina is associated with injury to or relaxation of the pelvic floor muscles. Major symptoms noted by patients with descensus are a feeling of heaviness, fullness or falling out in the perineal area. In cases where the cervix and uterus are low in the vaginal canal, the cervix may be seen protruding from the introitus. A prolapse into the upper barrel of the vagina is first degree, through the vaginal barrel to the region of the introitus is second degree, and out through the introitus is third degree or total.

Medical management of such conditions involves the use of a pessary. Surgical repair for prolapse of the uterus and cervix generally involves a vaginal hysterectomy with anterior and posterior colporrhaphy.

Endometrial Cancer: Adenocarcinoma of the endometrium is mainly a malignancy of postmenopausal women and is increasingly virulent with advancing age. There are no accepted routine screening methods for detecting endometrial cancer in asymptomatic women or in women at increased risk. Even though a routine Pap smear cannot be relied on as a screen for endometrial cancer, this type of malignancy should be suspected in any nonpregnant woman with atypical endometrial cells or in any postmenopausal woman with normal endometrial cells on a Pap smear (Scott, 2003). Abnormal uterine bleeding is the most common initial symptom of endometrial cancer. It is recommended that perimenopausal women with abnormal bleeding undergo an endometrial biopsy.

Endometrial cancer is staged according to the International Federation of Gynecology and Obstetrics (FIGO) staging system. The recommendation is for all medically operable patients with clinical stage I disease, regardless of tumor grade, to undergo an extrafascial TAH and bilateral salpingo-oophorectomy for both staging and therapeutic purposes. A radical hysterectomy may be appropriate in certain circumstances in which the disease is known to involve the cervix or parametrium (Scott, 2003).

Ovarian and Fallopian Tube Cancers: Epithelial ovarian cancer is one of the most common gynecologic malignancies. The most significant risk factor for ovarian cancer is a family history of a first-degree relative (e.g., mother, daughter, sister) with the disease. Some symptoms that may be suggestive of ovarian cancer include pelvic or abdominal pain, bloating, and urinary urgency or frequency, particularly if these symptoms are new or occur frequently. Ovarian cancer is difficult to diagnose at an earlier, more curable stage because of the location of the ovaries and the biology of most epithelial cancers. Cancer of the Fallopian tube is less common, and is managed with treatments similar to those used for epithelial ovarian cancer. Total hysterectomy and bilateral salpingo-oophorectomy are performed as part of the surgical management of patients with ovarian and fallopian tube cancers (National Comprehensive Cancer Network Guidelines™ [NCCN Guidelines™], 2010).

Endometrial Hyperplasia: Endometrial hyperplasia is generally considered a precursor to endometrial cancer. The condition occurs during periods of long-term unopposed estrogen stimulation, such as anovulation, particularly around the time of menopause. The World Health Organization (WHO) identifies four categories of endometrial hyperplasia according to their premalignant potential: simple, complex, simple with atypia, and complex with atypia.

Mild complex hyperplasia with atypia often responds to progestin therapy and is an option for those women who are interested in preserving the uterus for childbearing. Three months of progestin therapy is the initial recommended therapy (Stenchever, 2001). Since approximately 25–30% of atypical hyperplasia, which is diagnosed via endometrial biopsy, can potentially progress to endometrial cancer, the suggested treatment is hysterectomy when preservation of the uterus is not desired. The more severe the atypia, the less chance it will reverse itself with hormone therapy.

According to the ACOG guidelines for the management of endometrial cancer, atypical endometrial hyperplasia and endometrial cancer should be considered part of a continuum. The diagnosis remains uncertain as long as the uterus is in situ. For women who have completed childbearing, hysterectomy should be recommended for the treatment of atypical endometrial hyperplasia because of the high risk of an underlying cancer. Women who want to maintain fertility may be treated with progestins in an attempt to reverse the lesion (ACOG, 2005).

Endometriosis: Endometriosis is the presence and growth of the glands and stroma of the lining of the uterus in an aberrant or heterotopic location. The classic symptoms of endometriosis are cyclic pelvic pain and infertility. However, approximately one-third of patients with endometriosis are asymptomatic, with the disease being discovered incidentally during an abdominal operation or visualized at laparoscopy for an unrelated problem. Most patients should undergo a diagnostic laparoscopy to establish the nature and extent of endometriosis before therapy. However, if other gynecological conditions, such as chronic pelvic inflammatory disease or neoplasia, have been ruled out, empiric medical therapy for 3–6 months with a GnRH agonist is a reasonable choice.

Surgical treatment is divided into conservative and definitive operations. Conservative surgery involves the resection or destruction of endometrial implants, lysis of adhesions, and attempts to restore normal pelvic anatomy. Definitive surgery involves hysterectomy, which includes the removal of the ovaries, the uterus and all visible ectopic foci of endometriosis.

Adenomyosis: Adenomyosis is caused by the presence of functioning ectopic endometrial tissue in the myometrium. The pathogenesis of adenomyosis remains unclear. Common presenting symptoms include menorrhagia, dysmenorrhea and an enlarged, sometimes tender uterus. Pain may be referred to the back and rectum. The presenting symptoms of adenomyosis overlap with those of other common gynecological disorders such as DUB, uterine leiomyomata and endometriosis. There is also a slightly increased rate of endometrial carcinoma in patients with adenomyosis. There is no proven medical treatment for the condition.

Attempts have been made to establish the diagnosis of adenomyosis preoperatively by transcervical needle biopsy of the myometrium, however the sensitivity of this testing method is reportedly too low to be of practical clinical value. The peer reviewed medical literature suggests that TVU be used as the initial imaging technique in patients suspected of having adenomyosis. Both ultrasound and magnetic resonance imaging (MRI) are useful to assist in differentiating between adenomyosis and uterine myomas in young women desiring future childbearing. Although adenomyosis can be suggested by ultrasound, sonohysterogram and/or hysteroscopy, a definitive diagnosis can usually only be made by histological examination of a hysterectomy specimen. Therefore, hysterectomy is more commonly indicated for the presenting symptoms of adenomyosis such as DUB, uterine leiomyomata and endometriosis.

Postpartum Hemorrhage: An estimated blood loss of more than 500 milliliters (mL) following a vaginal birth or a loss of more than 1000 mL after cesarean birth has been used for the diagnosis of postpartum hemorrhage. Postpartum hemorrhage is generally classified as primary or secondary, with primary hemorrhage occurring within the first 24 hours of delivery and secondary hemorrhage occurring between 24 hours and 6–12 weeks after giving birth. The management of postpartum hemorrhage may vary, depending on etiology of the bleeding, available treatment options, and the desire for future fertility. Medical treatment options for postpartum hemorrhage in the setting of decreased uterine tone include uterotonics and possibly tamponade of the uterus. Exploratory laparotomy is indicated if uterotonic agents with or without tamponade fail to control bleeding after a vaginal delivery. Surgical management may include uterine curettage, uterine artery ligation, or hysterectomy. Uterine atony and placenta accreta (i.e., the abnormal attachment of the placenta to the inner uterine wall) are the two most common reasons for postpartum hysterectomy (ACOG, 2006).

Hereditary Nonpolyposis Colorectal Cancer (HNPCC): HNPCC is an autosomal dominant condition caused by mutation of one of several DNA mismatch repair (MMR) genes. In addition to colorectal cancer, HNPCC patients and their relatives are at risk of a wide variety of other cancers. The most common is endometrial adenocarcinoma, which affects at least one female member in about 50% of HNPCC pedigrees. Ovarian cancer risk is reported to be 3.5 times higher in HNPCC families than in the general population. There is a lack of controlled studies evaluating the benefit of prophylactic surgery in at-risk HNPCC mutation carriers. However, based upon expert opinion the Cancer Genetics Studies Consortium recommended that prophylactic hysterectomy and bilateral salpingo-oophorectomy be presented as an option for women with HNPCC for prevention of endometrial and ovarian cancer in women known to have HNPCC or to be carriers of HNPCC-

associated mutations (Burke, et al., 1997). A systematic review by Lindor et al. (2006) also concluded that given the high risk for endometrial cancer and the moderately increased risk for ovarian cancer in women with HNPCC, prophylactic hysterectomy and oophorectomy is a reasonable option, following a careful discussion of the risks, benefits, and limitations of this procedure (Lindor et al. 2006). For additional information, refer to the Prophylactic Oophorectomy or Salpingo-oophorectomy With or Without Hysterectomy Coverage Policy.

Summary

Hysterectomy is effective in treating a number of gynecological disorders, including symptomatic leiomyoma, abnormal uterine bleeding, endometrial hyperplasia and surgical dysplasia. The procedure may also alleviate symptoms in some women with endometriosis, chronic pelvic pain, pelvic inflammatory disease and pelvic relaxation. Prophylactic hysterectomy with bilateral oophorectomy is recommended for individuals with hereditary nonpolyposis colorectal cancer (HNPCC)-related conditions who have been properly counseled. An appropriate diagnostic evaluation should be performed and alternative treatments considered prior to the recommendation of hysterectomy for any indication.

Coding/Billing Information

Note: This list of codes may not be all-inclusive.

Covered when medically necessary:

CPT [®] * Codes	Description
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 (eg, Marshall-Marchetti-Krantz, Burch)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58200	Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)
58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)
58240	Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof
58260	Vaginal hysterectomy, for uterus 250 grams or less
58262	Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s), and/or ovary(s)
58263	Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
58267	Vaginal hysterectomy, for uterus 250 grams or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58270	Vaginal hysterectomy, for uterus 250 grams 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 grams
58291	Vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)
58292	Vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s)

	and/or ovary(s), with repair of enterocele
58293	Vaginal hysterectomy, for uterus greater than 250 grams; with colpo-urethrocytopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58294	Vaginal hysterectomy, for uterus greater than 250 grams; with repair of enterocele
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
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58548	Laparoscopy, surgical, with radical hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with removal of tube(s) and ovary(s), if performed
58550	Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less
58552	Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; 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)
58951	Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy
58953	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;
58954	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy
58956	Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy
59525	Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)

ICD-9-CM Diagnosis Codes	Description
154.0	Malignant neoplasm of rectosigmoid junction
180.0-180.9	Malignant neoplasm of cervix uteri
182.0-182.8	Malignant neoplasm of body of uterus
183.0-183.9	Malignant neoplasm of ovary and other uterine adnexal
198.6	Secondary malignant neoplasm of ovary
218.0-218.9	Uterine leiomyoma
219.0-219.9	Other benign neoplasm of uterus
220	Benign neoplasm of ovary
221.0-221.9	Benign neoplasm of other female genital organs
233.1-233.39	Carcinoma in situ of breast and genitourinary system
456.5	Pelvic varices
614.6	Pelvic peritoneal adhesions, female (postoperative) (postinfection)

617.0-617.9	Endometriosis
618.00-618.9	Genital prolapse
620.0-620.9	Noninflammatory disorders of ovary, fallopian tube, and broad ligament
621.6	Malposition of uterus
622.10	Dysplasia of cervix; unspecified
622.11	Mild dysplasia of cervix
622.12	Moderate dysplasia of cervix
625.0-625.9	Pain and other symptoms associated with female genital organs
626.2	Excessive or frequent menstruation
626.4	Irregular menstrual cycle
626.8	Other disorder of menstruation and other abnormal bleeding from female genital tract
626.9	Unspecified disorder of menstruation and other abnormal bleeding from female genital tract
627.0	Premenopausal menorrhagia
627.1	Postmenopausal bleeding
627.8	Other specified menopausal and postmenopausal disorder
627.9	Unspecified menopausal and postmenopausal disorder
666.04-666.34	Postpartum hemorrhage
752.3	Other congenital anomaly of uterus
795.00	Abnormal glandular Papanicolaou smear of cervix
795.01	Papanicolaou smear of cervix with atypical squamous cells of undetermined significance (ASC-US)
795.02	Papanicolaou smear of cervix with atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC-H)
795.09	Other abnormal Papanicolaou smear of cervix and cervical HPV

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References

1. ACOG Committee on Practice Bulletins--Gynecology. ACOG Practice Bulletin No. 51. Chronic pelvic pain. *Obstet Gynecol.* 2004 Mar;103(3):589-605.
2. ACOG Committee on Practice Bulletins--Gynecology. ACOG Practice Bulletin No. 85: Pelvic organ prolapse. *Obstet Gynecol.* 2007 Sep;110(3):717-29.
3. ACOG Committee on Practice Bulletins-Gynecology. ACOG practice bulletin. Surgical alternatives to hysterectomy in the management of leiomyomas. Number 16, May 2000 (replaces educational bulletin number 192, May 1994). *Int J Gynaecol Obstet.* 2001 Jun;73(3):285-93.
4. ACOG Committee on Practice Bulletins--Gynecology. American College of Obstetricians and Gynecologists. ACOG practice bulletin: management of anovulatory bleeding. *Int J Gynaecol Obstet.* 2001 Mar;72(3):263-71.
5. Agency for Research and Quality (AHRQ). Management of uterine fibroids. Agency for Health Care Policy and Research. 2001 Jan;1(34):1-9.
6. American Cancer Society (ACS). Endometrial (Uterine) Cancer. Updated 2009 Nov. Accessed Mar 7, 2010. Available at URL address: <http://documents.cancer.org/140.00/140.00.pdf>
7. American College of Obstetricians and Gynecologists. ACOG Committee Opinion No. 388 November 2007: Supracervical hysterectomy. *Obstet Gynecol.* 2007 Nov;110(5):1215-7.

8. American College of Obstetricians and Gynecologists (ACOG). ACOG Committee Opinion. Number 311, April 2005. Appropriate use of laparoscopically assisted vaginal hysterectomy. *Obstet Gynecol.* 2005 Apr;105(4):929-30.
9. American College of Obstetricians and Gynecologists. ACOG practice bulletin. Alternatives to hysterectomy in the management of leiomyomas. *Obstet Gynecol.* 2008 Aug;112(2 Pt 1):387-400.
10. American College of Obstetricians and Gynecologists. ACOG practice bulletin, clinical management guidelines for obstetrician-gynecologists, number 65, August 2005: management of endometrial cancer. *Obstet Gynecol.* 2005 Aug;106(2):413-25.
11. American College of Obstetricians and Gynecologists. ACOG Practice Bulletin: Clinical Management Guidelines for Obstetrician-Gynecologists Number 76, October 2006: postpartum hemorrhage. *Obstet Gynecol.* 2006 Oct;108(4):1039-47.
12. Brill AI. Hysterectomy in the 21st century: different approaches, different challenges. *Clin Obstet Gynecol.* 2006 Dec;49(4):722-35.
13. Burke W, Petersen G, Lynch P, Botkin J, Daly M, Garber J, et al. Recommendations for follow-up care of individuals with an inherited predisposition to cancer: I. Hereditary nonpolyposis colon cancer. Cancer Genetics Studies Consortium. *JAMA.* 1997 Mar 19;277(11):915-9.
14. Chen LM, Yang KY, Little SE, Cheung MK, Caughey AB. Gynecologic cancer prevention in Lynch syndrome/hereditary nonpolyposis colorectal cancer families. *Obstet Gynecol.* 2007 Jul;110(1):18-25.
15. Committee on Gynecologic Practice, American College of Obstetricians and Gynecologists. ACOG Committee Opinion. Uterine artery embolization. *Obstet Gynecol.* 2004 Feb;103(2):403-4.
16. Garry R, Fountain J, Brown J, Manca A, Mason S, Sculpher M, et al. EVALUATE hysterectomy trial: a multicentre randomised trial comparing abdominal, vaginal and laparoscopic methods of hysterectomy. *Health Technol Assess.* 2004 Jun;8(26):1-154.
17. Ghezzi F, Cromi A, Bergamini V, Uccella S, Beretta P, Franchi M, et al. Laparoscopic-assisted vaginal hysterectomy versus total laparoscopic hysterectomy for the management of endometrial cancer: a randomized clinical trial. *J Minim Invasive Gynecol.* 2006 Mar-Apr;13(2):114-20.
18. Hoffman CP, Kennedy J, Borschel L, Burchette R, Kidd A. Laparoscopic hysterectomy: the Kaiser Permanente San Diego experience. *J Minim Invasive Gynecol.* 2005 Jan-Feb;12(1):16-24.
19. Hulka CA, Hall DA, McCarthy K, Simeone J. Sonographic findings in patients with adenomyosis: can sonography assist in predicting extent of disease? *AJR Am J Roentgenol.* 2002 Aug;179(2):379-83.
20. Johnson N, Barlow D, Lethaby A, Tavender E, Curr L, Garry R. Methods of hysterectomy: systematic review and meta-analysis of randomised controlled trials. *BMJ.* 2005 Jun 25;330(7506):1478.
21. Johnson N, Barlow D, Lethaby A, Tavender E, Curr E, Garry R. Surgical approach to hysterectomy for benign gynaecological disease. *Cochrane Database Syst Rev.* 2006 Apr 19;(2):CD003677.
22. Karaman Y, Bingol B, Gunenc Z. Prevention of complications in laparoscopic hysterectomy: experience with 1120 cases performed by a single surgeon. *J Minim Invasive Gynecol.* 2007 Jan-Feb;14(1):78-84.
23. Lethaby A, Ivanova V, Johnson NP. Total versus subtotal hysterectomy for benign gynaecological conditions. *Cochrane Database Syst Rev.* 2006 Apr 19;(2):CD004993.
24. Leung SW, Chan CS, Lo SF, Pang CP, Pun TC, Yuen PM. Comparison of the different types of "laparoscopic total hysterectomy". *J Minim Invasive Gynecol.* 2007 Jan-Feb;14(1):91-6.

25. Lifford KL, Barbieri RL. Diagnosis and management of chronic pelvic pain. *Urol Clin North Am*. 2002 Aug;29(3):637-47.
26. Lindor NM, Petersen GM, Hadley DW, Kinney AY, Miesfeldt S, Lu KH, et al. Recommendations for the care of individuals with an inherited predisposition to Lynch syndrome: a systematic review. *JAMA*. 2006 Sep 27;296(12):1507-17.
27. Lone FW, Balogun M, Khan KS. Adenomyosis: not such an elusive diagnosis any longer. *J Obstet Gynaecol*. 2006 Apr;26(3):225-8.
28. Maher C, Baessler K, Glazener CM, Adams EJ, Hagen S. Surgical management of pelvic organ prolapse in women: a short version Cochrane review. *Neurourol Urodyn*. 2008;27(1):3-12.
29. Margulies R, Miller L. Fruit size as a model for teaching first trimester uterine sizing in bimanual examination. *Obstet Gynecol*. 2001 Aug;98(2):341-4.
30. Marjoribanks J, Lethaby A, Farquhar C. Surgery versus medical therapy for heavy menstrual bleeding. *Cochrane Database Syst Rev*. 2006 Apr 19;(2):CD003855.
31. Mettler, Ahmed-Ebbiary, Schollmeyer. Laparoscopic hysterectomy: Challenges and limitations. *Minim Invasive Ther Allied Technol*. 2005;14(3):145-59.
32. National Cancer Institute (NCI). Endometrial Cancer Prevention (PDQ®). Updated 2009 Jun. Accessed Mar 7, 2010. Available at URL address: <http://www.cancer.gov/cancertopics/pdq/prevention/endometrial/healthprofessional>
33. National Cancer Institute (NCI). Endometrial Cancer Treatment (PDQ®). Updated 2009 May. Accessed Mar 7, 2010. Available at URL address: http://www.cancer.gov/cancertopics/pdq/treatment/endometrial/healthprofessional/allpages#Section_36
34. National Cancer Institute (NCI). Ovarian Epithelial Cancer Treatment (PDQ®). Updated 2009 Apr. Accessed Mar 7, 2010. Available at URL address: http://www.cancer.gov/cancertopics/pdq/treatment/ovarianepithelial/healthprofessional/allpages#Section_288
35. National Comprehensive Cancer Network® (NCCN). NCCN GUIDELINES™ Clinical Guidelines in Oncology™. © National Comprehensive Cancer Network, Inc 2010, All Rights Reserved. Ovarian Cancer Including Fallopian Tube Cancer and Primary Peritoneal Cancer V.2.2010. Accessed March 10, 2010. Available at URL address: http://www.nccn.org/professionals/physician_gls/PDF/ovarian.pdf
36. National Institute for Clinical Excellence (NICE). IPG239 Laparoscopic techniques for hysterectomy: Guidance. Nov 2007. Accessed Mar 12, 2008. Available at URL address: <http://www.nice.org.uk/nicemedia/pdf/IPG239Guidance.pdf>
37. Nieboer TE, Johnson N, Lethaby A, Tavender E, Curr E, Garry R, van Voorst S, Mol BW, Kluivers KB. Surgical approach to hysterectomy for benign gynaecological disease. *Cochrane Database Syst Rev*. 2009 Jul 8;(3):CD003677.
38. No authors listed. ACOG Committee Opinion No. 444: choosing the route of hysterectomy for benign disease. *Obstet Gynecol*. 2009 Nov;114(5):1156-8.
39. No authors listed. ACOG criteria set. Quality evaluation and improvement in practice: Abdominal hysterectomy with or without adnexectomy for endometriosis. Number 27, October 1997. Committee on Quality Assessment. American College of Obstetricians and Gynecologists. *Int J Gynaecol Obstet*. 1998 Jan;60(1):92-3.

40. Obermair A, Manolitsas TP, Leung Y, Hammond IG, McCartney AJ. Total laparoscopic hysterectomy versus total abdominal hysterectomy for obese women with endometrial cancer. *Int J Gynecol Cancer*. 2005 Mar-Apr;15(2):319-24.
41. O'Hanlan KA, Huang GS, Garnier AC, Dibble SL, Reuland ML, Lopez L, et al. Total laparoscopic hysterectomy versus total abdominal hysterectomy: cohort review of patients with uterine neoplasia. *JSL*. 2005 Jul-Sep;9(3):277-86.
42. Parker WH. Total laparoscopic hysterectomy and laparoscopic supracervical hysterectomy. *Obstet Gynecol Clin North Am*. 2004 Sep;31(3):523-37, viii.
43. Ramirez PT, Slomovitz BM, Soliman PT, Coleman RL, Levenback C. Total laparoscopic radical hysterectomy and lymphadenectomy: the M. D. Anderson Cancer Center experience. *Gynecol Oncol*. 2006 Aug;102(2):252-5. Epub 2006 Feb 10.
44. Seracchioli R, Venturoli S, Vianello F, Govoni F, Cantarelli M, Gualerzi B, et al. Total laparoscopic hysterectomy compared with abdominal hysterectomy in the presence of a large uterus. *J Am Assoc Gynecol Laparosc*. 2002 Aug;9(3):333-8.
45. Scott JR, Gibbs RS, Karlan BY, Haney AF, editors. *Danforth's obstetrics and gynecology*. Philadelphia, PA: Lippincott Williams & Wilkins; 2003. p. 235-60.
46. Stenchever MA, Droegemueller W, Herbst AL, Mishell D Jr., editors. *Comprehensive gynecology*. 4th ed. St. Louis, MO: Mosby, Inc.; 2001.

Policy History

Pre-Merger Organizations	Last Review Date	Policy Number	Title
CIGNA HealthCare	4/15/2008	0128	Hysterectomy
Great-West Healthcare	10/26/2006	05.299.05	Hysterectomy

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