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MEDICAL POLICY – 7.01.578

Endometrial Ablation

Ref. Policy: MP-089

Effective Date:	Apr. 1, 2025	RELATED MEDICAL POLICIES:
Last Revised:	Mar. 24, 2025	None
Replaces:	N/A	

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Introduction

Endometrial ablation is a minimally invasive surgical treatment that destroys the lining of the uterus. It is used to treat abnormal uterine bleeding, which is excessive menstrual blood loss that interferes with quality of life. The goal of endometrial ablation is to reduce menstrual blood flow. The doctor inserts thin tools through the vagina and cervix. Extreme cold, electrical current, lasers, microwaves, radiofrequencies, or heated fluids are types of ablation methods that may be used. This policy describes when endometrial ablation may be considered medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Service	Medical Necessity
Endometrial ablation	**Endometrial ablation may be considered medically necessary when the patient meets ALL of the following criteria:**

Service	Medical Necessity
	• The patient is premenopausal with a normal endometrial cavity by ultrasound evaluation and has been diagnosed with menorrhagia or has patient-perceived heavy menstrual bleeding interfering with normal activities of daily life • The patient is not pregnant and has no desire for future fertility • The patient has tested negative for uterine cancer and endometrial hyperplasia, negative cervical cytology and endometrial tissue sampling/biopsy demonstrating lack of cancer or endometrial hyperplasia • The device is approved for this procedure by the US Food and Drug Administation (FDA) • The patient has failed to respond to more conservative therapies (e.g., medical therapy including treatment with hormones, medications) **Note:** See Related Information below for **Limitations**

Coding

Code	Description
CPT	
58353	Endometrial ablation, without hysteroscopic guidance
58356	Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed
58563	Hysteroscopy, surgical, with endometrial ablation
ICD-10 Codes Covered if Selection Criteria are Met:	
D25.0-D25.9	Leiomyoma of uterus
N92.0-N92.6	Excessive, frequent, and irregular menstruation
N93.0-N93.8	Abnormal uterine and vaginal bleeding

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Related Information

Limitations

- If the patient has been diagnosed with menorrhagia or excessive bleeding in the context of submucosal myomata, the size should be less than 3 cm in diameter.
- Pathology test results must be performed within one year in order to meet criteria.
- • Endometrial Ablation is not recommended for adolescent members receiving gender affirming treatment due to higher rate of reoperation

Evidence Review

Background

Cryosurgical ablation uses probes at extremely low temperatures to freeze and destroy the endometrial lining of the uterus to reduce or prevent abnormal uterine bleeding from benign causes.

Electrocautery (resecting rollerball, loop, and triangular mesh) ablation is used to deliver energy via an electric current applied to the endometrial lining to cauterize the tissue.

Endometrial laser ablation (ELA) is a hysterosopic procedure in which light from a surgical laser is used to coagulate and destroy the endometrium, the glandular inner lining of the uterus.

Microwave ablation is when microwave energy is sent through a narrow, microwave antenna that has been placed inside the tissue. The heat created destroys the tissue.

Radiofrequency, impedance-controlled (RF) is a surgical device that uses RF energy to expand in the uterine cavity and then destroy the endometrial lining of the uterus. This technique is indicated for premenopausal women with menorrhagia from benign causes.

Thermal balloon endometrial ablation (TBEA) uses a balloon filled with heated fluid to destroy the endometrium. For hydrothermal endometrial ablation (HTEA), heated liquid is applied directly to the endometrium.

Regulatory Status

The following devices have been approved by the US Food and Drug Administration (FDA) for use in endometrial ablation as a treatment for menorrhagia:

- Cryo probes
- Electric (resecting rollerball, loop, triangular mesh)
- Laser
- Microwave endometrial ablation (MEA) System
- High radiofrequency, impedance-controlled (RF)
- Thermoablation (heated saline, thermal fluid filled balloon)

ThermaChoice device for thermal balloon endometrial ablation (TBEA) and the Hydro ThermAblator device for hydrothermal endometrial ablation (HTEA) have been approved by the FDA.

References

1. National Institute for Health and Care Excellence (NICE). Clinical Guidelines (CG). Heavy Menstrual Bleeding: assessment and management. NG88. Published: March 14, 2018. Last Updated: May 24, 2021. **https://www.nice.org.uk/guidance/ng88**. Accessed March 10, 2025.
2. U.S. Food & Drug Administration (FDA). Medical Device Approval: NovaSure™ Impedance Controlled Endometrial Ablation System - P010013. Issued: 09/28/2001. **https://www.accessdata.fda.gov/cdrh_docs/pdf/P010013b.pdf**. Accessed March 10, 2025.
3. U.S. Food & Drug Administration. Medical Device Approval: Microwave Endometrial Ablation (MEA) System P020031. Issued 09/23/2003. Page Last Updated: 11/20/2023. **https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpma/pma.cfm?id=P020031**. Accessed March 10, 2025.
4. ACOG "Management of Endometrial Intraepithelial Neoplasia or Atypical Enometrial Hyperplasia", September 2023; The American College of Obstetricians and Gynecologists. **https://www.acog.org/-/media/project/acog/acogorg/clinical/files/clinical-consensus/articles/2023/09/management-of-endometrial-intraepithelial-neoplasia-or-atypical-endometrial-hyperplasia.pdf?rev=5981eb54f6024ab8be9125cc24241736&hash=B92C7E59813682B411A9EC83704FB202**. Accessed March 10, 2025.

History

Date	Comments
09/16/19	New policy, approved August 13, 2019, effective January 1, 2020. Endometrial ablation may be considered medically necessary when the patient meets all of the criteria outlined in this policy.
08/01/20	Annual Review, approved July 2, 2020. No changes to policy statement.
08/01/21	Annual Review, approved July 9, 2021. No changes to policy statement, references updated.
07/01/22	Annual Review, approved June 27, 2022. No changes to policy statement, references updated.
11/01/23	Annual Review, approved October 23, 2023. No changes to policy statement, references updated.
04/01/24	Annual Review, approved March 25, 2024. No changes to policy statement, references updated.
04/01/25	Annual Review, approved March 24, 2025. No changes to policy statement, references updated.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy only applies to Individual Plans.