Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Endometrial Ablation Questionnaire

Endometrial Ablation

Blue Care Network provides coverage for endometrial ablation only when provided in the outpatient treatment setting. Prior authorization requests for endometrial ablation **in the provider office treatment setting** should be submitted through e-referral. The submitter will be prompted to complete a questionnaire to determine the appropriateness of the requested service. The questions that will be asked are listed below. Requests for this procedure to be performed in the **provider office treatment setting** will pend for review of the treatment setting.

Some questions below refer to various types of ablation procedures. Please see the following definitions:

- **Laser and resectoscopic endometrial ablation**: Utilizes radiofrequency-alternating current by way of a loop electrode, ball or barrel-shaped electrode, grooved or spiked electrodes with a high wattage that vaporizes the endometrium.
- **Nonresectoscopic endometrial ablation systems**: Refers to techniques or devices placed in the endometrial cavity to perform endometrial ablation. These systems include: cryotherapy (Her Option®), heated free fluid (Hydro ThermAblator®, HTA® System), microwave (Microwave Endometrial Ablation (MEA) from Microsulis Medical/Hologic), radiofrequency electricity (Novasure®), and thermal balloon (ThermaChoice, ThermaChoice II, ThermaChoice III, Cavaterm™).

Procedure code	Description
*58353	Endometrial ablation, thermal, without hysteroscopic guidance
*58356	Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed
*58563	Hysteroscopy, surgical; with endometrial ablation (e.g., endometrial resection, electrosurgical ablation, thermoablation)

1.	For microwave (e.g. Microwave Endometrial Ablation System) ONLY, select ANY of the following that are present. Note: If procedure NOT listed above, you MUST select NOT APPLICABLE.	☐ Essure contraceptive inserts ☐ Myometrial thickness < 10 mm ☐ Endometrial cavity < 6 cm long ☐ None of the above are present ☐NOT APPLICABLE
2.	For microwave or radiofrequency ablation (e.g. Novasure) ONLY, select ANY of the following that are present. Note: If procedure NOT listed above, you MUST select NOT APPLICABLE.	☐ Myometrial thickness < 10 mm ☐ Endometrial cavity < 6 cm long ☐ None of the above are present ☐NOT APPLICABLE
3	For microwave or radiofrequency ablation (e.g. Novasure) with Essure contraceptive inserts present, has correct insert placement been confirmed by an Essure Confirmation Test? Note: If procedure NOT listed above, you MUST select N/A.	☐ Yes ☐ No ☐ N/A
4.	Is there an anatomical condition where myometrium weakness could exist (e.g., previous classic C-section, removal of fibroid in uterus wall)? Note: If NOT nonresectoscopic, select NOT APPLICABLE.	☐ Yes ☐ No ☐ NOT APPLICABLE
5.	Is there documentation in the records of a discussion with the patient of all alternative treatment options?	☐ Yes ☐ No
6.	**Does the patient have:**	
7.	A current pregnancy or wish to be pregnant in the future?	☐ Yes ☐ No

Blue Care Network of Michigan
A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Endometrial Ablation Questionnaire

8.	Active pelvic inflammatory disease or hydrosalpinx (blocked fallopian tube due to fluid, not due to tubal ligation)?	☐ Yes ☐ No
9.	An intrauterine (IUD) device in place?	☐ Yes ☐ No
10.	Documented history of menorrhagia (heavy bleeding)?	☐ Yes ☐ No
11.	Within the past two years, did the patient have a D & C or endometrial biopsy AND was endometrial cancer or pre-cancerous changes of the endometrium ruled out?	☐ Yes, and cancerous condition ruled out ☐ Tests did NOT rule out cancer ☐ No, tests were not performed
12.	Submucosal fibroids (below the lining of the uterus) larger than 3 cm?	☐ Yes ☐ No
13.	Measured length of the endometrial cavity for nonresectoscopic approaches (e.g., Novasure, Cavaterm, ThermaChoice, Her Option, Hydro ThermAblation, HTA System?) Note: If approach is other than above, select NOT APPLICABLE.	☐ Greater than 10 cm ☐ Less than 10 cm ☐ NOT APPLICABLE
14.	Measured length of endometrial cavity for microwave (Microwave Endometrial Ablation System (MEA) from Microsulis Medical/Hologic)? Note: If approach is NOT microwave, you must select NOT APPLICABLE.	☐ Less than 6 cm ☐ Greater than 6 cm and less than14 cm ☐ Greater than 14 cm ☐ NOT APPLICABLE

***CPT codes, descriptions and two-digit numeric modifiers only are copyright 2010 American Medical Association. All rights reserved.**

Reference:

Blue Cross Blue Shield of Michigan and Blue Care Network medical policy titled *Endometrial Ablation.*