Hysterectomy - Single Service

Clinical Guidelines for Medical Necessity Review

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Important Notices

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Guideline Information:

Specialty Area: Obstetrics and Gynecology
Guideline Name: Hysterectomy - Single Service

Literature review current through: August 21, 2023
Document last updated: August 23, 2023
Type: [**X**] Adult (18+ yo) | [_] Pediatric (0-17yo)

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Medical Necessity Criteria

Service: Hysterectomy

General Guidelines

- **Units, Frequency, & Duration:** A hysterectomy procedure is a one-time medical service.
- **Criteria for Subsequent Requests:** None.
- **Recommended Clinical Approach:** Types of hysterectomy include supracervical (removal of uterus and the upper part of the cervix); total (removal of the entire uterus and the cervix); and radical (removal of the uterus, cervix, tissue on both sides of the cervix, and the upper part of the vagina). Procedures include vaginal, laparoscopic, laparoscopic-assisted vaginal, robotic, and abdominal. The route of hysterectomy depends on the size and shape of the vagina and uterus; the ability to reach the uterus in cases of descensus or pelvic adhesions); the severity of extrauterine disease; and if a concurrent procedure is needed. The provider will provide education on the procedure types to aid in the patient's informed decision-making.[1]
  Exclusions: Women who wish to become pregnant.

Medical Necessity Criteria

Indications

➔ **Hysterectomy** is appropriate if **ANY** of the following is **TRUE**[1]:

- ◆ The patient has severe bleeding or abnormal uterine bleeding as indicated by **ANY** of the following[2-3]:
  - Abnormal uterine bleeding with **ALL** of the following[4-5]:
    - Etiology not specified by another procedure (e.g., hysteroscopy, imaging); **AND**
    - Therapies such as an intrauterine device, systemic hormonal therapy, tranexamic acid, or uterine-sparing procedures (e.g., endometrial ablation) are not indicated; **OR**
  - Postpartum hemorrhage[6]; **OR**
  - Other hemorrhages; **OR**
  - Uterine abnormality; **OR**

- The patient has malignancy and premalignant disease as indicated by **ANY** of the following[7]:
  - Cervical cancer or adenocarcinoma in situ[8]; **OR**
  - Endometrial or other uterine cancer; **OR**
  - Ovarian, fallopian tube, or primary peritoneal cancer[9]; **OR**
  - Endometrial intraepithelial neoplasia[11]; **OR**
  - Cervical intraepithelial neoplasia (CIN)[12];**OR**
  - Hereditary nonpolyposis colorectal cancer (HNPCC) or Lynch syndrome[13]; **OR**
  - For the prevention of **ANY** of the following[10]:
    - Malignant gestational trophoblastic disease[14-15]; **OR**
    - PTEN hamartoma tumor syndrome, Cowden syndrome, Bannayan-Riley-Ruvalcaba syndrome, Proteus syndrome or Proteus-like syndrome[16]; **OR**
    - Peutz-Jeghers syndrome[17]; **OR**
    - Patient referred for a bilateral oophorectomy for hormone receptor-positive breast cancer (HR+/HER2) and wants a coincident hysterectomy[18-19]; **OR**
    - Patient decides to have a hysterectomy in addition to a risk-reducing bilateral salpingo-oophorectomy (e.g., BRCA, BRIP1, PALB2, RAD51C, or RAD51D gene mutations)[18-19]; **OR**
- The patient has a uterine leiomyoma and **ANY** of the following is **TRUE**[2,20-21]:
  - Abnormal uterine bleeding; **OR**
  - Iron-deficiency anemia; **OR**
  - Dyspareunia; **OR**
  - Malignancy suspected; **OR**
  - Pelvic pain or pressure; **OR**
  - Urinary or bowel dysfunction; **OR**
- The patient has endometriosis as indicated by **ALL** of the following[22-23]:
  - Diagnosis confirmed by histology on biopsy, laparoscopic visualization, or identification of endometrioma on pelvic imaging; **AND**
  - Symptoms do not improve with use of (or patient cannot tolerate) progestins, gonadotropin-releasing hormone analogues, or uterine-sparing therapies (e.g., destruction of implants, removal of endometrioma, lysis of adhesions); **OR**

- The patient has pelvic organ prolapse and **ALL** of the following are **TRUE**[24-26]:
  - Patient is symptomatic as indicated by **ANY** of the following:
    - Defecatory dysfunction (e.g., incomplete emptying, constipation, incontinence, pain); **OR**
    - Voiding dysfunction (e.g., incomplete emptying, difficulty urinating, incontinence, recurrent infection); **OR**
    - Physical activity limitations; **OR**
    - Discomfort (e.g., pressure, pain); **OR**
    - Sexual dysfunction due to prolapse (dyspareunia); **OR**
    - Vaginal bulge or visible prolapse; **AND**
  - Symptoms do not improve with use of (or patient cannot tolerate) pessary, pelvic floor muscle training, apical [uterine] vault prolapse suspension, or other uterine-sparing therapies; **OR**
- The patient has chronic pelvic pain as indicated by **ALL** of the following[1]:
  - At least six months of persistent pain; **AND**
  - Symptoms do not improve with uterine-sparing therapy (e.g., progestins, oral contraceptives, analgesics, gonadotropin-releasing hormone analogues, antidepressants, physical therapy); **OR**
- The patient has pelvic inflammatory disease (PID).

Non-Indications

→ **Hysterectomy** is not appropriate if **ANY** of the following is **TRUE**:

- When surgery is not safe or beneficial to the patient; **OR**
- The patient is undergoing vaginal hysterectomy and **ANY** of the following is **TRUE**[27]:
  - Pelvic radiation; **OR**
  - Large uterus; **OR**
  - Prior pelvic surgeries; **OR**
  - Suspected severe pelvic adhesion and anatomical distortion from PID (pelvic inflammatory disease) or endometriosis; **OR**
  - Morbid obesity; **OR**

- Women who have never given birth or carried a child (nulliparity); **OR**
- Lack of uterine descent.

Level of Service Criteria

Inpatient or Outpatient.

Procedure Codes (HCPCS/CPT)

HCPCS/CPT Code	Code 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 (e.g., 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)
58260	Vaginal hysterectomy, for uterus 250 g or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
58267	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic

	control
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy
58290	Vaginal hysterectomy, for uterus greater than 250 g
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele
58294	Vaginal hysterectomy, for uterus greater than 250 g; 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 g or less
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58554	Laparoscopy, surgical, with vaginal hysterectomy,

	for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58575	Laparoscopy, surgical, total hysterectomy for resection of malignancy (tumor debulking), with omentectomy including salpingo-oophorectomy, unilateral or bilateral, when performed
58951	Resection (initial) 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)

Medical Evidence

The American College of Obstetricians and Gynecologists (ACOG) published the following publications on hysterectomy and related topics:

- Choosing the Route of Hysterectomy for Benign Disease (Committee Opinion No. 701)[1]
- Endometrial Intraepithelial Neoplasia (Committee Opinion No. 631)[11]
- Hereditary Cancer Syndromes and Risk Assessment (Committee Opinion No. 793)[10]
- Management of Abnormal Uterine Bleeding Associated with Ovulatory Dysfunction (Practice Bulletin No. 136)[5]
- Management of Acute Abnormal Uterine Bleeding in Nonpregnant Reproductive-Aged Women (Committee Opinion No. 557)[4]
- Postpartum Hemorrhage (Practice Bulletin No. 183)[6]
- Robot-Assisted Surgery for Noncancerous Gynecologic Conditions: ACOG (Committee Opinion No. 810)[28]
- Uterine Morcellation for Presumed Leiomyomas (Committee Opinion No. 822)[20]

Lee et al. (2019) analyzed randomized control trials (RCTs) concerning operation time, postoperative pain, and surgical complications of laparoscopic and vaginal hysterectomies. Data from 18 studies (n=1618 patients) find that vaginal hysterectomy is the preference for benign indications. The procedure reports improved postoperative pain scores at 24 hours compared to laparoscopic hysterectomy and reduced surgical time. The authors did not identify significant differences regarding the length of hospital stay or return to regular activity.[29]

Hassan et al. (2023) provide an update to a previous systematic review on "the long-term outcomes of bilateral salpingo-oophorectomy (BSO) at the time of hysterectomy." A meta-analysis of studies included women who had surgery compared to those who did not. Breast cancer risk decreased in young women who had a hysterectomy with BSO; however, there was an increase in colorectal cancer. Stroke, as well as cardiovascular and coronary heart disease, were also reported in the group. Patients who did not have surgery before age 50 have an increased risk of hyperlipidemia, diabetes, hypertension, dementia, and depression.[30]

Alkatout et al. (2023) conducted a review (35 studies) on the outcomes following total or subtotal hysterectomy for patients with endometriosis or

adenomyosis. No significant outcomes were reported with respect to recurrence of disease, sexual function, quality of life, and overall patient satisfaction. The authors note the need for RCTs in these areas.[31]

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