HYSTERECTOMY FOR BENIGN CONDITIONS

Protocol: OBG034
Effective Date: June 1, 2017

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INSTRUCTIONS FOR USE

This protocol provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee's document (e.g., Certificate of Coverage (COC) or Evidence of Coverage (EOC)) may differ greatly. In the event of a conflict, the enrollee's specific benefit document supercedes this protocol. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this Protocol. Other Protocols, Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Protocols, Policies and Guidelines as necessary. This protocol is provided for informational purposes. It does not constitute medical advice. This policy does not govern Medicare Group Retiree members.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

COMMERCIAL, MEDICARE, & MEDICAID COVERAGE RATIONALE

For information regarding medical necessity review, when applicable, see the following MCG™ Care Guidelines, 21st edition, 2017:

- Hysterectomy, Abdominal, ORG: S-650 (ISC)
- Hysterectomy, Vaginal, ORG: S-660 (ISC)
- Hysterectomy, Laparoscopic, ORG: S-665 (ISC)

MCG™ Care Guidelines: Hysterectomy, Abdominal S-650 (ISC)

Clinical Indications for Procedure

- Procedure is indicated for 1 or more of the following:
  - Abnormal uterine bleeding and ALL of the following:
    - Investigation has been performed including ALL of the following:
      - Laboratory studies
Hysterectomy for Benign Conditions

- Imaging or hysteroscopy (eg, evaluate for endometrial hyperplasia or malignancy)
  - Investigation has not identified specific etiology of abnormal uterine bleeding (e.g. endometrial hyperplasia, leiomyoma)
  - Hormonal therapy (e.g. intrauterine delivery system or systemic hormonal therapy) cannot be used because of 1 or more of the following:
    - It is contraindicated.
    - It was tried but did not adequately treat patient's condition.
    - It is not appropriate for severity of patient's condition (eg, severe persistent bleeding).
  - Uterine-sparing procedures (eg, endometrial ablation) cannot be used because of 1 or more of the following:
    - They were tried but did not adequately treat patient's condition.
    - They are not appropriate for severity of patient's condition.
    - Hysterectomy preferred (patient concern about recurrence after endometrial ablation)

- Cervical cancer or adenocarcinoma in situ
  - Cervical intraepithelial neoplasia (CIN) and ALL of the following:
    - Recurrent biopsy-confirmed CIN-2,3 after ablative or excisional procedure
    - Repeat excisional procedure not feasible

- Endometrial or other uterine cancer
  - Endometrial hyperplasia and 1 or more of the following:
    - Complex atypical hyperplasia on endometrial sampling
    - Endometrial hyperplasia on endometrial sampling and failure of 6-month trial of hormonal therapy with progestins
  - Pelvic pain due to endometriosis and ALL of the following:
    - Endometriosis confirmed by histology on biopsy, laparoscopic visualization, or identification of endometrioma on transvaginal ultrasound
    - Symptoms persist despite treatment with progestins or gonadotropin-releasing hormone analogues.
    - Symptoms persist or recur despite treatment with uterine-sparing surgery (eg, destruction of implants, removal of endometrioma, lysis of adhesions).
  - Malignant gestational trophoblastic disease and 1 or more of the following:
    - Patient has no desire for future fertility.
    - Uterine conservation is not appropriate (eg, recurrent disease, resistance to chemotherapy).
  - Gynecologic cancer prevention for patient with 1 or more of the following:
    - Hereditary nonpolyposis colorectal cancer (ie, HNPCC, or Lynch syndrome)
    - Other need for prophylactic bilateral salpingo-oophorectomy and patient chooses to have coincident hysterectomy (eg, BRCA mutation)
  - Leiomyoma ("fibroid") and ALL of the following:
    - Significant symptoms or findings due to leiomyoma, including 1 or more of the following:
      - Abnormal uterine bleeding
      - Iron-deficiency anemia
      - Dyspareunia
      - Malignancy suspected
      - Pelvic pain or pressure
      - Urinary or bowel dysfunction
    - Investigation (eg, endometrial sampling) has ruled out other causes for symptoms.
Alternative treatment (eg, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of 1 or more of the following:
- Alternative treatment was tried but did not adequately treat patient’s condition.
- Alternative treatment is not appropriate for severity of patient's condition (eg, massive involvement of uterus).

- Ovarian or fallopian tube cancer
  - Pelvic organ prolapse and ALL of the following:
    - Stage II, III, or IV uterine prolapse is present.
    - The prolapse is symptomatic as indicated by 1 or more of the following:
      - Cervical ulceration
      - Dyspareunia
      - Inability to wear a tampon
      - Mass sensation
      - Urinary incontinence
      - Recurrent urinary-tract infections
      - Urinary retention
      - Vaginal bleeding
  - Uterine-sparing treatments (eg, pessary, apical (uterine) vault prolapse suspension) cannot be used because of 1 or more of the following:
    - Uterine-sparing treatment did not adequately treat patient's condition.
    - Uterine-sparing treatment is not appropriate for severity of patient's condition (eg, severe prolapse).
    - Uterine-sparing treatment was declined by patient (eg, pessary).
  - Pelvic pain and ALL of the following:
    - Comprehensive evaluation (eg, pain specialist, mental health evaluation) has been performed or is not indicated.
    - Investigations (eg, laparoscopy, endoscopy, imaging) have not identified specific etiology of symptoms (eg, interstitial cystitis, inflammatory bowel disease).
    - Pain has persisted longer than 6 months.
    - Uterine-sparing treatments (eg, oral contraceptives, progestins, gonadotropin-releasing hormone analogues, analgesics, antidepressants, physical therapy) have been unsuccessful.
  - Tubo-ovarian abscess and ALL of the following:
    - Surgery is indicated by 1 or more of the following:
      - Ruptured tubo-ovarian abscess
      - Unruptured tubo-ovarian abscess requires surgical treatment because of ALL of the following:
        - Insufficient response to IV antibiotics
        - Percutaneous drainage (eg, interventional radiologic approach) is not feasible.
    - Uterine-sparing surgery (eg, salpingo-oophorectomy) is not feasible or not clinically appropriate.
  - Severe bleeding (eg, postpartum or other hemorrhage) or uterine abnormality (eg, rupture) that cannot be controlled by conservative care.

MCG™ Care Guidelines: Hysterectomy, Vaginal S-660 (ISC)
Clinical Indications for Procedure
- Procedure is indicated for 1 or more of the following:
Hysterectomy for Benign Conditions

- Abnormal uterine bleeding and **ALL** of the following:
  - Investigation has been performed including **ALL** of the following:
    - Laboratory studies
    - Imaging or hysteroscopy (e.g. evaluate for endometrial hyperplasia or malignancy)
  - Investigation has not identified specific etiology of abnormal uterine bleeding (e.g., endometrial hyperplasia, leiomyoma)
  - Hormonal therapy (e.g., intrauterine delivery system or systemic hormonal therapy) cannot be used because of **1 or more of the following**:
    - It is contraindicated.
    - It was tried but did not adequately treat patient's condition.
    - It is not appropriate for severity of patient's condition (e.g., severe persistent bleeding).
  - Uterine-sparing procedures (e.g., endometrial ablation) cannot be used because of **1 or more of the following**:
    - Procedure contraindicated (extreme uterine flexion or version, extremely thin myometrium)
    - Procedure tried but did not adequately treat patient's condition.
    - Procedure not appropriate for severity of patient's condition
    - Hysterectomy preferred (e.g., patient concern about recurrence after endometrial ablation)
- Cervical adenocarcinoma in situ
- Cervical intraepithelial neoplasm (CIN) and **ALL** of the following:
  - Recurrent biopsy-confirmed CIN-2,3 after ablative or excisional procedure
  - Repeat excisional procedure is not feasible.
- Early-stage cervical cancer (e.g., stage 1A1)
- Early-stage endometrial cancer in selected patients (e.g., elderly)
- Endometrial hyperplasia and **1 or more of the following**:
  - Complex atypical hyperplasia on endometrial sampling
  - Endometrial hyperplasia on endometrial sampling and failure of 6-month trial of hormonal therapy with progestins
- Pelvic pain due to endometriosis and **ALL** of the following:
  - Endometriosis confirmed by histology on biopsy, laparoscopic visualization, or identification of endometrioma on transvaginal ultrasound
  - Symptoms persist despite treatment with progestins or gonadotropin-releasing hormone analogues.
  - Symptoms persist or recur despite treatment with uterine-sparing surgery (e.g., destruction of implants, removal of endometrioma, lysis of adhesions).
- Malignant gestational trophoblastic disease and **1 or more of the following**:
  - Patient has no desire for future fertility.
  - Uterine conservation is not appropriate (e.g., recurrent disease, resistance to chemotherapy).
- Gynecologic cancer prevention for patient with **1 or more of the following**:
  - Hereditary nonpolyposis colorectal cancer (i.e., HNPCC, or Lynch syndrome)
  - Other need for prophylactic bilateral salpingo-oophorectomy and patient chooses to have coincident hysterectomy (e.g., BRCA mutation)
- Leiomyoma ("fibroid") and **ALL** of the following:
  - Significant symptoms or findings due to leiomyoma, including **1 or more of the following**:
    - Abnormal uterine bleeding
- Iron-deficiency anemia
- Dyspareunia
- Malignancy suspected
- Pelvic pain or pressure
- Urinary or bowel dysfunction
  - Investigation (eg, endometrial sampling) has ruled out other causes for symptoms.
  - Alternative treatment (eg, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of 1 or more of the following:
    - Alternative treatment was tried but did not adequately treat patient's condition.
    - Alternative treatment not appropriate for severity of patient's condition (eg, massive involvement of uterus).

- Pelvic organ prolapse and ALL of the following:
  - Stage II, III, or IV uterine prolapse is present.
  - The prolapse is symptomatic as indicated by 1 or more of the following:
    - Cervical ulceration
    - Dyspareunia
    - Inability to wear a tampon
    - Mass sensation
    - Urinary incontinence
    - Recurrent urinary tract infections
    - Urinary retention
    - Vaginal bleeding
  - Uterine-sparing treatment (eg, pessary, apical (uterine) vault prolapse suspension) cannot be used because 1 or more of the following:
    - Uterine-sparing treatment did not adequately treat patient's condition.
    - Uterine-sparing treatment is not appropriate for severity of patient's condition (eg, severe prolapse).
    - Uterine-sparing treatment has been declined by patient (eg, pessary)

- Pelvic pain and ALL of the following:
  - Comprehensive evaluation (eg, pain specialist, mental health evaluation) has been performed or is not indicated.
  - Investigations (eg, laparoscopy, endoscopy, imaging) have not identified specific etiology of symptoms (eg, interstitial cystitis, inflammatory bowel disease).
  - Pain has persisted longer than 6 months.
  - Uterine-sparing treatments (eg, oral contraceptives, progestins, gonadotropin-releasing hormone analogues, analgesics, antidepressants, physical therapy) have been unsuccessful.

MCG™ Care Guidelines: Hysterectomy, Laparoscopic S-665 (ISC)

Clinical Indications for Procedure

Procedure is indicated for 1 or more of the following:

- Abnormal uterine bleeding and ALL of the following:
  - Investigation has been performed including ALL of the following:
    - Laboratory studies
    - Imaging or hysteroscopy (e.g. evaluate for endometrial hyperplasia or malignancy)
  - Investigation has not identified specific etiology of abnormal uterine bleeding (eg, endometrial hyperplasia, leiomyoma).
Hormonal therapy (eg, intrauterine delivery system or systemic hormonal therapy) cannot be used because of 1 or more of the following:
- It is contraindicated.
- It was tried but did not adequately treat patient's condition.
- It is not appropriate for severity of patient's condition (eg, severe persistent bleeding).

Uterine-sparing procedure (eg, endometrial ablation) cannot be used because of 1 or more of the following:
- Procedure contraindicated (extreme uterine flexion or version, extremely thin myometrium)
- Procedure tried but did not adequately treat patient's condition
- Procedure not appropriate for severity of patient's condition
- Hysterectomy preferred (eg, patient concern about recurrence after endometrial ablation)

- Cervical adenocarcinoma in situ
- Cervical intraepithelial neoplasia (CIN) and ALL of the following:
  - Recurrent biopsy-confirmed CIN-2,3 after ablative or excisional procedure
  - Repeat excisional procedure is not feasible.
- Early-stage cervical cancer
- Early stage ovarian cancer, known or suspected (eg, suspicious adnexal mass
- Endometrial cancer
- Endometrial hyperplasia and 1 or more of the following:
  - Complex atypical hyperplasia on endometrial sampling
  - Endometrial hyperplasia on endometrial sampling and failure of 6-month trial of hormonal therapy with progestins
- Pelvic pain due to endometriosis and ALL of the following:
  - Endometriosis confirmed by histology on biopsy, laparoscopic visualization, or identification of endometrioma on transvaginal ultrasound
  - Symptoms persist despite treatment with progestins or gonadotropin-releasing hormone analogues.
  - Symptoms persist or recur despite treatment with uterine-sparing surgery (eg, destruction of implants, removal of endometrioma, lysis of adhesions).
- Malignant gestational trophoblastic disease and 1 or more of the following:
  - Patient has no desire for future fertility.
  - Uterine conservation is not appropriate (eg, recurrent disease, resistance to chemotherapy)
- Gynecologic cancer prevention for patient with 1 or more of the following:
  - Hereditary nonpolyposis colorectal cancer (ie, HNPCC, or Lynch syndrome)
  - Other need for prophylactic bilateral salpingo-oophorectomy and patient chooses to have coincident hysterectomy (eg, BRCA mutation)
- Leiomyoma ("fibroid") and ALL of the following:
  - Significant symptoms or findings due to leiomyoma, including 1 or more of the following:
    - Abnormal uterine bleeding
    - Iron-deficiency anemia
    - Dyspareunia
    - Malignancy suspected
    - Pelvic pain or pressure
    - Urinary or bowel dysfunction
- Investigation (eg, endometrial sampling) has ruled out other causes for symptoms.
- Alternative treatment (eg, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of 1 or more of the following:
  - Alternative treatment was tried but did not adequately treat patient's condition.
  - Alternative treatment not appropriate for severity of patient's condition (eg, massive involvement of uterus).
- Pelvic organ prolapse and ALL of the following:
  - Stage II, III, or IV uterine prolapse is present.
  - The prolapse is symptomatic as indicated by 1 or more of the following:
    - Cervical ulceration
    - Dyspareunia
    - Inability to wear a tampon
    - Mass sensation
    - Urinary incontinence
    - Recurrent urinary tract infections
    - Urinary retention
    - Vaginal bleeding
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    - Uterine-sparing treatment is not appropriate for severity of patient's condition (eg, severe prolapse).
    - Uterine-sparing treatment has been declined by patient (eg, pessary).
- Pelvic pain and ALL of the following:
  - Comprehensive evaluation (eg, pain specialist, mental health evaluation) has been performed or is not indicated.
  - Investigations (eg, laparoscopy, endoscopy, imaging) have not identified specific etiology of symptoms (eg, interstitial cystitis, inflammatory bowel disease).
  - Pain has persisted longer than 6 months.
  - Uterine-sparing treatments (eg, oral contraceptives, progestins, gonadotropin-releasing hormone analogues, analgesics, antidepressants, physical therapy) have been unsuccessful.
- Tubo-ovarian abscess and ALL of the following:
  - Surgery is indicated by 1 or more of the following:
    - Ruptured tubo-ovarian abscess
    - Unruptured tubo-ovarian abscess requires surgical treatment because of ALL of the following:
      - Insufficient responses to IV antibiotics
      - Percutaneous drainage (eg, interventional radiologic approach) not feasible
  - Uterine-sparing surgery (eg. salpingo-oophorectomy) is not feasible or not clinically appropriate.

**End of MCG

Medicare does not have a National Coverage Determination (NCD) specifically for hysterectomy procedures for benign conditions. Local Coverage Determinations (LCDs) for Nevada do not exist at this time (Accessed April 2017).
For Medicare and Medicaid Determinations Related to States Outside of Nevada:
Please review Local Coverage Determinations that apply to other states outside of Nevada.
http://www.cms.hhs.gov/mcd/search

Important Note: Please also review local carrier Web sites in addition to the Medicare Coverage
database on the Centers for Medicare and Medicaid Services’ Website.

DESCRIPTION OF SERVICES

A hysterectomy is a surgical procedure to remove the uterus, and in some cases, the ovaries and fallopian tubes as well. In a total hysterectomy, the entire uterus, including the cervix, is removed. In a supracervical or partial hysterectomy, the upper part of the uterus is removed, but the cervix is left in place. Benign conditions that might be treated with a hysterectomy include uterine fibroids, endometriosis, pelvic organ prolapse and abnormal uterine bleeding.

Hysterectomies can be performed vaginally, abdominally or with laparoscopic or robotic assistance. In a vaginal hysterectomy, the uterus is removed through the vagina. In an abdominal hysterectomy, the uterus is removed through an incision in the lower abdomen. A laparoscopic approach uses a laparoscope to guide the surgery. A laparoscope is a thin, lighted tube that is inserted into the abdomen through a small incision in or around the navel. The scope has a small camera that projects images onto a monitor. Additional small incisions are made in the abdomen for other surgical instruments used during the surgery. In a total laparoscopic hysterectomy, the uterus is removed in small pieces through the incisions or through the vagina. In a laparoscopic-assisted vaginal hysterectomy, the uterus is removed through the vagina, and the laparoscope is used to guide the surgery. In a robotic-assisted laparoscopic hysterectomy, the surgeon uses a robot attached to the instruments to assist in the surgery (ACOG, 2015).

CLINICAL EVIDENCE

Studies have shown that a vaginal approach to hysterectomy has fewer complications, requires a shorter hospital stay and is associated with better outcomes than a laparoscopic or abdominal approach.

A Cochrane review of 47 randomized controlled trials (n=5102) evaluating the abdominal, laparoscopic, and vaginal approach concluded that vaginal hysterectomy (VH) appears to be superior to laparoscopic and abdominal hysterectomy. VH is preferred to abdominal hysterectomy (AH) when possible, citing the advantages of a more rapid recovery and fewer postoperative complications of fever and/or infection. Where VH is not possible, a laparoscopic approach is preferred over AH with the same advantages as the vaginal approach, but requires a longer operating time and had more urinary tract injuries (Aarts et al., 2015).

A meta-analysis of five randomized studies comparing total laparoscopic hysterectomy (TLH) and VH for benign disease reported no differences in perioperative complications between the two procedures. TLH was associated with reduced postoperative pain scores and reduced hospital stay but took longer to perform. No differences in blood loss, rate of conversion to laparotomy or urinary tract injury were identified (Gendy et al., 2011).
A Cochrane review of 34 randomized controlled trials (n=4495) of AH, TLH, and VH concluded that VH should be performed in preference to AH where possible. The authors found that VH meant a quicker return to normal activities, fewer infections and episodes of raised temperature after surgery and a shorter hospital stay compared to AH. When a vaginal approach is not possible, a laparoscopic approach may avoid the need for an AH. TLH meant a quicker return to normal activities, less blood loss and a smaller drop in blood count, a shorter hospital stay and fewer wound infections and episodes of raised temperature after surgery compared to AH; however, laparoscopic surgery is associated with longer operating times and higher rates of urinary tract injury. More research is needed, particularly to examine the long-term effects of the different types of surgery (Nieboer et al., 2009).

Walsh et al. (2009) performed a meta-analysis of randomized controlled trials to compare outcomes in total abdominal hysterectomy (TAH) and TLH for benign disease in women who were not candidates for a vaginal approach. Results indicated that TLH is associated with reduced overall peri-operative complications and reduced estimated blood loss. Additionally, there are trends towards shorter hospital stay and postoperative hematoma formation compared to TAH. However, there were longer operating times in the TLH group. Although the rates of major complication were not statistically different, the authors note that this analysis is likely underpowered to detect many major complications. Larger studies are needed to assess the impact on major complications and long-term clinical outcomes.

Professional Societies

**American Association of Gynecologic Laparoscopists (AAGL)**

An AAGL position statement concludes that most hysterectomies for benign disease should be performed either vaginally or laparoscopically. These approaches are associated with low surgical risks and can be performed with a short hospital stay. Abdominal hysterectomy should be reserved for the minority of women for whom a laparoscopic or vaginal approach is not appropriate (2011).

**American College of Obstetricians and Gynecologists (ACOG)**

An ACOG committee opinion states that vaginal hysterectomy is the approach of choice whenever feasible. Evidence demonstrates that, in general, vaginal hysterectomy is associated with better outcomes and fewer complications than laparoscopic or abdominal hysterectomy. Laparoscopic hysterectomy is an alternative to abdominal hysterectomy when a vaginal hysterectomy is not indicated or feasible (ACOG, 2009. Updated 2011).

**U.S. FOOD AND DRUG ADMINISTRATION (FDA)**

The interventions described in this policy are surgical procedures and are not subject to FDA approval. There are many surgical instruments approved for use in pelvic and abdominal surgery. See the following website to search for specific products. Available at: [http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm](http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm). Accessed April 2017.

A November 24, 2014 FDA Safety Communication recommends that manufacturers of laparoscopic power morcellators with a general indication or a specific gynecologic indication prominently include the following black box warning and contraindications in their product labeling:
• **Warning:**
  o Uterine tissue may contain unsuspected cancer. The use of laparoscopic power morcellators during fibroid surgery may spread cancer, and decrease the long-term survival of patients. This information should be shared with patients when considering surgery with the use of these devices.

• **Contraindications:**
  o Laparoscopic power morcellators are contraindicated in gynecologic surgery in which the tissue to be morcellated is known or suspected to contain malignancy.
  o Laparoscopic power morcellators are contraindicated for removal of uterine tissue containing suspected fibroids in patients who are peri- or post-menopausal, or are candidates for en bloc tissue removal, for example through the vagina or via a mini-laparotomy incision.

See the following website for additional information.

**APPLICABLE CODES**

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

<table>
<thead>
<tr>
<th>CPT Codes</th>
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<tbody>
<tr>
<td><strong>Abdominal</strong></td>
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<tr>
<td>58150</td>
<td>Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)</td>
</tr>
<tr>
<td>58152</td>
<td>Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpourethrocystopexy (eg, Marshall-Marchetti-Krantz, Burch)</td>
</tr>
<tr>
<td>58180</td>
<td>Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)</td>
</tr>
<tr>
<td><strong>Laparoscopic</strong></td>
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<tr>
<td>58541</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less</td>
</tr>
<tr>
<td>58542</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58543</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58544</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
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<tr>
<td>58570</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less</td>
</tr>
<tr>
<td>58571</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)</td>
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<td>CPT Code</td>
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<tr>
<td>58572</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g</td>
</tr>
<tr>
<td>58573</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
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<tr>
<td><strong>Vaginal</strong></td>
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<tr>
<td>58260</td>
<td>Vaginal hysterectomy, for uterus 250 g or less</td>
</tr>
<tr>
<td>58262</td>
<td>Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)</td>
</tr>
<tr>
<td>58263</td>
<td>Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele</td>
</tr>
<tr>
<td>58267</td>
<td>Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control</td>
</tr>
<tr>
<td>58270</td>
<td>Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele</td>
</tr>
<tr>
<td>58275</td>
<td>Vaginal hysterectomy, with total or partial vaginectomy</td>
</tr>
<tr>
<td>58280</td>
<td>Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele</td>
</tr>
<tr>
<td>58290</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g</td>
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<tr>
<td>58291</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
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<tr>
<td>58292</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s); with repair of enterocele</td>
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<tr>
<td>58293</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control</td>
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<tr>
<td>58294</td>
<td>Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele</td>
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**Laparoscopic – Assisted Vaginal**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>58550</td>
<td>Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 g or less</td>
</tr>
<tr>
<td>58552</td>
<td>Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58553</td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g</td>
</tr>
<tr>
<td>58554</td>
<td>Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)</td>
</tr>
</tbody>
</table>

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**REFERENCES**


### PROTOCOL HISTORY/REVISION INFORMATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
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<tr>
<td>04/27/2017</td>
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<tr>
<td>06/25/2015</td>
<td>Corporate Medical Affairs Committee</td>
</tr>
</tbody>
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The foregoing Health Plan of Nevada/Sierra Health & Life Health Operations protocol has been adopted from an existing UnitedHealthcare coverage determination guideline that was researched, developed and approved by the UnitedHealthcare Coverage Determination Committee.