Medical Policy
Radiofrequency Ablation to Treat Uterine Fibroids

Policy Number: 050

Authorization Requirements

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<th>Commercial and Connector/Qualified Health Plans</th>
<th>MassHealth</th>
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<tr>
<td>• Laparoscopic radiofrequency ablation</td>
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<td>• Transcervical radiofrequency ablation</td>
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Overview
The purpose of this document is to describe the guidelines Mass General Brigham Health Plan utilizes to determine the medical necessity for laparoscopic or transcervical radiofrequency ablation to treat uterine fibroids. The treating specialist must request prior authorization for the procedure.

Coverage Guidelines

Initial Treatment
The use of an FDA approved device to destroy uterine fibroids through laparoscopic or transcervical ultrasound-guided radiofrequency ablation (e.g., Acessa™ or Sonata™) may be considered medically necessary when the member has one or more of the following symptoms directly attributed to uterine fibroids:
1. Excessive menstrual bleeding (menorrhagia)
2. Urinary symptoms or gastrointestinal symptoms (e.g., urinary frequency, abdominal bloating, constipation)
3. Pelvic pain
4. Lower back pain
5. Painful sexual relations (dyspareunia)

Exclusions
1. Fibroid size greater than 9 cm for Acessa and greater than 7 cm for Sonata
2. The member has an acute pelvic infection
3. The member has a diagnosis of gynecological cancer or a pre-cancerous lesion (e.g., atypical endometrial hyperplasia, leiomyosarcoma, etc.)
4. The member has an abnormal pap smear test result without appropriate followup
5. The member is currently pregnant
6. Presence of an intrauterine device (IUD), unless removed prior to the introduction of the Sonata Treatment Device
7. Techniques for myolysis using energy sources other than radiofrequency ablation

Medicare Variations
Mass General Brigham Health Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS)
for coverage determinations for its Medicare Advantage plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals are the basis for coverage determinations. When there is no guidance from CMS for the requested service, Mass General Brigham Health Plan’s medical policies are used for coverage determinations.

Definitions

Laparoscopic Ultrasound-Guided Radiofrequency Ablation: A minimally invasive procedure that uses a laparoscopic ultrasound probe to determine the location and size of fibroids. Then a small electrode array delivers radiofrequency energy to destroy the fibroids.

Transcervical Radiofrequency Ablation: A minimally invasive procedure that integrates intrauterine ultrasound imaging with radiofrequency transcervical incisionless treatment to destroy uterine fibroids.

Codes

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage.

This list of codes applies to commercial and MassHealth plans only.

<table>
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<tr>
<th>Authorized CPT/HCPCS Codes</th>
<th>Code Description</th>
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<tr>
<td>58674</td>
<td>Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency</td>
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<tr>
<td>0404T</td>
<td>Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency</td>
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Effective


March 2022: Annual Review. References updated

March 2021: Effective Date.

References


Commonwealth of Massachusetts. MassHealth Provider Manuals.


