2017.1 Procedures Criteria

PATIENT:	Name	DOB	ID#	GROUP#
	Facility		Service Date	
PROVIDER:	Name		Fax#	Phone#
	Signature		Date	NPI/ID#

ICD-10:
CPT®:

Subset: Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy[1, 2, 3, 4, 5, 6, 7, 8, 9, 10]
Requested Service: Hysterectomy + BSO for Endometriosis
Age:[11] Age ≥ 18

INSTRUCTIONS: Answer the following questions

☐ **Endometriosis by laparoscopy**[12, 13, 14, 15]

1. Treatment within last year, Choose all that apply:
   - ☐ A) GnRH agonist ≥ 8 weeks[16]
   - ☐ B) Hormone therapy ≥ 8 weeks[17]
   - ☐ C) Danazol ≥ 8 weeks[18]
   - ☐ D) Other clinical information (add comment)

   - If 1 or more options A, B or C selected and option D not selected, then go to question 2
   - No other options lead to the requested service

2. Continued symptoms after treatment[19]
   - ☐ Yes
   - ☐ No

   - If option Yes selected, then go to question 3
   - No other options lead to the requested service

3. Choose all that apply:
   - ☐ A) Most recent cervical cytology normal or treated per guidelines[20]
   - ☐ B) Pregnancy excluded by negative human chorionic gonadotropin (HCG) or HCG planned prior to procedure or sterilization by history or patient not sexually active by history[21, 22, 23, 24]
   - ☐ C) Other clinical information (add comment)

3. Choose all that apply: ***(Continued...)***

- If the number of options selected is 2 and option C not selected, then the rule is satisfied; you may stop here [25]
- No other options lead to the requested service

Notes

(1)
These criteria include the following procedures:
Hysterectomy, Abdominal, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy
Hysterectomy, Abdominal, Total +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy
Hysterectomy, Laparoscopic, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy
Hysterectomy, Laparoscopic, Total (TLH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy
Hysterectomy, Vaginal +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy

(2)
I/O Setting:
Hysterectomy, Abdominal, Supracervical +/- BSO or Bilateral Salpingectomy - Inpatient
Hysterectomy, Abdominal, Total +/- BSO or Bilateral Salpingectomy - Inpatient
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) +/- BSO or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting
Hysterectomy, Laparoscopic, Supracervical +/- BSO or Bilateral Salpingectomy - Outpatient
Hysterectomy, Laparoscopic, Total (TLH) +/- BSO or Bilateral Salpingectomy - Outpatient
Hysterectomy, Vaginal +/- BSO or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting

(3)
For cervical cancer stage I-IIA and endometrial cancer stage II, see the "Hysterectomy, Radical" criteria subset.

(4)
Whether to perform prophylactic oophorectomy at the time of hysterectomy done for benign disease in premenopausal women is controversial; there are no published randomized studies to support conservation or prophylactic removal of the ovaries, although observational studies suggest that surgical menopause may increase cardiovascular and overall mortality risk (Orozco et al., The Cochrane database of systematic reviews 2014, 7: CD005638). Generally, bilateral salpingo-oophorectomy (BSO) is recommended for women with BRCA1 or BRCA2 mutations or Lynch syndrome, for postmenopausal women, and for women who have invasive endometrial or ovarian carcinoma (National Comprehensive Cancer Network, The NCCN Clinical Practice Guidelines in Oncology: Genetic/Familial High-risk Assessment: Breast and Ovarian V2.2015. 2015 [cited Jul 21 2015]; National Comprehensive Cancer Network, The NCCN Clinical Practice Guidelines in Oncology, Genetic/Familial High-Risk Assessment: Colorectal V.2.2014. 2014 [cited Jan 21 2015]). BSO may be considered in women who have chronic pelvic pain, pelvic inflammatory disease, or endometriosis, although the risks of surgery should be balanced against the anticipated benefits. Ovarian retention should be considered for premenopausal women who do not have a genetic predisposition to ovarian cancer. Ovarian epithelial carcinoma may originate in cells from the fallopian tube. Therefore, salpingectomy without oophorectomy may be considered in low-risk women who undergo hysterectomy or other pelvic surgery for benign disease, which allows for ovarian cancer risk reduction without surgical menopause (ACOG, Obstetrics and Gynecology: Committee Opinion No. 620. 2015, 125: 279-81; Society of Gynecologic Oncology, SGO Clinical Practice Statement: Salpingectomy for Ovarian Cancer Prevention 2013 [cited Sept 2015]).

(5)
Although the use of robotic-assisted hysterectomy has increased over the past several years, there are few prospective studies comparing robotic-assisted to laparoscopic surgery for treating benign disease. Several studies support its use for endometrial cancer (ACOG, Obstetrics and Gynecology Committee Opinion No. 628. 2015, 125: 760-7; Yu et al., Journal of surgical oncology 2013, 107: 653-8; Ramirez et al., Gynecologic oncology 2012, 124: 180-4). A large retrospective study found similar outcomes between the robotic-assisted and laparoscopic techniques but this study, as well as others, reported that robotic surgery was more expensive (Wright et al., JAMA 2013, 309: 689-98; Yu et al., Journal of surgical oncology 2013, 107: 653-8). A Cochrane review demonstrated that robotic-assisted gynecologic surgery required more intraoperative time but allowed for a shorter hospital stay than laparoscopic surgery. There is no clear evidence to determine which surgery has the lowest complication rate (Liu et al., The Cochrane database of systematic reviews 2014, 12: CD011422). Robotic-assisted surgery can be performed as an outpatient surgery in some patients (Lee et al., Gynecologic oncology 2014, 133: 552-5).

(6)
Laparoscopically assisted vaginal hysterectomy (LAVH) is performed by mobilization of the uterus and its upper pedicles laparoscopically; the uterine vessels are not secured by the endoscopic route. A vaginal hysterectomy is then performed.

(7)
Total laparoscopic hysterectomy (TLH), is performed by mobilization of the uterus and its upper pedicles laparoscopically; the uterine vessels are then secured by the endoscopic route. The fundus is then divided and removed through the abdominal wall incisions.

(8)
Supracervical hysterectomy (subtotal hysterectomy) performed as an open or laparoscopic procedure has been thought to preserve sexual, bladder, and bowel function by minimizing disruption of the pelvic floor support and neurovascular supply when compared with total hysterectomy. However, there is inconsistent evidence to show there is an improvement or significant difference in surgical complications, incontinence rate, bladder function, or sexual function when subtotal hysterectomy is compared to total hysterectomy (Lethaby et al., Cochrane Database Syst Rev 2012, 4: CD004993). One 5-year follow-up study of a randomized controlled trial, however, did show higher rates of urinary incontinence and vaginal bleeding in women who had a supracervical hysterectomy compared with those who had a total hysterectomy (Andersen et al., BJOG: An International Journal of Obstetrics and Gynaecology 2015, 122: 851-7). Disadvantages of supracervical hysterectomy include cervical stump complications (e.g., bleeding, pain) and the small risk of developing cervical cancer in the cervical stump (ACOG, Obstet Gynecol 2007 Committee Opinion No. 388; 110(5): 1215-1217. Reaffirmed, 2013). Supracervical hysterectomy may not be appropriate in women who have gynecological cancers, endometrial hyperplasia, or cervical dysplasia (ACOG, Obstet Gynecol 2007 Committee Opinion No. 388; 110(5): 1215-1217. Reaffirmed, 2013).

(9)
Vaginal hysterectomy offers many advantages to the abdominal or laparoscopic approach including no abdominal incision, less pain, quicker recovery, and, if technically feasible, it is the preferred surgical route (Sesti et al., Archives of Gynecology and Obstetrics 2014, 290: 485-91; American College of Obstetricians and Gynecologists, Obstet Gynecol 2009, 114: 1156-8. Reaffirmed 2011; Nieboer et al., Cochrane Database Syst Rev 2009; (1): CD003677). The vaginal technique, however, can be limited in its ability to treat ovarian pathology and large uteri. The preoperative use of GnRH agonists may help shrink large uteri so that a vaginal hysterectomy can be performed (Elzaher et al., European Journal of Obstetrics, Gynecology, and Reproductive Biology 2013, 169: 326-30). Vaginal hysterectomy may be difficult to perform in nulliparous women, obese women, and women with a history of cesarean delivery.

(10)
InterQual® Procedures criteria are derived from the systematic, continuous review and critical appraisal of the most current evidence-based literature and include input from our independent panel of clinical experts. To generate the most appropriate recommendations, a comprehensive literature review of the clinical evidence was conducted. Sources searched included PubMed, Agency for Healthcare Research and Quality (AHRQ) Comparative Effectiveness Reviews, the Cochrane Library, Choosing Wisely, Centers for Medicare &Medicaid Services (CMS) National Coverage Determinations, the National Institute of Health and Care Excellence (NICE), and the National Guideline Clearinghouse. Other medical literature databases, medical content providers, data sources, regulatory body websites, and specialty society resources may also have been used. Relevant studies were assessed for risk of bias following principles described in the Cochrane Handbook. The resulting evidence was assessed for consistency, directness, precision, effect size, and publication bias. Observational trials were also evaluated for the presence of a dose-response gradient and the likely effect of plausible confounders.

(11)
These criteria address adult diagnoses or indications. The diagnoses or indications are not applicable to individuals < 18 and therefore, this content should only be applied to adults.

(12)
Def: Endometriosis is defined as the presence of functioning endometrial glands and stroma at a site outside the uterine cavity.

(13)
Hysterectomy with bilateral salpingo-oophorectomy and removal of endometriomas is maximally aggressive treatment for endometriosis associated with intractable pain, an adnexal mass, or failed previous conservative therapy. A review of the literature revealed high recurrence and reoperation rates in women whose ovaries were preserved at the time of hysterectomy; residual endometriomas can also contribute to recurrence (ACOG, Obstet Gynecol 2010, Practice Bulletin no. 114: 223-36. Reaffirmed, 2016; Rizk et al., Facts, views &vision in ObGyn 2014, 6: 219-27).

(14)
Definitive diagnosis of endometriosis is made by histology of tissue surgically removed, most often by diagnostic laparoscopy. Biopsies of suspicious areas should be taken, as visual diagnosis is often inaccurate (ACOG, Obstet Gynecol 2010, Practice Bulletin no. 114: 223-36. Reaffirmed, 2016; Leyland et al., J Obstet Gynaecol Can 2010, 32: S1-32).

(15)
Appropriate approaches for endometriosis include:
Hysterectomy, Abdominal, Supracervical + BSO
Hysterectomy, Abdominal, Total + BSO
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) + BSO
Hysterectomy, Laparoscopic, Supracervical + BSO
Hysterectomy, Laparoscopic, Total (TLH) + BSO
Hysterectomy, Vaginal + BSO

(16)

The GnRH agonists include leuprolide, nafarelin, and goserelin. These compounds mimic the action of GnRH and, thereby, suppress the hormones produced by the ovary that stimulate endometrial growth.

(17)
Medical therapy to treat symptoms of endometriosis may include combined contraceptive or progestin alone; their use is considered a first-line option (Brown and Farquhar, The Cochrane database of systematic reviews 2014, 3: CD009590). Depot medroxyprogesterone acetate, the progestin contraceptive implant, and the levonorgestrel intra-uterine system may also improve pain due to endometriosis (ACOG, Obstetrics and gynecology Practice Bulleting No. 110. 2010, 115: 206-218. Reaffirmed, 2014).

(18)
If symptoms do not respond to an oral contraceptive pill or GnRH agonist, then treatment with danazol or a progestin (e.g., depot medroxyprogesterone) is appropriate (Giudice, N Engl J Med 2010, 362: 2389-98; Leyland et al., J Obstet Gynaecol Can 2010, 32: S1-32).

(19)
Symptoms of endometriosis include chronic recurrent pelvic pain, dysmenorrhea, infertility, and dyspareunia.

(20)
Cervical cytology should be documented as normal per screening protocols or if abnormal (e.g., human papilloma virus (HPV) positive, low-grade squamous intraepithelial lesion (LSIL), treated following the most current guidelines (American College of Obstetricians and Gynecologists, Obstet Gynecol 2016, 128: e111-30; Massad et al., J Low Genit Tract Dis 2013, 17: S1-S27; Saslow et al., Am J Clin Pathol 2012, 137: 516-42).

(21)
Pregnancy and related complications (e.g., ectopic pregnancy, incomplete abortion, inevitable abortion) must be excluded before performing this procedure.

(22)
Pregnancy testing can be by measurement of either a serum or urine human chorionic gonadotropin and may be documented in the medical record by either the primary care physician, gynecologist, or surgeon.

(23)
The documentation should include a history of sterilization (i.e., tubal ligation) without a subsequent pregnancy. These criteria do not include sterilization of a partner, nor does it cover alternate birth control methods (e.g., oral contraceptive pill use, intrauterine device insertion).

(24)
Patients have varying definitions of sexual activity (e.g., number of partners, timing of most recent episode, frequency of sexual activity). Unless the provider can confirm on examination that the patient has never had sexual intercourse, whether a patient is sexually active or not is a matter of clinical judgment.

(25)
I/O Setting:
Hysterectomy, Abdominal, Supracervical + BSO - Inpatient
Hysterectomy, Abdominal, Total + BSO - Inpatient
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) + BSO - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting
Hysterectomy, Laparoscopic, Supracervical + BSO - Outpatient
Hysterectomy, Laparoscopic, Total (TLH) + BSO - Outpatient
Hysterectomy, Vaginal + BSO - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting

ICD-10-CM (circle all that apply): N80.0, N80.1, N80.2, Other_____

ICD-10-PCS (circle all that apply): 0UT20ZZ, 0UT24ZZ, 0UT70ZZ, 0UT74ZZ, 0UT90ZZ, 0UT94ZZ, 0UT97ZZ, 0UT98ZZ, 0UT9FZZ, 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ, Other_____

CPT® (circle all that apply): 58150, 58152, 58180, 58262, 58263, 58291, 58292, 58542, 58544, 58552, 58554, 58571, 58573, Other_____