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 or Bilateral Salpingectomy for Abnormal uterine bleeding (AUB) or Postmenopausal bleeding
Age:[11] Age ≥ 18

INSTRUCTIONS: Choose one of the following options and continue to the appropriate section

☐ 10. Abnormal uterine bleeding (AUB) in premenopausal woman[12, 13]

☐ 20. Postmenopausal bleeding[14]

☐ 10. Abnormal uterine bleeding (AUB) in premenopausal woman[12, 13]

1. Choose all that apply:
   - ☐ A) Abnormal bleeding[15]
   - ☐ B) Vagina and cervix normal by physical examination
   - ☐ C) Thyroid disease excluded by history or physical examination or testing[16]
   - ☐ D) Most recent cervical cytology normal or treated per guidelines[17]
   - ☐ E) 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[18, 19, 20, 21]
   - ☐ F) Imaging or hysteroscopy within last year negative for endometrial lesion[22]
   - ☐ G) Other clinical information (add comment)

   - If the number of options selected is 6 and option G not selected, then go to question 2
   - No other options lead to the requested service

2. Choose one:[23]
   - ☐ A) Age < 45
   - ☐ B) Age ≥ 45

   - If option A selected, then go to question 3
   - If option B selected, then go to question 6

3. Choose all that apply:

☐ 10. Abnormal uterine bleeding (AUB) in premenopausal woman ***(Continued...)***

- ☐ A) Bleeding interferes with ADLs
- ☐ B) Anemia
- ☐ C) Other clinical information (add comment)

- If 1 or more options A or B selected and option C not selected, then go to question 4
- No other options lead to the requested service

4. Treatment within last year, Choose all that apply:

- ☐ A) Hormone therapy[24]
- ☐ B) Tranexamic acid x3 consecutive cycles[25]
- ☐ C) Endometrial ablation or resection[26]
- ☐ 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 5
- No other options lead to the requested service

5. Continued bleeding after treatment

- ☐ Yes
- ☐ No

- If option Yes selected, then the rule is satisfied; you may stop here [27]
- No other options lead to the requested service

6. Endometrium normal within last year, Choose all that apply:

- ☐ A) By endometrial biopsy
- ☐ B) By hysteroscopy with dilatation and curettage
- ☐ C) Other clinical information (add comment)

- If 1 or more options A or B selected and option C not selected, then go to question 7
- No other options lead to the requested service

7. Choose all that apply:

- ☐ A) Bleeding interferes with ADLs
- ☐ B) Anemia
- ☐ C) Other clinical information (add comment)

- If 1 or more options A or B selected and option C not selected, then go to question 8
- No other options lead to the requested service

8. Treatment within last year, Choose all that apply:

☐ 10. Abnormal uterine bleeding (AUB) in premenopausal woman ***(Continued...)***

- ☐ A) Hormone therapy[24]
- ☐ B) Tranexamic acid x3 consecutive cycles[25]
- ☐ C) Endometrial ablation or resection[26]
- ☐ 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 9
- No other options lead to the requested service

9. Continued bleeding after treatment

- ☐ Yes
- ☐ No

- If option Yes selected, then the rule is satisfied; you may stop here [27]
- No other options lead to the requested service

☐ **20. Postmenopausal bleeding**[14]

1. Choose all that apply:

- ☐ A) Vagina and cervix normal by physical examination
- ☐ B) Most recent cervical cytology normal or treated per guidelines[17]
- ☐ C) Endometrium normal within last 3 months by biopsy and ultrasound
- ☐ D) Other clinical information (add comment)

- If the number of options selected is 3 and option D not selected, then go to question 2
- No other options lead to the requested service

2. Currently taking hormone replacement therapy[28, 29]

- ☐ Yes
- ☐ No

- If option No selected, then the rule is satisfied; you may stop here [27]
- If option Yes selected, then go to question 3

3. Continued abnormal bleeding after, Choose one:[30]

- ☐ A) Change in hormone replacement therapy
- ☐ B) Discontinuation of hormone replacement therapy
- ☐ C) Other clinical information (add comment)

- If option A or B selected, then the rule is satisfied; you may stop here [27]
- 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)

Abnormal uterine bleeding (AUB) is diagnosed by excluding structural and nonstructural conditions for the bleeding. A history and laboratory assessment can help exclude systemic conditions, coagulopathy, medication, or thyroid dysfunction as the cause, while physical examination or ultrasound excludes structural causes such as fibroids or ectopic pregnancy. AUB is associated with bleeding patterns over a period of time that may include heavy and intermenstrual bleeding.

(13)

Appropriate approaches for abnormal uterine bleeding (AUB) include:
Hysterectomy, Abdominal, Supracervical +/- BSO or Bilateral Salpingectomy
Hysterectomy, Abdominal, Total +/- BSO or Bilateral Salpingectomy
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) +/- BSO or Bilateral Salpingectomy
Hysterectomy, Laparoscopic, Supracervical +/- BSO or Bilateral Salpingectomy
Hysterectomy, Laparoscopic, Total (TLH) +/- BSO or Bilateral Salpingectomy
Hysterectomy, Vaginal +/- BSO or Bilateral Salpingectomy

(14)

Appropriate approaches for postmenopausal bleeding include:
Hysterectomy, Abdominal, Supracervical +/- BSO or Bilateral Salpingectomy
Hysterectomy, Abdominal, Total +/- BSO or Bilateral Salpingectomy
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) +/- BSO or Bilateral Salpingectomy
Hysterectomy, Laparoscopic, Supracervical +/- BSO or Bilateral Salpingectomy
Hysterectomy, Laparoscopic, Total (TLH) +/- BSO or Bilateral Salpingectomy
Hysterectomy, Vaginal +/- BSO or Bilateral Salpingectomy

(15)
Abnormal bleeding includes menorrhagia (heavy and prolonged menses) and menometrorrhagia (heavy and prolonged bleeding during and between menses).

(16)
Hypothyroidism or hyperthyroidism may cause a variety of menstrual irregularities such as menorrhagia (heavy and prolonged menses), amenorrhea (no menses), or oligomenorrhea (scant menses). Documentation to exclude a thyroid disorder as a cause of the bleeding may be performed at any time in the work-up of the patient.

(17)
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).

(18)
Pregnancy and related complications (e.g., ectopic pregnancy, incomplete abortion, inevitable abortion) must be excluded before performing this procedure.

(19)
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.

(20)
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).

(21)
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.

(22)
Imaging studies (e.g., ultrasound, sonohysterogram) are performed to exclude a structural cause of the bleeding. Direct examination by hysteroscopy can also evaluate and eliminate structural abnormalities.

(23)
The incidence of endometrial cancer increases with age. A retrospective review of endometrial samples from women between the ages of 30 and 50 found a significant increase in the risk for atypical hyperplasia or endometrial cancer in those between the ages of 45 and 50 (Iram et al., European journal of obstetrics, gynecology, and reproductive biology 2010, 148: 86-9). Women over the age of 45 tend to have a worse prognosis and often have less differentiated, more advanced stage disease. Therefore, endometrial biopsy should be performed in women with abnormal uterine bleeding 45 years of age or older to exclude premalignant lesions, carcinoma, or other pathology that may cause bleeding (ACOG, Obstet Gynecol Practice Bulletin No. 128. 2012, 120: 197-206. Reaffirmed, 2016; ACOG, Obstetrics and gynecology Practice Bulleting No. 136. 2013, 122: 176-185; Marret et al., Eur J Obstet Gynecol Reprod Biol 2010, 152: 133-7). Biopsy may also be considered in women as young as 40 or in those whose bleeding does not improve with hormonal or other therapy (Singh et al., Journal of obstetrics and gynaecology Canada: JOGC 2013, 35: 473-9). If a hysterectomy is to be performed, the biopsy results will guide what type of surgery should be performed (ACOG, Obstetrics and gynecology Practice Bulleting No. 136. 2013, 122: 176-185).

(24)
Hormone therapy to treat abnormal uterine bleeding includes cyclic or continuous combined oral contraceptive or progestin only hormone therapy (ACOG, Obstetrics and gynecology Practice Bulleting No. 110. 2010, 115: 206-218. Reaffirmed, 2014; ACOG, Obstetrics and gynecology Practice Bulleting No. 136. 2013, 122: 176-185; Singh et al., Journal of obstetrics and gynaecology Canada: JOGC 2013, 35: 473-9). A variety of routes may be used including oral, dermal patch, or vaginal ring. The levonorgestrel-releasing intrauterine system has been shown to significantly reduce bleeding and cramping, and may be considered a first line treatment for women with heavy abnormal bleeding (ACOG, Obstetrics and gynecology Practice Bulleting No. 110. 2010, 115: 206-218. Reaffirmed, 2014; Gupta et al., N Engl J Med 2013, 368: 128-37; Heliovaara-Peippo et al., American journal of obstetrics and gynecology 2013, 209: 535 e1- e14; Silva-Filho et al., Contraception 2013, 87: 409-15; Singh et al., Journal of obstetrics and gynaecology Canada: JOGC 2013, 35: 473-9; Sesti et al., Journal of women's health 2012, 21: 851-7). For those who cannot tolerate or did not have success on other therapies or who are not surgical candidates, danazol and GnRH agonists may be options (Singh et al., Journal of obstetrics and gynaecology Canada: JOGC 2013, 35: 473-9).

(25)

Tranexamic acid is an antifibrinolytic taken during menstruation and has been shown to be an effective treatment to decrease abnormal heavy uterine bleeding and improve quality of life (Singh et al., Journal of obstetrics and gynaecology Canada: JOGC 2013, 35: 473-9; Pinkerton, Menopause 2011, 18: 453-61).

(26)

If medical therapy fails or is not an option for abnormal uterine bleeding, hysteroscopic endometrial resection or ablation may be performed as an alternative to hysterectomy (Obstet Gynecol Practice Bulletin No. 81 2007; 109(5): 1233-1248. Reaffirmed, 2015; Fergusson et al., The Cochrane database of systematic reviews 2013, 11: CD000329; Marret et al., Eur J Obstet Gynecol Reprod Biol 2010, 152: 133-7). Non-hysteroscopic techniques for endometrial ablation (e.g., thermal balloon, cryoablation, microwave, electrode ablation) have also been shown to be beneficial for the treatment of abnormal bleeding (Lethaby et al., The Cochrane database of systematic reviews 2013, 8: CD001501; Singh et al., Journal of obstetrics and gynaecology Canada: JOGC 2013, 35: 473-9; Daniels et al., BMJ 2012, 344: e2564).

(27)

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

(28)

The risks and benefits of hormone therapy long-term use should be carefully considered for each patient, as the benefit changes with age, menopausal symptoms, comorbidities, and the presence of risk factors for adverse outcomes (e.g., stroke, CAD). Review of major studies, such as the Heart and Estrogen/Progestin Replacement Study Follow-Up (HERS) and the Women's Health Initiative (WHI), indicates the risk/benefit ratio for hormone therapy is most favorable if it is initiated closer to menopause. This benefit decreases in older women and in women who are more distant from menopause (Furness et al., Cochrane Database Syst Rev 2012, 8: CD000402; North American Menopause Society, Menopause 2012, 19: 257-71).

(29)

For patients not currently taking hormone therapy, an evaluation of the endometrium is still indicated prior to hysterectomy for postmenopausal bleeding.

(30)

Postmenopausal bleeding should always be investigated, as it could be a sign of endometrial cancer (ACOG, Obstetrics and gynecology ACOG Practice Bulletin No. 149, 2015, 125: 1006-26; American College of Obstetricians and Gynecologists, CO No. 440 Obstet Gynecol 2009; 114(2 Pt 1): 409-411. Reaffirmed, 2013). Postmenopausal bleeding is defined as bleeding after 1 year of amenorrhea in a woman not receiving hormone therapy or unexpected bleeding in patients receiving cyclic hormone therapy or bleeding after 1 year of continuous hormone therapy.

ICD-10-CM (circle all that apply): N92.0, N92.1, N92.2, N92.5, N93.8, N95.0, N95.2, 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, 58260, 58262, 58263, 58290, 58291, 58292, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, Other_____