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 Suspected Ovarian or Tubal cancer
Age:[11] Age ≥ 18

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

☐ 10. Suspected ovarian cancer by imaging[12, 13]

☐ 20. Suspected tubal cancer by imaging[14, 13]

☐ **10. Suspected ovarian cancer by imaging**[12, 13]

There are no questions for the requested service.

☐ **20. Suspected tubal cancer by imaging**[14, 13]

There are no questions for 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)
Adnexal masses that are suspicious for cancer based on clinical assessment and transvaginal ultrasound warrant surgical exploration (Liu and Zanotti, Obstet Gynecol 2011, 117: 1413-28). CT or MRI performed for another reason may also raise the suspicion of cancer.

(13)
Appropriate approaches for ovarian cancer or tubal cancer include:
Hysterectomy, Abdominal, Supracervical + BSO
Hysterectomy, Abdominal, Total + BSO
Hysterectomy, Laparoscopic, Supracervical + BSO
Hysterectomy, Laparoscopic, Total (TLH) + BSO

(14)
Tubal cancer is most commonly detected by US. CT or MRI performed for another reason may have demonstrated the cancer.

ICD-10-CM (circle all that apply): C56.9, C57.00, Other_____

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

CPT® (circle all that apply): 58150, 58152, 58180, 58542, 58544, 58571, 58573, Other_____