Hysterectomy for Benign Conditions

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COVERAGE CRITERIA 2
POLICY CROSS REFERENCES 8
POLICY GUIDELINES 8
CLINICAL EVIDENCE AND LITERATURE REVIEW 11
HEALTH EQUITY CONSIDERATIONS 12
BILLING GUIDELINES AND CODING 12
REFERENCES 14
POLICY REVISION HISTORY 15

INSTRUCTIONS FOR USE: Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Company reserves the right to determine the application of medical policies and make revisions to medical policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PLAN PRODUCT AND BENEFIT APPLICATION

☒ **Commercial** ☒ **Medicaid/OHP*** ☐ **Medicare****

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

**Medicare Members

This *Company* policy may be applied to Medicare Plan members only when directed by a separate *Medicare* policy. Note that investigational services are considered **"not medically necessary"** for Medicare members.

COVERAGE CRITERIA

Criteria are mainly based on InterQual® 2024 Criteria.

Note: Hysterectomies for malignant conditions other than CIN I, II, and III are not reviewed in this policy and may be considered medically necessary.

Abnormal uterine bleeding

I. Hysterectomy for abnormal uterine bleeding may be **considered medically necessary** in **premenopausal** members when **all** of the following criteria are met (A.-I.):

   A. Documented abnormal uterine bleeding for at least 6 months and one of the following conditions is present:
      1. Bleeding interferes with activities of daily living (ADLs) (see Policy Guidelines for definition); **or**
      2. Member has anemia (see Policy Guidelines for definition); **and**
   B. Pregnancy has been excluded; **and**
   C. Thyroid disease has been excluded or treated; **and**
   D. Member's vagina and cervix are determined to be without suspicious physical exam findings; **and**
   E. Most recent cervical cytology is normal or has been treated if abnormal; and
   F. Imaging or hysteroscopy within the last year have been negative for endometrial lesion; **and**
   G. For women ages 45 years or greater, endometrium was determined to be without malignant or suspicious pathology through endometrial biopsy or hysteroscopy with dilation and curettage; **and**

H. If bleeding disorders have been identified (e.g., hemophilia, von Willebrand disease, acquired platelet function defects, etc.), they have been treated; and
I. One or more of the following treatments was administered within the last year and failed to prevent bleeding, or member has documented contraindications to all of the following treatments (1.-3.):
    1. Hormone therapy ≥ 3 months (see Policy Guidelines for definition of hormone therapy); **or**
    2. Tranexamic acid for 3 consecutive cycles; **or**
    3. Endometrial ablation or resection.

II. Hysterectomy for abnormal uterine bleeding may be **considered medically necessary** in **postmenopausal** members when **all** of the following criteria are met:

A. Member's vagina and cervix are determined to be without suspicious findings by physical examination; **and**
B. Most recent cervical cytology is normal or has been treated if abnormal; **and**
C. Endometrium is determined to be normal within the last 3 months by biopsy and ultrasound or cannot be determined due to previous treatment with endometrial ablation.

III. Hysterectomy for abnormal uterine bleeding is considered **not medically necessary** when criterion I or II are not met.

Adenomyosis

IV. Hysterectomy may be considered **medically necessary** for members with suspected adenomyosis when **all** of the following criteria are met (A.-E.):

A. Adenomyosis is suspected by imaging; **and**
B. Most recent cervical cytology was normal; **and**
C. One or more of the following symptoms is present:
    1. Abnormal bleeding
    2. Pelvic or abdominal pain or discomfort and other etiologies have been excluded
    3. Urinary frequency or urgency and other etiologies have been excluded
    4. Dyspareunia; **and**
D. In cases of abnormal bleeding:
    1. Vaginal and cervical exams are normal; **and**
    2. Pregnancy has been excluded in premenopausal women; **and**
    3. Bleeding interferes with ADLs or member has anemia (see Policy Guidelines for definition); **and**
E. One or more of the following treatments was used within the past year and symptoms continue:
    1. NSAIDS for ≥ 8 weeks
    2. GnRH agonist for ≥ 8 weeks
    3. Hormone therapy for ≥ 8 weeks (see Policy Guidelines for definition of hormone therapy)

4. Uterine artery embolization.

V. Hysterectomy is considered **not medically necessary** for members with suspected adenomyosis when criterion IV is not met.

Fibroids

VI. Hysterectomy may be considered **medically necessary** for postmenopausal members with fibroids when **all** of the following criteria are met (A.-C.):

A. Most recent cervical cytology is normal or has been treated if abnormal; and
B. One of the following is true:
    1. Significant enlargement of uterine or fibroid size by imaging within 1 year; **or**
    2. Ureteral compression by imaging; **or**
    3. Pelvic or abdominal pain or discomfort and other etiologies excluded; **or**
    4. Urinary frequency or urgency and other etiologies excluded; **or**
    5. Dyspareunia and other etiologies excluded**and**
C. Laparoscopic power morcellation is not planned with hysterectomy

VII. Hysterectomy may be considered **medically necessary** for premenopausal members with fibroids when **all** of the following criteria are met (A.-D.):

A. Most recent cervical cytology is normal or has been managed if abnormal; and
B. Pregnancy excluded by negative HCG or HCG planned prior to procedure or sterilization by history or patient not sexually active by history; **and**
C. One of the following is true (1.-6.):
    1. Abnormal uterine bleeding with anemia by history or interferes with ADLs and vaginal and cervical lesions have been ruled out; **or**
    2. Significant enlargement of uterine or fibroid size by imaging within 1 year; **or**
    3. Ureteral compression by imaging; **or**
    4. Pelvic or abdominal pain or discomfort and other etiologies excluded; **or**
    5. Urinary frequency or urgency and other etiologies excluded; **or**
    6. Dyspareunia and other etiologies excluded; **and**
D. One of the following are true (1.-2.):
    1. Laparoscopic power morcellation is not planned with hysterectomy; or
    2. If laparoscopic power morcellation is planned with hysterectomy, then all of the following are true (a.-c.):
        a. There is no known or suspected malignancy by testing in tissue to be morcellated; **and**
        b. Not a candidate for en bloc or intact tissue removal; **and**
        c. Member has no increased risk for uterine malignancy and risks and benefits of morcellation have been thoroughly discussed with member

VIII. Hysterectomy is considered **not medically necessary** for pre- and postmenopausal members with fibroids when criteria VI or VII are not met.

Chronic Pelvic Pain

IX. Hysterectomy may be considered **medically necessary** for members with chronic abdominal or pelvic pain when **all** of the following criteria are met:

A. Clinical documentation that the member has had chronic pelvic pain for ≥ 6 months; and
B. History, comprehensive physical examination, and an ultrasound conducted within the last year are nondiagnostic for etiology of pain; and
C. One or more of the following tests was conducted within the last year and found to be nondiagnostic for etiology of pain:
    1. CT or MRI
    2. Diagnostic laparoscopy; and
D. Complete blood count is normal; and
E. Urinalysis or urine culture is normal; and
F. Pregnancy is excluded in premenopausal women; and
G. 4 or more weeks of NSAIDS were tried without improvement, or not tolerated or contraindicated; **and**
H. One or more of the following treatments was used within the past year and did not improve pain levels:
    1. GnRH agonist for ≥ 8 weeks
    2. Hormone therapy for ≥ 8 weeks (see Policy Guidelines for definition of hormone therapy)
    3. One course of antibiotic treatment.
    4. Pelvic floor physical therapy ≥ 6 weeks
    5. Cognitive behavioral therapy ≥ 6 weeks
    6. Sex therapy ≥ 8 weeks
    7. Trigger point injections
    8. Antidepressant medication ≥ 4 weeks
    9. Neuropathic medications ≥ 4 weeks

X. Hysterectomy is considered **not medically necessary** for members with abdominal or pelvic pain when criterion IX is not met.

CIN 2, CIN 2/3, CIN 3

XI. Hysterectomy may be considered **medically necessary** for members with CIN 2, CIN 2/3 or CIN 3 when one or more of the following criteria are met:
A. Excisional procedure has been performed and CIN 2, 2/3, or 3 is not resolved ≥ 6 months post procedure; or
B. Member has CIN 3 with negative margins on a cone, but with glandular involvement; or
C. Member has spontaneous CIN 3 or carcinoma in situ (CIS) with rapid development and no other recent history; or
D. Any CIN 2, 2/3, or 3 (after cone or LEEP rules out invasion) on an immunocompromised member (e.g., HIV); or
E. Persistent high-risk HPV in a patient over the age of 40 years; or

F. Glandular dysplasias (i.e., atypical glandular cells [AGC] and adenocarcinoma in situ) due to the skip nature of the lesions

XII. Hysterectomy is considered **not medically necessary** for members with CIN 2, CIN 2/3 or CIN 3 when criterion XI is not met.

Endometrial Hyperplasia

XIII. Hysterectomy may be considered **medically necessary** for women with endometrial hyperplasia with cellular atypia on biopsy or dilation and curettage (D & C).

XIV. Hysterectomy is considered **not medically necessary** for women with endometrial hyperplasia without evidence of cellular atypia on biopsy or D & C.

Endometriosis

XV. Hysterectomy may be considered **medically necessary** for members with endometriosis when all of the following criteria are met:

A. Endometriosis was diagnosed through laparoscopy and symptoms are ongoing or recurrent despite surgical treatment (e.g., laparoscopic removal of endometrioma, destruction of implants); and
B. Symptoms include at least one of the following:
    1. Severe dysmenorrhea; or
    2. Painful bowel movements
C. One or more of the following treatments was used within the past year and did not reduce endometriosis symptoms:
    1. GnRH agonist for ≥ 3 months; or
    2. Hormone therapy for ≥ 3 months
D. Member's most recent cervical cytology was normal or treated per current national guidelines; and
E. Pregnancy has been excluded in premenopausal women

XVI. Hysterectomy is considered **not medically necessary** for members with endometriosis when criterion XV is not met.

Pelvic Inflammatory Disease

XVII. Hysterectomy may be considered **medically necessary** for members with chronic pelvic inflammatory disease (PID) when all of the following criteria are met:

A. Member has pelvic pain; and
B. Member has had ≥ 2 clinically documented episodes of acute PID; and
C. At least one infection has been diagnosed by positive culture; and
D. Member's most recent cervical cytology is normal or has been treated if abnormal; and
E. Pregnancy has been excluded in premenopausal women; and

F. PID is unresponsive to conventional medical management, including antibiotic therapy, or treatment is contraindicated.

Tubo-Ovarian Abscess

XVIII. Hysterectomy may be **considered medically necessary** for members with tubo-ovarian abscess (TOA) that has not ruptured when all of the following criteria are met:

A. Ectopic pregnancy has been excluded in premenopausal women; and
B. Member has one or more of the following symptoms:
    1. Pelvic pain
    2. Abdominal tenderness
    3. Persistent adnexal mass
    4. Temperature > 100.4 °F (38.0 °C)
    5. White blood count is higher than normal;
    6. Erythrocyte sedimentation rate (ESR) is higher than normal;
    7. C-reactive protein (CRP) is higher than normal; and
C. Member experiences persistent or worsening symptoms during IV antibiotic treatment; and
D. Drainage was unsuccessful or not indicated

XIX. Hysterectomy may be **considered medically necessary** for members with a ruptured tubo-ovarian abscess (TOA) when the following conditions have been met:
A. Ectopic pregnancy has been excluded in premenopausal women; **and**
B. Salpingectomy or salpingectomy-oophorectomy without hysterectomy is not appropriate, not indicated, or was not sufficient.

XX. Hysterectomy is considered **not medically necessary** for members with PID or TOA when criteria XVII-XIX are not met.

Uterine Prolapse

XXI. Hysterectomy may be **considered medically necessary** for members uterine prolapse when all of the following criteria are met:

A. Member has Stage II (Grade 2), Stage III (Grade 3), or Stage IV (Grade 4) uterine prolapse (see Policy Guidelines for staging); and
B. Member has one or more of the following symptoms:
    1. Pelvic pressure or mass sensation;
    2. Pelvic pain;
    3. Urinary stress incontinence;
    4. Incomplete bladder emptying;
    5. Ulceration with bleeding or spotting;
    6. Vaginal splinting;
    7. Sexual dysfunction or dyspareunia or coital incontinence;
    8. Fecal incontinence;
    9. Incomplete bowel emptying; and

C. Member's most recent cervical cytology is normal or has been treated if abnormal; and
D. Failure, contraindication, or individual non-acceptance of uterine sparing treatments (surgical or non-surgical). Non-surgical options include use of pessary, pelvic floor muscle training, or uterine prolapse suspension; and
E. Pregnancy has been excluded in premenopausal women.

XXII. Hysterectomy is considered **not medically necessary** for members with uterine prolapse when criterion XX is not met.

POLICY CROSS REFERENCES

None

The full Company portfolio of current Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

Cervical Cytology Treatment Protocol

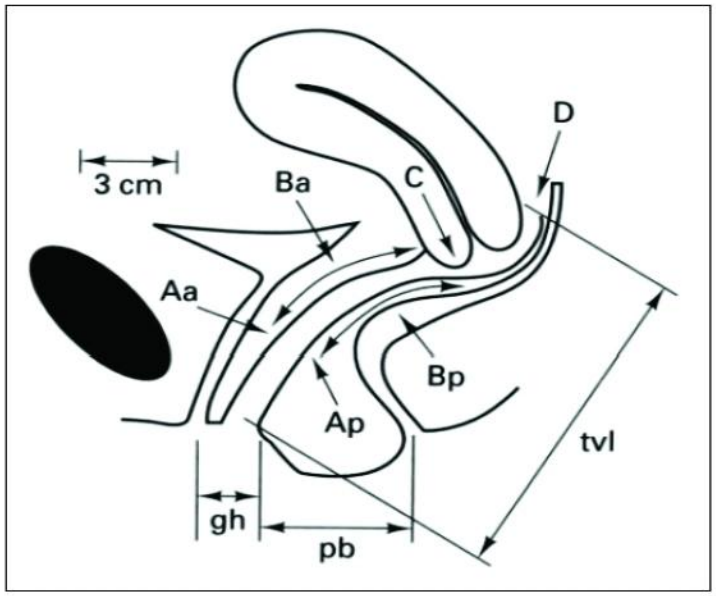
In 2019, the ASCCP updated guidelines for Risk-Based Management for abnormal cervical cancer screening tests and cancer precursors. For current guidelines on the appropriate treatment for abnormal cervical cytology, see the ASCCP website: https://www.asccp.org/management-guidelines

Pelvic Organ Prolapse Quantitation system (POP-Q)[1]

Table 1: Pelvic Organ Prolapse Staging

Stage 0	No prolapse
	Aa, Ba, Ap, Bp are -3 cm and C or D≤ -(tvl - 2) cm
Stage 1	Most distal portion of the prolapse -1 cm (above the level of hymen)
Stage 2	Most distal portion of the prolapse ≥ -1 cm but ≤ +1 cm (≤1 cm above or below the hymen)
Stage 3	Most distal portion of the prolapse > +1 cm but < +(tvl - 2) cm (beyond the hymen; protrudes no farther than 2 cm less than the total vaginal length)
Stage 4	Complete eversion; most distal portion of the prolapse ≥ + (tvl - 2) cm

Points and landmarks for POP-Q system examination[2]



DOCUMENTATION REQUIREMENTS

In order to determine the medical necessity of the request, the following documentation must be provided at the time of the request. Medical records to include documentation of all of the following:

- All medical records and chart notes pertinent to the request. This includes:
  - History, including conservative treatments
  - Description of cervical cytology in the past 5 years
  - Physical examination
  - Treatment plan
  - Current hemoglobin if primary indication is abnormal uterine bleeding

DEFINITIONS

Anemia: Hemoglobin less than 10 g/dL or hemoglobin less than 11 g/dL if use of iron is documented.[3]

Hormone therapy: hormone therapy may include any of the following treatments: cyclic or continuous combined oral contraceptive or progestin only hormone therapy, dermal patch, vaginal ring, or progestin intrauterine devices (IUDs). Copper IUDs are not considered conservative treatment/hormone therapy, and may increase abnormal bleeding. For those who cannot tolerate other therapies, danazol and GnRH agonists may be appropriate.[4]

Activities of Daily Living (ADLs): The ADLs considered for this policy describe essential skills that are required to facilitate independent living and enable meaningful engagement in life. Examples may include, but are not limited to, the following:

- Obtaining restful sleep
- Doing routine activities of living (bathing, dressing, self-care, etc.)

- Participating in social activities with family and friends
- Driving safely
- Exercising
- Traveling

BACKGROUND

Abnormal Uterine Bleeding

Abnormal uterine bleeding refers to abnormal quantity, duration, or schedule of uterine bleeding.[5] It can be caused by structural uterine conditions such as fibroids, polyps, adenomyosis, or neoplasia, or nonuterine causes such as ovulatory dysfunction or medication side effects. Abnormal uterine bleeding is a common gynecologic problem and may cause anemia and decrease quality of life. Initial treatment is commonly pharmacologic, aiming to control bleeding and treat anemia.

Adenomyosis

Adenomyosis is a disorder in which endometrial tissue grows into the muscular wall of the uterus, resulting in enlargement of the uterus.[6] Symptoms of adenomyosis include uterine enlargement, abnormal uterine bleeding and painful menses. It is estimated that adenomyosis is present in 20 to 35% of women. Standard treatment includes hysterectomy, hormonal medications and uterine artery embolization.

Chronic Pelvic Pain

Chronic pelvic pain (CPP) is pain in the pelvic area that lasts for 6 months or longer, generally defined as a non-cyclic pain unrelated to pregnancy, although there is no consensus on an exact definition. CPP has been reported to affect around 25% of reproductive-age women and can be the result of identifiable pathology such as endometriosis, or can persist without a cause. Treatment depends on underlying cause, and involve both surgical and non-surgical treatments.

Cervical Intraepithelial Neoplasia (CIN)

Cervical intraepithelial dysplasia (CIN) is a premalignant condition in which abnormal cells are found on the uterine cervix.[7] Human papillomavirus (HPV) is the major etiological cause of CIN and cervical cancer. There are 3 stages of CIN, increasing with severity, CIN 1, CIN 2, and CIN 3. Treatment depends on stage, age of patient, and a number of other factors, and ranges from a watch and wait strategy to more invasive procedures such as LEEP.

Endometrial Hyperplasia

Endometrial hyperplasia is a thickening of the endometrium, and is classified by the 2014 World health Organization system as 1) hyperplasia without atypia, referring to thickening without atypical nuclear features in the glands; and 2) endometrial intraepithelial neoplasia (EIN), or hyperplasia with atypia, referring to thickening of the endometrial wall with abnormal cells.[8] Endometrial hyperplasia is most common in perimenopausal or early postmenopausal patients. Treatments include progestin therapy and hysterectomy.

Endometriosis

Endometriosis is an inflammatory disease in which endometrial tissue grows outside of the uterus. Endometrial growth can appear in the pelvis, bowel, diaphragm, and pleural cavity.[9] Endometriosis can cause dysmenorrhea, dyspareunia, chronic pain, and infertility. Treatments are individualized based on presentation, symptom severity, reproductive desires, patient age, medication side effects, surgical complication rates, and cost. They may include NSAIDS, hormonal contraceptives, surgical resection, and nerve transection procedures.

Pelvic Inflammatory Disease

Pelvic inflammatory disease (PID) is an infection of the upper genital tract structures in women, and may involve any or all of the uterus, fallopian tubes, and ovaries.[10] PID is often caused by certain sexually transmitted diseases such as chlamydia and gonorrhea. Symptoms include pain in lower abdomen, fever, unusual discharge, burning sensation when urinating, and bleeding between periods. Treatment includes antibiotics and treating the underlying cause of the infection.

Uterine Prolapse

Uterine prolapse occurs when muscles and tissue in the pelvis stretch and weaken, causing the uterus to drop down into the vagina.[11] Uterine prolapse most often affects postmenopausal women who have had one or more vaginal deliveries. Symptoms include urine leakage, fullness in the pelvis, bulging in the vagina, low back pain, and constipation. Treatments include pessary, lifestyle changes, or surgery.

Hysterectomy

Hysterectomy is a surgical procedure to remove the uterus.

CLINICAL EVIDENCE AND LITERATURE REVIEW

CLINICAL PRACTICE GUIDELINES

Oregon Health Authority- Health Evidence Review Commission (HERC)

In 2021, HERC published a prioritized list of health services and hysterectomy criteria for the following conditions: Endometriosis, adenomyosis, uterine leiomyomata, abnormal bleeding in premenopausal women, chronic pelvic pain, and dysmenorrhea.[3]

InterQual

Criteria for this policy were based on the following InterQual guidelines, published in March 2024:[4]

- Hysterectomy for abnormal uterine bleeding for premenopausal and postmenopausal women.
- Hysterectomy for Adenomyosis or Fibroids
- Hysterectomy for chronic abdominal or pelvic pain
- Hysterectomy for cervical intra-epithelial neoplasia (CIN) 2, CIN 2/3, or CIN 3

- Hysterectomy for endometrial hyperplasia
- Hysterectomy for endometriosis
- Hysterectomy for pelvic inflammatory disease
- Hysterectomy for uterine prolapse

HEALTH EQUITY CONSIDERATIONS

The Centers for Disease Control and Prevention (CDC) defines health equity as the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving health equity requires addressing health disparities and social determinants of health. A health disparity is the occurrence of diseases at greater levels among certain population groups more than among others. Health disparities are linked to social determinants of health which are non-medical factors that influence health outcomes such as the conditions in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life. Social determinants of health include unequal access to health care, lack of education, poverty, stigma, and racism.

The U.S. Department of Health and Human Services Office of Minority Health calls out unique areas where health disparities are noted based on race and ethnicity. Providence Health Plan (PHP) regularly reviews these areas of opportunity to see if any changes can be made to our medical or pharmacy policies to support our members obtaining their highest level of health. Upon review, PHP creates a Coverage Recommendation (CORE) form detailing which groups are impacted by the disparity, the research surrounding the disparity, and recommendations from professional organizations. PHP Health Equity COREs are updated regularly and can be found online here.

BILLING GUIDELINES AND CODING

Hysterectomy CPT codes will require Prior Authorization when billed with any of the following diagnosis codes for benign conditions:

A18.17	N70.03	N80.01	N87.0	N94.6
A54.24	N70.11	N80.02	N87.1	N94.89
A54.85	N70.12	N80.03	N87.9	N94.9
A56.11	N70.13	N80.1	N92.0	N95.0
A74.81	N70.91	N80.101	N92.1	N99.4
D06.1	N70.92	N80.102	N92.3	N99.85
D06.7	N70.93	N80.2	N92.4	R10.2
D06.9	N71.0	N80.3	N92.5	R87.610
D21.9	N71.1	N80.352	N92.6	R87.611
D25.0	N71.9	N80.4	N93.0	R87.612
D25.1	N72	N80.5	N93.8	R87.613
D25.2	N73.4	N80.8	N93.9	R87.619

D25.9	N73.5	N80.9	N94.0	R87.810
G89.29	N73.6	N81.2	N94.10	
K66.0	N73.8	N81.3	N94.11	
N39.3	N73.9	N81.4	N94.12	
N39.46	N74	N81.89	N94.19	
N70.01	N80.0	N85.00	N94.4	
N70.02	N80.00	N85.01	N94.5	

CODES*		
CPT	58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
	58152	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocystopexy (eg, Marshall-Marchetti-Krantz, Burch)
	58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
	58260	Vaginal hysterectomy, for uterus 250 g or less
	58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
	58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
	58267	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
	58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
	58275	Vaginal hysterectomy, with total or partial vaginectomy
	58290	Vaginal hysterectomy, for uterus greater than 250 g
	58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
	58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele
	58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less
	58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
	58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g
	58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
	58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less
	58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
	58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g
	58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
	58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less

	58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
	58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g
	58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
HCPCS	None	

***Coding Notes:**

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

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POLICY REVISION HISTORY

DATE	REVISION SUMMARY
2/2023	Converted to new policy template.
8/2023	Interim update. Edited list of diagnosis codes.
12/2023	Annual review. Updates to criteria based on 2023 InterQual guidelines.
1/2025	Annual review. Updated criteria based on 2024 InterQual guidelines. Diagnosis codes added.
11/2025	Annual review. Updated policy guidelines with new definition.
11/2026	Annual review. No changes.