NO. 91575

MENORRHAGIA TREATMENT

Effective: 09/01/2026
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Policy scope: This medical policy addresses the treatment of menorrhagia (heavy menstrual bleeding), including medical and procedural interventions used to reduce excessive uterine bleeding and improve associated symptoms.

Related policies:

- Uterine Fibroid Treatment No. 91573

I. MEDICAL NECESSITY CRITERIA

Procedures to treat menorrhagia may be considered medically necessary.

INCLUSIONS:

A. The following procedures:

1. Hysterectomy; or
2. Dilation and curettage; or
3. Endometrial ablation by cryoablation, hysteroscopic-assisted electrocautery utilizing a resectoscope with a wire loop, hydrothermal, microwave, radiofrequency (e.g., NovaSure™ Impedence Controlled), or thermal balloon when all of the following are present:

a. Symptomatic menorrhagia (blood loss >80 mL per cycle, bleeding for >8 days, blood loss sufficient to cause anemia or blood loss or symptoms that significantly interfere with normal activities)
b. Underlying anatomic or pathologic medical conditions have been ruled out (e.g., active infectious process or pelvic inflammatory disease, uterine polyps or other surgically correctable source of bleeding)
c. Cervical cytology is negative
d. Endometrial cancer or precancer is not present
e. Adnexal tumors are not present
f. Desire for childbearing completed
g. The device utilized for endometrial ablation must be an FDA approved device and used as labeled.

II. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) COVERAGE DETERMINATION

Any applicable federal or state mandates will take precedence over this medical coverage policy.

Medicare: Refer to the CMS Online Manual System (IOMs) and Transmittals.
For the most current applicable CMS National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) refer to CMS Medicare Coverage Database.

The information below is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. MAC jurisdiction for purposes of local coverage determinations is governed by the geographic service area where the Medicare Advantage plan is contracted to provide the service. Please refer to the Medicare Coverage Database website for the most current applicable NCD, LCD, LCA, and CMS Online Manual System/Transmittals.

National Coverage Determinations (NCDs)	
None identified	
Local Coverage Determinations (LCDs)	
CGS Administrators, LLC	None identified
First Coast Service Options, Inc.	None identified
Wellpoint Federal (formerly National Government Services, Inc.)	None identified
Noridian Healthcare Solutions	None identified
Novitas Solutions, Inc.	None identified
Palmetto GBA	None identified
WPS Insurance Corporation	None identified

III. BACKGROUND

Abnormal uterine bleeding is defined as a change in the frequency of menses, the duration of flow, or the amount of blood loss. The most common presenting complaint is excessive or prolonged bleeding, also referred to as menorrhagia.

Treatments include watchful waiting, pharmacological therapy (e.g., nonsteroidal anti-inflammatory drugs, oral contraceptives, and oral and intrauterine progestins), dilation and curettage, and hysterectomy. If optimal nonsurgical medical therapies fail, are contraindicated, or cause intolerable side effects, then endometrial ablation or hysterectomy are options in women who have no wish for future pregnancies. Approaches to endometrial ablation have evolved from first generation techniques to newer second- and third-generation approaches. Current evidence suggests that compared to first-generation techniques (endometrial laser ablation, transcervical resection of the endometrium, rollerball endometrial ablation), second-generation approaches (thermal balloon endometrial ablation, microwave endometrial ablation, hydrothermal ablation, bipolar radiofrequency endometrial ablation, endometrial cryotherapy) are of equivalent efficacy for heavy menstrual bleeding (Bofill Rodriguez, 2019).

IV. GUIDELINES / POSITION STATEMENTS

Medical/Professional Society	Guideline
American College of Obstetrics and Gynecology (ACOG)	Management of Acute Abnormal Uterine Bleeding in Nonpregnant Reproductive-Aged Women (2013) Diagnosis of Abnormal Uterine Bleeding in Reproductive-Aged Women (2012) Screening and Management of Bleeding Disorders in Adolescents With Heavy Menstrual Bleeding (2019)
The Society of Obstetricians and Gynecologists of Canada (SOGC)	Guideline No. 292-Abnormal Uterine Bleeding in Pre-Menopausal Women (2018) Guideline No. 453: Endometrial Ablation in the Management of Abnormal Uterine Bleeding (2024)
International Federation of Gynecology and Obstetrics (FIGO)	FIGO classification system (PALM-COEIN) for causes of abnormal uterine bleeding in nongravid women of reproductive age (2011)
National Institute for Health and Care Excellence (NICE)	Heavy menstrual bleeding: assessment and management (2018)

V. REGULATORY (US FOOD AND DRUG ADMINISTRATION)

See U.S. Food & Drug Administration (FDA) Medical Device Databases for the most current information.

Device	Premarket Approval, 513(f)(2)(De Novo), or 510(k) Number	Decision date

Cerene® Cryotherapy Device	P180032	3/29/2019
Minerva Endometrial Ablation System	P140013	7/27/2015
NovaSure Impedance Controlled Endometrial Ablation System	P010013	9/28/2001

VI. CODING

ICD-10 Codes that may support medical necessity

N80.0	Endometriosis of uterus
N85.9	Noninflammatory disorder of uterus, unspecified
N92.0	Excessive and frequent menstruation with regular cycle
N92.1	Excessive and frequent menstruation with irregular cycle
N92.4	Excessive bleeding in the premenopausal period
N92.6	Irregular menstruation, unspecified
N93.8	Other specified abnormal uterine and vaginal bleeding
N93.9	Abnormal uterine and vaginal bleeding, unspecified

CPT/HCPCS Codes

58353	Endometrial ablation, thermal, without hysteroscopic guidance
58356	Endometrial cryoablation with ultrasonic guidance, including endometria curettage, when performed
58563	Hysteroscopy, surgical; with endometrial ablation (e.g., endometria resection, electrosurgical ablation, thermoablation)

J7297 Levonorgestrel-releasing intrauterine contraceptive system (Liletta), 52 mg
J7298 Levonorgestrel-releasing intrauterine contraceptive system (Mirena), 52 mg

58300	Insertion of intrauterine device (IUD)
58301	Removal of intrauterine device (IUD)

VII. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, devices, services and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service or procedure is medically necessary. For more information, refer to the Priority Health Provider Manual.

To access Evicore guidelines: Log into Priority Health Prism → Authorizations → Authorization Criteria Lookup.

To access InterQual guidelines: Log into Priority Health Prism → Authorizations → Authorization Criteria Lookup.

Individual case review may allow coverage for care or treatment that is investigational yet promising for the conditions described. Requests for individual consideration require

prior plan approval. All determinations of coverage for experimental, investigational, or unproven treatment will be made by a Priority Health medical director or clinical pharmacist. The exclusion of coverage for experimental, investigational, or unproven treatment may be reviewed for exception if the condition is either a terminal illness, or a chronic, life threatening, severely disabling disease that is causing serious clinical deterioration.

VIII. APPLICATION TO PRODUCTS

Coverage is subject to the member's specific benefits. Group-specific policy will supersede this policy when applicable.

- **HMO/EPO**: This policy applies to insured HMO/EPO plans.
- **POS**: This policy applies to insured POS plans.
- **PPO**: This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
- **ASO**: For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
- **INDIVIDUAL**: For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.
- **MEDICARE**: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
- **MEDICAID/HEALTHY MICHIGAN PLAN**: For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

IX. REFERENCES

General Abnormal Uterine Bleeding / Menorrhagia

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Medical Management

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Endometrial Ablation and Endometrial Resection

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Hysterectomy and Alternative Surgical Treatments

1. Kho CL, Mathur M. Uterine artery embolisation for acute dysfunctional uterine bleeding with failed medical therapy: a novel approach to management. *BMJ Case Rep.* 2015;2015:bcr2014204446. doi:10.1136/bcr-2014-204446.
2. Wheeler TL 2nd, Murphy M, Rogers RG, et al.; Society of Gynecologic Surgeons Systematic Review Group. Clinical practice guideline for abnormal uterine bleeding: hysterectomy versus alternative therapy. *J Minim Invasive Gynecol.* 2012;19(1):81-88

SUMMARY OF CHANGES

Deletions:

- I.A.1 – Removed hormonal therapy/pharmacotherapy criteria
- Deleted reference to Priority Health Provider Manual for information on IUDs for contraception

Past committee review dates: 8/10, 8/11, 8/12, 8/13, 8/14, 8/15, 8/16, 8/17, 8/18, 8/19, 8/20, 8/21, 8/22, 8/23, 8/24, 8/25, 8/26

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