Priority Health	BILLING POLICY No. TBD
Gynecologic Surgery	
Date of origin: September 2025	**Review dates:**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

This policy will outline billing requirements for different gynecologic surgeries. Gynecology surgery includes any surgical procedure that involves the organs and structure of the female pelvic region. Some examples include treatment for a condition such as endometriosis, fibroids (benign tumors), ovarian cysts, cancer, chronic pelvic pain, pelvic inflammatory disease, uterine prolapse or abnormal bleeding.

MEDICAL POLICY

- Uterine Fibroid Treatment - 91573

For Medicare

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Uterine Fibroid Treatment

- Radiofrequency ablation of uterine fibroid(s) (e.g., CPT codes 58674, 58580, 0404T) and myomectomy of leiomyoma (e.g., CPT codes 58140-58146, 58545, 58546, 58561) should not be reported together when performed on the same leiomyoma. Example: If a physician begins a laparoscopic radiofrequency ablation of a uterine fibroid but must convert to a laparoscopic myomectomy to complete the procedure, only the laparoscopic myomectomy should be reported.
- If a laparoscopy or endoscopy is performed to assess extent of disease or surgical area, it is not separately reportable.
- If a laparoscopic radiofrequency ablation is started but completed as a laparoscopic myomectomy, only the latter should be reported.
- if an endoscopic procedure is performed as an integral part of an open procedure, only the open procedure is reportable
- Only the completed procedure should be billed. Example: if a laparoscopic radiofrequency ablation is started but completed as a laparoscopic myomectomy, only the myomectomy should be reported.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

Modifier 58 may be reported to indicate that the diagnostic laparoscopy or endoscopy and non-laparoscopic or non-endoscopic therapeutic procedures were staged or planned procedures

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

REFERENCES

NCCI Manual Chapter 7

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made