Maryland
DEPARTMENT OF HEALTH

Transcervical radiofrequency ablation (CPT Code 0404T)

Uterine fibroids are benign growths in or around the uterus. Fibroids can range in size and may cause significant symptoms, including heavy menstrual bleeding, abdominal/pelvic pressure, dyspareunia, gastrointestinal symptoms, and dysmenorrhea. These symptoms may worsen over time if the fibroids are left untreated. Various minimally invasive treatments for uterine fibroids have been proposed as alternatives to surgery. Among these approaches are laparoscopic, percutaneous, and transcervical techniques to induce myolysis, which includes radiofrequency ablation (RFA), laser and bipolar needles, cryomyolysis, and magnetic resonance imaging-guided laser ablation. This policy applies specifically to transcervical radiofrequency ablation.

I. Criteria for Initial Approval

Transcervical radiofrequency ablation (RFA) as a treatment for symptomatic uterine fibroids may be considered for coverage when **ALL** of the criteria below are met, confirmed with supporting medical documentation.

- Patient is 18 years and older.
- Evidence of uterine fibroids less than 7 cm is provided via ultrasound or other imaging.
- Patient has at least one of the following symptoms that is a direct result of the fibroid(s):
    - Menorrhagia or other abnormal uterine bleeding that interferes with daily activities or causes anemia.
    - Pelvic pain or pressure.
    - Lower back pain affecting activities of daily living.
    - Urinary symptoms (e.g., urinary frequency, urgency) related to bulk compression of the bladder.
    - Gastrointestinal symptoms related to bulk compression of the bowel (e.g., constipation, bloating).
    - Dyspareunia.
- Documentation of failure of conservative management.

II. Required Clinical Information

- History of the medical condition requiring surgical intervention and **ALL** of the following:

- Recent history and physical exam, and related medical progress notes
  - Documentation of patient's symptoms believed to be caused by uterine fibroids
  - Documentation of efforts to medically manage symptoms
- Documentation of a recent sonogram or other imaging studies documenting fibroid(s) number, size, and location
- Documentation of failure of conservative management
- Documentation counseling regarding risks and potential impact of the procedure on future pregnancy risks and complications

III. Coverage Limitations and Exclusions

The following are examples of coverage limitations and exclusions:

- Myomas larger than 7 cm
- Acute pelvic inflammatory disease or active pelvic infection
- Abnormal pap smear test results that have not been adequately evaluated.
- Suspected gynecologic malignancy/premalignancy requiring further workup
- Intrauterine devices (IUD)
- Intratubal implants currently in use
- Current or suspected pregnancy

IV. Length of Preauthorization for Initial Therapy

Preauthorization will be in effect for 3 months when criteria for initial approval are met.

V. Billing Code/Information

CPT Code 0404T: Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency

Prior authorization of benefits is not the practice of medicine nor the substitute for the independent medical judgment of a treating medical provider. The materials provided are a component used to assist in making coverage decisions and administering benefits. Prior authorization does not constitute a contract or guarantee regarding member eligibility or payment. Prior authorization criteria are established based on a collaborative effort using input from the current medical literature and based on evidence available at the time.

Approved by MDH Clinical Criteria Committee: 9/6/2023

Last Reviewed Date: 9/6/23