EXHIBIT 19-A

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN; ZACHARY MARTELL; BRIAN MCNEMAR, SHAWN ANDERSON a/k/a SHAUNTAE ANDERSON; and LEANNE JAMES, individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; JASON HAUGHT,** in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and **THE HEALTH PLAN OF WEST VIRGINIA, INC.,**

Defendants.

DEFENDANTS' THIRD SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES

DOCUMENT REQUESTS

7. If Defendants contend that the Exclusion of Gender-Confirming Care is supported by any governmental interest not encompassed in the Requests above, all Documents supporting that contention.

Exhibit
JM 12

SUPPLEMENTAL RESPONSE: Please see the attached budget and expenditure-related documents, Exhibits 60 - 85, Bates Numbers DHHRBMS002863 – DHHRBMS012160.

10. Documents sufficient to identify the circumstances in which orchiectomy, penectomy, vaginoplasty, hysterectomy, phalloplasty, mammoplasty, breast reconstruction surgery, and/or mastectomy are covered through the West Virginia Medicaid Program, including but not limited to Diagnostic Codes, Procedure Codes, contracts, health plans, clinical guidelines and/or criteria, medical necessity criteria, and pre/prior authorization requirements and procedures where applicable.

SUPPLEMENTAL RESPONSE: Please see Exhibits 10 – 26, Bates Numbers DHHRBMS001009 – DHHRBMS001112, previously produced. Additionally, please see Exhibits 50 – 57, Bates Numbers DHHRBMS002754 – DHHRBMS002784.

WILLIAM CROUCH,
CYNTHIA BEANE, and
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,

By counsel

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IN THE UNITED STATES DISTRICT COURT
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CHRISTOPHER FAIN; ZACHARY MARTELL; BRIAN MCNEMAR, SHAWN ANDERSON a/k/a SHAUNTAE ANDERSON; and LEANNE JAMES, individually and on behalf of all others similarly situated,

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Defendants.

CERTIFICATE OF SERVICE

I, Kimberly M. Bandy, counsel for Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, do hereby certify that on the 30th day of November, 2021, a true and exact copy of **DEFENDANTS' THIRD SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF REQUESTS FOR PRODUCTION TO DEFENDANTS WILLIAM CROUCH, CYNTHIA BEANE, AND WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES** was served on counsel via electronic means as follows:

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InterQual®

2021, Oct. 2021 Release CP:Procedures

Subset: Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy [1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11]

Requested Service: Hysterectomy +/- Salpingo-Oophorectomy or Salpingectomy for Endometriosis

Age: Age ≥ 18

Patient:	Name:	DOB:	ID #:	GROUP #:
	Sex (circle): M / F	Height:	Weight:	
Provider/PCP:	Name:	Fax #:	Phone #:	
	NPI/ID #:	Signature:		Date:
Servicing:	Vendor/Facility:		Phone #:	
	Diagnosis/ICD:	Service Date:	Authorization: / / to / /	

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ICD-10:

CPT®:

INSTRUCTIONS: Answer the following questions

☐ 10. Endometriosis by laparoscopy

1. Treatment within last year, Choose all that apply:
   - ☐ A) GnRH agonist ≥ 8 weeks [12]
   - ☐ B) Hormone therapy ≥ 8 weeks [13]
   - ☐ C) Danazol ≥ 8 weeks [14]
   - ☐ D) Other clinical information (add comment)

> • If 1 or more options A, B or C selected and option D not selected, then go to question 2
> • No other options lead to the requested service

2. Continued symptoms after treatment [15]
   - ☐ A) Yes
   - ☐ B) No

> • If option Yes selected, then go to question 3
> • No other options lead to the requested service

EXHIBIT 10

Endometriosis by laparoscopy (continued...)

3. Choose all that apply:
   - ☐ A) Most recent cervical cytology normal or managed per guidelines (16)
   - ☐ B) Pregnancy excluded by negative HCG or HCG planned prior to procedure or sterilization by history or patient not sexually active by history (17, 18, 19, 20)
   - ☐ C) Other clinical information (add comment)

• If the number of options selected is 2 and option C not selected, then the rule is satisfied; you may stop here (21) • No other options lead to the requested service

Reference

Ltd - This requested service is designated as 'Limited Evidence' in this clinical scenario. Criteria cannot be met.

2nd - Secondary review required. Criteria cannot be met.

Off-label - Use of a drug for an indication not approved by the U.S. Food and Drug Administration (FDA).

Notes:

1:
InterQual® content contains numerous references to gender. Depending on the context, these references may refer to either genotypic or phenotypic gender. At the individual patient level, a variety of factors, including, but not limited to, gender identity and gender affirmation via surgery or hormonal manipulation, may affect the applicability of some InterQual criteria. This is most often the case with genetic testing and procedures that assume the presence of gender-specific anatomy. With these considerations in mind, all references to gender in InterQual have been reviewed and modified when appropriate. InterQual users should carefully consider issues related to patient genotype and anatomy, especially for transgender individuals, when appropriate.

2:
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, ECRI Guidelines Trust®, Agency for Healthcare Research and Quality (AHRQ) Comparative Effectiveness Reviews, the Cochrane Library, Choosing Wisely, Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, and the National Institute of Health and Care Excellence (NICE). 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.

3:
Whether to perform prophylactic oophorectomy at the time of hysterectomy done for benign disease in premenopausal women may be considered. 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 (Version 3.2019). 2019; National Comprehensive Cancer Network, The NCCN clinical practice guidelines in oncology, genetic/familial high-risk assessment: colorectal (Version 3.2019). 2019). BSO may also 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 reduces the risk of ovarian cancer without the development of surgical menopause (American College of Obstetrics and Gynecologists, Obstet Gynecol 2019, 133: e279-e84; Society of Gynecologic Oncology, SGO Clinical Practice Statement: Salpingectomy for Ovarian Cancer Prevention 2013).

4:
Although robotic-assisted hysterectomy is being done, there are few prospective studies comparing robotic assisted to laparoscopic surgery for treating benign disease (ACOG, Obstetrics and Gynecology Committee Opinion No. 628. 2015, 125: 760-7. Reaffirmed 2017; Yu et al., Journal of surgical oncology 2013, 107: 653-8). A Cochrane review, however, demonstrated that robotic-assisted gynecologic surgery required more intraoperative time but reduced hospital stay when compared to 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 (Lawrie et al., Cochrane Database Syst Rev 2019, 4: Cd011422).

5:
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.

6:
Vaginal hysterectomy offers many advantages to the abdominal or laparoscopic approach including no abdominal incision, less pain, and quicker recovery; if technically feasible, it is the preferred surgical route (American College of Obstetricians and Gynecologists (ACOG), Obstet Gynecol 2017, 129: e155-e9; Sesti et al., Archives of Gynecology and Obstetrics 2014, 290: 485-91). The vaginal technique, however, can be limited in its ability to treat ovarian pathology in 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.

7:
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

8:
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.

9:
I/O Setting:
Hysterectomy, Abdominal, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Abdominal, Total +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting
Hysterectomy, Laparoscopic, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Laparoscopic, Total (TLH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Vaginal +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting

10:
For cervical cancer stage I-IIA and endometrial cancer stage II, see the "Hysterectomy, Radical" criteria subset.

11:
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).

12:
The GnRH agonists include leuprolide, nafarelin, and goserelin. These compounds mimic the action of GnRH and, thereby, suppress the hormones produced by the ovary that stimulate endometrial growth.

13:
Medical therapy to treat symptoms of endometriosis may include combined contraceptive or progestin alone; their use is considered a first-line option (Brown and Farquhar, The Cochrane database of systematic reviews 2014, 3: CD009590). Depot medroxyprogesterone acetate, the progestin contraceptive implant, and the levonorgestrel intra-uterine system may also improve pain due to endometriosis (ACOG, Obstetrics and gynecology Practice Bulletin No. 110. 2010, 115: 206-218. Reaffirmed 2018).

14:
If symptoms do not respond to an oral contraceptive pill or GnRH agonist, then treatment with danazol or a progestin (e.g., depot medroxyprogesterone) is appropriate (Brown and Farquhar, Cochrane Database Syst Rev 2014: Cd009590).

15:
Symptoms of endometriosis include chronic recurrent pelvic pain, dysmenorrhea, infertility, and dyspareunia.

16:
Cervical cytology should be evaluated according to current screening protocols. Screening intervals and tests used (cervical cytology alone, high-risk human papillomavirus [hrHPV] testing alone, hrHPV and cytology together [co-testing]) will vary based on patient's age and risk factors. If the most recent cervical cytology is documented as normal, no further testing is needed. Any abnormalities detected during cervical cancer screening should be managed according to current guidelines. Management may include repeat testing, observation, surveillance, biopsy, ablation, or excisional treatment based on the identified level of risk for each patient (Redman et al., Eur J Obstet Gynecol Reprod Biol 2021, 256: 57-62; Perkins et al., J Low Genit Tract Dis 2020, 24: 102-31; US Preventative Services Task Force et al., JAMA 2018, 320: 674-86; Wentzensen et al., J Low Genit Tract Dis 2017, 21: 216-22).

17:
Pregnancy and related complications (e.g., ectopic pregnancy, incomplete abortion, inevitable abortion) must be excluded before performing this procedure.

18:
Pregnancy testing can be performed by measurement of either a serum or urine HCG and may be documented in the medical record by either the PCP, a gynecologist, or a surgeon.

19:
The documentation should include a history of sterilization (i.e., tubal ligation) without a subsequent pregnancy. These criteria do not include sterilization of a partner or alternate birth control methods (e.g., oral contraceptive pill use, intrauterine device insertion).

20:
Patients have varying definitions of sexual activity (e.g., number of partners, timing of most recent episode, frequency of sexual activity). Unless the provider can confirm on examination that the patient has never had sexual intercourse, whether a patient is sexually active or not is a matter of clinical judgment.

21:
I/O Setting:
Hysterectomy, Abdominal, Supracervical +/- Bilateral Salpingo-oophorectomy (BSO) - Inpatient
Hysterectomy, Abdominal, Total +/- Bilateral Salpingo-oophorectomy (BSO) - Inpatient
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) +/- Bilateral Salpingo-oophorectomy (BSO) - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting
Hysterectomy, Laparoscopic, Supracervical +/-Bilateral Salpingo-oophorectomy (BSO) - Outpatient
Hysterectomy, Laparoscopic, Total (TLH) +/- Bilateral Salpingo-oophorectomy (BSO) - Outpatient
Hysterectomy, Vaginal +/- Bilateral Salpingo-oophorectomy (BSO) - Due to variations in practice, this procedure can

be performed in the inpatient or outpatient setting

ICD-10-CM (circle all that apply): C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C56.1, C56.2, C56.3, C56.9, C57.00, C57.01, C57.02, C79.82, D06.0, D06.1, D06.7, D06.9, D25.0, D25.1, D25.2, D25.9, N70.01, N70.02, N70.03, N70.11, N70.12, N70.13, N70.91, N70.92, N70.93, N71.1, N71.9, N72, N73.1, N73.4, N73.8, N73.9, N80.0, N80.1, N80.2, N80.3, N80.4, N80.5, N80.6, N80.8, N80.9, N81.2, N81.3, N81.4, N85.00, N85.01, N85.02, N87.0, N87.1, N87.9, N92.1, N92.4, N92.5, N93.0, N93.1, N93.8, N93.9, N95.0, O01.0, O01.1, O01.9, O72.0, O72.1, O72.2, O72.3, R10.10, R10.11, R10.12, R10.13, R10.2, R10.30, R10.31, R10.32, R10.33, R10.811, R10.812, R10.813, R10.814, R10.815, R10.816, R10.817, R10.819, R10.821, R10.822, R10.823, R10.824, R10.825, R10.826, R10.827, R10.829, R10.83, R10.84, R10.9, R19.00, R19.01, R19.02, R19.03, R19.04, R19.05, R19.06, R19.07, R19.09, R93.5, Z14.8, Z15.01, Z15.02, Z15.04, Z15.09, Z15.89, Other _____

ICD-10-PCS (circle all that apply): 0UT20ZZ, 0UT24ZZ, 0UT27ZZ, 0UT28ZZ, 0UT2FZZ, 0UT70ZZ, 0UT74ZZ, 0UT77ZZ, 0UT78ZZ, 0UT7FZZ, 0UT90ZL, 0UT90ZZ, 0UT94ZL, 0UT94ZZ, 0UT97ZL, 0UT97ZZ, 0UT98ZL, 0UT98ZZ, 0UT9FZL, 0UT9FZZ, 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ, Other _____

CPT® (circle all that apply): 58150, 58152, 58180, 58260, 58262, 58263, 58290, 58291, 58292, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58575, Other _____

InterQual®

2021, Oct. 2021 Release CP:Procedures

Subset: Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11)

Requested Service: Hysterectomy + BSO for BRCA gene mutation

Age: Age ≥ 18

Patient:	Name:	DOB:	ID #:	GROUP #:
	Sex (circle): M / F	Height:	Weight:	
Provider/PCP:	Name:	Fax #:	Phone #:	
	NPI/ID #:	Signature:	Date:	
Servicing:	Vendor/Facility:		Phone #:	
	Diagnosis/ICD:	Service Date:	Authorization: / / to / /	

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ICD-10:

CPT®:

INSTRUCTIONS: Answer the following questions

☐ 10. BRCA1 or BRCA2 gene mutation by genetic testing

There are no questions for the requested service

Reference

Ltd - This requested service is designated as 'Limited Evidence' in this clinical scenario. Criteria cannot be met.

2nd - Secondary review required. Criteria cannot be met.

Off-label - Use of a drug for an indication not approved by the U.S. Food and Drug Administration (FDA).

EXHIBIT 11

Notes:

1:
InterQual® content contains numerous references to gender. Depending on the context, these references may refer to either genotypic or phenotypic gender. At the individual patient level, a variety of factors, including, but not limited to, gender identity and gender affirmation via surgery or hormonal manipulation, may affect the applicability of some InterQual criteria. This is most often the case with genetic testing and procedures that assume the presence of gender-specific anatomy. With these considerations in mind, all references to gender in InterQual have been reviewed and modified when appropriate. InterQual users should carefully consider issues related to patient genotype and anatomy, especially for transgender individuals, when appropriate.

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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, ECRI Guidelines Trust®, Agency for Healthcare Research and Quality (AHRQ) Comparative Effectiveness Reviews, the Cochrane Library, Choosing Wisely, Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, and the National Institute of Health and Care Excellence (NICE). 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.

3:
Whether to perform prophylactic oophorectomy at the time of hysterectomy done for benign disease in premenopausal women may be considered. 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 (Version 3.2019). 2019; National Comprehensive Cancer Network, The NCCN clinical practice guidelines in oncology, genetic/familial high-risk assessment: colorectal (Version 3.2019). 2019). BSO may also 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 reduces the risk of ovarian cancer without the development of surgical menopause (American College of Obstetrics and Gynecologists, Obstet Gynecol 2019, 133: e279-e84; Society of Gynecologic Oncology, SGO Clinical Practice Statement: Salpingectomy for Ovarian Cancer Prevention 2013).

4:
Although robotic-assisted hysterectomy is being done, there are few prospective studies comparing robotic assisted to laparoscopic surgery for treating benign disease (ACOG, Obstetrics and Gynecology Committee Opinion No. 628. 2015, 125: 760-7. Reaffirmed 2017; Yu et al., Journal of surgical oncology 2013, 107: 653-8). A Cochrane review, however, demonstrated that robotic-assisted gynecologic surgery required more intraoperative time but reduced hospital stay when compared to 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 (Lawrie et al., Cochrane Database Syst Rev 2019, 4: Cd011422).

5:
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.

6:
Vaginal hysterectomy offers many advantages to the abdominal or laparoscopic approach including no abdominal incision, less pain, and quicker recovery; if technically feasible, it is the preferred surgical route (American College of Obstetricians and Gynecologists (ACOG), Obstet Gynecol 2017, 129: e155-e9; Sesti et al., Archives of Gynecology and Obstetrics 2014, 290: 485-91). The vaginal technique, however, can be limited in its ability to treat ovarian pathology in 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.

7:
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

8:
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.

9:
I/O Setting:
Hysterectomy, Abdominal, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Abdominal, Total +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting
Hysterectomy, Laparoscopic, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Laparoscopic, Total (TLH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Vaginal +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting

10:
For cervical cancer stage I-IIA and endometrial cancer stage II, see the "Hysterectomy, Radical" criteria subset.

11:
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).

Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy

Hysterectomy + BSO for BRCA gene mutation

ICD-10-CM (circle all that apply): C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C56.1, C56.2, C56.3, C56.9, C57.00, C57.01, C57.02, C79.82, D06.0, D06.1, D06.7, D06.9, D25.0, D25.1, D25.2, D25.9, N70.01, N70.02, N70.03, N70.11, N70.12, N70.13, N70.91, N70.92, N70.93, N71.1, N71.9, N72, N73.1, N73.4, N73.8, N73.9, N80.0, N80.1, N80.2, N80.3, N80.4, N80.5, N80.6, N80.8, N80.9, N81.2, N81.3, N81.4, N85.00, N85.01, N85.02, N87.0, N87.1, N87.9, N92.1, N92.4, N92.5, N93.0, N93.1, N93.8, N93.9, N95.0, O01.0, O01.1, O01.9, O72.0, O72.1, O72.2, O72.3, R10.10, R10.11, R10.12, R10.13, R10.2, R10.30, R10.31, R10.32, R10.33, R10.811, R10.812, R10.813, R10.814, R10.815, R10.816, R10.817, R10.819, R10.821, R10.822, R10.823, R10.824, R10.825, R10.826, R10.827, R10.829, R10.83, R10.84, R10.9, R19.00, R19.01, R19.02, R19.03, R19.04, R19.05, R19.06, R19.07, R19.09, R93.5, Z14.8, Z15.01, Z15.02, Z15.04, Z15.09, Z15.89, Other _____

ICD-10-PCS (circle all that apply): 0UT20ZZ, 0UT24ZZ, 0UT27ZZ, 0UT28ZZ, 0UT2FZZ, 0UT70ZZ, 0UT74ZZ, 0UT77ZZ, 0UT78ZZ, 0UT7FZZ, 0UT90ZL, 0UT90ZZ, 0UT94ZL, 0UT94ZZ, 0UT97ZL, 0UT97ZZ, 0UT98ZL, 0UT98ZZ, 0UT9FZL, 0UT9FZZ, 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ, Other _____

CPT® (circle all that apply): 58150, 58152, 58180, 58262, 58291, 58542, 58544, 58552, 58554, 58571, 58573, 58575, Other _____

InterQual®

2021, Oct. 2021 Release CP:Procedures

Subset: Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11)

Requested Service: Hysterectomy +/- BSO or Bilateral Salpingectomy for Endocervical adenocarcinoma in situ
Age: Age ≥ 18

Patient:	Name:	DOB:	ID #:	GROUP #:
	Sex (circle): M / F	Height:	Weight:	
Provider/PCP:	Name:	Fax #:	Phone #:	
	NPI/ID #:	Signature:		Date:
Servicing:	Vendor/Facility:		Phone #:	
	Diagnosis/ICD:	Service Date:	Authorization: / / to / /	

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ICD-10:

CPT®:

INSTRUCTIONS: Answer the following questions

☐ 10. Endocervical adenocarcinoma in situ by biopsy

There are no questions for the requested service

Reference

Ltd - This requested service is designated as 'Limited Evidence' in this clinical scenario. Criteria cannot be met.

2nd - Secondary review required. Criteria cannot be met.

Off-label - Use of a drug for an indication not approved by the U.S. Food and Drug Administration (FDA).

EXHIBIT 12

Notes:

1:
InterQual® content contains numerous references to gender. Depending on the context, these references may refer to either genotypic or phenotypic gender. At the individual patient level, a variety of factors, including, but not limited to, gender identity and gender affirmation via surgery or hormonal manipulation, may affect the applicability of some InterQual criteria. This is most often the case with genetic testing and procedures that assume the presence of gender-specific anatomy. With these considerations in mind, all references to gender in InterQual have been reviewed and modified when appropriate. InterQual users should carefully consider issues related to patient genotype and anatomy, especially for transgender individuals, when appropriate.

2:
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, ECRI Guidelines Trust®, Agency for Healthcare Research and Quality (AHRQ) Comparative Effectiveness Reviews, the Cochrane Library, Choosing Wisely, Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, and the National Institute of Health and Care Excellence (NICE). 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.

3:
Whether to perform prophylactic oophorectomy at the time of hysterectomy done for benign disease in premenopausal women may be considered. 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 (Version 3.2019). 2019; National Comprehensive Cancer Network, The NCCN clinical practice guidelines in oncology, genetic/familial high-risk assessment: colorectal (Version 3.2019). 2019). BSO may also 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 reduces the risk of ovarian cancer without the development of surgical menopause (American College of Obstetrics and Gynecologists, Obstet Gynecol 2019, 133: e279-e84; Society of Gynecologic Oncology, SGO Clinical Practice Statement: Salpingectomy for Ovarian Cancer Prevention 2013).

4:
Although robotic-assisted hysterectomy is being done, there are few prospective studies comparing robotic assisted to laparoscopic surgery for treating benign disease (ACOG, Obstetrics and Gynecology Committee Opinion No. 628. 2015, 125: 760-7. Reaffirmed 2017; Yu et al., Journal of surgical oncology 2013, 107: 653-8). A Cochrane review, however, demonstrated that robotic-assisted gynecologic surgery required more intraoperative time but reduced hospital stay when compared to 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 (Lawrie et al., Cochrane Database Syst Rev 2019, 4: Cd011422).

5:
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.

6:
Vaginal hysterectomy offers many advantages to the abdominal or laparoscopic approach including no abdominal incision, less pain, and quicker recovery; if technically feasible, it is the preferred surgical route (American College of Obstetricians and Gynecologists (ACOG), Obstet Gynecol 2017, 129: e155-e9; Sesti et al., Archives of Gynecology and Obstetrics 2014, 290: 485-91). The vaginal technique, however, can be limited in its ability to treat ovarian pathology in 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.

7:
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

8:
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.

9:
I/O Setting:
Hysterectomy, Abdominal, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Abdominal, Total +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting
Hysterectomy, Laparoscopic, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Laparoscopic, Total (TLH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Vaginal +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting

10:
For cervical cancer stage I-IIA and endometrial cancer stage II, see the "Hysterectomy, Radical" criteria subset.

11:
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).

Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy

Hysterectomy +/- BSO or Bilateral Salpingectomy for Endocervical adenocarcinoma in situ

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ICD-10-CM (circle all that apply): C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C56.1, C56.2, C56.3, C56.9, C57.00, C57.01, C57.02, C79.82, D06.0, D06.1, D06.7, D06.9, D25.0, D25.1, D25.2, D25.9, N70.01, N70.02, N70.03, N70.11, N70.12, N70.13, N70.91, N70.92, N70.93, N71.1, N71.9, N72, N73.1, N73.4, N73.8, N73.9, N80.0, N80.1, N80.2, N80.3, N80.4, N80.5, N80.6, N80.8, N80.9, N81.2, N81.3, N81.4, N85.00, N85.01, N85.02, N87.0, N87.1, N87.9, N92.1, N92.4, N92.5, N93.0, N93.1, N93.8, N93.9, N95.0, O01.0, O01.1, O01.9, O72.0, O72.1, O72.2, O72.3, R10.10, R10.11, R10.12, R10.13, R10.2, R10.30, R10.31, R10.32, R10.33, R10.811, R10.812, R10.813, R10.814, R10.815, R10.816, R10.817, R10.819, R10.821, R10.822, R10.823, R10.824, R10.825, R10.826, R10.827, R10.829, R10.83, R10.84, R10.9, R19.00, R19.01, R19.02, R19.03, R19.04, R19.05, R19.06, R19.07, R19.09, R93.5, Z14.8, Z15.01, Z15.02, Z15.04, Z15.09, Z15.89, Other _____

ICD-10-PCS (circle all that apply): 0UT20ZZ, 0UT24ZZ, 0UT27ZZ, 0UT28ZZ, 0UT2FZZ, 0UT70ZZ, 0UT74ZZ, 0UT77ZZ, 0UT78ZZ, 0UT7FZZ, 0UT90ZZ, 0UT94ZZ, 0UT97ZZ, 0UT98ZZ, 0UT9FZZ, 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ, Other _____

CPT® (circle all that apply): 58150, 58152, 58260, 58262, 58263, 58290, 58291, 58292, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58575, Other _____

InterQual®

2021, Oct. 2021 Release CP:Procedures

Subset: Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11)

Requested Service: Hysterectomy + BSO for Endometrial cancer

Age: Age ≥ 18

Patient:	Name:	DOB:	ID #:	GROUP #:
	Sex (circle): M / F	Height:	Weight:	
Provider/PCP:	Name:	Fax #:	Phone #:	
	NPI/ID #:	Signature:		Date:
Servicing:	Vendor/Facility:		Phone #:	
	Diagnosis/ICD:	Service Date:	Authorization: / / to / /	

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ICD-10:

CPT®:

INSTRUCTIONS: Answer the following questions

☐ 10. Stage I or IA or IB endometrial cancer by pathology

There are no questions for the requested service

Reference

Ltd - This requested service is designated as 'Limited Evidence' in this clinical scenario. Criteria cannot be met.

2nd - Secondary review required. Criteria cannot be met.

Off-label - Use of a drug for an indication not approved by the U.S. Food and Drug Administration (FDA).

EXHIBIT 13

Notes:

1:
InterQual® content contains numerous references to gender. Depending on the context, these references may refer to either genotypic or phenotypic gender. At the individual patient level, a variety of factors, including, but not limited to, gender identity and gender affirmation via surgery or hormonal manipulation, may affect the applicability of some InterQual criteria. This is most often the case with genetic testing and procedures that assume the presence of gender-specific anatomy. With these considerations in mind, all references to gender in InterQual have been reviewed and modified when appropriate. InterQual users should carefully consider issues related to patient genotype and anatomy, especially for transgender individuals, when appropriate.

2:
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3:
Whether to perform prophylactic oophorectomy at the time of hysterectomy done for benign disease in premenopausal women may be considered. 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 (Version 3.2019). 2019; National Comprehensive Cancer Network, The NCCN clinical practice guidelines in oncology, genetic/familial high-risk assessment: colorectal (Version 3.2019). 2019). BSO may also 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 reduces the risk of ovarian cancer without the development of surgical menopause (American College of Obstetrics and Gynecologists, Obstet Gynecol 2019, 133: e279-e84; Society of Gynecologic Oncology, SGO Clinical Practice Statement: Salpingectomy for Ovarian Cancer Prevention 2013).

4:
Although robotic-assisted hysterectomy is being done, there are few prospective studies comparing robotic assisted to laparoscopic surgery for treating benign disease (ACOG, Obstetrics and Gynecology Committee Opinion No. 628. 2015, 125: 760-7. Reaffirmed 2017; Yu et al., Journal of surgical oncology 2013, 107: 653-8). A Cochrane review, however, demonstrated that robotic-assisted gynecologic surgery required more intraoperative time but reduced hospital stay when compared to 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 (Lawrie et al., Cochrane Database Syst Rev 2019, 4: Cd011422).

5:
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.

6:
Vaginal hysterectomy offers many advantages to the abdominal or laparoscopic approach including no abdominal incision, less pain, and quicker recovery; if technically feasible, it is the preferred surgical route (American College of Obstetricians and Gynecologists (ACOG), Obstet Gynecol 2017, 129: e155-e9; Sesti et al., Archives of Gynecology and Obstetrics 2014, 290: 485-91). The vaginal technique, however, can be limited in its ability to treat ovarian pathology in 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.

7:
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

8:
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.

9:
I/O Setting:
Hysterectomy, Abdominal, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Abdominal, Total +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting
Hysterectomy, Laparoscopic, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Laparoscopic, Total (TLH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Vaginal +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting

10:
For cervical cancer stage I-IIA and endometrial cancer stage II, see the "Hysterectomy, Radical" criteria subset.

11:
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).

Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy

Hysterectomy + BSO for Endometrial cancer

Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy

Hysterectomy + BSO for Endometrial cancer

ICD-10-CM (circle all that apply): C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C56.1, C56.2, C56.3, C56.9, C57.00, C57.01, C57.02, C79.82, D06.0, D06.1, D06.7, D06.9, D25.0, D25.1, D25.2, D25.9, N70.01, N70.02, N70.03, N70.11, N70.12, N70.13, N70.91, N70.92, N70.93, N71.1, N71.9, N72, N73.1, N73.4, N73.8, N73.9, N80.0, N80.1, N80.2, N80.3, N80.4, N80.5, N80.6, N80.8, N80.9, N81.2, N81.3, N81.4, N85.00, N85.01, N85.02, N87.0, N87.1, N87.9, N92.1, N92.4, N92.5, N93.0, N93.1, N93.8, N93.9, N95.0, O01.0, O01.1, O01.9, O72.0, O72.1, O72.2, O72.3, R10.10, R10.11, R10.12, R10.13, R10.2, R10.30, R10.31, R10.32, R10.33, R10.811, R10.812, R10.813, R10.814, R10.815, R10.816, R10.817, R10.819, R10.821, R10.822, R10.823, R10.824, R10.825, R10.826, R10.827, R10.829, R10.83, R10.84, R10.9, R19.00, R19.01, R19.02, R19.03, R19.04, R19.05, R19.06, R19.07, R19.09, R93.5, Z14.8, Z15.01, Z15.02, Z15.04, Z15.09, Z15.89, Other _____

ICD-10-PCS (circle all that apply): 0UT20ZZ, 0UT24ZZ, 0UT28ZZ, 0UT2FZZ, 0UT70ZZ, 0UT74ZZ, 0UT78ZZ, 0UT7FZZ, 0UT90ZZ, 0UT94ZZ, 0UT98ZZ, 0UT9FZZ, 0UTC0ZZ, 0UTC4ZZ, 0UTC8ZZ, Other _____

CPT® (circle all that apply): 58150, 58152, 58552, 58554, 58571, 58573, 58575, Other _____

InterQual®

2021, Oct. 2021 Release CP:Procedures

Subset: Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11)

Requested Service: Hysterectomy + BSO for Endometrial hyperplasia (postmenopausal)

Age: Age ≥ 18

Patient:	Name:	DOB:	ID #:	GROUP #:
	Sex (circle): M / F	Height:	Weight:	
Provider/PCP:	Name:	Fax #:	Phone #:	
	NPI/ID #:	Signature:		Date:
Servicing:	Vendor/Facility:		Phone #:	
	Diagnosis/ICD:	Service Date:	Authorization: / / to / /	

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ICD-10:

CPT®:

INSTRUCTIONS: Answer the following questions

☐ 10. Endometrial hyperplasia with cellular atypia by biopsy or dilatation and curettage (D & C)

1. Choose one:
   - ☐ A) Premenopausal woman
   - ☐ B) Postmenopausal woman (12)
   - ☐ C) Other clinical information (add comment)

> • If option B selected, then the rule is satisfied; you may stop here (13)
> • No other options lead to the requested service

Reference

Ltd - This requested service is designated as 'Limited Evidence' in this clinical scenario. Criteria cannot be met.

2nd - Secondary review required. Criteria cannot be met.

Off-label - Use of a drug for an indication not approved by the U.S. Food and Drug Administration (FDA).

EXHIBIT 14

Notes:

1:
InterQual® content contains numerous references to gender. Depending on the context, these references may refer to either genotypic or phenotypic gender. At the individual patient level, a variety of factors, including, but not limited to, gender identity and gender affirmation via surgery or hormonal manipulation, may affect the applicability of some InterQual criteria. This is most often the case with genetic testing and procedures that assume the presence of gender-specific anatomy. With these considerations in mind, all references to gender in InterQual have been reviewed and modified when appropriate. InterQual users should carefully consider issues related to patient genotype and anatomy, especially for transgender individuals, when appropriate.

2:
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, ECRI Guidelines Trust®, Agency for Healthcare Research and Quality (AHRQ) Comparative Effectiveness Reviews, the Cochrane Library, Choosing Wisely, Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, and the National Institute of Health and Care Excellence (NICE). 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.

3:
Whether to perform prophylactic oophorectomy at the time of hysterectomy done for benign disease in premenopausal women may be considered. 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 (Version 3.2019). 2019; National Comprehensive Cancer Network, The NCCN clinical practice guidelines in oncology, genetic/familial high-risk assessment: colorectal (Version 3.2019). 2019). BSO may also 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 reduces the risk of ovarian cancer without the development of surgical menopause (American College of Obstetrics and Gynecologists, Obstet Gynecol 2019, 133: e279-e84; Society of Gynecologic Oncology, SGO Clinical Practice Statement: Salpingectomy for Ovarian Cancer Prevention 2013).

4:
Although robotic-assisted hysterectomy is being done, there are few prospective studies comparing robotic assisted to laparoscopic surgery for treating benign disease (ACOG, Obstetrics and Gynecology Committee Opinion No. 628. 2015, 125: 760-7. Reaffirmed 2017; Yu et al., Journal of surgical oncology 2013, 107: 653-8). A Cochrane review, however, demonstrated that robotic-assisted gynecologic surgery required more intraoperative time but reduced hospital stay when compared to 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 (Lawrie et al., Cochrane Database Syst Rev 2019, 4: Cd011422).

5:
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.

6:
Vaginal hysterectomy offers many advantages to the abdominal or laparoscopic approach including no abdominal incision, less pain, and quicker recovery; if technically feasible, it is the preferred surgical route (American College of Obstetricians and Gynecologists (ACOG), Obstet Gynecol 2017, 129: e155-e9; Sesti et al., Archives of Gynecology and Obstetrics 2014, 290: 485-91). The vaginal technique, however, can be limited in its ability to treat ovarian pathology in 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.

7:
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

8:
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.

9:
I/O Setting:
Hysterectomy, Abdominal, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Abdominal, Total +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting
Hysterectomy, Laparoscopic, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Laparoscopic, Total (TLH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Vaginal +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting

10:
For cervical cancer stage I-IIA and endometrial cancer stage II, see the "Hysterectomy, Radical" criteria subset.

11:
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).

12:
Hysterectomy with removal of both ovaries and fallopian tubes is usually performed in postmenopausal women because the risk for the development of ovarian cancer is higher than for premenopausal women.

13:
I/O Setting:
Hysterectomy, Abdominal, Total + Bilateral Salpingo-Oophorectomy (BSO) - Inpatient
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) + Bilateral Salpingo-Oophorectomy (BSO) - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting
Hysterectomy, Laparoscopic, Total (TLH) + Bilateral Salpingo-Oophorectomy (BSO) - Outpatient
Hysterectomy, Vaginal + Bilateral Salpingo-Oophorectomy (BSO) - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting

Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy

Hysterectomy + BSO for Endometrial hyperplasia (postmenopausal)

ICD-10-CM (circle all that apply): C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C56.1, C56.2, C56.3, C56.9, C57.00, C57.01, C57.02, C79.82, D06.0, D06.1, D06.7, D06.9, D25.0, D25.1, D25.2, D25.9, N70.01, N70.02, N70.03, N70.11, N70.12, N70.13, N70.91, N70.92, N70.93, N71.1, N71.9, N72, N73.1, N73.4, N73.8, N73.9, N80.0, N80.1, N80.2, N80.3, N80.4, N80.5, N80.6, N80.8, N80.9, N81.2, N81.3, N81.4, N85.00, N85.01, N85.02, N87.0, N87.1, N87.9, N92.1, N92.4, N92.5, N93.0, N93.1, N93.8, N93.9, N95.0, O01.0, O01.1, O01.9, O72.0, O72.1, O72.2, O72.3, R10.10, R10.11, R10.12, R10.13, R10.2, R10.30, R10.31, R10.32, R10.33, R10.811, R10.812, R10.813, R10.814, R10.815, R10.816, R10.817, R10.819, R10.821, R10.822, R10.823, R10.824, R10.825, R10.826, R10.827, R10.829, R10.83, R10.84, R10.9, R19.00, R19.01, R19.02, R19.03, R19.04, R19.05, R19.06, R19.07, R19.09, R93.5, Z14.8, Z15.01, Z15.02, Z15.04, Z15.09, Z15.89, Other _____

ICD-10-PCS (circle all that apply): 0UT20ZZ, 0UT24ZZ, 0UT27ZZ, 0UT28ZZ, 0UT2FZZ, 0UT70ZZ, 0UT74ZZ, 0UT77ZZ, 0UT78ZZ, 0UT7FZZ, 0UT90ZZ, 0UT94ZZ, 0UT97ZZ, 0UT98ZZ, 0UT9FZZ, 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ, Other _____

CPT® (circle all that apply): 58150, 58152, 58262, 58263, 58291, 58292, 58552, 58554, 58571, 58573, 58575, Other _____

InterQual®

2021, Oct. 2021 Release CP:Procedures

Subset: Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11)

Requested Service: Hysterectomy + BSO for Lynch II syndrome

Age: Age ≥ 18

Patient:	Name:	DOB:	ID #:	GROUP #:
	Sex (circle): M / F	Height:	Weight:	
Provider/PCP:	Name:	Fax #:	Phone #:	
	NPI/ID #:	Signature:	Date:	
Servicing:	Vendor/Facility:		Phone #:	
	Diagnosis/ICD:	Service Date:	Authorization: / / to / /	

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ICD-10:

CPT®:

INSTRUCTIONS: Answer the following questions

☐ 10. Lynch II syndrome

There are no questions for the requested service

Reference

Ltd - This requested service is designated as 'Limited Evidence' in this clinical scenario. Criteria cannot be met.

2nd - Secondary review required. Criteria cannot be met.

Off-label - Use of a drug for an indication not approved by the U.S. Food and Drug Administration (FDA).

EXHIBIT 15

Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy

Hysterectomy + BSO for Lynch II syndrome

Notes:

1:
InterQual® content contains numerous references to gender. Depending on the context, these references may refer to either genotypic or phenotypic gender. At the individual patient level, a variety of factors, including, but not limited to, gender identity and gender affirmation via surgery or hormonal manipulation, may affect the applicability of some InterQual criteria. This is most often the case with genetic testing and procedures that assume the presence of gender-specific anatomy. With these considerations in mind, all references to gender in InterQual have been reviewed and modified when appropriate. InterQual users should carefully consider issues related to patient genotype and anatomy, especially for transgender individuals, when appropriate.

2:
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, ECRI Guidelines Trust®, Agency for Healthcare Research and Quality (AHRQ) Comparative Effectiveness Reviews, the Cochrane Library, Choosing Wisely, Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, and the National Institute of Health and Care Excellence (NICE). 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.

3:
Whether to perform prophylactic oophorectomy at the time of hysterectomy done for benign disease in premenopausal women may be considered. 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 (Version 3.2019). 2019; National Comprehensive Cancer Network, The NCCN clinical practice guidelines in oncology, genetic/familial high-risk assessment: colorectal (Version 3.2019). 2019). BSO may also 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 reduces the risk of ovarian cancer without the development of surgical menopause (American College of Obstetrics and Gynecologists, Obstet Gynecol 2019, 133: e279-e84; Society of Gynecologic Oncology, SGO Clinical Practice Statement: Salpingectomy for Ovarian Cancer Prevention 2013).

4:
Although robotic-assisted hysterectomy is being done, there are few prospective studies comparing robotic assisted to laparoscopic surgery for treating benign disease (ACOG, Obstetrics and Gynecology Committee Opinion No. 628. 2015, 125: 760-7. Reaffirmed 2017; Yu et al., Journal of surgical oncology 2013, 107: 653-8). A Cochrane review, however, demonstrated that robotic-assisted gynecologic surgery required more intraoperative time but reduced hospital stay when compared to 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 (Lawrie et al., Cochrane Database Syst Rev 2019, 4: Cd011422).

5:
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.

6:
Vaginal hysterectomy offers many advantages to the abdominal or laparoscopic approach including no abdominal incision, less pain, and quicker recovery; if technically feasible, it is the preferred surgical route (American College of Obstetricians and Gynecologists (ACOG), Obstet Gynecol 2017, 129: e155-e9; Sesti et al., Archives of Gynecology and Obstetrics 2014, 290: 485-91). The vaginal technique, however, can be limited in its ability to treat ovarian pathology in 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.

7:
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

8:
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.

9:
I/O Setting:
Hysterectomy, Abdominal, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Abdominal, Total +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting
Hysterectomy, Laparoscopic, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Laparoscopic, Total (TLH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Vaginal +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting

10:
For cervical cancer stage I-IIA and endometrial cancer stage II, see the "Hysterectomy, Radical" criteria subset.

11:
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).

Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy

Hysterectomy + BSO for Lynch II syndrome

Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy

Hysterectomy + BSO for Lynch II syndrome

ICD-10-CM (circle all that apply): C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C56.1, C56.2, C56.3, C56.9, C57.00, C57.01, C57.02, C79.82, D06.0, D06.1, D06.7, D06.9, D25.0, D25.1, D25.2, D25.9, N70.01, N70.02, N70.03, N70.11, N70.12, N70.13, N70.91, N70.92, N70.93, N71.1, N71.9, N72, N73.1, N73.4, N73.8, N73.9, N80.0, N80.1, N80.2, N80.3, N80.4, N80.5, N80.6, N80.8, N80.9, N81.2, N81.3, N81.4, N85.00, N85.01, N85.02, N87.0, N87.1, N87.9, N92.1, N92.4, N92.5, N93.0, N93.1, N93.8, N93.9, N95.0, O01.0, O01.1, O01.9, O72.0, O72.1, O72.2, O72.3, R10.10, R10.11, R10.12, R10.13, R10.2, R10.30, R10.31, R10.32, R10.33, R10.811, R10.812, R10.813, R10.814, R10.815, R10.816, R10.817, R10.819, R10.821, R10.822, R10.823, R10.824, R10.825, R10.826, R10.827, R10.829, R10.83, R10.84, R10.9, R19.00, R19.01, R19.02, R19.03, R19.04, R19.05, R19.06, R19.07, R19.09, R93.5, Z14.8, Z15.01, Z15.02, Z15.04, Z15.09, Z15.89, Other _____

ICD-10-PCS (circle all that apply): 0UT20ZZ, 0UT24ZZ, 0UT70ZZ, 0UT74ZZ, 0UT90ZL, 0UT90ZZ, 0UT94ZL, 0UT94ZZ, 0UTC0ZZ, 0UTC4ZZ, Other _____

CPT® (circle all that apply): 58150, 58152, 58571, 58573, 58575, Other _____

InterQual®

2021, Oct. 2021 Release CP:Procedures

Subset: Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11)

Requested Service: Hysterectomy + BSO for Suspected Ovarian or Tubal cancer

Age: Age ≥ 18

Patient:	Name:	DOB:	ID #:	GROUP #:
	Sex (circle): M / F	Height:	Weight:	
Provider/PCP:	Name:	Fax #:	Phone #:	
	NPI/ID #:	Signature:		Date:
Servicing:	Vendor/Facility:		Phone #:	
	Diagnosis/ICD:	Service Date:	Authorization: / / to / /	

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ICD-10:

CPT®:

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

- ▢ 10. Suspected ovarian cancer by imaging
- ▢ 20. Suspected tubal cancer by imaging

▢ 10. Suspected ovarian cancer by imaging

There are no questions for the requested service

▢ 20. Suspected tubal cancer by imaging

There are no questions for the requested service

Reference

Ltd - This requested service is designated as 'Limited Evidence' in this clinical scenario. Criteria cannot be met.

2nd - Secondary review required. Criteria cannot be met.

Off-label - Use of a drug for an indication not approved by the U.S. Food and Drug Administration (FDA).

Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy

Hysterectomy + BSO for Suspected Ovarian or Tubal cancer

Notes:

1:
InterQual® content contains numerous references to gender. Depending on the context, these references may refer to either genotypic or phenotypic gender. At the individual patient level, a variety of factors, including, but not limited to, gender identity and gender affirmation via surgery or hormonal manipulation, may affect the applicability of some InterQual criteria. This is most often the case with genetic testing and procedures that assume the presence of gender-specific anatomy. With these considerations in mind, all references to gender in InterQual have been reviewed and modified when appropriate. InterQual users should carefully consider issues related to patient genotype and anatomy, especially for transgender individuals, when appropriate.

2:
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, ECRI Guidelines Trust®, Agency for Healthcare Research and Quality (AHRQ) Comparative Effectiveness Reviews, the Cochrane Library, Choosing Wisely, Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, and the National Institute of Health and Care Excellence (NICE). 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.

3:
Whether to perform prophylactic oophorectomy at the time of hysterectomy done for benign disease in premenopausal women may be considered. 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 (Version 3.2019). 2019; National Comprehensive Cancer Network, The NCCN clinical practice guidelines in oncology, genetic/familial high-risk assessment: colorectal (Version 3.2019). 2019). BSO may also 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 reduces the risk of ovarian cancer without the development of surgical menopause (American College of Obstetrics and Gynecologists, Obstet Gynecol 2019, 133: e279-e84; Society of Gynecologic Oncology, SGO Clinical Practice Statement: Salpingectomy for Ovarian Cancer Prevention 2013).

4:
Although robotic-assisted hysterectomy is being done, there are few prospective studies comparing robotic assisted to laparoscopic surgery for treating benign disease (ACOG, Obstetrics and Gynecology Committee Opinion No. 628. 2015, 125: 760-7. Reaffirmed 2017; Yu et al., Journal of surgical oncology 2013, 107: 653-8). A Cochrane review, however, demonstrated that robotic-assisted gynecologic surgery required more intraoperative time but reduced hospital stay when compared to 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 (Lawrie et al., Cochrane Database Syst Rev 2019, 4: Cd011422).

5:
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.

6:
Vaginal hysterectomy offers many advantages to the abdominal or laparoscopic approach including no abdominal incision, less pain, and quicker recovery; if technically feasible, it is the preferred surgical route (American College of Obstetricians and Gynecologists (ACOG), Obstet Gynecol 2017, 129: e155-e9; Sesti et al., Archives of Gynecology and Obstetrics 2014, 290: 485-91). The vaginal technique, however, can be limited in its ability to treat ovarian pathology in 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.

7:
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

8:
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.

9:
I/O Setting:
Hysterectomy, Abdominal, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Abdominal, Total +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting
Hysterectomy, Laparoscopic, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Laparoscopic, Total (TLH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Vaginal +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting

10:
For cervical cancer stage I-IIA and endometrial cancer stage II, see the "Hysterectomy, Radical" criteria subset.

11:
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).

Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy

Hysterectomy + BSO for Suspected Ovarian or Tubal cancer

Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy

Hysterectomy + BSO for Suspected Ovarian or Tubal cancer

ICD-10-CM (circle all that apply): C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C56.1, C56.2, C56.3, C56.9, C57.00, C57.01, C57.02, C79.82, D06.0, D06.1, D06.7, D06.9, D25.0, D25.1, D25.2, D25.9, N70.01, N70.02, N70.03, N70.11, N70.12, N70.13, N70.91, N70.92, N70.93, N71.1, N71.9, N72, N73.1, N73.4, N73.8, N73.9, N80.0, N80.1, N80.2, N80.3, N80.4, N80.5, N80.6, N80.8, N80.9, N81.2, N81.3, N81.4, N85.00, N85.01, N85.02, N87.0, N87.1, N87.9, N92.1, N92.4, N92.5, N93.0, N93.1, N93.8, N93.9, N95.0, O01.0, O01.1, O01.9, O72.0, O72.1, O72.2, O72.3, R10.10, R10.11, R10.12, R10.13, R10.2, R10.30, R10.31, R10.32, R10.33, R10.811, R10.812, R10.813, R10.814, R10.815, R10.816, R10.817, R10.819, R10.821, R10.822, R10.823, R10.824, R10.825, R10.826, R10.827, R10.829, R10.83, R10.84, R10.9, R19.00, R19.01, R19.02, R19.03, R19.04, R19.05, R19.06, R19.07, R19.09, R93.5, Z14.8, Z15.01, Z15.02, Z15.04, Z15.09, Z15.89, Other _____

ICD-10-PCS (circle all that apply): 0UT20ZZ, 0UT24ZZ, 0UT70ZZ, 0UT74ZZ, 0UT90ZL, 0UT90ZZ, 0UT94ZL, 0UT94ZZ, 0UTC0ZZ, 0UTC4ZZ, Other _____

CPT® (circle all that apply): 58150, 58152, 58180, 58542, 58544, 58571, 58573, 58575, Other _____

InterQual®

2021, Oct. 2021 Release CP:Procedures

Subset: Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy [1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11]

Requested Service: Hysterectomy +/- BSO or Bilateral Salpingectomy for Abnormal uterine bleeding or Postmenopausal bleeding
Age: Age ≥ 18

Patient:	Name:	DOB:	ID #:	GROUP #:
	Sex (circle): M / F	Height:	Weight:	
Provider/PCP:	Name:	Fax #:	Phone #:	
	NPI/ID #:	Signature:		Date:
Servicing:	Vendor/Facility:		Phone #:	
	Diagnosis/ICD:	Service Date:	Authorization: / / to / /	

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ICD-10:

CPT®:

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

- ☐ 10. Abnormal uterine bleeding in premenopausal woman
- ☐ 20. Postmenopausal bleeding

☐ 10. Abnormal uterine bleeding in premenopausal woman

1. Choose all that apply:
   - ☐ A) Abnormal uterine bleeding [12]
   - ☐ B) Vagina and cervix normal by physical examination
   - ☐ C) Thyroid disease excluded by history or physical examination or testing [13]
   - ☐ D) Most recent cervical cytology normal or managed per guidelines [14]
   - ☐ E) Pregnancy excluded by negative human chorionic gonadotropin (HCG) or HCG planned prior to procedure or sterilization by history or patient not sexually active by history [15, 16, 17, 18]
   - ☐ F) Imaging or hysteroscopy within last year negative for endometrial lesion [19]
   - ☐ G) Other clinical information (add comment)

   • If the number of options selected is 6 and option G not selected, then go to question 2
   • No other options lead to the requested service

Abnormal uterine bleeding in premenopausal woman (continued...)

2. Choose one: (20)
   - ☐ A) Age < 45
   - ☐ B) Age ≥ 45

   • If option A selected, then go to question 3
   • If option B selected, then go to question 6

3. Choose all that apply: (21)
   - ☐ A) Bleeding interferes with ADLs
   - ☐ B) Anemia by history
   - ☐ C) Other clinical information (add comment)

   • If 1 or more options A or B selected and option C not selected, then go to question 4
   • No other options lead to the requested service

4. Treatment within last year, Choose all that apply:
   - ☐ A) Hormone therapy (22)
   - ☐ B) Tranexamic acid x3 consecutive cycles (23)
   - ☐ C) Endometrial ablation or resection (24)
   - ☐ D) Other clinical information (add comment)

   • If 1 or more options A, B or C selected and option D not selected, then go to question 5
   • No other options lead to the requested service

5. Continued bleeding after treatment
   - ☐ A) Yes
   - ☐ B) No

   • If option Yes selected, then the rule is satisfied; you may stop here (25)
   • No other options lead to the requested service

6. Endometrium normal within last year, Choose all that apply:
   - ☐ A) By endometrial biopsy
   - ☐ B) By hysteroscopy with dilatation and curettage (D & C)
   - ☐ C) Other clinical information (add comment)

   • If 1 or more options A or B selected and option C not selected, then go to question 7
   • No other options lead to the requested service

7. Choose all that apply: (21)
   - ☐ A) Bleeding interferes with ADLs
   - ☐ B) Anemia by history
   - ☐ C) Other clinical information (add comment)

   • If 1 or more options A or B selected and option C not selected, then go to question 8
   • No other options lead to the requested service

Abnormal uterine bleeding in premenopausal woman (continued...)

8. Treatment within last year, Choose all that apply:
   - ☐ A) Hormone therapy (22)
   - ☐ B) Tranexamic acid x3 consecutive cycles (23)
   - ☐ C) Endometrial ablation or resection (24)
   - ☐ D) Other clinical information (add comment)

   • If 1 or more options A, B or C selected and option D not selected, then go to question 9
   • No other options lead to the requested service

9. Continued bleeding after treatment
   - ☐ A) Yes
   - ☐ B) No

   • If option Yes selected, then the rule is satisfied; you may stop here (25)
   • No other options lead to the requested service

☐ 20. Postmenopausal bleeding

1. Choose all that apply:
   - ☐ A) Vagina and cervix normal by physical examination
   - ☐ B) Most recent cervical cytology normal or managed per guidelines (14)
   - ☐ C) Endometrium normal within last 3 months by biopsy and ultrasound
   - ☐ D) Other clinical information (add comment)

   • If the number of options selected is 3 and option D not selected, then go to question 2
   • No other options lead to the requested service

2. Currently taking hormone replacement therapy (26)
   - ☐ A) Yes
   - ☐ B) No

   • If option No selected, then the rule is satisfied; you may stop here (25)
   • If option Yes selected, then go to question 3

3. Continued abnormal bleeding after, Choose one: (27)
   - ☐ A) Change in hormone replacement therapy
   - ☐ B) Discontinuation of hormone replacement therapy
   - ☐ C) Other clinical information (add comment)

   • If option A or B selected, then the rule is satisfied; you may stop here (25)
   • No other options lead to the requested service

Reference

Ltd - This requested service is designated as 'Limited Evidence' in this clinical scenario. Criteria cannot be met.

2nd - Secondary review required. Criteria cannot be met.

Off-label - Use of a drug for an indication not approved by the U.S. Food and Drug Administration (FDA).

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3:
Whether to perform prophylactic oophorectomy at the time of hysterectomy done for benign disease in premenopausal women may be considered. 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 (Version 3.2019). 2019; National Comprehensive Cancer Network, The NCCN clinical practice guidelines in oncology, genetic/familial high-risk assessment: colorectal (Version 3.2019). 2019). BSO may also 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 reduces the risk of ovarian cancer without the development of surgical menopause (American College of Obstetrics and Gynecologists, Obstet Gynecol 2019, 133: e279-e84; Society of Gynecologic Oncology, SGO Clinical Practice Statement: Salpingectomy for Ovarian Cancer Prevention 2013).

4:
Although robotic-assisted hysterectomy is being done, there are few prospective studies comparing robotic assisted to laparoscopic surgery for treating benign disease (ACOG, Obstetrics and Gynecology Committee Opinion No. 628. 2015, 125: 760-7. Reaffirmed 2017; Yu et al., Journal of surgical oncology 2013, 107: 653-8). A Cochrane review, however, demonstrated that robotic-assisted gynecologic surgery required more intraoperative time but reduced hospital stay when compared to 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 (Lawrie et al., Cochrane Database Syst Rev 2019, 4: Cd011422).

5:
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.

6:
Vaginal hysterectomy offers many advantages to the abdominal or laparoscopic approach including no abdominal incision, less pain, and quicker recovery; if technically feasible, it is the preferred surgical route (American College of Obstetricians and Gynecologists (ACOG), Obstet Gynecol 2017, 129: e155-e9; Sesti et al., Archives of Gynecology and Obstetrics 2014, 290: 485-91). The vaginal technique, however, can be limited in its ability to treat ovarian pathology in 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.

7:
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

8:
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.

9:
I/O Setting:
Hysterectomy, Abdominal, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Abdominal, Total +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting
Hysterectomy, Laparoscopic, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Laparoscopic, Total (TLH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Vaginal +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting

10:
For cervical cancer stage I-IIA and endometrial cancer stage II, see the "Hysterectomy, Radical" criteria subset.

11:
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).

12:
Abnormal uterine bleeding includes menorrhagia (heavy and prolonged menses) and menometrorrhagia (heavy and prolonged bleeding during and between menses).

13:
Hypothyroidism or hyperthyroidism may cause a variety of menstrual irregularities such as menorrhagia (heavy and prolonged menses), amenorrhea (no menses), or oligomenorrhea (scant menses). Documentation to exclude a thyroid disorder as a cause of the bleeding may be performed at any time in the workup of the patient.

14:
Cervical cytology should be evaluated according to current screening protocols. Screening intervals and tests used (cervical cytology alone, high-risk human papillomavirus [hrHPV] testing alone, hrHPV and cytology together [co-testing]) will vary based on patient's age and risk factors. If the most recent cervical cytology is documented as normal, no further testing is needed. Any abnormalities detected during cervical cancer screening should be managed according to current guidelines. Management may include repeat testing, observation, surveillance, biopsy, ablation, or excisional treatment based on the identified level of risk for each patient (Redman et al., Eur J Obstet Gynecol Reprod Biol 2021, 256: 57-62; Perkins et al., J Low Genit Tract Dis 2020, 24: 102-31; US Preventative Services Task Force et al., JAMA 2018, 320: 674-86; Wentzensen et al., J Low Genit Tract Dis 2017, 21: 216-22).

15:
Pregnancy and related complications (e.g., ectopic pregnancy, incomplete abortion, inevitable abortion) must be excluded before performing this procedure.

16:
Pregnancy testing can be by measurement of either a serum or urine HCG and may be documented in the medical record by either the primary care physician, gynecologist, or surgeon.

17:
The documentation should include a history of sterilization (i.e., tubal ligation) without a subsequent pregnancy. These criteria do not include sterilization of a partner or alternate birth control methods (e.g., oral contraceptive pill use, intrauterine device insertion).

18:
Patients have varying definitions of sexual activity (e.g., number of partners, timing of most recent episode, frequency of sexual activity). Unless the provider can confirm on examination that the patient has never had sexual intercourse, whether a patient is sexually active or not is a matter of clinical judgment.

19:
Imaging studies (e.g., ultrasound, sonohysterogram) are performed to exclude a structural cause of the uterine bleeding. Direct examination by hysteroscopy can also evaluate and eliminate structural abnormalities.

20:
The incidence of endometrial cancer increases with age. Women over the age of 45 tend to have a worse prognosis and often have less differentiated, more advanced stage disease. Therefore, endometrial biopsy should be performed in women with abnormal uterine bleeding 45 years of age or older to exclude premalignant lesions, carcinoma, or other pathology that may cause bleeding (ACOG, Obstet Gynecol Practice Bulletin No. 128. 2012, 120: 197-206. Reaffirmed 2016; ACOG, Obstetrics and gynecology Practice Bulleting No. 136. 2013, 122: 176-185. Reaffirmed 2018). Biopsy may also be considered in women as young as 40 or in those whose bleeding does not improve with hormonal or other therapy (Singh et al., Journal of obstetrics and gynaecology Canada: JOGC 2013, 35: 473-9). If a hysterectomy is to be performed, the biopsy results will guide what type of surgery should be performed (ACOG, Obstetrics and gynecology Practice Bulleting No. 136. 2013, 122: 176-185. Reaffirmed 2018).

21:
Abnormal uterine bleeding is considered significant enough to warrant intervention when there is documented anemia by history (currently has anemia or has been treated for anemia related to the bleeding) or bleeding

significantly impacts quality of life. The International Federation of Gynecology and Obstetrics classification system for abnormal uterine bleeding provides a framework to evaluate and manage this condition. This system helps identify the cause of bleeding as either structural (e.g., polyp, adenomyosis, leiomyoma, malignancy/hyperplasia) or unrelated to structure (e.g., coagulopathy, ovulatory dysfunction, endometrial, iatrogenic) and then formulate an individual plan of care (Kolhe, Int J Womens Health 2018, 10: 127-36).

22:
Hormone therapy to treat abnormal uterine bleeding includes cyclic or continuous combined oral contraceptive or progestin only hormone therapy (ACOG, Obstetrics and gynecology Practice Bulletin No. 110. 2010, 115: 206-218. Reaffirmed 2018; ACOG, Obstetrics and gynecology Practice Bulleting No. 136. 2013, 122: 176-185. Reaffirmed 2018; Singh et al., Journal of obstetrics and gynaecology Canada: JOGC 2013, 35: 473-9). Oral medication, a dermal patch, or vaginal ring may be used. The levonorgestrel releasing intrauterine system has been shown to significantly reduce bleeding and cramping, and may be considered a first-line treatment for women with heavy abnormal bleeding (ACOG, Obstetrics and gynecology Practice Bulletin No. 110. 2010, 115: 206-218. Reaffirmed 2018; Gupta et al., N Engl J Med 2013, 368: 128-37; Heliovaara-Peippo et al., American journal of obstetrics and gynecology 2013, 209: 535 e1- e14; Singh et al., Journal of obstetrics and gynaecology Canada: JOGC 2013, 35: 473-9). For those who cannot tolerate or did not have success on other therapies or who are not surgical candidates, danazol and GnRH agonists may be options (Singh et al., Journal of obstetrics and gynaecology Canada: JOGC 2013, 35: 473-9).

23:
Tranexamic acid is an antifibrinolytic taken during menstruation and has been shown to be an effective treatment to decrease heavy abnormal uterine bleeding and improve quality of life (Singh et al., Journal of obstetrics and gynaecology Canada: JOGC 2013, 35: 473-9).

24:
If medical therapy fails or is not an option for abnormal uterine bleeding, hysteroscopic endometrial resection or ablation may be performed as an alternative to hysterectomy (Fergusson et al., Cochrane Database Syst Rev 2019, 8: Cd000329; Obstet Gynecol Practice Bulletin No. 81 2007; 109(5): 1233-1248. Reaffirmed 2018).
Nonhysteroscopic techniques for endometrial ablation (e.g., thermal balloon, cryoablation, microwave, electrode ablation) have also been shown to be beneficial for the treatment of abnormal uterine bleeding (Fergusson et al., Cochrane Database Syst Rev 2019, 8: Cd000329; Singh et al., Journal of obstetrics and gynaecology Canada: JOGC 2013, 35: 473-9).

25:
I/O Setting:
Hysterectomy, Abdominal, Supracervical +/- Bilateral Salpingo-oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Abdominal, Total +/- Bilateral Salpingo-oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) +/- Bilateral Salpingo-oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting
Hysterectomy, Laparoscopic, Supracervical +/- Bilateral Salpingo-oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Laparoscopic, Total (TLH) +/- Bilateral Salpingo-oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Vaginal +/- Bilateral Salpingo-oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting

26:
The risks and benefits of long-term hormone replacement therapy use should be carefully considered for each patient, as the benefit changes with age, menopausal symptoms, comorbidities, and the presence of risk factors for adverse outcomes (e.g., stroke, coronary artery disease). Review of major studies, such as the Heart and Estrogen/Progestin Replacement Study Follow-Up (HERS) and the Women's Health Initiative (WHI), indicates the risk-benefit ratio for hormone therapy is most favorable if it is initiated closer to menopause. This benefit decreases in older women and in women who are more temporally removed from menopause (North American Menopause Society, Menopause 2017, 24: 728-53).

27:

Postmenopausal bleeding should always be investigated, as it could be a sign of endometrial cancer (American College of Obstetricians and Gynecologists, Obstet Gynecol 2018, 131: 945-6; ACOG, Obstetrics and gynecology ACOG Practice Bulletin No. 149, 2015, 125: 1006-26. Reaffirmed 2019; Khati et al., ACR Appropriateness Criteria((R)) Abnormal Vaginal Bleeding. 2014). Postmenopausal bleeding is defined as bleeding after 1 year of amenorrhea in a woman not receiving hormone replacement therapy or unexpected bleeding in patients receiving cyclic hormone therapy or bleeding after 1 year of continuous hormone therapy.

Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy

Hysterectomy +/- BSO or Bilateral Salpingectomy for Abnormal uterine bleeding or Postmenopausal bleeding

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ICD-10-CM (circle all that apply): C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C56.1, C56.2, C56.3, C56.9, C57.00, C57.01, C57.02, C79.82, D06.0, D06.1, D06.7, D06.9, D25.0, D25.1, D25.2, D25.9, N70.01, N70.02, N70.03, N70.11, N70.12, N70.13, N70.91, N70.92, N70.93, N71.1, N71.9, N72, N73.1, N73.4, N73.8, N73.9, N80.0, N80.1, N80.2, N80.3, N80.4, N80.5, N80.6, N80.8, N80.9, N81.2, N81.3, N81.4, N85.00, N85.01, N85.02, N87.0, N87.1, N87.9, N92.1, N92.4, N92.5, N93.0, N93.1, N93.8, N93.9, N95.0, O01.0, O01.1, O01.9, O72.0, O72.1, O72.2, O72.3, R10.10, R10.11, R10.12, R10.13, R10.2, R10.30, R10.31, R10.32, R10.33, R10.811, R10.812, R10.813, R10.814, R10.815, R10.816, R10.817, R10.819, R10.821, R10.822, R10.823, R10.824, R10.825, R10.826, R10.827, R10.829, R10.83, R10.84, R10.9, R19.00, R19.01, R19.02, R19.03, R19.04, R19.05, R19.06, R19.07, R19.09, R93.5, Z14.8, Z15.01, Z15.02, Z15.04, Z15.09, Z15.89, Other _____

ICD-10-PCS (circle all that apply): 0UT20ZZ, 0UT24ZZ, 0UT27ZZ, 0UT28ZZ, 0UT2FZZ, 0UT70ZZ, 0UT74ZZ, 0UT77ZZ, 0UT78ZZ, 0UT7FZZ, 0UT90ZL, 0UT90ZZ, 0UT94ZL, 0UT94ZZ, 0UT97ZL, 0UT97ZZ, 0UT98ZL, 0UT98ZZ, 0UT9FZL, 0UT9FZZ, 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ, Other _____

CPT® (circle all that apply): 58150, 58152, 58180, 58260, 58262, 58263, 58290, 58291, 58292, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58575, Other _____

InterQual®

2021, Oct. 2021 Release CP:Procedures

Subset: Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy [1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11]

Requested Service: Hysterectomy +/- BSO or Bilateral Salpingectomy for Adenomyosis or Fibroids

Age: Age ≥ 18

Patient:	Name:	DOB:	ID #:	GROUP #:
	Sex (circle): M / F	Height:	Weight:	
Provider/PCP:	Name:	Fax #:	Phone #:	
	NPI/ID #:	Signature:		Date:
Servicing:	Vendor/Facility:		Phone #:	
	Diagnosis/ICD:	Service Date:	Authorization: / / to / /	

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ICD-10:

CPT®:

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

- ☐ 10. Adenomyosis suspected by imaging
- ☐ 20. Fibroids by imaging in postmenopausal woman
- ☐ 30. Fibroids by imaging in premenopausal woman

☐ 10. Adenomyosis suspected by imaging

1. Choose one: [12]
   - ☐ A) Abnormal bleeding [13]
   - ☐ B) Pelvic or abdominal pain or discomfort and other etiologies excluded [14]
   - ☐ C) Urinary frequency or urgency and other etiologies excluded
   - ☐ D) Dyspareunia [15]
   - ☐ E) Other clinical information (add comment)

• If option A selected, then go to question 2 • If option B, C or D selected, then go to question 4 • No other options lead to the requested service

Adenomyosis suspected by imaging (continued...)

2. Choose all that apply: (16)
   - ☐ A) Vagina and cervix normal by physical examination
   - ☐ B) Pregnancy excluded by negative HCG or HCG planned prior to procedure or sterilization by history or patient not sexually active by history
   - ☐ C) Other clinical information (add comment)

   • If the number of options selected is 2 and option C not selected, then go to question 3
   • No other options lead to the requested service

3. Choose all that apply: (17)
   - ☐ A) Bleeding interferes with ADLs
   - ☐ B) Anemia by history
   - ☐ C) Other clinical information (add comment)

   • If 1 or more options A or B selected and option C not selected, then go to question 4
   • No other options lead to the requested service

4. Treatment within last year, Choose all that apply: (18)
   - ☐ A) NSAIDs ≥ 8 weeks
   - ☐ B) GnRH agonist ≥ 8 weeks (19)
   - ☐ C) Hormone therapy ≥ 8 weeks
   - ☐ D) Uterine artery embolization
   - ☐ E) Other clinical information (add comment)

   • If 1 or more options A, B, C or D selected and option E not selected, then go to question 5
   • No other options lead to the requested service

5. Continued symptoms or findings after treatment
   - ☐ A) Yes
   - ☐ B) No

   • If option Yes selected, then go to question 6
   • No other options lead to the requested service

6. Choose all that apply:
   - ☐ A) Most recent cervical cytology normal or managed per guidelines (20)
   - ☐ B) Pregnancy excluded by negative HCG or HCG planned prior to procedure or sterilization by history or patient not sexually active by history (21, 22, 23, 24)
   - ☐ C) Other clinical information (add comment)

   • If the number of options selected is 2 and option C not selected, then the rule is satisfied; you may stop here (25)
   • No other options lead to the requested service

☐ 20. Fibroids by imaging in postmenopausal woman

Fibroids by imaging in postmenopausal woman (continued...)

1. Choose all that apply: (26, 27)
   - ▢ A) Uterine size doubled by ultrasound within 1 year
   - ▢ B) Ureteral compression by imaging (28)
   - ▢ C) Pelvic or abdominal pain or discomfort and other etiologies excluded
   - ▢ D) Urinary frequency or urgency and other etiologies excluded
   - ▢ E) Dyspareunia and other etiologies excluded (15)
   - ▢ F) Other clinical information (add comment)

   • If 1 or more options A, B, C, D or E selected and option F not selected, then go to question 2
   • No other options lead to the requested service

2. Most recent cervical cytology normal or managed per guidelines (20)
   - ▢ A) Yes
   - ▢ B) No

   • If option Yes selected, then go to question 3
   • No other options lead to the requested service

3. Laparoscopic power morcellation planned with hysterectomy (29)
   - ▢ A) Yes
   - ▢ B) No

   • If option No selected, then the rule is satisfied; you may stop here (25)
   • No other options lead to the requested service

▢ 30. Fibroids by imaging in premenopausal woman

1. Choose one: (27)
   - ▢ A) Abnormal uterine bleeding with anemia by history or interferes with ADLs (13, 17)
   - ▢ B) Uterine size doubled by ultrasound (US) within 1 year (30)
   - ▢ C) Ureteral compression by imaging (28)
   - ▢ D) Pelvic or abdominal pain or discomfort and other etiologies excluded
   - ▢ E) Urinary frequency or urgency and other etiologies excluded
   - ▢ F) Dyspareunia and other etiologies excluded (15)
   - ▢ G) Other clinical information (add comment)

   • If option A selected, then go to question 2
   • If option B, C, D, E or F selected, then go to question 3
   • No other options lead to the requested service

2. Vagina and cervix normal by physical examination (31)
   - ▢ A) Yes
   - ▢ B) No

   • If option Yes selected, then go to question 3
   • No other options lead to the requested service

Fibroids by imaging in premenopausal woman (continued...)

3. Choose all that apply:
   - ☐ A) Most recent cervical cytology normal or managed per guidelines [20]
   - ☐ B) Pregnancy excluded by negative HCG or HCG planned prior to procedure or sterilization by history or patient not sexually active by history [21, 22, 23, 24]
   - ☐ C) Other clinical information (add comment)

   - If the number of options selected is 2 and option C not selected, then go to question 4
   - No other options lead to the requested service

4. Laparoscopic power morcellation planned with hysterectomy [32, 33]
   - ☐ A) Yes
   - ☐ B) No

   - If option No selected, then the rule is satisfied; you may stop here [25]
   - If option Yes selected, then go to question 5

5. Choose all that apply:
   - ☐ A) No known or suspected malignancy by testing in tissue to be morcellated [34]
   - ☐ B) Not a candidate for **en bloc** or intact tissue removal [35]
   - ☐ C) Other clinical information (add comment)

   - If the number of options selected is 2 and option C not selected, then go to question 6
   - No other options lead to the requested service

6. Increased risk for uterine malignancy, Choose one:
   - ☐ A) Pelvic irradiation by history
   - ☐ B) Tamoxifen use by history
   - ☐ C) Lynch ll syndrome
   - ☐ D) Hereditary leiomyomatosis and renal cell cancer
   - ☐ E) Childhood retinoblastoma by history
   - ☐ F) Postmenopausal with fibroids by imaging [36]
   - ☐ G) None of the above, more choices

   - If option G selected, then go to question 7
   - No other options lead to the requested service

7. Risks and benefits of morcellation discussed with patient [37]
   - ☐ A) Yes
   - ☐ B) No

   - If option Yes selected, then the rule is satisfied; you may stop here [25]
   - No other options lead to the requested service

Reference

Ltd - This requested service is designated as 'Limited Evidence' in this clinical scenario. Criteria cannot be met.

2nd - Secondary review required. Criteria cannot be met.

Off-label - Use of a drug for an indication not approved by the U.S. Food and Drug Administration (FDA).

Notes:

1:
InterQual® content contains numerous references to gender. Depending on the context, these references may refer to either genotypic or phenotypic gender. At the individual patient level, a variety of factors, including, but not limited to, gender identity and gender affirmation via surgery or hormonal manipulation, may affect the applicability of some InterQual criteria. This is most often the case with genetic testing and procedures that assume the presence of gender-specific anatomy. With these considerations in mind, all references to gender in InterQual have been reviewed and modified when appropriate. InterQual users should carefully consider issues related to patient genotype and anatomy, especially for transgender individuals, when appropriate.

2:
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, ECRI Guidelines Trust®, Agency for Healthcare Research and Quality (AHRQ) Comparative Effectiveness Reviews, the Cochrane Library, Choosing Wisely, Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, and the National Institute of Health and Care Excellence (NICE). 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.

3:
Whether to perform prophylactic oophorectomy at the time of hysterectomy done for benign disease in premenopausal women may be considered. 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 (Version 3.2019). 2019; National Comprehensive Cancer Network, The NCCN clinical practice guidelines in oncology, genetic/familial high-risk assessment: colorectal (Version 3.2019). 2019). BSO may also 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 reduces the risk of ovarian cancer without the development of surgical menopause (American College of Obstetrics and Gynecologists, Obstet Gynecol 2019, 133: e279-e84; Society of Gynecologic Oncology, SGO Clinical Practice Statement: Salpingectomy for Ovarian Cancer Prevention 2013).

4:
Although robotic-assisted hysterectomy is being done, there are few prospective studies comparing robotic assisted to laparoscopic surgery for treating benign disease (ACOG, Obstetrics and Gynecology Committee Opinion No. 628. 2015, 125: 760-7. Reaffirmed 2017; Yu et al., Journal of surgical oncology 2013, 107: 653-8). A Cochrane review, however, demonstrated that robotic-assisted gynecologic surgery required more intraoperative time but reduced hospital stay when compared to 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 (Lawrie et al., Cochrane Database Syst Rev 2019, 4: Cd011422).

5:
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.

6:
Vaginal hysterectomy offers many advantages to the abdominal or laparoscopic approach including no abdominal incision, less pain, and quicker recovery; if technically feasible, it is the preferred surgical route (American College of Obstetricians and Gynecologists (ACOG), Obstet Gynecol 2017, 129: e155-e9; Sesti et al., Archives of Gynecology and Obstetrics 2014, 290: 485-91). The vaginal technique, however, can be limited in its ability to treat ovarian pathology in 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.

7:
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

8:
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.

9:
I/O Setting:
Hysterectomy, Abdominal, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Abdominal, Total +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting
Hysterectomy, Laparoscopic, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Laparoscopic, Total (TLH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Vaginal +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting

10:
For cervical cancer stage I-IIA and endometrial cancer stage II, see the "Hysterectomy, Radical" criteria subset.

11:
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).

12:
There are no symptoms that are pathognomonic for adenomyosis and many of the symptoms are associated with other common gynecologic disorders (e.g., fibroids, abnormal uterine bleeding, endometriosis).

13:
Abnormal uterine bleeding includes menorrhagia (heavy and prolonged menses) and menometrorrhagia (heavy and prolonged bleeding during and between menses).

14:
The pain associated with adenomyosis is varied and includes cramping that may begin days or weeks prior to menses, dyspareunia, or dysuria.

15:
Dyspareunia is difficult or painful sexual intercourse.

16:
A history and laboratory assessment to evaluate vaginal bleeding can help exclude systemic conditions, coagulopathy, and medication or thyroid dysfunction, while the physical examination excludes vaginal or cervical causes of bleeding.

17:
Abnormal uterine bleeding is considered significant enough to warrant intervention when there is documented anemia by history (currently has anemia or has been treated for anemia related to the bleeding) or bleeding significantly impacts quality of life. The International Federation of Gynecology and Obstetrics classification system for abnormal uterine bleeding provides a framework to evaluate and manage this condition. This system helps identify the cause of bleeding as either structural (e.g., polyp, adenomyosis, leiomyoma, malignancy/hyperplasia) or unrelated to structure (e.g., coagulopathy, ovulatory dysfunction, endometrial, iatrogenic) and then formulate an individual plan of care (Kolhe, Int J Womens Health 2018, 10: 127-36).

18:
Although hysterectomy is an effective treatment for symptomatic adenomyosis, medical treatment options include progestin, the levonorgestrel intra-uterine system, GnRH agonists, and nonsteroidal anti-inflammatory drugs (ACOG, Obstetrics and gynecology Practice Bulletin No. 110. 2010, 115: 206-218. Reaffirmed 2018; Streuli et al., Expert opinion on pharmacotherapy 2014, 15: 2347-60). Surgical options include uterine artery embolization and uterine artery occlusion with partial resection (Nijenhuis et al., Cardiovascular and interventional radiology 2015, 38: 65-71; Liu et al., European journal of obstetrics, gynecology, and reproductive biology 2014, 176: 20-4; Smeets et al., Cardiovascular and interventional radiology 2012, 35: 815-9).

19:
The GnRH agonists include leuprolide, nafarelin, and goserelin. These compounds mimic the action of GnRH and, thereby, suppress the hormones produced by the ovary that stimulate endometrial growth.

20:
Cervical cytology should be evaluated according to current screening protocols. Screening intervals and tests used (cervical cytology alone, high-risk human papillomavirus [hrHPV] testing alone, hrHPV and cytology together [co-testing]) will vary based on patient's age and risk factors. If the most recent cervical cytology is documented as normal, no further testing is needed. Any abnormalities detected during cervical cancer screening should be managed according to current guidelines. Management may include repeat testing, observation, surveillance, biopsy, ablation, or excisional treatment based on the identified level of risk for each patient (Redman et al., Eur J Obstet Gynecol Reprod Biol 2021, 256: 57-62; Perkins et al., J Low Genit Tract Dis 2020, 24: 102-31; US Preventative Services Task Force et al., JAMA 2018, 320: 674-86; Wentzensen et al., J Low Genit Tract Dis 2017, 21: 216-22).

21:
Pregnancy and related complications (e.g., ectopic pregnancy, incomplete abortion, inevitable abortion) must be excluded before performing this procedure.

22:
Pregnancy testing can be performed by measurement of either a serum or urine HCG and may be documented in the medical record by either the PCP, a gynecologist, or a surgeon.

23:
The documentation should include a history of sterilization (i.e., tubal ligation) without a subsequent pregnancy. These criteria do not include sterilization of a partner or alternate birth control methods (e.g., oral contraceptive pill use, intrauterine device insertion).

24:
Patients have varying definitions of sexual activity (e.g., number of partners, timing of most recent episode, frequency of sexual activity). Unless the provider can confirm on examination that the patient has never had sexual intercourse, whether a patient is sexually active or not is a matter of clinical judgment.

25:
I/O Setting:
Hysterectomy, Abdominal, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Abdominal, Total +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy- Inpatient
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting
Hysterectomy, Laparoscopic, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Laparoscopic, Total (TLH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Vaginal +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting

26:
If fibroids are associated with postmenopausal bleeding, see the "Postmenopausal bleeding" indication within this criteria subset.

27:
Common pelvic pressure symptoms associated with uterine fibroids include pain, pressure, dyspareunia, and urinary frequency or urgency. These symptoms must be directly attributed to uterine enlargement due to fibroids and other potential causes need to be excluded prior to surgical intervention.

28:
Ureteral compression may be seen at the time of ultrasound.

29:
Power morcellation, which causes intraperitoneal dissemination of myometrium, should never be done for fibroids in postmenopausal women because the incidence of cancer is higher in these women (American College of Obstetricians and Gynecologists, Obstet Gynecol 2019, 133: e238-e48; U.S. Food and Drug Administration (FDA), Updated Assessment of The Use of Laparoscopic Power Morcellators to Treat Uterine Fibroids, December 2017).

30:
Rapid growth of uterine fibroids alone in premenopausal women is not a reliable sign of malignant transformation. Uterine sarcoma is rare and the symptoms are similar to benign fibroids. Imaging and endometrial biopsy may help with the diagnosis, but it is often discovered postoperatively.

31:
Abnormal uterine bleeding due to vaginal, cervical, endometrial, or ovarian conditions may raise the suspicion of malignancy. Bleeding from conditions other than fibroids (e.g., polyps, malignancy) should be excluded prior to the procedure. Testing preprocedure to exclude other etiologies of bleeding may include evaluation for cervical pathology (e.g., Pap smear), imaging, and in some cases endometrial biopsy.

32:
When performing a totally laparoscopic or vaginal procedure, it may be necessary to divide, or morcellate, the specimen to remove it. There is concern that morcellation may result in contamination of the wound, which can lead to upstaging of occult malignancy, iatrogenic endometriosis, or parasitic leiomyomata. The Food and Drug Administration (FDA) reports there is evidence for differences in disease recurrence and survival between women undergoing morcellation and those who do not (U.S. Food and Drug Administration (FDA), Updated Assessment of The Use of Laparoscopic Power Morcellators to Treat Uterine Fibroids, December 2017; Beckmann et al., Geburtshilfe und Frauenheilkunde 2015, 75: 148-64; Pereira et al., Journal of minimally invasive gynecology 2015, 22: 163-76; Siedhoff et al., American journal of obstetrics and gynecology 2015, 212: 591 e1-8; Singh et al., J Obstet Gynaecol Can 2015, 37: 68-81; Vilos et al., Journal of obstetrics and gynaecology Canada: JOGC 2015, 37: 157-81; American Association of Gynecologic Laparoscopists, Journal of minimally invasive gynecology AAGL practice report Morcellation 2014, 21: 517-30). Cohort studies and meta-analyses show a low prevalence of occult malignancy in hysterectomy and myomectomy specimens, including specimens that have undergone morcellation (Bojahr et al., Arch Gynecol Obstet 2015, 292(3): 665-72; Brohl et al., The Oncologist 2015, 20: 433-9; Lieng et al., Journal of minimally invasive gynecology 2015, 22: 410-4; Mahnert et al., Obstetrics and gynecology 2015, 125: 397-405; Singh et al., J Obstet Gynaecol Can 2015, 37: 68-81; Tan-Kim et al., American journal of obstetrics and gynecology 2015, 212: 594 e1-10; Wright et al., JAMA 2014, 312: 1253-5). Data regarding the risk of upstaging of occult malignancy are mixed (Beckmann et al., Geburtshilfe und Frauenheilkunde 2015, 75: 148-64; Bojahr et al., Arch Gynecol Obstet 2015, 292(3): 665-72; Pritts et al., Journal of minimally invasive gynecology 2015, 22: 26-33; George et al., Cancer 2014, 120: 3154-8). The American College of Obstetricians and Gynecologist and others maintains that, with proper evaluation and limiting morcellation to nonmalignant conditions, minimally invasive surgery continues to have a place in the treatment of fibroids (Brolmann et al., Gynecol Surg 2015, 12: 3-15; Singh et al., J Obstet Gynaecol Can 2015, 37: 68-81; ACOG, Power Morcellation and Occult Malignancy in Gynecologic Surgery: A Special Report. 2014). The FDA recommends against the use of laparoscopic power morcellators during myomectomy or hysterectomy when the tissue to be morcellated is known or suspected to contain malignancy, in women who are peri- or post-menopausal with uterine tissue that contains suspected fibroids, or in candidates for en bloc tumor resection or intact tissue removal by a vaginal, laparoscopic port, or mini-laparotomy approach (U.S. Food and Drug Administration (FDA), Updated Assessment of The Use of Laparoscopic Power Morcellators to Treat Uterine Fibroids, December 2017). Additional contraindications to morcellation include known or suspected malignancy, prophylactic surgery for high cancer risk genetic conditions, and history of therapy known to increase cancer risk, such as radiation or tamoxifen (Sizzi et al., Eur J Obstet Gynecol Reprod Biol 2018, 220: 30-8; U.S. Food and Drug Administration (FDA), Updated Assessment of The Use of Laparoscopic Power Morcellators to Treat Uterine Fibroids, December 2017; Beckmann et al., Geburtshilfe und Frauenheilkunde 2015, 75: 148-64; Singh et al., J Obstet Gynaecol Can 2015, 37: 68-81; American Association of Gynecologic Laparoscopists, Journal of minimally invasive gynecology AAGL practice report Morcellation 2014, 21: 517-30; American Urogynecologic Society, AUGS position statement on Power Morcellation 2014).

33:
The Food and Drug Administration safety warning addresses the risks associated with laparoscopic power morcellators that are inserted into the peritoneal cavity and not those that are inserted into the uterus via hysteroscope. These are considered different procedures with different risk profiles. There is no evidence that hysteroscopic morcellation results in the spread of malignant cells (U.S. Food and Drug Administration (FDA), Updated Assessment of The Use of Laparoscopic Power Morcellators to Treat Uterine Fibroids, December 2017; National Institute for Health and Clinical Excellence (NICE). Hysteroscopic morcellation of uterine leiomyomas (fibroids), June 2015).

34:
Prior to hysterectomy or myomectomy with morcellation, women should be evaluated for coexisting uterine or cervical malignancy. Preoperative evaluation for uterine sarcomas has limitations and cannot reliably detect unexpected cancers; however, suspected or known uterine cancer should not be removed by morcellation. In addition to cervical cytology, endometrial assessment may include tissue sampling, ultrasound, or MRI. CT and PET are less effective in differentiating between leiomyoma and uterine leiomyosarcoma (American College of Obstetricians and Gynecologists, Obstet Gynecol 2019, 133: e238-e48; Sizzi et al., Eur J Obstet Gynecol Reprod Biol 2018, 220: 30-8; U.S. Food and Drug Administration (FDA), Updated Assessment of The Use of Laparoscopic Power Morcellators to Treat Uterine Fibroids, December 2017).

35:
En bloc tissue removal or removing tissue as an intact specimen reduces the risk of dissemination and upstaging an

occult sarcoma. Routine use of laparoscopic power morcellators is not recommended when en bloc resection through a vaginal, laparoscopic, or mini-laparotomy approach is a viable option (U.S. Food and Drug Administration (FDA), Updated Assessment of The Use of Laparoscopic Power Morcellators to Treat Uterine Fibroids, December 2017; ACOG, Power Morcellation and Occult Malignancy in Gynecologic Surgery: A Special Report. 2014).

36:
Increased age is considered a risk factor for the development of uterine sarcoma. Therefore, peri- or postmenopausal women with uterine tissue containing fibroids should not undergo laparoscopic power morcellation (American College of Obstetricians and Gynecologists, Obstet Gynecol 2019, 133: e238-e48; U.S. Food and Drug Administration (FDA), Updated Assessment of The Use of Laparoscopic Power Morcellators to Treat Uterine Fibroids, December 2017).

37:
Patients should be counseled regarding the benefits, risks (including the potential for the spread of occult malignancy which may decrease survival), and alternatives when morcellation is planned (American College of Obstetricians and Gynecologists, Obstet Gynecol 2019, 133: e238-e48; U.S. Food and Drug Administration (FDA), Updated Assessment of The Use of Laparoscopic Power Morcellators to Treat Uterine Fibroids, December 2017; Vilos et al., Journal of obstetrics and gynaecology Canada: JOGC 2015, 37: 157-81).

Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy

Hysterectomy +/- BSO or Bilateral Salpingectomy for Adenomyosis or Fibroids

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ICD-10-CM (circle all that apply): C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C56.1, C56.2, C56.3, C56.9, C57.00, C57.01, C57.02, C79.82, D06.0, D06.1, D06.7, D06.9, D25.0, D25.1, D25.2, D25.9, N70.01, N70.02, N70.03, N70.11, N70.12, N70.13, N70.91, N70.92, N70.93, N71.1, N71.9, N72, N73.1, N73.4, N73.8, N73.9, N80.0, N80.1, N80.2, N80.3, N80.4, N80.5, N80.6, N80.8, N80.9, N81.2, N81.3, N81.4, N85.00, N85.01, N85.02, N87.0, N87.1, N87.9, N92.1, N92.4, N92.5, N93.0, N93.1, N93.8, N93.9, N95.0, O01.0, O01.1, O01.9, O72.0, O72.1, O72.2, O72.3, R10.10, R10.11, R10.12, R10.13, R10.2, R10.30, R10.31, R10.32, R10.33, R10.811, R10.812, R10.813, R10.814, R10.815, R10.816, R10.817, R10.819, R10.821, R10.822, R10.823, R10.824, R10.825, R10.826, R10.827, R10.829, R10.83, R10.84, R10.9, R19.00, R19.01, R19.02, R19.03, R19.04, R19.05, R19.06, R19.07, R19.09, R93.5, Z14.8, Z15.01, Z15.02, Z15.04, Z15.09, Z15.89, Other _____

ICD-10-PCS (circle all that apply): 0UT20ZZ, 0UT24ZZ, 0UT27ZZ, 0UT28ZZ, 0UT2FZZ, 0UT70ZZ, 0UT74ZZ, 0UT77ZZ, 0UT78ZZ, 0UT7FZZ, 0UT90ZL, 0UT90ZZ, 0UT94ZL, 0UT94ZZ, 0UT97ZL, 0UT97ZZ, 0UT98ZL, 0UT98ZZ, 0UT9FZL, 0UT9FZZ, 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ, Other _____

CPT® (circle all that apply): 58150, 58152, 58180, 58260, 58262, 58263, 58290, 58291, 58292, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58575, Other _____

InterQual®

2021, Oct. 2021 Release CP:Procedures

Subset: Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy [1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11]

Requested Service: Hysterectomy +/- BSO or Bilateral Salpingectomy for Chronic abdominal or pelvic pain
Age: Age ≥ 18

Patient:	Name:	DOB:	ID #:	GROUP #:
	Sex (circle): M / F	Height:	Weight:	
Provider/PCP:	Name:	Fax #:	Phone #:	
	NPI/ID #:	Signature:		Date:
Servicing:	Vendor/Facility:		Phone #:	
	Diagnosis/ICD:	Service Date:	Authorization: / / to / /	

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ICD-10:

CPT®:

INSTRUCTIONS: Answer the following questions

☐ 10. Chronic abdominal or pelvic pain, unknown etiology

1. Choose all that apply:
   - ☐ A) History and physical examination nondiagnostic for etiology of pain
   - ☐ B) CBC normal
   - ☐ C) Urinalysis or urine culture normal
   - ☐ D) Most recent cervical cytology normal or managed per guidelines [12]
   - ☐ E) Pregnancy excluded by negative human chorionic gonadotropin (HCG) or HCG planned prior to procedure or sterilization by history or patient not sexually active by history [13, 14, 15, 16]
   - ☐ F) Ultrasound within last year nondiagnostic for etiology of pain
   - ☐ G) Other clinical information (add comment)

   • If the number of options selected is 6 and option G not selected, then go to question 2
   • No other options lead to the requested service

2. Testing within last year nondiagnostic for etiology of pain, Choose all that apply:
   - ☐ A) CT or MRI
   - ☐ B) Diagnostic laparoscopy [17]
   - ☐ C) Other clinical information (add comment)

   • If 1 or more options A or B selected and option C not selected, then go to question 3
   • No other options lead to the requested service

EXHIBIT 19

Chronic abdominal or pelvic pain, unknown etiology (continued...)

3. Treatment within last year, Choose all that apply: (18)
   - ☐ A) NSAIDs ≥ 4 weeks
   - ☐ B) Hormone therapy ≥ 8 weeks (19)
   - ☐ C) GnRH agonist ≥ 8 weeks (20)
   - ☐ D) Antibiotic treatment x1 course
   - ☐ E) Other clinical information (add comment)

   • If 1 or more options A, B, C or D selected and option E not selected, then go to question 4
   • No other options lead to the requested service

4. Continued pain after treatment
   - ☐ A) Yes
   - ☐ B) No

   • If option Yes selected, then the rule is satisfied; you may stop here Ltd 2nd (21, 22, 23)
   • No other options lead to the requested service

Reference

Ltd - This requested service is designated as 'Limited Evidence' in this clinical scenario. Criteria cannot be met.

2nd - Secondary review required. Criteria cannot be met.

Off-label - Use of a drug for an indication not approved by the U.S. Food and Drug Administration (FDA).

Notes:

1:
InterQual® content contains numerous references to gender. Depending on the context, these references may refer to either genotypic or phenotypic gender. At the individual patient level, a variety of factors, including, but not limited to, gender identity and gender affirmation via surgery or hormonal manipulation, may affect the applicability of some InterQual criteria. This is most often the case with genetic testing and procedures that assume the presence of gender-specific anatomy. With these considerations in mind, all references to gender in InterQual have been reviewed and modified when appropriate. InterQual users should carefully consider issues related to patient genotype and anatomy, especially for transgender individuals, when appropriate.

2:
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, ECRI Guidelines Trust®, Agency for Healthcare Research and Quality (AHRQ) Comparative Effectiveness Reviews, the Cochrane Library, Choosing Wisely, Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, and the National Institute of Health and Care Excellence (NICE). 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.

3:
Whether to perform prophylactic oophorectomy at the time of hysterectomy done for benign disease in premenopausal women may be considered. 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 (Version 3.2019). 2019; National Comprehensive Cancer Network, The NCCN clinical practice guidelines in oncology, genetic/familial high-risk assessment: colorectal (Version 3.2019). 2019). BSO may also 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 reduces the risk of ovarian cancer without the development of surgical menopause (American College of Obstetrics and Gynecologists, Obstet Gynecol 2019, 133: e279-e84; Society of Gynecologic Oncology, SGO Clinical Practice Statement: Salpingectomy for Ovarian Cancer Prevention 2013).

4:
Although robotic-assisted hysterectomy is being done, there are few prospective studies comparing robotic assisted to laparoscopic surgery for treating benign disease (ACOG, Obstetrics and Gynecology Committee Opinion No. 628. 2015, 125: 760-7. Reaffirmed 2017; Yu et al., Journal of surgical oncology 2013, 107: 653-8). A Cochrane review, however, demonstrated that robotic-assisted gynecologic surgery required more intraoperative time but reduced hospital stay when compared to 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 (Lawrie et al., Cochrane Database Syst Rev 2019, 4: Cd011422).

5:
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.

6:
Vaginal hysterectomy offers many advantages to the abdominal or laparoscopic approach including no abdominal incision, less pain, and quicker recovery; if technically feasible, it is the preferred surgical route (American College of Obstetricians and Gynecologists (ACOG), Obstet Gynecol 2017, 129: e155-e9; Sesti et al., Archives of Gynecology and Obstetrics 2014, 290: 485-91). The vaginal technique, however, can be limited in its ability to treat ovarian pathology in 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.

7:
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

8:
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.

9:
I/O Setting:
Hysterectomy, Abdominal, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Abdominal, Total +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting
Hysterectomy, Laparoscopic, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Laparoscopic, Total (TLH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Vaginal +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting

10:
For cervical cancer stage I-IIA and endometrial cancer stage II, see the "Hysterectomy, Radical" criteria subset.

11:
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).

12:
Cervical cytology should be evaluated according to current screening protocols. Screening intervals and tests used (cervical cytology alone, high-risk human papillomavirus [hrHPV] testing alone, hrHPV and cytology together [co-testing]) will vary based on patient's age and risk factors. If the most recent cervical cytology is documented as normal, no further testing is needed. Any abnormalities detected during cervical cancer screening should be managed according to current guidelines. Management may include repeat testing, observation, surveillance, biopsy, ablation, or excisional treatment based on the identified level of risk for each patient (Redman et al., Eur J Obstet Gynecol Reprod Biol 2021, 256: 57-62; Perkins et al., J Low Genit Tract Dis 2020, 24: 102-31; US Preventative Services Task Force et al., JAMA 2018, 320: 674-86; Wentzensen et al., J Low Genit Tract Dis 2017, 21: 216-22).

13:
Pregnancy and related complications (e.g., ectopic pregnancy, incomplete abortion, inevitable abortion) must be excluded before performing this procedure.

14:
Patients have varying definitions of sexual activity (e.g., number of partners, timing of most recent episode, frequency of sexual activity). Unless the provider can confirm on examination that the patient has never had sexual intercourse, whether a patient is sexually active or not is a matter of clinical judgment.

15:
The documentation should include a history of sterilization (i.e., tubal ligation) without a subsequent pregnancy. These criteria do not include sterilization of a partner or alternate birth control methods (e.g., oral contraceptive pill use, intrauterine device insertion).

16:
Pregnancy testing can be by measurement of either a serum or urine HCG and may be documented in the medical record by either the primary care physician, gynecologist, or surgeon.

17:
Diagnostic laparoscopy may be used in evaluating chronic pelvic pain to identify possible pathologic causes for the pain. Endometriosis is a common cause of pelvic pain and laparoscopy is used to diagnose and treat endometrial lesions. Laparoscopy can also diagnosis other gynecological pathology that may cause chronic pelvic pain such as adhesions and pelvic inflammatory disease (Yunker et al., Obstet Gynecol Surv 2012, 67: 417-25; Won and Abbott, Int J Womens Health 2010, 2: 263-77).

18:
Conservative or less invasive interventions should be tried prior to recommending hysterectomy for the treatment of chronic pelvic pain. Medications such as progesterone and GnRH agonists have shown benefit in decreasing pain, as has a multidisciplinary approach to pain management (Yunker et al., Obstet Gynecol Surv 2012, 67: 417-25). Presacral neurectomy and uterine nerve ablation are techniques that disrupt the nerves that carry pain stimuli to the pelvis. Although several studies have shown significant improvement in pain scores after treatment, the evidence to support these techniques in the treatment of pelvic pain is limited and therefore, these procedures cannot be recommended (Won and Abbott, Int J Womens Health 2010, 2: 263-77; Daniels et al., JAMA 2009; 302(9): 955-961; National Institute for Health and Clinical Excellence (NICE), Interventional procedure overview of laparoscopic uterine nerve ablation (LUNA) for chronic pelvic pain. February 2007, 26).

19:
Although there are few high quality studies, hormone therapy including progestin alone, combined estrogen and progestin, and GnRH agonists have been reported to improve noncyclic chronic pelvic pain (Brown and Farquhar, Cochrane Database Syst Rev 2014: Cd009590).

20:
The GnRH agonists include leuprolide, nafarelin, and goserelin. These compounds mimic the action of GnRH and, thereby, suppress the hormones produced by the ovary that stimulate endometrial growth.

21:
Recommendations are designated as “Limited Evidence” based on one or more of the following:

- Research to date has not demonstrated this intervention’s equivalence or superiority to the current standard of care.
- The balance of benefits and harms does not clearly favor this intervention.
- The clinical utility of this intervention has not been clearly established.
- The evidence is mixed, unclear, or of low quality.
- This intervention is not standard of care.
- New technology is still being investigated.

22:
The evaluation of chronic pain can be extensive and finding a cause of the pain may remain elusive. The process of elimination does not ensure that hysterectomy will resolve the pain and pain can persist even after a hysterectomy. Evidence is inconclusive and lacking in controlled trials in regard to the benefit of surgical intervention for chronic pelvic pain (Andrews et al., In: Noncyclic Chronic Pelvic Pain Therapies for Women: Comparative Effectiveness. 2012; Yunker et al., Obstet Gynecol Surv 2012, 67: 417-25). Therefore, requests for hysterectomy for chronic pelvic pain should be reviewed prior to approval.

23:
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

Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy

Hysterectomy +/- BSO or Bilateral Salpingectomy for Chronic abdominal or pelvic pain

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ICD-10-CM (circle all that apply): C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C56.1, C56.2, C56.3, C56.9, C57.00, C57.01, C57.02, C79.82, D06.0, D06.1, D06.7, D06.9, D25.0, D25.1, D25.2, D25.9, N70.01, N70.02, N70.03, N70.11, N70.12, N70.13, N70.91, N70.92, N70.93, N71.1, N71.9, N72, N73.1, N73.4, N73.8, N73.9, N80.0, N80.1, N80.2, N80.3, N80.4, N80.5, N80.6, N80.8, N80.9, N81.2, N81.3, N81.4, N85.00, N85.01, N85.02, N87.0, N87.1, N87.9, N92.1, N92.4, N92.5, N93.0, N93.1, N93.8, N93.9, N95.0, O01.0, O01.1, O01.9, O72.0, O72.1, O72.2, O72.3, R10.10, R10.11, R10.12, R10.13, R10.2, R10.30, R10.31, R10.32, R10.33, R10.811, R10.812, R10.813, R10.814, R10.815, R10.816, R10.817, R10.819, R10.821, R10.822, R10.823, R10.824, R10.825, R10.826, R10.827, R10.829, R10.83, R10.84, R10.9, R19.00, R19.01, R19.02, R19.03, R19.04, R19.05, R19.06, R19.07, R19.09, R93.5, Z14.8, Z15.01, Z15.02, Z15.04, Z15.09, Z15.89, Other _____

ICD-10-PCS (circle all that apply): 0UT20ZZ, 0UT24ZZ, 0UT27ZZ, 0UT28ZZ, 0UT2FZZ, 0UT70ZZ, 0UT74ZZ, 0UT77ZZ, 0UT78ZZ, 0UT7FZZ, 0UT90ZL, 0UT90ZZ, 0UT94ZL, 0UT94ZZ, 0UT97ZL, 0UT97ZZ, 0UT98ZL, 0UT98ZZ, 0UT9FZL, 0UT9FZZ, 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ, Other _____

CPT® (circle all that apply): 58150, 58152, 58180, 58260, 58262, 58263, 58290, 58291, 58292, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58575, Other _____

InterQual®

2021, Oct. 2021 Release CP:Procedures

Subset: Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11)

Requested Service: Hysterectomy +/- BSO or Bilateral Salpingectomy for CIN 2, CIN 2,3, or CIN 3 or Endometrial hyperplasia (premenopausal)
Age: Age ≥ 18

Patient:	Name:	DOB:	ID #:	GROUP #:
	Sex (circle): M / F	Height:	Weight:	
Provider/PCP:	Name:	Fax #:	Phone #:	
	NPI/ID #:	Signature:		Date:
Servicing:	Vendor/Facility:		Phone #:	
	Diagnosis/ICD:	Service Date:	Authorization: / / to / /	

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ICD-10:

CPT®:

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

- ☐ 10. Cervical intra-epithelial neoplasia (CIN) 2, CIN 2,3, or CIN 3 by biopsy
- ☐ 20. Endometrial hyperplasia with cellular atypia by biopsy or dilatation and curettage (D & C)

☐ 10. Cervical intra-epithelial neoplasia (CIN) 2, CIN 2,3, or CIN 3 by biopsy

1. Excisional procedure performed (12)
   - ☐ A) Yes
   - ☐ B) No

   • If option Yes selected, then go to question 2
   • No other options lead to the requested service

2. Continued CIN 2, CIN 2,3, or CIN 3 by endocervical curettage (ECC) or biopsy ≥ 4 months post excisional procedure (13)
   - ☐ A) Yes
   - ☐ B) No

   • If option Yes selected, then the rule is satisfied; you may stop here (14)
   • No other options lead to the requested service

☐ 20. Endometrial hyperplasia with cellular atypia by biopsy or dilatation and curettage (D & C)

EXHIBIT
tabbies
20

Endometrial hyperplasia with cellular atypia by biopsy or dilatation and curettage (D & C) (continued...)

1. Choose one:
   - ☐ A) Premenopausal woman
   - ☐ B) Postmenopausal woman (15)
   - ☐ C) Other clinical information (add comment)

- If option A selected, then the rule is satisfied; you may stop here (14)
- No other options lead to the requested service

Reference

Ltd - This requested service is designated as 'Limited Evidence' in this clinical scenario. Criteria cannot be met.

2nd - Secondary review required. Criteria cannot be met.

Off-label - Use of a drug for an indication not approved by the U.S. Food and Drug Administration (FDA).

Notes:

1:
InterQual® content contains numerous references to gender. Depending on the context, these references may refer to either genotypic or phenotypic gender. At the individual patient level, a variety of factors, including, but not limited to, gender identity and gender affirmation via surgery or hormonal manipulation, may affect the applicability of some InterQual criteria. This is most often the case with genetic testing and procedures that assume the presence of gender-specific anatomy. With these considerations in mind, all references to gender in InterQual have been reviewed and modified when appropriate. InterQual users should carefully consider issues related to patient genotype and anatomy, especially for transgender individuals, when appropriate.

2:
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, ECRI Guidelines Trust®, Agency for Healthcare Research and Quality (AHRQ) Comparative Effectiveness Reviews, the Cochrane Library, Choosing Wisely, Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, and the National Institute of Health and Care Excellence (NICE). 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.

3:
Whether to perform prophylactic oophorectomy at the time of hysterectomy done for benign disease in premenopausal women may be considered. 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 (Version 3.2019). 2019; National Comprehensive Cancer Network, The NCCN clinical practice guidelines in oncology, genetic/familial high-risk assessment: colorectal (Version 3.2019). 2019). BSO may also 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 reduces the risk of ovarian cancer without the development of surgical menopause (American College of Obstetrics and Gynecologists, Obstet Gynecol 2019, 133: e279-e84; Society of Gynecologic Oncology, SGO Clinical Practice Statement: Salpingectomy for Ovarian Cancer Prevention 2013).

4:
Although robotic-assisted hysterectomy is being done, there are few prospective studies comparing robotic assisted to laparoscopic surgery for treating benign disease (ACOG, Obstetrics and Gynecology Committee Opinion No. 628. 2015, 125: 760-7. Reaffirmed 2017; Yu et al., Journal of surgical oncology 2013, 107: 653-8). A Cochrane review, however, demonstrated that robotic-assisted gynecologic surgery required more intraoperative time but reduced hospital stay when compared to 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 (Lawrie et al., Cochrane Database Syst Rev 2019, 4: Cd011422).

5:
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.

6:
Vaginal hysterectomy offers many advantages to the abdominal or laparoscopic approach including no abdominal incision, less pain, and quicker recovery; if technically feasible, it is the preferred surgical route (American College of Obstetricians and Gynecologists (ACOG), Obstet Gynecol 2017, 129: e155-e9; Sesti et al., Archives of Gynecology and Obstetrics 2014, 290: 485-91). The vaginal technique, however, can be limited in its ability to treat ovarian pathology in 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.

7:
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

8:
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.

9:
I/O Setting:
Hysterectomy, Abdominal, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Abdominal, Total +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting
Hysterectomy, Laparoscopic, Supracervical +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Laparoscopic, Total (TLH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Vaginal +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting

10:
For cervical cancer stage I-IIA and endometrial cancer stage II, see the "Hysterectomy, Radical" criteria subset.

11:
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).

12:
Excisional procedures include laser conization, cold knife conization, loop electrosurgical excision procedure (LEEP), and loop electrosurgical conization and are performed to obtain a specimen from the transformation zone and endocervical canal for histopathological evaluation. One technique has not been proven to be superior to another (Martin-Hirsch et al., The Cochrane database of systematic reviews 2013, 12: CD001318).

13:
Cervical intra-epithelial neoplasia (CIN) 2, CIN 2,3, or CIN 3 are indications for hysterectomy if conservative excisional surgery fails. Retesting is done approximately 4 months after conservative treatment, as the cervix needs time to heal and continued inflammation can result in abnormal biopsy results. When future childbearing is desired or in younger women with CIN 2, continued conservative surgery may be repeated until the childbearing years end (American College of Obstetricians and Gynecologists, Obstet Gynecol 2013, 122: 1338-67. Reaffirmed 2018; Massad et al., J Low Genit Tract Dis 2013, 17: S1-S27).

14:
I/O Setting:
Hysterectomy, Abdominal, Total +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Inpatient
Hysterectomy, Laparoscopically Assisted Vaginal (LAVH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting
Hysterectomy, Laparoscopic, Total (TLH) +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Outpatient
Hysterectomy, Vaginal +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy - Due to variations in practice, this procedure can be performed in the inpatient or outpatient setting

15:
Hysterectomy with removal of both ovaries and fallopian tubes is usually performed in postmenopausal women because the risk for the development of ovarian cancer is higher than for premenopausal women.

Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy

Hysterectomy +/- BSO or Bilateral Salpingectomy for CIN 2, CIN 2,3, or CIN 3 or Endometrial hyperplasia (premenopausal)

ICD-10-CM (circle all that apply): C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C56.1, C56.2, C56.3, C56.9, C57.00, C57.01, C57.02, C79.82, D06.0, D06.1, D06.7, D06.9, D25.0, D25.1, D25.2, D25.9, N70.01, N70.02, N70.03, N70.11, N70.12, N70.13, N70.91, N70.92, N70.93, N71.1, N71.9, N72, N73.1, N73.4, N73.8, N73.9, N80.0, N80.1, N80.2, N80.3, N80.4, N80.5, N80.6, N80.8, N80.9, N81.2, N81.3, N81.4, N85.00, N85.01, N85.02, N87.0, N87.1, N87.9, N92.1, N92.4, N92.5, N93.0, N93.1, N93.8, N93.9, N95.0, O01.0, O01.1, O01.9, O72.0, O72.1, O72.2, O72.3, R10.10, R10.11, R10.12, R10.13, R10.2, R10.30, R10.31, R10.32, R10.33, R10.811, R10.812, R10.813, R10.814, R10.815, R10.816, R10.817, R10.819, R10.821, R10.822, R10.823, R10.824, R10.825, R10.826, R10.827, R10.829, R10.83, R10.84, R10.9, R19.00, R19.01, R19.02, R19.03, R19.04, R19.05, R19.06, R19.07, R19.09, R93.5, Z14.8, Z15.01, Z15.02, Z15.04, Z15.09, Z15.89, Other _____

ICD-10-PCS (circle all that apply): 0UT20ZZ, 0UT24ZZ, 0UT27ZZ, 0UT28ZZ, 0UT2FZZ, 0UT70ZZ, 0UT74ZZ, 0UT77ZZ, 0UT78ZZ, 0UT7FZZ, 0UT90ZZ, 0UT94ZZ, 0UT97ZZ, 0UT98ZZ, 0UT9FZZ, 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ, Other _____

CPT® (circle all that apply): 58150, 58152, 58260, 58262, 58263, 58290, 58291, 58292, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58575, Other _____