Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Hysterectomy, Certain Elective

Effective: August 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX number below	Yes ☒ No ☐
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

- Harvard Pilgrim Health Care Commercial products
- Tufts Health Plan Commercial products
- Tufts Health Direct
- Tufts Health Together
- Tufts Health RITogether
- Tufts Health One Care

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax please refer to this reference chart for the appropriate fax number (varies by product).

For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

For Harvard Pilgrim Health Care Members:

This policy utilizes InterQual® criteria and/or tools, which Harvard Pilgrim may have customized. You may request authorization and complete the automated authorization questionnaire via HPHConnect at www.harvardpilgrim.org/providerportal. In some cases, clinical documentation may be required to complete a medical necessity review. Please submit required documentation as follows:

- Clinical notes/written documentation – via HPHConnect Clinical Upload or secure fax (800-232-0816)

Providers may view and print the medical necessity criteria and questionnaire via HPHConnect for providers (Select Researched and the InterQual® link) or contact the commercial Provider Service Center at 800-708-4414. (To register for HPHConnect, follow the instructions here). Members may access materials by logging into their online account (visit www.harvardpilgrim.org, click on Member Login, then Plan Details, Prior Authorization for Care, and the link to clinical criteria) or by calling Member Services at 888-333-4742.

For Tufts Health Plan Members:

To obtain InterQual® SmartSheets™"

- **Tufts Health Plan Commercial Plan products:** If you are a registered Tufts Health Plan provider click here to access the Provider Website. If you are not a Tufts Health Plan provider, please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888-884-2404
- **Tufts Health Public Plans products:** InterQual® SmartSheet(s) available as part of the prior authorization process

Tufts Health Plan requires the use of current InterQual® Smartsheet(s) to obtain prior authorization.

In order to obtain prior authorization for procedure(s), choose the appropriate InterQual® SmartSheet(s) listed below. The completed SmartSheet(s) must be sent to the applicable fax number indicated above, according to Plan.

Overview

The Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) and MassHealth for coverage determinations for its Dual Product Eligible plan members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals and MassHealth Medical Necessity Determinations are the basis for coverage determinations. Article - Sterilization (A59060) (cms.gov) is being supplemented using InterQual to provide additional detail regarding medical necessity criteria.

For the service of Hysterectomy, evidence is sufficient for coverage. In addition to the coverage of hysterectomy for illness or injury referenced in this CMS Article, InterQual provides guidance for the use of hysterectomy for various indications. The guidance for the use of this expanded criteria for these indications is supported American Congress of Obstetricians and Gynecologists.

The use of this criteria in the utilization management process will ensure access to evidence based clinically appropriate care. See References section below for all evidence accessed in the development of these criteria.

Clinical Guideline Coverage Criteria

The Plan requires the use of the following InterQual Subsets or SmartSheets to obtain prior authorization for hysterectomy:

- Hysterectomy, +/- BSO for Abnormal Uterine Bleeding or Postmenopausal Bleeding
- Hysterectomy, +/- BSO for Adenomyosis or Fibroids
- Hysterectomy, +/- BSO for BRCA gene mutation
- Hysterectomy, +/- BSO for Chronic Abdominal or Pelvic Pain
- Hysterectomy, +/- BSO for CIN 2, CIN 2,3 or CIN 3 or Endometrial Hyperplasia (premenopausal)
- Hysterectomy, +/- BSO for Endometrial hyperplasia (postmenopausal)
- Hysterectomy, +/- BSO for Endometriosis
- Hysterectomy, +/- BSO for Lynch II syndrome
- Hysterectomy, +/- BSO for Pelvic Inflammatory Disease (PID) or Tubo-ovarian abscess
- Hysterectomy, +/- BSO for Postpartum uterine bleeding
- Hysterectomy, +/- BSO for Uterine Prolapse

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes – Hysterectomy, Abdominal, +/- BSO

Code	Description
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
58152	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocystopexy (e.g., Marshall-Marchetti-Krantz, Burch)

Table 2: CPT/HCPCS Codes – Hysterectomy, Vaginal, +/- BSO

Code	Description
58260	Vaginal hysterectomy, for uterus 250 g or less;
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
58290	Vaginal hysterectomy, for uterus greater than 250 g;
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

Table 3: CPT/HCPCS Codes – Hysterectomy, Laparoscopically Assisted Vaginal (LAVH), +/- BSO

Code	Description
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
58290	Vaginal hysterectomy, for uterus greater than 250 g;
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

Code	Description
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele
58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

Table 4: CPT/HCPCS Codes – Hysterectomy, Open/Laparoscopic Supracervical (LSH), +/- BSO

Code	Description
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

Table 5: CPT/HCPCS Codes – Hysterectomy, Total Laparoscopic (TLH), +/- BSO

Code	Description
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

References:

1. Committee Opinion No 701: Choosing the Route of Hysterectomy for Benign Disease. *Obstet Gynecol*. 2017;129(6):e155-e159. doi:10.1097/AOG.0000000000002112
2. Aarts JW, Nieboer TE, Johnson N, et al. Surgical approach to hysterectomy for benign gynecological disease. *Cochrane Database Syst Rev*. 2015;2015(8):CD003677. Published 2015 Aug 12. doi:10.1002/14651858.CD0036

Approval And Revision History

June 17, 2020 Reviewed by the Medical Policy Approval Committee (MPAC), renewed without changes

Subsequent endorsement date(s) and changes made:

- June 16, 2021: Reviewed by IMPAC, renewed without changes
- July 21, 2021: Reviewed by IMPAC, clarification of title of InterQual Smartsheet for CIN 2, CIN 2,3 or CIN 3 or Endometrial Hyperplasia, addition of code 58270, and removal of end dated code 58293
- February 1, 2022: Template Updated
- April 20, 2022: Reviewed by Medical Policy Approval Committee (MPAC), the following codes are removed from the MNG-58267, 58275 and 58280, effective July 1, 2022. Addition of note “For hysterectomy procedures related to gender affirming surgery, please refer to Gender Affirming Services MNG”
- July 20, 2022: Reviewed by MPAC, renewed without changes
- June 21, 2023: Reviewed by MPAC, renewed without changes
- July 19, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Rebranded Unify to One Care and updated overview, effective January 1, 2024

- December 1, 2023: Reviewed and approved by the UM Committee effective January 1, 2024
- June 13, 2024: Reviewed and approved by the UM Committee effective July 1, 2024
- June 20, 2024: Reviewed by MPAC for 2024 InterQual Upgrade, effective July 1, 2024
- August 30, 2024: Reviewed by MPAC, renewed without changes, effective October 1, 2024
- May 21, 2025: Reviewed by MPAC for 2025 InterQual Update effective July 1, 2025
- May 20, 2026: Reviewed by MPAC for 2026 InterQual Update, effective July 1, 2026
- July 15, 2026: Reviewed by MPAC, annual review; InterQual update, effective August 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.