Driscoll Health Plan
Medical Necessity Guideline

Medical Necessity Guideline: Laparoscopic or Open removal of fallopian tubes and/or ovaries for Elective Sterilization or Opportunistic Salpingectomy	**Creation Date:** 05/11/2022	**Review Date:** 05/16/2023	**Effective Date:** 06/07/2022

PURPOSE:

To define the indications for and authorization requirements for Laparoscopic or Open Removal of Fallopian Tubes and/or Ovaries for elective sterilization or Opportunistic Salpingectomy with regards to procedure codes **58661** and **58700.**

DEFINITIONS:

Procedure Code 58661 - Laparoscopy, surgical; with the removal of adnexal structures (partial or total oophorectomy and/or salpingectomy).
Procedure Code 58700 - Salpingectomy, complete or partial, unilateral or bilateral (separate procedure).

GUIDELINE:

Partial or complete oophorectomy and/or salpingectomy (Procedure Codes 58661 and 58700) will require prior authorization for all indications.[5]
Bilateral tubal ligation (BTL) is a benefit under Texas Medicaid for sterilization under the appropriate circumstances.[5]
Performance of salpingectomy/oophorectomy as an opportunistic procedure (patients already undergoing pelvic surgery for benign disease) should not be performed with the primary purpose of sterilization but to reduce the risk of hereditary breast and/or ovarian cancer.[1,4]
Salpingectomy and oophorectomy with the primary purpose of sterilization will be considered with documentation that the member is at risk for hereditary breast or ovarian cancer.[1,2,5]

Documentation Requirements:

Medical documentation, including the risk of hereditary breast and/or ovarian cancer, must be provided, indicating the need for procedure codes 58661/58700. Such documentation of increased risk includes [2] one of the following criteria and/or submit the required **Attestation** form (see Attachment A below):

- Member is middle-aged or older (approximately between ages 45 to 65)
- Have close family members (such as mother, sister, aunt, or grandmother) on either mother's or father's side who have had ovarian and/or breast cancer (meets one or more of the following criteria):
    - Several relatives with either breast or ovarian cancer -- generally, 2 or more with ovarian cancer and 3 or more with breast cancers on the same side of the family.
    - A relative with primary cancers of both breasts.

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  - A relative who had both breast and ovarian cancer.
  - A male relative with breast cancer.
- Have a genetic mutation (abnormality) called BRCA1 or BRCA2, or one associated with Lynch syndrome.
- A relative with a known BRCA mutation.
- Member has had breast, uterine, or colorectal (colon) cancer.
- Member is of an Eastern European or Ashkenazi Jewish background.

BACKGROUND:

Research suggests that in patients with a genetic inclination to ovarian cancer, the risk of developing ovarian cancer is reduced if the fallopian tubes are removed. The findings appear to show that ovarian cancer may originate from the fimbriated end of the tube.[1] This data has been extrapolated to consider removing the fallopian tubes and the uterus at hysterectomy if ovaries are to be preserved. Most breast and ovarian cancers that occur in women in the general population are not hereditary. The genes most affected in hereditary breast and ovarian cancer are the breast cancer 1 (BRCA1) and breast cancer 2 (BRCA2) genes. About 3% of breast cancers (about 7,500 women per year) and 10% of ovarian cancers (about 2,000 women per year) result from inherited mutations in the BRCA1 and BRCA2 genes. For women who have a BRCA mutation, the risk of developing breast or ovarian cancer is significantly increased, with current risk estimates ranging from 50%-85% for breast cancer and 10%-40% for ovarian cancer by age 70, and important steps can be taken to help lower risk for cancer in these women.[2]

Ovarian function does not appear to be affected by salpingectomy at the time of hysterectomy. In one observational study by Venturella et al., 71 women underwent laparoscopic hysterectomy with opportunistic bilateral salpingectomy. Their ovarian function was monitored for 3–5 years after surgery. In these women, follicle-stimulating hormone, antimüllerian hormone, antral follicle count, vascular index, flow index, and vascular flow index were used to determine ovarian function and then compared with a control group that included 652 healthy women with intact uterus and adnexa. Results showed no difference between the two groups.[3] Salpingectomy at the time of hysterectomy or as a means of tubal sterilization appears to be safe. It does not increase the risk of complications such as blood transfusions, readmissions, postoperative complications, infections, or fever compared with hysterectomy alone or tubal ligation.[1]

In a meta-analysis of salpingectomy vs. tubal ligation for sterilization performed by Mills et al., they found that there were few differences between the procedures, with no differences in blood loss, length of hospital stays, pre- or post-operative complication, antimüllerian hormone or wound complications. A single study showed a reduced pregnancy rate with salpingectomy, but it was not statistically significant. The authors concluded that salpingectomy is as safe and efficacious as tubal ligation for sterilization and may be preferred, where appropriate, to reduce the risk of ovarian cancer.[4]

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Salpingectomy for elective sterilization does not provide a demonstrated advantage over bilateral tubal ligation in pregnancy prevention. Per the Texas Medicaid Provider and Procedures Manual, salpingectomy and/or oophorectomy (58661 and 58700) is not recognized as a routine indication for elective sterilization.[5]

InterQual ® criteria for **58661** and **58700** include ectopic pregnancy, hereditary breast or ovarian cancer syndrome, hydrosalpinx or pyosalpinx, lynch II syndrome, tubo-ovarian abscess, torsion of ovary or ovarian cyst, ovarian cyst rupture, or ovarian tumor. [6]

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PROVIDER CLAIMS CODES:

Providers must use one of the following diagnosis codes in conjunction with all family planning procedures and services:

Diagnosis Codes							
Z30011	Z30013	Z30014	Z30015	Z30016	Z30017	Z30018	Z3002
Z3009	Z302	Z3040	Z3041	Z3042	Z30430	Z30431	Z30432
Z30433	Z3044	Z3045	Z3046	Z3049	Z308	Z309	Z9851
Z9852							

Current CPT codes recognized by CMS for Sterilization		
58600	58605	58611
58615	58670	58671

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REFERENCES:

1. American College of Obstetrics and Gynecology - Opportunistic Salpingectomy as a Strategy for Epithelial Ovarian Cancer Prevention, Committee Opinion, Number 774, April 2019; Reaffirmed 2020; https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/04/opportunistic-salpingectomy-as-a-strategy-for-epithelial-ovarian-cancer-prevention; Accessed 5/09/2022.
2. Centers for Disease Control and Prevention. Hereditary Breast and Ovarian Cancer. https://www.cdc.gov/genomics/disease/breast_ovarian_cancer/index.htm (Accessed May 2022)
3. Venturella R, Lico D, Borelli M, Imbrogno MG, Cevenini G, Zupi E, et al. 3 to 5 years later: long-term effects of prophylactic bilateral salpingectomy on ovarian function. J Minim Invasive Gynecol 2017;24:145–50
4. American Journal of Obstetrics & Gynecology- Salpingectomy vs tubal Ligation for Sterilization: A Systematic Review and Meta-Analysis, Volume 224, Issue 3,Parch 01, 2021
5. Texas Medicaid Provider and Procedures Manual – Gynecological, Obstetrics, and Family Planning Title XIX Services, 2.2.8 Sterilization and Sterilization-Related , May 2022. Section 2.2.8.4 and 2.2.8.6
6. InterQual 2022 © criteria- Salpingectomy

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DOCUMENT HISTORY:

DHP Committee that Approved	***Review Approval Date (last 5 years)***				
Medical Director	06/22/2022	05/16/2023			
CMO	06/22/2022	06/06/2023			
Medical Policy Workgroup *Effective 2022*	06/22/2022	06/06/2023			
Utilization Management & Appeals *Effective January 2021*	07/05/2022	06/20/2023			
Provider Advisory Committee (PAC) *Effective 2022*	06/22/2022	06/09/2023			
Clinical Management Committee *Effective March 2021*	07/11/2022	07/20/2023			
Executive Quality Committee *Effective 2021*	09/27/2022	07/25/2023			

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Document Owner	*Organization*	*Department*
Dr. Fred McCurdy, Medical Director	Driscoll Health Plan	Utilization Management

Review/Revision Date	*Review/Revision Information, etc.*
05/24/2022	New revised Policy, reviewed and final editing by Dr. Fred McCurdy
05/16/2023	Reviewed by Drs Roxanne Doucet and Fred McCurdy
03/21/2024	Attachment A- Bilateral Tubal Ligation Attestation Form were updated for formatting and form identifier with no change to content.

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Attachment A

Driscoll Health Plan

Laparoscopic or Open Removal of Fallopian Tubes and/or Ovaries for Elective Sterilization or Opportunistic Salpingectomy Attestation

I attest, in support of the request for Laparoscopic or Open removal of fallopian tubes and/or ovaries for Elective Sterilization or Opportunistic Salpingectomy, one of the following applies:

- ☐ Has a close family member or members (such as mother, sister, aunt, or grandmother) on either mother's or father's side who have had ovarian and/or breast cancer as defined by:
  - Several relatives with either breast or ovarian cancer -- 2 or more with ovarian cancer and 3 or more with breast cancer on the same side of the family.
  - A relative with primary cancers of both breasts.
  - A relative who had both breast and ovarian cancer.
- ☐ Have a genetic mutation (abnormality) called BRCA1 or BRCA2, or one associated with Lynch syndrome.
- ☐ A relative with a known BRCA mutation.
- ☐ Member has had breast, uterine, or colorectal (colon) cancer.
- ☐ Member is of an Eastern European or Ashkenazi Jewish background.

Member Name: _____

Member DOB: _____

Member ID: _____

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Physician Name (Print)

Physician Signature

Date

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