

Document ID#: 2111962
Subject: Hysterectomy, Certain Elective
Effective Date: December 16, 2009

Clinical Documentation and Prior Authorization Required	√	Type of Review - Case Management	
Not Covered		Type of Review – Precertification Department	√
		Administrative Process (Internal Use Only)	RN

Note: Background, product, and disclaimer information is located at the end of this document.

In order to obtain prior authorization for Hysterectomy, Certain Elective, an InterQual[®] SmartSheet[™] for **one of the following procedures** must be completed and faxed to the Tufts Health Plan Precertification Department at 617-972-9409.

- Hysterectomy, Abdominal
- Hysterectomy, Vaginal
- Hysterectomy, Laparoscopic Supracervical (LSH)
- Hysterectomy and BSO, Abdominal
- Hysterectomy and BSO, Laparoscopically Assisted Vaginal (LAVH)
- Hysterectomy and BSO, Laparoscopic Supracervical (LSH)
- Hysterectomy and BSO, Vaginal

InterQual[®] SmartSheets[™] for this procedure are available by logging on to our web site and accessing the Prior Authorization InterQual[®] Criteria Link under the Clinical Resources section. If you are not a Tufts Health Plan Registered Provider, please click on the Provider Log-in and follow instructions.

For a list of the specific CPT procedure codes requiring prior authorization, [click here](#).

Approval History

Original effective date: August 16, 2005.

Subsequent Endorsement Date(s) and Changes Made:

- November 28, 2007: Reviewed and renewed.
- January 8, 2007: A completed InterQual[®] SmartSheet[™] is required. The requirement of additional information for the authorization of a hysterectomy was removed from guideline.
- March 10, 2008 CPT codes 58541, 58542, 58543, and 58544 were added to the prior authorization program, with an effective date of July 1, 2008. (see CPT Code List)
- July 1, 2009: Reviewed by Medical Affairs Medical Policy, no changes
- December 16, 2009: Reviewed and no changes made.

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for Tufts Health Plan benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. Tufts Health Plan makes 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, but 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 the Tufts Health Plan service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan revises and updates Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to all fully insured Tufts Health Plan products unless otherwise noted in this guideline or the Member's benefit document. This guideline does not apply to Tufts Health Plan Medicare Preferred or to certain delegated service arrangements. 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. Applicable state or federal mandates will take precedence. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLinkSM.

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.