2020 Minerva Endometrial Ablation System
Coding Reference Sheet

Diagnosis Indications

The Minerva Endometrial Ablation System is intended to ablate the endometrial lining of the uterus in pre-menopausal women with menorrhagia (excessive bleeding) due to benign causes for whom childbearing is complete.

ICD-10-CM[1] Diagnosis Codes

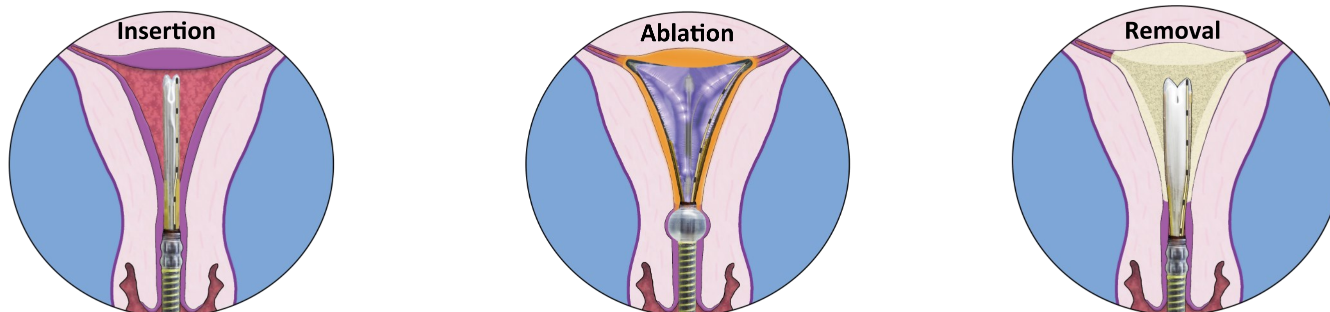
ICD-10-CM diagnosis codes are assigned by used by both professionals, eg, physicians, and facilities, eg, hospitals, to indicate the reason for the procedure.

Menorrhagia	**N92.0**	Excessive and frequent menstruation with regular cycle
	N92.1	Excessive and frequent menstruation with irregular cycle
	N92.4	Excessive bleeding in the premenopausal period
Dysfunctional uterine bleeding	**N93.8**	Other specified abnormal uterine and vaginal bleeding

The codes above are representative of diagnoses that may be eligible for endometrial ablation. Check with the payer for eligible diagnoses on individual cases.

Procedure Description

The Minerva Endometrial Ablation System introduces a silicone balloon into the uterus where it is filled with Argon gas. Radiofrequency energy is applied and is used to ionize the Argon gas converting it to plasma, which treats the uterine lining (endometrium). The procedure does not require hysteroscopic guidance, although a hysteroscopy may be performed before and/or after the ablation. Typical sites of service include the physician office, hospital outpatient setting or ambulatory surgery center.



CPT® Procedure[2] Codes

CPT procedure codes are assigned by physicians for all sites of service and by facilities for outpatient sites of service, including the hospital outpatient setting and ambulatory surgery centers.

Endometrial Ablation	**58353**	Endometrial ablation, thermal, without hysteroscopic guidance
	58563[3]	Hysteroscopy, surgical, with endometrial ablation (e.g. endometrial resection, electrosurgical ablation, thermoablation)

The reimbursement information provided by Minerva is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules and policies. This information is provided for illustrative purposes only and does not constitute reimbursement or legal advice. Minerva encourages providers to submit accurate and appropriate claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services and to submit appropriate codes, changes, and modifiers for services that are rendered. Minerva recommends that you consult with your payers, reimbursement specialists and/or legal counsel regarding coding, coverage and reimbursement matters. Minerva does not promote the use of its products outside their FDA-approved label.

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The payments below use Medicare reimbursements systems. Non-Medicare payers may also use these systems, adaptations of them, or similar methodologies in reimbursing physicians, hospitals, and ambulatory surgery centers.

Physician RBRVS Payment[4]

Under Medicare's RBRVS prospective payment system, each CPT code is assigned a relative value unit (RVU) given as points. Using a standard conversion factor, the RVU is then converted to a flat payment amount.

CPT Code	Description	*Non-Facility[5]*		*Facility[5]*	
		2020 RVUs	**2020 Natl Avg Payment**	**2020 RVUs**	**2020 Natl Avg Payment**
58353	Endometrial ablation, thermal, without hysteroscopic guidance	28.51	$1,029	6.54	$236
58563	Hysteroscopy, surgical, with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)	55.61	$2,007	7.18	$259

Hospital Outpatient APC Payment[6]

In Medicare's APC prospective payment system, each CPT code is assigned to an ambulatory payment class (APC). Each APC has a relative weight which is converted to a flat payment amount using a standard conversion factor specific to hospital outpatient. Payment for the procedure is generally comprehensive and includes payment for all other ancillary services.

CPT Code	Description	2020 APC	SI[7]	2020 Relative Weight	2020 Natl Avg Payment
58353	Endometrial ablation, thermal without hysteroscopic guidance	**5415,** Level 5 Gynecologic Procedures	J1	52.8702	$4,271
58563	Hysteroscopy, surgical, with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)	**5415,** Level 5 Gynecologic Procedures	J1	52.8702	$4,271

Ambulatory Surgery Center Payment[6]

Medicare payment to ASCs is based on hospital outpatient APCs. Each CPT code is assigned a comparable weight which is converted to payment using a conversion factor specific to ASCs. Payment for the procedure is generally comprehensive and includes payment for all other ancillary services.

CPT Code	Mult Proc Indicator[8]	PI[9]	2020 Weight	2020 Natl Avg Payment
58353, Endometrial ablation, thermal, without hysteroscopic guidance	Y	A2	38.0413	$1,816
58563, Hysteroscopy, surgical, with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)	Y	A2	38.0413	$1,816

References

(1)Centers for Disease Control and Prevention, National Center for Health Statistics. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). http://www.cdc.gov/nchs/icd/icd10cm.htm. Updated October 1, 2019. (2)CPT copyright 2019 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. (3)AMA CPT Assistant, January 2015. See also American Congress of Obstetricians and Gynecologists (ACOG), Practice Management and Coding Update, March 2008. Reprinted at: https://listserv.acog.org/pipermail/coding/2008/000026.html. (4)Centers for Medicare & Medicaid Services. Medicare Program; CY2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B Policies Final Rule; 84 Fed. Reg. 62568-635-63. https://www.govinfo.gov/content/pkg/FR-2019-11-15/pdf/2019-24086.pdf . Published November 15, 2019. Final payment to an individual physician is adjusted by the Geographic Practice Cost Indices. Coinsurance, deductible, and other patient obligations are included in the payment amount.. (5)The RVUs and physician payment vary with the site of service. Non-Facility is used for services provided by the physician in the physician office. Facility is used for services provided by the physician in hospitals and ambulatory surgery centers. RVUs and payments are usually higher for Non-Facility because the physician bears all costs at that site of service, as opposed to Facility where the hospital or ASC bears the cost of equipment and supplies. (6)Centers for Medicare & Medicaid Services. Medicare Program: Changes to Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems...Final Rule. 84 Fed Reg 61142-61492. https://www.govinfo.gov/content/pkg/FR-2019-11-12/pdf/2019-24138.pdf . Published November 12, 2019. (7)The J1 Status Indicator (SI) of J1 denotes a "comprehensive APC" where payment is made only for the primary procedure. Payment for any other procedures and all ancillary services provided during the same encounter is packaged into the payment for the primary procedure. (8)When marked Y, codes are subject to multiple procedure discounting with payment at 100% of the rate for the first procedure and 50% of the rate for additional procedures performed. (9)The A2 Payment Indicator (PI) denotes a surgical procedure for which payment is based on the hospital outpatient rate adjusted for the ASC setting.