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1.0 Description of the Procedure, Product, or Service

Hysterectomy is defined as the operation of excising the uterus either through the abdominal wall or through the vagina.

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)

- a. An eligible beneficiary shall be enrolled in either:
 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(The term “Specific” found throughout this policy only applies to this policy)

- a. Medicaid
None Apply.
- b. NCHC
None Apply

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:
<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

The following diagnoses are accepted as validation of medical necessity for hysterectomies:

- a. Malignant and pre-malignant lesions of the female reproductive tract
- b. Endometriosis
- c. Adenomyosis
- d. Leiomyomas or fibroids
- e. Salpingitis and oophoritis
- f. Mild to moderate cervical dysplasia, when prior conservative procedures failed.
- g. Hyperplasia of the endometrium
- h. Dysfunctional uterine bleeding, severe idiopathic menorrhagia and/or metrorrhagia
- i. Inflammatory peritonitis
- j. Intractable procidentia (prolapsed uterus)
- k. Perforation of the uterus by IUD

- l. Class IV or V pap smear
- m. Prophylactic oophorectomy for positive family history of BRCA-1 (breast cancer gene)
- n. Traumatic injury to the uterus with irreparable damage
- o. Complications of childbirth such as uterine rupture or intractable hemorrhage (for Medicaid beneficiaries only)

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.2.3 NCHC Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Hysterectomy procedures are not covered when:

- a. the hysterectomy is performed for the purpose of sterilization; or
- b. the procedure is a component of a more comprehensive procedure already paid for on the same date of service (Medicaid and NCHC do not allow a component procedure to be paid on the same date of service as a comprehensive procedure)

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

- a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
 - 1. No services for long-term care.
 - 2. No nonemergency medical transportation.
 - 3. No EPSDT.

4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Medicaid and NCHC shall not require prior approval for hysterectomy.

5.2 Informed Consent

Except when designated an emergency abdominal surgery, the beneficiary shall be informed orally and in writing prior to the surgery as to the nature of the surgery and of the fact that the surgery will render the beneficiary permanently incapable of reproducing. The beneficiary or her representative, if any, shall sign a written acknowledgement of receipt of that information.

5.3 Hysterectomy Statement

One of three federally approved hysterectomy statements (refer to **Attachment B**) shall be completed, as applicable, with the following information indicated on the statement:

- a. the beneficiary’s identification number
- b. the beneficiary’s name and address
- c. the beneficiary’s signature and date
- d. the witness’ signature
- e. the date of surgery
- f. the surgeon’s signature, if applicable

5.3.1 Improper Hysterectomy Statements

Improperly worded, incomplete, altered, or traced hysterectomy statements cannot be accepted.

5.3.2 Witness Signatures

- a. If the beneficiary signs with an “X”, two people shall witness and sign the hysterectomy statement.
- b. If the beneficiary is mentally incompetent, the beneficiary’s legal guardian and one other person shall witness and sign the hysterectomy statement.
- c. If the beneficiary is under the age of 21, the beneficiary’s legal guardian and one other person shall witness and sign the hysterectomy statement.

5.3.3 Name Changes

If the beneficiary name on the claim and the name on the hysterectomy consent form are different, a signed name change statement (refer to **Attachment C**) that verifies the beneficiary whose name appears on the claim and statement are the same person, shall be included with the hysterectomy consent form.

5.3.4 Emergency Situations

When a beneficiary requires a hysterectomy due to a life-threatening emergency situation, the requirement to obtain informed consent is waived if the physician determines that prior acknowledgement is not possible. The physician who performs the hysterectomy shall certify in writing that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgment was not possible. This shall include the following:

- a. a description of the nature of the emergency
- b. the beneficiary's name
- c. the beneficiary's address
- d. the physician's dated signature
- e. all relevant medical records

5.3.5 Hysterectomy Performed During a Retroactive Eligibility Period

If a beneficiary receives retroactive eligibility after a hysterectomy is performed, a valid hysterectomy statement shall be submitted as indicated in **Subsection 5.3, 5.3.1** and **5.3.2** for coverage.

5.3.6 Previous Sterilization

When a beneficiary who is already sterile requires a hysterectomy, the physician who performs the hysterectomy shall certify in writing that the beneficiary was already sterile at the time of the hysterectomy. The certification shall include the following:

- a. the cause of the sterility (e.g. age, congenital disorder, previous sterilization, post-menopausal)
- a. the beneficiary's name
- b. the beneficiary's address
- c. the physician's dated signature
- d. all relevant medical records

5.3.7 Submitting Hysterectomy Statements

The hysterectomy statement shall be on file with DMA's fiscal agent in order to process the claim.

Note: The hysterectomy statement may be submitted with the claim if the claim is submitted on paper. When a claim is submitted electronically but no hysterectomy statement is on file, the claim will suspend for two weeks to allow time for the statement to be received and processed. Refer to **Attachment B** for additional information on submitting the hysterectomy statement.

5.4 Medical Necessity Documentation

Medical record documentation shall support the medical necessity for the hysterectomy procedure. Medical records shall be submitted for the following individuals and/or diagnoses:

- a. individuals under the age of 21
- b. pelvic inflammatory disease
- c. mild to moderate cervical dysplasia, when prior conservative procedures failed

- d. carcinoma in situ of unspecified organs, and
- e. uterine hemorrhage from placenta previa.

Medical record documentation shall include:

- a. history and physical
- b. operative notes
- c. pathology report
- d. discharge summary, and
- e. reports for treatments performed prior to the hysterectomy (e.g., laparoscopic procedures, dilations and curettage, conizations or cervical biopsies).

5.5 Dilation and Curettage

A dilation and curettage is covered when performed at the time of an abdominal hysterectomy. A dilation and curettage is not covered when performed in conjunction with a vaginal hysterectomy.

5.6 Outpatient Hysterectomies

Outpatient hysterectomies are covered. Observation charges for hysterectomies are not routinely covered. These charges are covered only in situations where a beneficiary exhibits an uncommon or unusual reaction, or other postoperative complications that require monitoring or treatment beyond the usual services provided in the immediate post-operative period. When observation charges are billed, medical record documentation supporting medical necessity shall be submitted with the claims. The records shall include the following:

- a. history and physical
- b. operative notes
- c. pathology report
- d. discharge summary, and
- e. reports for treatments performed prior to the hysterectomy (e.g., laparoscopic procedures, dilations and curettage, conizations or cervical biopsies).

5.7 Recovery Room Services

Routine recovery room services are not to be billed as observation services.

5.8 Limitations

Hysterectomy procedures are covered for an individual once in a lifetime.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s)..

8.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1985

Revision Information:

Date	Section Revised	Change
5/1/07	Attachment A	Added UB-04 as an accepted claims form.
7/1/2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."
3/12/12	Throughout	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 1E-1 under Session Law 2011-145 § 10.41.(b)
3/12/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
10/1/12	Throughout	Replaced "recipient" with "beneficiary."
10/1/12	Subsection 5.3	Moved old sections 5.5 through 5.5.2 to the area under informed consent to form Subsections 5.3 through 5.3.3.

Date	Section Revised	Change
1/1/13	Subsections 5.3.1, 5.3.3, 5.3.4, 5.3.5, 5.3.6, 5.6	Added one new line to Section 5.3.6 to coincide with information stated in Section 5.3.4; Added one new line to Section 5.6 to coincide with information stated in Section 5.4.; Revised 5.3.5 to add the corrected Subsections; added wording in Subsection 5.3.3; changed wording in Subsections 5.3.4 and 5.3.1;
1/1/13	Attachment B	Added wording that was left off the latest policy revisions in October and March to Attachment B.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

ICD-10-CM Procedure codes for UB-04 Claim Form

ICD-10-ProcedureCode(s)		
0DTP0ZZ	0TTB0ZZ	0UT90ZZ
0DTP4ZZ	0TTB4ZZ	0UT94ZZ
0DTP7ZZ	0TTB7ZZ	0UT97ZZ
0DTP8ZZ	0TTB8ZZ	0UT98ZZ
0DTQ0ZZ	0TTD0ZZ	0UT9FZZ
0DTQ4ZZ	0TTD4ZZ	0UTC0ZZ
0DTQ7ZZ	0TTD7ZZ	0UTC4ZZ
0DTQ8ZZ	0TTD8ZZ	0UTC7ZZ
0TB60ZZ	0UT20ZZ	0UTC8ZZ
0TB64ZZ	0UT24ZZ	0UTC9ZZ
0TB67ZZ	0UT27ZZ	0UTG0ZZ
0TB68ZZ	0UT28ZZ	0UTG4ZZ
0TB70ZZ	0UT2FZZ	0UTG7ZZ
0TB74ZZ	0UT40ZZ	0UTG8ZZ
0TB77ZZ	0UT44ZZ	0UTGFZZ
0TB78ZZ	0UT47ZZ	0UTM0ZZ
0TBB0ZZ	0UT48ZZ	0UTM4ZZ
0TBB4ZZ	0UT4FZZ	0UTM7ZZ
0TBB7ZZ	0UT70ZZ	0UTM8ZZ
0TBB8ZZ	0UT74ZZ	0UTMFZZ
0TBD0ZZ	0UT77ZZ	
0TBD4ZZ	0UT78ZZ	
0TBD8ZZ	0UT7FZZ	

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Code(s)	
51925	58293
58150	58294
58152	58548
58180	58550
58200	58552
58210	58553
58240	58554
58260	58570
58262	58571
58263	58572
58267	58573
58270	58951
58275	58953
58280	58954
58285	58956
58290	59135
58291	59525
58292	

Note: Prenatal and childbirth services are not covered under NCHC.

All physicians (primary, assistant, etc.) shall bill the same hysterectomy procedure code for the same beneficiary, same date of service. All providers shall use the correct procedure code for the type of hysterectomy performed to eliminate recoupments.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

D. Modifiers

Providers shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Inpatient hospital, Outpatient hospital, Office.

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at

<http://www.ncdhhs.gov/dma/plan/sp.pdf>.

For NCHC refer to G.S. 108A-70.21(d), located at

http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html

H. Reimbursement

Providers shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>

Attachment B: Hysterectomy Statements

The entire form (including all three attestations) must be copied on professional letterhead. Complete only the section appropriate to the beneficiary's situation. Copies of the Hysterectomy Statements form can be downloaded from DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

Hysterectomy Statement

NPI: _____

RID: _____

If the patient signs the hysterectomy statement prior to surgery:

I HAVE BEEN INFORMED ORALLY AND IN WRITING THAT A HYSTERECTOMY WILL RENDER ME PERMANENTLY INCAPABLE OF BEARING CHILDREN:

Patient Name (Please print): _____

Patient Signature: _____

Patient Address: _____

Witness Name (Please print): _____

Witness Signature: _____

Date Signed: _____

If the provider fails to obtain the patient's statement prior to surgery, however, has informed her that she would be incapable of bearing children (this is an exception, not a rule, and will be reviewed as such):

PRIOR TO MY SURGERY ON _____ (Date of surgery), I WAS INFORMED ORALLY AND IN WRITING THAT A HYSTERECTOMY WOULD RENDER ME PERMANENTLY INCAPABLE OF BEARING CHILDREN:

Patient Name (Please print): _____

Patient Signature: _____

Patient Address: _____

Witness Name (Please print): _____

Witness Signature: _____

Date Signed: _____

If the patient is sterile due to age, a congenital disorder, a previous sterilization, or if the hysterectomy was performed on an emergency basis because of life-threatening circumstances (life-threatening should indicate that the patient is unable to respond to the information pertaining to the acknowledgement agreement. Federal regulations do not recognize metastasis of any kind as life threatening or an emergency):

Patient Name: _____

Patient Address: _____

The above named patient was sterile prior to the hysterectomy due to: _____

or

A hysterectomy was performed on the above named patient on an emergency basis, and the patient was unable to respond because of the following life-threatening circumstances: _____

Physician Name (Please print): _____

Physician Signature: _____

Date Signed: _____

DMA-3047 11.01.2013

Attachment C: Example of Name Change Statement

Dr. Any Provider
101 Any Hwy
Any City NC 22222

Medicaid ID Number: 88888888T

To Whom It May Concern:

Jane Beneficiary has changed her name to Jane Doe.

Dr. Any Provider (Signature of representative at provider's office is required)