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1.0 Description of the Procedure, Product, or Service

Sterilization is any medical procedure, treatment, or operation for the purpose of rendering a beneficiary permanently incapable of reproducing.

1.1 Definitions

1.1.1 Tubal Procedure

Female sterilization, also called tubal occlusion or ligation, is a permanent contraceptive method for women who do not want more children. The method requires a simple surgical procedure that prevents the egg from passing down the fallopian tubes into the uterus. A doctor can block the fallopian tubes several different ways. They can be clipped closed with bands or rings. They can be cut and tied closed, or they can be cauterized with an electric needle. Once the fallopian tubes are cauterized, scar tissue forms, which blocks them. A surgical cut must be made in either the abdomen just above the pubic hair, in the belly button and lower abdomen, or in the back wall of the vagina. The procedure can be done using a local anesthetic to numb the area, or a general anesthetic. The two most common female sterilization approaches are minilaparotomy, which is usually performed under local anesthesia with light sedation, and laparoscopy, which requires general anesthesia.

1.1.2 Hysteroscopic Procedure

The hysteroscopic approach to permanent sterilization, also known as the Essure System, does not require an incision or general anesthesia. It is indicated for women who desire permanent birth control (female sterilization) by bilateral occlusion of the fallopian tubes. A hysteroscope is inserted through the vagina and cervix into the uterus for direct visualization. Next, a small catheter with the micro-insert mounted at the tip is inserted through the hysteroscope into each of the fallopian tubes (one at a time) and the micro-inserts are released. The micro-inserts irritate the lining of the fallopian tube, causing the growth of scar tissue and the eventual permanent blockage of the fallopian tube.

1.1.3 Vasectomy

Vasectomy is an operation designed to make a male sterile by making small incisions in the skin of the scrotum, with a local anesthetic. The vas deferens is severed and the scrotal incision closed. The entire procedure is repeated on the opposite side.

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

Medicaid

Medicaid shall cover sterilization procedures for both men and women age 21 and over.

NCHC

NCHC shall not cover Sterilization Procedures.

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 clinician).

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 *Basic Medicaid and NC Health Choice Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid and NC Health Choice Billing Guide:

<http://www.ncdhhs.gov/dma/basicmed/>

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 a 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 a NCHC beneficiary.

2.3 Mental Competency

The beneficiary must be mentally competent.

Note: If a judicial court orders a sterilization for a beneficiary who is a ward of the county, and is mentally incompetent, Medicaid is not responsible for the reimbursement of the sterilization.

2.4 Undocumented Aliens

Undocumented aliens are eligible for Medicaid emergency services only. Sterilization procedures are not considered an emergency service. Therefore, undocumented aliens are not eligible for sterilization procedures.

3.0 When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria Covered

Medicaid shall cover procedures, products, and services related to this policy when they are 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

None Apply:

3.2.2 Medicaid Additional Criteria Covered

This service covers procedures, products, and services related to this policy when they are medically necessary and:

- a. the beneficiary meets the eligibility requirements listed in **Section 2.0**; and
- b. the procedure is provided according the federal regulations listed in 42 CFR 441.250 through 259 (<http://www.gpoaccess.gov/cfr/index.html>).

3.2.3 Hysterosalpingogram

For beneficiaries who have undergone the Essure sterilization procedure, this service covers a separate hysterosalpingogram (HSG) to confirm occlusion of the fallopian tubes, three to four months after placement of the micro-inserts.

3.2.4 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 a Medicaid Beneficiary under 21 Years of Age.

There is no EPSDT exception to the following requirements. The Code of Federal Regulations (CFR) at 42 Sec. 441.253 states that federal financial participation is available in expenditures for the sterilization of a beneficiary only if the beneficiary is at least 21 years old at the time consent is obtained.

4.1 General Criteria Not Covered

Medicaid shall not cover procedures, products, and services 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

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

Procedures, products, and services related to this policy are not covered when:

- a. the procedure is not provided according to the federal guidelines listed in 42 CFR 441.250 through 259 have not been met;
- b. the procedure is ordered by a judicial court for a beneficiary who is a ward of the county and is mentally incompetent;
"Mentally incompetent individual" is defined in 42 CFR 441.251, revised October 1, 1999, as an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.
- c. the beneficiary is an institutionalized individual;
"Institutionalized individual" is defined in 42 CFR 441.251, revised October 1, 1999, as an individual who is either:
 1. involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or
 2. confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.

4.2.3 Essure System Contraindications

The Essure System should not be used in any beneficiary who:

- a. is uncertain about her desire to end fertility;
- b. can have only one micro-insert inserted (including patients with apparent contralateral proximal tubal occlusion and patients with a suspected unicornuate uterus);
- c. has previously undergone a tubal ligation; or
- d. has any of the following conditions:
 1. pregnancy or suspected pregnancy;
 2. delivery or termination of a pregnancy less than six weeks before Essure micro-insert placement;
 3. active or recent upper or lower pelvic infection;
 4. known allergy to contrast media; or
 5. known hypersensitivity to nickel, confirmed by skin test.

4.2.4 Post-Procedure Hysterosalpingogram

Post-procedure HSG is not covered for any condition or diagnosis other than confirmation of occlusion of the fallopian tubes after the Essure sterilization procedure.

4.2.5 Sterilization Reversals

Reversal of sterilization is not covered. Examples of sterilization reversal procedures include reverse bilateral fallopian tube trans-section by means of bilateral salpingoplasty and reversal of a bilateral vasectomy by means of a bilateral vasovasostomy.

4.2.6 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 a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Medicaid shall not require prior approval for Sterilization Procedures.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the prior approval request;
- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy; and

5.2.2 Specific

Federal regulations require the N.C. Medicaid program to obtain documentation prior to rendering a sterilization procedure indicating that the provider has complied with the requirements listed in 42 CFR 441.250 through 259. For sterilization procedures, this documentation must include a correctly completed consent form as explained in **Subsection 5.3**.

5.3 Sterilization Consent

The beneficiary shall provide voluntary informed consent in accordance with Medicaid policy and the federal regulations listed in 42 CFR 441.257 and 258. The beneficiary shall be:

- a. at least 21 years of age when she or he signs the consent form, or when the consent form is signed;
- b. given the opportunity to ask, and receive answers to, questions concerning the procedure, and provided a copy of the consent form;
- c. advised that the sterilization consent may be withdrawn at any time before the sterilization procedure without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the beneficiary might otherwise be entitled;
- d. counseled in alternative methods of family planning and birth control;
- e. advised that the sterilization procedure is considered to be irreversible;
- f. provided a thorough explanation of the specific sterilization procedure to be performed;
- g. provided a thorough explanation of the possible discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
- h. provided a full description of the benefits or advantages that may be expected as a result of the sterilization;
- i. provided suitable arrangements to ensure that information is effectively communicated if the beneficiary is blind, deaf, or otherwise handicapped;
- j. provided an interpreter if the beneficiary does not understand the language used on the consent form or the language used by the person obtaining consent; and
- k. permitted to have a witness of his or her choice present when the consent is obtained.

5.3.1 Date of Consent

Consent must be obtained at least 30, but not more than 180, days prior to the date of the sterilization, except under the following circumstances.

- a. **Premature Delivery:** Informed consent must have been given at least 30 days before the expected date of delivery, and at least 72 hours must have passed since the informed consent was given.

- b. Emergency Abdominal Surgery: At least 72 hours must have passed since the informed consent was given.

5.3.2 Obtaining Consent

Informed consent for sterilization may not be obtained while the beneficiary to be sterilized is:

- a. in labor;
- b. seeking to obtain or obtaining an abortion; or
- c. under the influence of alcohol or other substances that affect the beneficiary's state of awareness.

Any state or local requirements for obtaining consent, except those requiring spousal consent, must be followed.

5.3.3 Date of Confinement

The estimated date of confinement (date of delivery) must be documented on the sterilization consent form in cases of premature delivery.

5.3.4 Consent Form

Providers shall ensure that a valid sterilization consent form has been completed prior to rendering a sterilization procedure. The sterilization consent form is a federally mandated document and must be completed according to the instructions listed in **Attachment B**, Instructions for Completing the Consent Form.

Refer to **Attachment C** for a sample of the sterilization consent form.

- a. A new consent form cannot be initiated after the sterilization procedure or after the consent form has been submitted to the Division of Medical Assistance's (DMA) fiscal agent.
- b. An existing consent form already on file at DMA's fiscal agent may be modified to correct an error made on the consent form **unless** the error occurred in one of the following areas:
 - 1. Beneficiary signature;
 - 2. Date the consent form was signed by the beneficiary;
 - 3. Interpreter's signature;
 - 4. Date the consent form was signed by the interpreter;
 - 5. Signature of the person obtaining the consent (witness signature); or
 - 6. Date the consent form was signed by the person obtaining the consent (witness).
- c. If an error, other than one listed above, occurred on the consent form during the initial completion of the consent form, the form must be voided and a new consent form initiated.
- d. If an error on the consent form is found after the consent form is sent to the fiscal agent, providers shall:
 - 1. Strikethrough the error once on the original copy of the consent and make the correction.
 - 2. Not use white-out or erase the error for correction purposes.
 - 3. Send the corrected consent to DMA's fiscal agent at the address located in **Attachment B Section C (3)**.

- e. The provider obtaining consent shall maintain the original completed sterilization consent form in the beneficiary's health records. A copy of this consent form must be provided to the beneficiary. Copies should also be provided to the physician or provider conducting the procedure, the interpreter (if one is being used), and any other state agency or program requiring this documentation. A copy should be retained at the service site where the consent is being obtained.
- f. Providers shall add a valid NPI to the top left margin of the sterilization consent form and the Recipient Identification Number (RID) to the top right margin of the sterilization consent form for the form to be processed appropriately for validation.
- g. A valid sterilization consent must be on file with DMA's fiscal agent before payment can be made for a sterilization procedure.

5.3.5 Signatures

The beneficiary to be sterilized and the person obtaining the beneficiary's consent shall sign and date the sterilization consent form.

The physician's signature must be dated on or after the date of service (procedure date).

All handwritten signatures must be legible or the name must be printed below the written signature. Printed handwritten signatures are acceptable for the beneficiary, interpreter, witness, and physician.

The following types of signatures will **not** be accepted:

- a. A changed, altered, revised, or modified signature. This includes erasures or use of correction fluid or correction tape on the signature.
- b. A traced signature. This is a copy of an original signature, produced by following its lines with a pen or pencil through a transparent medium.
- c. Use of a signature stamp in lieu of an actual witness, interpreter, or physician signature on the sterilization consent form.
- d. Use of initials and abbreviations **are not** acceptable for the first name of the beneficiary, interpreter, witness, or physician.
- e. Signature of another physician on the consent instead of the physician who performed the procedure.

5.4 Interpreter Services

When telephone interpreter services are needed to complete the sterilization consent form for non-English-speaking Medicaid beneficiaries, the interpreter's signature, date of the interpreter's service, and the language used must be documented on the sterilization consent form. In lieu of getting the interpreter's signature on the sterilization consent form at the time the service is provided, the interpreter who explains the procedure by telephone may fax or mail the attestation of interpreter services to the provider. Criteria for the faxed or mailed attestation are as follows:

- a. The wording of the attestation must be taken directly from the sterilization consent form.
- b. The interpreter shall write his or her signature and the date the interpreter services were rendered on the attestation form.

- c. The dates with the signatures of the beneficiary, interpreter, and person obtaining consent must all be the same.
- d. The attestation form must include the beneficiary's name, as it appears on the Medicaid identification card, as well as the Recipient identification number.
- e. A copy of the attestation must be attached to the consent form when the provider submits the statement to Medicaid's fiscal agent.
- f. The provider shall maintain the original attestation document with the consent form in the beneficiary's medical record.

5.5 Name Change Statement

A signed name change statement must be provided to DMA's fiscal agent when the beneficiary's name listed on the claim is different than the name on the sterilization consent form. The name change statement must verify that the names are for the same person. This statement must be written on the provider's office letterhead. (See **Attachment B**, Instructions for Completing the Consent Form.)

5.6 Limitations

This service places reasonable unit limitations on procedures and services. When extenuating circumstances require a provider to exceed a unit limitation, the denied claim and medical records must be submitted as an adjustment for reconsideration. The following sterilization limitations apply:

- a. Sterilization procedures are covered for a beneficiary once in a lifetime unless documentation supports repeat due to failed procedure.
- b. Medicaid allows 100% reimbursement of the allowable amount on the fee schedule for a sterilization and vaginal delivery or sterilization and cesarean section when they are the only surgery procedures performed on the same date of service.
- c. Dilation and curettage performed on same date of service as sterilization will be suspended for medical review. Medical records may be requested.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services 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 a Medicaid Beneficiary 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, its divisions or its fiscal agent.

7.2 Claims Review

Manual review of sterilization claims is performed in accordance with CMS-approved guidelines to ensure that the procedure complies with federally mandated guidelines.

7.3 Claims Reimbursement

All provider types submitting claims for reimbursement, including any associated services following sterilization, will be denied or recouped if the sterilization consent form on file is invalid.

8.0 Policy Implementation and History

Original Effective Date: January 1, 1974

History:

Date	Section Revised	Change
07/01/2008	Subsections 1.2, 4.1.1, 3.2, 4.2, and Attachment A	Coverage of the Essure System procedure (effective with N.C. Medicaid approval date, September 1, 2003) and the hysterosalpingogram procedure (effective with N.C. Medicaid approval date, December 1, 2003) was added to the policy.
03/12/2012	all sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
07/01/2013	Section 5.3.4	Added information regarding consent form changes.
07/01/2013	Section 5.3.5	Added information regarding acceptable signatures, signature stamps usage, and use of initials
07/01/2013	Section 5.4	Changed wording from “should” to “must” in (a)
07/01/2013	Attachment B	Changes made in #'s 7, 11, 15, and 23 regarding the use of initials and signature stamps
07/01/2013	Attachment C	Added new consent form approved by CMS
07/01/2013	All sections and attachment(s)	Replaced “recipient” with “beneficiary.”
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-Code(s)
Z30.2

The only diagnosis code to be considered strictly for the purpose of elective sterilization is Z30.2, "Encounter for sterilization."

Note: All claims must be billed with ICD-10-CM diagnosis code Z30.2 as the primary or secondary diagnosis code on the claim.

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.

C1. Physician Claims

Laparoscopic Procedures

CPT Code(s)
58600
58605
58611
58615

58670
58671

Essure Procedure

CPT Code(s)
58565
58579

Hysterosalpingogram

CPT Code(s)
58340
74740

Note: CPT procedure code 58340 must be billed on the same date of service procedure code 74740.

Vasectomy Procedures

CPT Code(s)
55250
55450

C2. Hospital Claims

ICD-10-PCS Code(s)			
0U570ZZ	0UL74DZ	0VLH0CZ	0VLQ3ZZ
0U573ZZ	0UL74ZZ	0VLH0DZ	0VLQ4CZ
0U574ZZ	0UL77DZ	0VLH0ZZ	0VLQ4ZZ
0U577ZZ	0UL77ZZ	0VLH3CZ	0VTQ0ZZ
0U578ZZ	0UL78DZ	0VLH3DZ	0VTQ4ZZ
0UL70CZ	0UL78ZZ	0VLH3ZZ	0VLQ0DZ
0UL70DZ	0V5Q0ZZ	0VLH4CZ	0VLQ3DZ
0UL70ZZ	0V5Q3ZZ	0VLH4DZ	0VLQ4DZ
0UL73CZ	0V5Q4ZZ	0VLH4ZZ	
0UL73DZ	0VBQ0ZZ	0VLQ0CZ	
0UL73ZZ	0VBQ3ZZ	0VLQ0ZZ	
0UL74CZ	0VBQ4ZZ	0VLQ3CZ	

Revenue Code(s)
RC 278
RC 320

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

Provider(s) shall follow applicable modifier guidelines.

All providers, except ambulatory surgical centers, must append modifier FP to the procedure code when billing for sterilization procedures. Other modifiers must be used, as applicable.

E. Billing Units

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

F. Place of Service

Physicians' offices, ambulatory surgery centers, outpatient clinics, inpatient and outpatient hospitals.

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

Provider(s) shall bill their usual and customary charges.

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

I. Denied Claims

1. Additional Information Required

When a claim is denied with an explanation of benefits (EOB) that indicates additional information is required (such as records to verify a procedure code or a date of service), the claim must be resubmitted with the requested documents and a copy of the valid consent form attached.

2. Undocumented Aliens

If an inpatient or outpatient hospital claims reimbursement for a sterilization procedure for an undocumented alien, the claim will be denied with a code indicating "beneficiary eligible for emergency services only." Providers shall:

- a. resubmit the claim as an adjustment, placing non-emergent charges (such as sterilization) in the Non-Covered column, and
- b. note the change in the Remarks field.

Note: Failure to complete both the Non-Covered column and the Remarks field will result in denial.

Attachment B: Instructions for Completing the Consent Form

Copies of the Sterilization Consent form can be downloaded from DMA's website at
<http://www.ncdhhs.gov/dma/provider/forms.htm>

A. Completing the Form

Following is the list of fields included in the federal consent form requirements for sterilization. All areas are required to be completed except area 9 (race) and areas 10, 11, and 12, if not applicable. **Fields in bold print cannot be altered. Once an error is made in these areas, consent form cannot be re-submitted.** This guide will assist in correct completion of consent forms and should help to decrease the number of denials related to errors in completing the form.

1. Person or facility that provided information concerning sterilization.
2. Type of sterilization procedure to be performed.
3. Beneficiary's date of birth (must be at least 21 years of age when the consent form is signed). Date of birth must match beneficiary files.
4. Name of beneficiary as it appears on the Medicaid Identification card.
5. The full name of the physician scheduled to do the surgery (abbreviations, initials, or "doctor on call" are unacceptable). May use "Physician on call for Any Provider OB/GYN clinic."
6. Type of sterilization procedure to be performed.
7. **Beneficiary's signature which must be dated cannot be altered, traced over, or corrected. Initials are not acceptable for the first name. The signature must be legible. If not, the Beneficiary's name must be typed or printed under the signature.**
8. **Date the consent form was signed. The date of the beneficiary's signature must be at least 30 days and no more than 180 days prior to the date of the sterilization. The count begins the day following the beneficiary's signature date.**
9. Race and ethnicity (not required).
10. Language in which the form was read to the beneficiary, if an interpreter was used.
11. **Signature of the interpreter. Initials are not acceptable for the first name. Use of a signature stamp is not acceptable.**
12. **Signature date of the interpreter (same as # 8 and # 16).**
13. Name of beneficiary.
14. Name of sterilization procedure.
15. **Signature of person obtaining consent must be dated (see # 16) and legible. If not legible, the name must be typed or printed above or below the signature. Initials are not acceptable for the first name. Use of a signature stamp is not acceptable.**
16. **Date (this date must be the same as the beneficiary signature date). Note: the doctor can also be the person obtaining consent.**
17. The full name and address of the facility, including street name and number, city, state, and zip code, where the consent was obtained and witnessed.
18. Name of beneficiary.
19. Actual date of sterilization. Date of surgery may be changed on consent form with submission of operative records verifying date of service.
20. Type of sterilization procedure performed.
21. The box is to be checked if the delivery was premature (write the beneficiary's expected delivery date in the space provided).

22. The box is to be checked if emergency abdominal surgery was performed. Claim must be submitted with operative records.
23. Physician's signature must be legible or name must be printed below the signature.
Initials are not acceptable for the first name. The use of a signature stamp is not acceptable. The physician signing the consent shall be the physician who performed the procedure.
24. Date must be on or after the date of service.
25. Providers NPI number must be added to the top left margin of the consent form.
26. The Recipient Identification Number (RID) [formerly Medicaid Identification Number (MID)] must be added to the top right margin of the consent form.

B. Abbreviations/Guide for Completion of Sterilization Consent Form

The following abbreviations are acceptable on the sterilization consent form as a description of the type of sterilization procedure:

BTF	Bilateral tubal fulguration
BTS	Bilateral tubal sterilization
BTC	Bilateral tubal cauterization
BTL	Bilateral tubal ligation
BPS	Bilateral postpartum sterilization
PPBTL	Postpartum bilateral tubal ligation
LTC	Laparoscopic tubal cautery

Acceptable written wording:

Application of fallopian rings/laparoscopic
Elective cauterization of fallopian tubes
Hulka clip occlusion
Laparoscopic tubal ligation
Pomeroy
Modified Pomeroy
Parkland
Tubal banding
Tubal sterilization
Yeon rings
Essure system

Unacceptable wording (not specific to type of procedure):

Tubal coagulation

C. Submitting Sterilization Consents Separately

When submitting sterilization consents separately from the claim, follow these instructions.

1. **Write the beneficiary's RID number** in the upper right corner of the consent form.
Medicaid's fiscal agent must have the RID to enter the form into the system.
2. **Verify** that all the information on the form is correct.
3. Mail the consent to:
CSC
PO Box 30968
Raleigh NC 27622

4. **Send only** sterilization consents submitted separately from the claim to PO Box 30968. Upon receipt, Medicaid's fiscal agent will review the consent to ensure adherence to federally mandated guidelines.
5. File claims electronically, or mail paper claims submitted without a consent to:

(Physicians)	(Hospitals)
CSC	CSC
PO Box 30968	PO Box 30968
Raleigh NC 27622	Raleigh NC 27622

D. Name Change Policy for Surgical Procedures

If the beneficiary's name on the claim and the name on the sterilization form are different, a signed name change statement verifying that they are the same person must be included (refer to example below).

E. Name Change Statement (Example)

Dr. Any Provider
101 Any Hwy
Any City NC 22222
Recipient 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)

Attachment C: The Consent Form

Copies of the Sterilization Consent form can be downloaded from DMA's website at
<http://www.ncdhhs.gov/dma/provider/forms.htm>

<p>NPI _____ (25)</p>	<p>RID _____ (26)</p>
<p>CONSENT FORM</p>	
<p>NOTICE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving Federal funds.</p>	
<p>CONSENT TO STERILIZATION</p> <p>I have asked for and received information about sterilization from _____ (1) _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.</p> <p>I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.</p> <p>I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.</p> <p>I understand that I will be sterilized by an operation known as a _____ (2) _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.</p> <p>I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.</p> <p>I am at least 21 years of age and was born on _____ (3) _____ (Month/Day/Year).</p> <p>I, _____ (4) _____, hereby consent of my own free will to be sterilized by _____ (5) _____ (doctor) by a method called _____ (6) _____. My consent expires 180 days from the date of my signature below.</p> <p>I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.</p> <p>I have received a copy of this form.</p> <p>_____, (7) _____ (Signature) _____ (Date) _____ (8) _____ (Month/Day/Year)</p> <p>You are requested to supply the following information, but it is not required:</p> <p>(9) Race and ethnicity designation (please check) <input type="checkbox"/> Black (not of Hispanic origin) <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian or Pacific Islander; <input type="checkbox"/> American Indian or Alaskan native; or <input type="checkbox"/> White (not of Hispanic origin).</p> <p>INTERPRETER'S STATEMENT</p> <p>If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ (10) _____ language and explained its content to him/her. To the best of my knowledge and belief he/she understood this explanation.</p> <p>_____, (11) _____ (Interpreter) _____ (Date) _____ (12) _____ (Month/Day/Year)</p>	<p>STATEMENT OF PERSON OBTAINING CONSENT</p> <p>Before _____ (13) _____ (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation _____ (14) _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.</p> <p>I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.</p> <p>I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.</p> <p>To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.</p> <p>_____, (15) _____ (Signature of person obtaining consent) _____ (Date) _____ (16) _____ (Month/Day/Year)</p> <p>_____, (17) _____ (Facility)</p> <p>_____, (Address)</p> <p>PHYSICIAN'S STATEMENT</p> <p>Shortly before I performed a sterilization operation upon _____ (18) _____ (Name of individual to be sterilized) on _____ (19) _____ (Date of sterilization) I explained to him/her the nature of the sterilization operation _____ (20) _____, the fact that it is _____ (specify type of operation) intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.</p> <p>I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.</p> <p>I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.</p> <p>To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.</p> <p>(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)</p> <p>(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.</p> <p>(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):</p> <p>(21) <input type="checkbox"/> Premature delivery. Individual's expected date of delivery: _____</p> <p>(22) <input type="checkbox"/> Emergency abdominal surgery: (describe circumstances): _____</p> <p>_____, (23) _____ (Physician) _____ (Date) _____ (24) _____ (Month/Day/Year)</p>

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