Division of Medicaid	New:	Date:
State of Mississippi Provider Policy Manual	Revised: X Current:	Date: 01/01/06
Section: Hospital Inpatient	Section: 25.29	
	Pages: 4	
Subject: Sterilization	Cross Reference:	

The Medicaid Program reimburses claims for sterilizations, hysterectomies and abortions in compliance with all federal and state regulations. In order to meet all guidelines, claims for these services must be filed as explained below. Any claim paid and subsequently found to be out of compliance with federal and/or state guidelines will be recouped.

Medicaid will cover sterilization procedures if they meet the Medicaid criteria listed below for a covered sterilization. There are no exceptions for each criterion.

The following criteria apply to all types of sterilization procedures, both male and female:

- 1. The beneficiary must be **mentally competent.** Medicaid benefits are not available for sterilization of a mentally incompetent or institutionalized individual.
- 2. The beneficiary must be 21 years old when the consent form is signed.
- 3. The beneficiary and only the beneficiary must sign the consent form voluntarily.
- 4. The consent form is **valid for 180 days** from the date it is signed by the patient.
- 5. The consent form must be **fully** and **accurately** completed.
- 6. There must be at least a 30-day waiting period between the date that the beneficiary signs the form and the date of the surgery.

An individual may be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least thirty (30) days before the expected date of delivery.

Caesarean deliveries are not routinely considered as emergency abdominal surgery.

The Division of Medicaid will require the appropriate medical documentation to justify any emergency abdominal procedures or premature deliveries. For premature deliveries, the physician must document the expected date of delivery.

When submitting the claim for sterilization services, the provider <u>MUST</u> attach a copy of the Sterilization Consent Form if one is not already on file with the fiscal agent. The form may be obtained from the fiscal agent. This form is required of all providers (i.e., primary and assistant surgeon, anesthesiologist, and hospital) involved in the sterilization procedure. The Sterilization Consent Form has four (4) parts and should be completed fully and accurately.

The Sterilization Consent Form should be completed as follows:

### 1. Consent to Sterilization

- Name of doctor or clinic <u>MUST</u> be entered
- Name of operation MUST be entered.

Section: 25.29

- Patient's date of birth <u>MUST</u> be entered.
- Patient's name MUST be entered.
- Name of doctor <u>MUST</u> be entered.
- Name of operation MUST be entered.
- Form MUST be signed and dated by the beneficiary.

### 2. Interpreter's Statement

• If an interpreter is necessary, that individual <u>MUST</u> complete this section, sign, and date the form on the same date as the beneficiary.

### 3. Statement of Person Obtaining Consent

- Patient's name MUST be entered.
- Name of operation MUST be entered.
- Person obtaining the consent <u>MUST</u> sign and date the form on the same day it was signed and dated by the beneficiary.
- Name and address of the facility where the consent is obtained MUST be entered.

### 4. Physician's Statement

- Name of individual MUST be entered.
- Date of sterilization MUST be entered.
- Type of operation <u>MUST</u> be entered.
- If paragraph (2) is true, the appropriate "block" MUST be checked.
- The physician performing the surgery <u>MUST</u> sign and date the form <u>AFTER</u> completing the operation.

Some general guidelines for filing sterilization claims:

- 1. The beneficiary must be 21 years old when the consent form is signed;
- 2. The consent form is valid for 180 days from the date it was signed by the patient; and
- 3. There must be at least a 30-day waiting period between the date the beneficiary signs the form and the date of the surgery. If emergency abdominal surgery is performed, the sterilization may be performed if 72 hours have elapsed from the time the beneficiary signed the form. STERILIZATIONS PERFORMED BEFORE THE 30-DAY WAITING PERIOD OR THE 72-HOUR LIMIT WILL NOT BE REIMBURSED.

Section: 25.29

# **CONSENT FORM**

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.

SATHER CHILDREN.  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 of rather a child in the furure. I have rejected these alternatives and chosen to be sterilized in the furure of the research of the procedure.  I make that that I will be sterilized by an operation known as a last content to be sterilized with the operation have been explained to me. All my questions have been answered to my satisfaction.  I understand that the operation will not be done until at least thirty questions have been answered to my satisfaction.  I understand that the operation have been explained to me. All my questions have been answered to my satisfaction.  I understand that the operation will not be done until at least thirty 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.  I am at least 21 years of age and was born on the sterilized will not result in the withholding of any benefits or medical services and the discount of the procedure	CONSENT TO STERILIZATION	STATEMENT OF PERSON OBTAINING CONSENT
when the same and the decision to be sterifized is conjected by to me. I was told that it could decide not to be sterifized is conjected by to me. I was told that it could decide not to be sterifized as conjected by the mean of the sterifized is conjected by the mean of the sterifized is conjected by the mean of the sterifized on the decide of the property of the sterifized is a final and irreversible procedure and the disconforts, risks and the other sterifized with it.  I UNDIFICATION THAT THE STERUZATION MUST BE CONDIDENT OR FATHER OF THE STERUZATION MUST BE CONDIDENT OR ONTO WANT TO BECOME PREGNANT, BEAR CHILDDEN OR FATHER OF THE STERUZATION MUST BE CONDIDENT OR ONTO WANT TO BECOME PREGNANT, BEAR CHILDDEN OR FATHER OF THE STERUZATION MUST BE CONDIDENT OR THE STERUZATION MUST BE CONDIDENT OR STATEMENT TO BECOME PREGNANT, BEAR CHILDDEN OR FATHER OF THE STATEMENT OF THE ST		Beforesigned the
difficultion to be settilized.  I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDER  I WAS teld about these temporary networks of bith control that see available which the through the very expected these attended to the sterilization of refater a child in the future. I have received the sea sterilized must be sterilized by an operation known as a landerstand that I will be sterilized by an operation known as a landerstand that I will be sterilized by an operation known as a landerstand that I will be sterilized by an operation known as a landerstand that I will be sterilized by an operation known as a landerstand that I will be sterilized by an operation known as a landerstand that I will be sterilized by an operation known as a landerstand that I will be sterilized by an operation known as a landerstand that I will be sterilized by an operation known as a landerstand that I will be sterilized by an operation known as a landerstand that I will be sterilized by an operation known as a landerstand that the operation will not be done until at least think will be a sterilized by the sterilized by	/doctor or clinic/	
Startifization is different because it is permanent.  Informed his includual to be sterilized that his/her consent can the constitution of the con	pletely 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	a final and irreversible procedure and the discomforts, risks and benefits associated with it.  I counseled the individual to be sterilized that alternative methods
SRED PERMANENT AND NOT REVERSIBLE I HAVE DECIDED THAT TO NOT WANT TO BECOME PERSONATE, BEAR CHILDREN OR PATHER CHILDREN OR PATHER CHILDREN OR PATHER CHILDREN OR PATHER CHILDREN OR THE WAS AND TO BECOME PERSONATE, BEAR CHILDREN OR THAT THE WAS AND THAT TO BECOME PERSONATE, BEAR CHILDREN OR THAT THE WAS AND THAT THE CHILDREN OR THAT THE WAS AND THAT THE		
I was told about those temporary methods of birth control that are available and could be provided in the which will allow me to bear available and could be provided to me which will allow me to bear available and could be provided to be sterilized. I have rejected these alternatives and chosen to be sterilized.  I understand that I will be sterilized by an operation known as a sessiciated with the operation have been explained to me. All my questions have been answered to my satisfaction.  I understand that I can change my mind at any time and that my decision are sufficiently formed programs.  I am at least 21 years of age and was born on the sterilized by the sterilization operation of my own free will no be sterilized by the sterilization operation of my own free will no be sterilized by the sterilization operation of my own free will no be sterilized by the sterilization and the sterilization operation of the sterilization operation of the sterilization operation of the sterilization operation of the sterilization operation operation operation operation of the sterilization operation of the sterilization operation operation operation of the sterilization operation of the sterilization operation operation operation operation operation operation operation operation operation of the sterilization operation ope		be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.
associated with the operation have been explained to me. All my questions have been explained to me. All my questions have been answered to my satisfaction.  I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision are provided by federally funded programs.  I am at least 21 years of age and was born on Meenth Day Year I and the constant to the release of this form and other medical records associated with it.  I also consent to the release of this form and other medical records about the operation so.  Representatives of the Department of Health Education, and Welfare or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.  I have received a copy of this form.  Assian or Pacific Islanded Day Meeting of the procedure and the disconsiderable in the control of the part of the procedure and the discompliance that the provided by Gederal laws were observed.  I am integration to the release of this form and other medical records the procedure and the discompliance that the provided by the decision of the procedure and the discompliance that the provided by the decision of the procedure and the discompliance that the provided by the decision of the procedure and the discompliance that the provided by the decision of the procedure and the discompliance that the provided by the decision of the procedure and the discompliance that the provided by the decision of the provided by the decision of the procedure and the discompliance that the provided by the decision of the procedure and the provided by the decision of the provid	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.	sterilized is at least 21 years old and appears mentally competent.  He/She knowingly and voluntarily requested to be sterilized and
associated with the operation have been explained to me, All my questions have been answered to my satisfaction or my satisfaction.  I understand that the operation will not be done until at least thirty days after I sign this form. Lunderstand 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 witholding of any benefits or medical services provided by federally funded programs.  I am at least 21 years of age and was born on Meonib Dry Year I am at least 21 years of age and was born on Meonib Dry Year I am at least 21 years of age and was born on Meonib Dry Year I am at least 21 years of age and was born on Meonib Dry Year I am at least 21 years of age and was born on Meonib Dry Year I am at least 21 years of age and was born on Meonib Dry Year I am at least 21 years of age and was born on Meonib Dry Year I am at least 21 years of age and was born on Meonib Dry Year My consent to the release of this form and other medical records about the operation to:  Representatives of the release of this form and other medical records about the operation to:  Representatives of the release of this form and other medical records about the operation to:  Representatives of the Department of Health Education and September 1 and the Control of the process of	•	Signature of person obtaining consent Date
The properties of the properti	. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.	Facility
Shortly before I performed a sterilization operation upon on result in the withholding of any benefits or medical services provided by federally funded programs.  I am at least 21 years of age and was born on Month Day Year I, whereby consent of my own free will to be sterilized by Month Day Year II, whereby consent of my own free will to be sterilized by Month Day Year II, whereby consent of my own free will to be sterilized by My consent expires 180 days from the date of my signature below.  I also consent to the release of this form and other medical records about the operation to:  Representatives of the Department of Health, Education, and Welfare or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.  I have received a copy of this form.  Also consent to the release of this form and other medical records that the provided by Federal I thinds. I consend that the provided by Federal I thinds. I consend the third of the process of the programs or projects funded by that Department but only for determining if Federal laws were observed.  I have received a copy of this form.  You are requested.  You are requested.  You are requested the supply the following information, but it is not required.  Assignative on the following information but it is not required.  Assignative on the following information of the process		Address
Shortly before I performed a sterilization operation upon revivided by federally funded programs.  I am at least 21 years of age and was born on hereby consent of my own free will to be sterilized by hereby consent of my own free will to be sterilized by hereby consent of my own free will to be sterilized by hereby consent to fmy own free will to be sterilized by a method called hereby consent to the release of this form and other medical records about the operation to:  Representatives of the Department of Health Education and bout the operation to:  Representatives of the Department of Health Education and bout the operation to:  Representatives of the Department of Health Education and bout the operation to:  Representatives of the Department of Health Education and bout only for determining if Federal laws were observed.  I have received a copy of this form.  You are requested to supply the following information, but it is not required:  You are requested to supply the following information, but it is not required.  Amperian inclina or  Amperian inclina or  Hispanic or the properation of the pr		PHYSICIAN'S STATEMENT
Amend and the straight of the	not result in the withholding of any benefits or medical services provided by federally funded programs.	
I have requested to supply the following information, but it and indigrates to be sterilized and specific sterilized to be sterilized by sterilized to be sterilized by sterilized to be sterilized and specific sterilized to be sterilized by sterilized to be sterilized and specifical to sterilized by sterilized to be sterilized and specifical to be sterilized by sterilized to be sterilized and specifical to be sterilized by sterilized by sterilized to be sterilized and specifical to be sterilized by sterilized and specifical to be sterilized by sterilized and specifical to be sterilized by sterilized and specifical sterilized by sterilized by sterilized and specifical sterilized by ster		Name of individual to be stacilized On Date of starilization
serilization operation of the sterilized by the serilization operation of the sterilization operation of the serilization operation to the release of this form and other medical records about the operation to:  Representatives of the Department of Health Education and Welfare or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.  I have received a copy of this form.  Signature  You are requested to sepph the following information, but it is not required:  Asian or Pacific Islander  White lock of Hispanic original Asias and statistics of the service of benefits of the individual to be sterilized and statistics of the service	•	operation , I explained to him/her the parture of the
white: PATIENT NAME    My consent to the release of this form and other medical records and the consent to the release of this form and other medical records about the operation to:   Also consent to the release of this form and other medical records about the operation to:   Representatives of the Department of Health Education and Welfare or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.    Signature		sterilization operation , the fact that
white: PATIENT NAME  My consent to the release of this form and other medical records about the operation to:  Representatives of the Department of Health Education and Welfare or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.  You are requested to seppit the following information, but it is not required:  Assian or Partific Islander:  Interpreter is provided to assist the isdividual to be sterilized to must be used. The partification is performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent to the sterilization may be received to be sterilized to the sterilization of the process of the	of my own free will to be sterilized by	
storment to the release of this form and other medical records about the operation to:  Representatives of the Department of Health Education and Welfare or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.  I have received a copy of this form.  Using the properties of the Department of Health Education and Welfare or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.  I have received a copy of this form.  Using the properties of the p	by a method called My consent expires 180 days from the date of my signature below.	forts, risks and benefits associated with it.  I counseled the individual to be sterlized that alternative methods
White: PATIENT Yellow: PHYSICIAN Pink: STATE AGENCY  Ovider Policy Manual Hospital Section: 25.29	about the operation to: Representatives of the Department of Health Education and Welfare or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.  I have received a copy of this form.    Signature	I infermed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any bealth services or benefits provided by Federal funds.  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.  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 bases, the second paragraph below must be used. Cress out the paragraph which is not used:  (1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.  (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):    Premature delivery   Individual's expected date of delivery:   Emergency abdominal surgery:   describe circumstances):
White: PATIENT Yellow: PHYSICIAN Pink: STATE AGENCY  Ovider Policy Manual Hospital Section: 25.29		
ovider Policy Manual Hospital Section: 25.29	PATIENT NAME	MEDICAID I.D. #
ovider Policy Manual Hospital Section: 25.29		
	XIX - SCF (2-96) White: PATIENT Yellow: PHYS	SICIAN Pink: STATE AGENCY

Page 3 of 4

## **Failed Sterilization Procedures**

The Division of Medicaid (DOM) provides coverage for covered sterilization procedures for males or females as "once-per-lifetime". In the event a second sterilization procedure is required due to failure of the first procedure, coverage will be provided for a second covered procedure. Documentation must be maintained in the beneficiary's medical record for the reason for the procedure failure and the date of the first sterilization.

Division of Medicaid State of Mississippi Provider Policy Manual		New: Date: Revised: X Date: 01/01/06 Current:
Section: Maternity Subject: Delivery and Tubal	Ligation Sterilization	Section: 38.06 Pages: 1 Cross Reference: Hospital Inpatient 25.25, 25.29 Surgery 52.03, 52.06 General Medical 53.19

Refer to Surgery Manual Section 52.03.

### **Delivery**

Hospital Inpatient Day Limits for Deliveries Refer to Hospital Inpatient, section 25.25

Reimbursement for Delivery
Refer to Surgery, section 52.03

Reimbursement for Multiple Birth Deliveries
Refer to Surgery, section 52.06

### **Sterilization**

The Division of Medicaid will reimburse covered sterilization procedures when the criteria for a covered sterilization are satisfied. Refer to Hospital Inpatient, section 25.29.

<u>Failed Sterilization Procedures</u>
<u>Refer to General Medical Policy, section 53.19.</u>

Reimbursement for Sterilizations Refer to Surgery, section 52.03.

Section: 38.06

Division of Medicaid State of Mississippi Provider Policy Manual		New: X Revised: Current:	Dat Dat	e: 01/01/06 e:
Section: General Medical P Subject: Failed Sterilization		Section: Pages: Cross Re	53. 19 1 ference:	

The Division of Medicaid (DOM) provides coverage for covered sterilization procedures for males or females as "once-per-lifetime". In the event a second sterilization procedure is required due to failure of the first procedure, coverage will be provided for a second covered procedure. The second procedure requires a second sterilization consent form to be completed. Documentation must be maintained in the beneficiary's medical record stating the date of the first sterilization and the reason for the procedure failure.

Section: 53.19