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 MUST 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 MUST be entered
   - Name of operation MUST be entered.
- Patient’s date of birth **MUST** be entered.
- Patient’s name **MUST** be entered.
- Name of doctor **MUST** 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 **MUST** 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 **MUST** 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 **MUST** be entered.
   - If paragraph (2) is true, the appropriate “block” **MUST** be checked.
   - The physician performing the surgery **MUST** sign and date the form **AFTER** 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.**
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.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____________________________. 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.

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.

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.

I understand that I will be sterilized by an operation known as a ___________. The discomforts, risks and benefits associated 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 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.

I am at least 21 years of age and was born on _____________.

I, ____________________________, hereby consent of my own free will to be sterilized by ___________________________. My consent expires 30 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.

You are requested to supply the following information, but it is not required:

Race and ethnicity statement (please check): □ American Indian or Alaska Native □ Black or African American □ Asian or Pacific Islander □ Hispanic □ White or of Hispanic origin

INTERPRETER'S STATEMENT

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 language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

________________________  __________________________
interpreter  __________________________

PATIENT NAME

________________________

MEDICAID I.D. #

White: PATIENT  Yellow: PHYSICIAN  Pink: STATE AGENCY

Signature  __________________________

Physician  __________________________

Date  __________________________

Section: 25.29

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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.
Delivery

Hospital Inpatient Day Limits for Delivery
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.

Failed Sterilization Procedures
Refer to General Medical Policy, section 53.19.

Reimbursement for Sterilizations
Refer to Surgery, section 52.03.
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.