POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**REFERENCE NUMBER:** SC.UM.45
EFFECTIVE DATE: 10/2009	**P&P NAME:** Sterilization and Hysterectomies
REVIEWED/REVISED DATE: 6/20; 6/21; 6/22	**RETIRED DATE:** N/A
BUSINESS UNIT: Absolute Total Care	**PRODUCT TYPE:** Medicaid
REGULATOR MOST RECENT APPROVAL DATE(S): N/A	

SCOPE:
Absolute Total Care Medical Management Departments

PURPOSE:
To provide guidelines for referral staff to document requests for sterilization and hysterectomies that is consistent and compliant with contract requirements.

DEFINITIONS: N/A

POLICY:
Absolute Total Care policy to ensure appropriate consent is in place prior to claims payment for sterilizations and hysterectomies, as well as address prior authorization requirements for hysterectomies.

PROCEDURE:

1. Sterilizations do not require prior authorization but do require Plan notification to ensure appropriate consent documentation is in place prior to claims payment. Hysterectomies do require plan authorization.

2. When a request for sterilization is received, the provider is advised that a copy of the signed **Consent for Sterilization Form** (**DHHS Form 687**) must be filed with the claim.

    a. Sterilization shall mean any medical procedure, treatment, or operation done for the purpose or rendering an individual permanently incapable of reproducing.
    b. The individual to be sterilized shall give informed consent not less than 30 calendar days (or not less than 72 hours in the case or premature delivery or emergency surgery), but not more than 180 calendar days, before the date of the sterilization. A new **Consent for Sterilization Form (DHHS Form 687)** is required if 180 days has passed before the surgery is provided.
    c. The **Consent for Sterilization Form (DHHS Form 687)** cannot be obtained while the patient is in the hospital for labor, childbirth, abortion or under the influence of alcohol or other substances that affects the patient's state of awareness.
    d. The Member must be at least 21 years of age at the time the consent is signed;
    e. The Member must be mentally competent;
    f. The Member is not institutionalized in a correctional facility, mental hospital, or other rehabilitative facility;
    g. The Member must voluntarily give informed consent on the approved **Consent for Sterilization Form (DHHS Form 687)**.
    h. An interpreter will be provided when language barriers exist. Arrangements will be made to effectively communicate the required information to a member who is visually impaired, hearing impaired or otherwise disabled.

3. When an authorization request for a medically necessary hysterectomy is received it must meet the following requirements.

    a) The Member or the Member's representative, if any, must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing.
    b) The Member or the Member's representative, if any, must sign and date an acknowledgment of receipt **Consent for Sterilization Form (DHHS Form 687) and Surgical Justification review for hysterectomy** prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age.

c) The **Consent for Sterilization Form (DHHS Form 687)** is acceptable when signed after the surgery only if it clearly states that the patient was informed prior to the surgery that she would be rendered incapable of reproduction.

d) The **Consent for Sterilization Form (DHHS Form 687)** is not required if the individual was already sterile before the hysterectomy or if the individual required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible. In these circumstances, a physician statement is required.

e) Hysterectomy shall not be covered if performed solely for the purpose of rendering an individual permanently incapable of reproducing.

f) Hysterectomy shall not be covered if there was more than one purpose for performing the hysterectomy, but the primary purpose was to render the individual permanently incapable of reproducing.

g) All prior approval requests for hysterectomies must be submitted with the **Consent for Sterilization Form (DHHS Form 687)** for review. There is a 30 day wait period from the date the **Consent for Sterilization Form (DHHS Form 687)** is signed before the surgery is performed. For urgent and emergent hysterectomy cases the 30 day wait is not required, however the reason for the emergency must be provided by the provider.

REFERENCES:
42 CFR 441 Subpart F
Section 4.2.14 - SCDHHS MCO P&P Guide

ATTACHMENTS:
Consent for Sterilization Form (DHHS Form 687)
Surgical Justification Review for Hysterectomy

SUPPORT/HELP: N/A

REGULATORY REPORTING REQUIREMENTS: N/A

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Annual Review	Removal of SCHIP from Product in Header. Minor grammatical corrections	09/01/2010
Annual Review	No changes/revisions	10/01/2011
Annual Review	Changed to Policy and Procedure	10/01/2012
Annual Review	No changes/revisions	10/01/2013
Ad Hoc Review	Under "Work Process" #2 added consent form name, "SCDHSS Form 1723".	01/01/2014
Annual Review	Typo corrections	10/01/2014
Ad Hoc Review	Updated signature approval	02/01/2015
Annual Review	Added Consent for Sterilization Form DHHS 1723. Added Surgical Justification Form for Hysterectomies. Under "Work Process" #2 and 2.g changed consent form name, "DHHS Form 1723". Under "Work Process" #3 added "(e) All prior approval requests for hysterectomies must be submitted 30 days prior to the scheduled surgery with the South Carolina Medicaid Surgical Justification Form and the Consent for Sterilization Form DHHS 1723 for review."	07/01/2016
Ad Hoc Review	Removed the attachment and any reference to South Carolina Medicaid Surgical Justification Form. Removed "prior authorization must be received 30 days before surgery.	12/01/2016

	Changed "consent form" to "**Consent for Sterilization Form"** Added to #3 g) "There is a 30 day wait period from the date the Consent for Sterilization Form is signed before the surgery is performed. For urgent and emergent hysterectomy cases the 30 day wait is not required, however the reason for the emergency must be provided by the provider." Changed the word individual and her to Member. Changed "Work Process" to "Procedure" and added Policy section.	
Annual Review	Updated with the new Consent to Sterilization Form number if 687. Added Surgical Justification Review for Hysterectomy to #3 (b). Changed the wording under #3 (d) from "acknowledgement form to "Consent for Sterilization Form (DHHS Form 687)". Updated the attachments to include the new "Consent for Sterilization Form" and added the "Surgical Justification Review for Hysterectomy".	06/01/2017
Annual Review	No changes/revisions	06/01/2018
Annual Review	New "Consent for Sterilization" form 687 reviewed and compared with policy. New form will be added as an "attachment" to this policy.	06/01/2019
Annual Review	No changes/revisions	06/01/2020
Annual Review	Grammatical corrections and updated policy template.	06/01/2021
Annual Review	Minor grammatical updates	06/01/2022

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

SOUTH CAROLINA MEDICAID PROGRAM
SURGICAL JUSTIFICATION REVIEW FOR HYSTERECTOMY

THIS COMPLETED FORM AND A SIGNED "ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION" FORM MUST BE RECEIVED 30 DAYS PRIOR TO SCHEDULED SURGERY.

PATIENT

NAME _____ **MEDICAID #** _____
LAST FIRST MI

BIRTHDATE _____ **GRAVITY** _____ **PARITY** _____
MONTH/DAY/YEAR

PROCEDURE CODE: _____ **DX CODE:** _____

HOSPITAL _____ _____
NAME NPI (IF AVAILABLE)

PLANNED ADMISSION DATE _____ **PLANNED SURGERY DATE** _____

TYPE OF HYSTERECTOMY PLANNED _____

GYNECOLOGICAL HISTORY/PHYSICAL EXAM RELATING TO PRINCIPAL DIAGNOSIS:

_____

_____

_____

_____

_____

_____

_____

HCT ___ **HGB** ___ **CHECK ONE: PREMENOPAUSAL** ____ **POSTMENOPAUSAL** ____

CONSERVATIVE TREATMENT/MEDICATION WITH DATES:

_____

_____

_____

PRIOR GYN SURGERY/DIAGNOSTIC PROCEDURES (INCLUDE COPIES OF ALL REPORTS):

_____

_____

_____

OFFICE NOTES AND ALL SUPPORTING DOCUMENTATION (e.g., ULTRASOUND, OPERATIVE AND PATH REPORTS, ETC.) ARE REQUIRED FOR APPROVAL AND SHOULD BE ATTACHED TO THIS FORM.

ATTENDING PHYSICIAN'S NAME _____ _____
LAST FIRST MI NPI

ADDRESS _____

CONTACT PERSON _____ **TELEPHONE** (____) _____

FAX (____) _____

SIGNATURE _____ **DATE** _____
ATTENDING PHYSICIAN

APPROVALS ARE VALID FOR 180 DAYS FROM DATE OF ISSUE.

Revised: 06/01/12

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Form Approved: OMB No. 0937-0166
Expiration date: 12/31/2018

CONSENT FOR STERILIZATION

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
Doctor or Clinic
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 Temporary Assistance for Needy Families (TANF) 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
Specify Type of Operation
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 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.

I am at least 21 years of age and was born on: _____
Date

I, _____, hereby consent of my own free will to be sterilized by _____
Doctor or Clinic

by a method called _____. My consent expires 180 days from the date of my signature below.
Specify Type of Operation

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 the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ _____
Signature *Date*

_____
Medicaid ID

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ 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's Signature *Date*

HHS-687 (10/12)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the consent form, I explained to him/her the nature of sterilization operation
Name of Individual

_____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.
Specify Type of Operation

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. 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.

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 consequences of the procedure.

_____ _____
Signature of Person Obtaining Consent *Date*

_____
Facility

_____
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ on _____
Name of Individual *Date of Sterilization*

I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.
Specify Type of Operation

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.

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.

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 paragraph**: 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.)

(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.

(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)*:

_____
_____
_____ _____
Physician's Signature *Date*