SHANDS
Jacksonville

POLICY NUMBER: FCA-2006-049
REVIEW RESPONSIBILITY:
REVISED: 06/01/08
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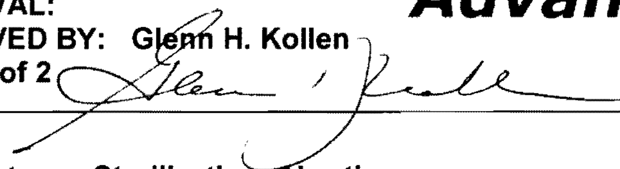
APPROVAL:
APPROVED BY: Glenn H. Kollen



First Coast Advantage

TITLE: **Hysterectomy, Sterilization, Abortion**

PURPOSE:

Compliance with Medicaid guidelines for Hysterectomies, Sterilizations, and Abortions. A log must be maintained of all hysterectomy, sterilization, and abortion procedures when preauthorized. The log must include the member's name and identifying information, date of procedure, and type of procedure.

PROCEDURE:

A. First Coast Advantage must cover hysterectomies when they are non-elective and medically necessary. The member must sign an Acknowledgement of Receipt of Hysterectomy information form (Attachment A). The acknowledgement form 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 acknowledgement was not possible (Attachment B).
   1. If medical necessity is met and the member is eligible for hysterectomy, the requesting provider is asked to fax or send copy of the Acknowledgement of Receipt of information form to the FCA preauthorization department. When the acknowledgement form is received, authorization is approved and the consent is filed with the request. If the hysterectomy is performed as an emergency, the inpatient review nurse must look for physician documentation that the procedure was done because of a life-threatening emergency before the hysterectomy can be authorized. The nurse reviewer will document physician's statement regarding the emergency in the review notes.

B. Sterilization must be documented with a completed consent form. (Attachment C). The member must be at least 18 years of age and must wait at least 30 days after signing the consent form to have the procedure, except in the instances of premature delivery or emergency abdominal surgery that takes place at least 72 hours after consent is obtained. The consent is effective for 180 days after the date signed.
   1. Preauthorization for sterilization will be given if all of the above requirements for sterilization are met. Authorization will be pended if copy of consent form is not provided to attach to the request. A copy of the completed consent form will be requested before paying sterilization claims when the procedure was not preauthorized.

C. Abortions may be performed because the life of the mother is or would be endangered if the fetus were carried to term or in cases of rape or incest. Abortions must be documented in the medical record by the attending physician stating why the abortion was necessary, or if the pregnancy is the result of an act of rape or incest. Abortions must be documented with a completed Abortion Certification form (Attachment D.)
   1. Authorization for abortions will only be given when all Medicaid guidelines have been met and the nurse will request a copy of the Abortion Certification Form. Authorization will be pended until copy of the completed form is received to attach to the request.

Attachments:

A. Acknowledgement of Receipt of Hysterectomy Information
B. Exception to Hysterectomy Acknowledgment Requirement
C. Sterilization Consent Form
D. Abortion Certification Form

STATE OF FLORIDA
HYSTERECTOMY
ACKNOWLEDGMENT FORM

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

PART A - PHYSICIAN STATEMENT:

______________________, ______________, understand that the Florida
(PRINT PHYSICIAN'S NAME) (PROVIDER NO.)
Medicaid Program shall not allow payment for a hysterectomy unless it is performed pursuant to the federal requirements stated in 42 CFR 441, Subpart F and accordingly Parts A and B of this form are being completed.

The hysterectomy to be performed is not solely for the purpose of rendering the below mentioned recipient permanently incapable of reproducing nor is the hysterectomy for medical purposes which by themselves do not mandate a hysterectomy. The nonelective hysterectomy is therefore being performed for the following medical reasons:

____
(ENTER DX AND EXPLAIN IF NECESSARY)

____

____

____

______________________________ ______________
PHYSICIAN'S SIGNATURE DATE

PART B - PATIENT STATEMENT:

It was explained verbally before surgery and in writing by completion of this form to:

____
(PRINT: RECIPIENT'S FIRST NAME, INITIAL, LAST NAME, MEDICAID I.D. #)

that the hysterectomy to be performed or which was performed would render her permanently incapable of reproducing.

______________________________ ______________
PATIENT'S SIGNATURE OR MARK DATE

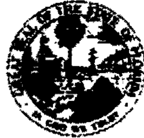
Patient's mark must be witnessed by her representative.

______________________________ ______________
INTERPRETER'S SIGNATURE, WHEN NECESSARY DATE

DISTRIBUTION OF COPIES:
ORIGINAL - Retain in patient's medical record at physician's office.
1 COPY - To patient.
Other copies as required - See note below.

NOTE: A copy of this form shall be attached to any and all Medicaid claims submitted by providers involved in the performance of the procedure.

HAF 7/94



STATE OF FLORIDA
STERILIZATION 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
(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 program 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 these 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 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

____
MONTH DAY YEAR

I, ______________________________, hereby consent

of my own free will be sterilized by ______________________
DOCTOR

by a method called ______________________. 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 and Human Services 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.

______________________ Date ______________
SIGNATURE MONTH/DAY/YEAR

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

Race and ethnicity designation (please check)

- ❑ American Indian or Alaska Native
- ❑ Asian or Pacific Islander
- ❑ Black (not of Hispanic origin)
- ❑ Hispanic
- ❑ White (not 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.

____
SIGNATURE DATE

STATEMENT OF PERSON OBTAINING CONSENT

Before ______________________________ signed the
NAME OF RECIPIENT
consent form, I explained to him/her the nature of the sterilization operation ______________________. The fact that is intended to be a final and irreversible procedure and the discomfort, risks and benefits associated with it.

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 component. 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 TO BE STERILIZED
______________________. I explained to him/her the
DATE OF STERILIZATION OPERATION

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.

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 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 forms. In these cases, the second paragraph below must be used. Cross 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:)

____
PHYSICIAN SIGNATURE DATE OF SURGERY

State of Florida
Abortion
Certification Form

SECTION I

1. Recipient's Name:______________________________

2. Address:______________________________

3. Medicaid Identification Number:______________________________

SECTION II

4. On the basis of my professional judgment, I have performed an abortion on the above named recipient for the following reason:

   - ☐ The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.
   - ☐ Based on all the information available to me, I concluded that this pregnancy was the result of an act of rape.
   - ☐ Based on all the information available to me, I concluded that this pregnancy was the result of an act of incest.

I have documented in the patient's medical record the reason for performing the abortion; and I understand that Medicaid reimbursement to me for this abortion is subject to recoupment if medical record documentation does not reflect the reason for the abortion as checked above.

5. ______________________________
   Physician's Name

6. ______________________________
   Physician's Signature

7. ______________________________
   Physician's Medicaid Provider Number

8. ______________________________
   Date of Signature

August 2001

STATE OF FLORIDA
EXCEPTION TO HYSTERECTOMY ACKNOWLEDGMENT REQUIREMENT
State of Florida Physicians Certification Statement for Exception to Hysterectomy Acknowledment Requirement

SECTION I

I ______________________, ______________ certify that
(PRINT PHYSICIAN NAME) (PROVIDER NUMBER)
the condition(s) marked below existed at the time a hysterectomy was performed for ______________________, ______________.
(PRINT RECIPIENT'S NAME) (MEDICAID I.D. NUMBER)

_______ A. The recipient was already sterile at the time of the hysterectomy.

Specify cause of sterility:

_______ Postmenopausal

_______ Congenital disorder: Specify ______________________

____

_______ Previously surgically sterilized: Specify method

____

_______ B. The recipient requires an emergency hysterectomy because of a life threatening emergency situation. (The emergency situation must render the recipient incapable of understanding or responding to the information pertaining to the acknowledgment agreement because of the emergency nature of her admission). Please describe the nature of the emergency below.

SECTION II

Physician Statement of Certification

For the above reason(s), I am requesting an exception to the hysterectomy acknowledgment requirement for the hysterectomy services indicated on the attached claim for (HCFA-1500 or UB 92).

____
(Physician Signature)

______________________ ______________________
Fiscal Agent Screening Supervisor (Date)

1 ☐
2 ☐
3 ☐
4 ☐
5 ☐
6 ☐
7 ☐
8 ☐
9 ☐
10 ☐