Sterilization and Abortion Policy Billing Instructions

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Hysterectomy

A hysterectomy is the removal of the whole uterus. Medicaid coverage is limited to hysterectomies that are medically necessary.

Recipients may act on their own or have a legal representative act on their behalf. For the purpose of this section, recipient refers to the recipient or their legal representative as applicable.

Acknowledgement form

A hysterectomy acknowledgement form is proof that the recipient was informed orally and in writing that the hysterectomy will make her permanently incapable of reproducing.

The Nevada Medicaid Hysterectomy Acknowledgement Form (FA-50) must be attached to the first claim submitted for the procedure, regardless of which provider submits it.

All claims related to the procedure will be denied if an acknowledgement form is not submitted.

All signatures on this form must be original signatures. A physician's rubber stamp signature will not be accepted.

Complete the applicable sections of form FA-50 to indicate if the recipient was informed orally and in writing before the surgery or after the surgery of the permanent consequences. The form instructions are located on page 2 of the form.

Only under the following circumstances may the recipient be informed of this *after* the surgery:

- The physician who performs the hysterectomy must complete Section III of form FA-50 to indicate that the recipient was already sterile at the time of the hysterectomy, and state the cause of the sterility.
- The physician performs the hysterectomy under a life-threatening emergency in which the physician determined prior written acknowledgement from the recipient was not possible. The physician must include a description of the nature of the emergency and must date the certification after the emergency.

Prior authorization requirements

Prior authorization is not required for a medically necessary hysterectomy procedure; however, prior authorization is required for the inpatient hospital admission.

Covered services

The table below shows covered codes to be used when billing for a hysterectomy.

Code	Description
00846	Anesthesia for radical hysterectomy
00944	Anesthesia for vaginal hysterectomy
01963	Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care
51597	Pelvic exenteration, complete, for vesical, prostatic or urethral malignancy, with or without hysterectomy and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58152	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s) with colpo-urethrocystopexy (e.g. Marshall-Marchetti-Krantz, Burch)

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Code	Description
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58200	Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tubes(s), with or without removal of ovary(s)
58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph noide sampling (biopsy), with or without removal of tubes(s), with or without removal of ovary(s)
58240	Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cericectomy, with or without removal of tubes(s), with or without removal of ovary(s), with removal of bladder and urethral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof
58260	Vaginal hysterectomy, for uterus 250 grams or less
58262	Vaginal hysterectomy, for uterus 250 grams or less; with removal of tubes(s) and/or ovary(s)
58263	Vaginal hysterectomy, for uterus 250 grams or less; with removal of tubes(s) and/or ovary(s), with repair of enterocele
58267	Vaginal hysterectomy, for uterus 250 grams or less; with copo-urethocystopexy (Marshall-Marchette-Krantz type, Pereyra type) with or without endoscopic control
58270	Vaginal hysterectomy, for uterus 250 grams or less; with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele
58285	Vaginal hysterectomy, radical (Schauta type operation)
58290	Vaginal hysterectomy, for uterus greater than 250 grams
58291	Vaginal hysterectomy, for uterus greater than 250 grams with removal of tube(s) and/or ovary(s)
58292	Vaginal hysterectomy, for uterus greater than 250 grams with removal of tube(s) and/or ovary(s), with repair of enterocele
58294	Vaginal hysterectomy, for uterus greater than 250 grams with repair of enterocele
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250g or less
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250g or less with removal of tubes and/or ovary
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250g
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250g with removal of tubes and/or ovary
58548	Laparoscopy, surgical, with radical hysterectomy
58550	Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less
58552	Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)

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Code	Description
58553	Laparoscopy surgical, with vaginal hysterectomy, for uterus greater than 250 grams
58554	Laparoscopy surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical with total hysterectomy, for uterus 250g or less
58571	Laparoscopy, surgical with total hysterectomy, for uterus 250g or less with removal of tubes and/or ovary
58572	Laparoscopy, surgical with total hysterectomy, for uterus greater than 250g
58573	Laparoscopy, surgical with total hysterectomy, for uterus greater than 250g with removal of tubes and/or ovary
58575	Laparoscopy, surgical with total hysterectomy for resection of malignancy, including salpingo-oophorectomy, unilateral/bilateral
58671	Laparoscopy surgical, withlysis of adhesions (salpingolysis, ovariolysis) (separate procedure) with occlusion of oviducts by device (e.g. band, clip, or Falope ring)
58951	Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy
59135	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach; interstitial, uterine pregnancy requiring total hysterectomy
59525	Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)

Intrauterine Devices and Subdermal Implants

Intrauterine devices (IUDs) (Mirena®, ParaGard® and Skyla®) and subdermal implants (Implanon® and Nexplanon®) must be billed with the appropriate National Drug Code (NDC) with a unit of 1, rather than the HCPCS code. This billing process will benefit physicians and practitioners because the reimbursement for these NDCs will be automatically updated weekly keeping reimbursement in line with industry standards.

Family planning: sterilization

Medicaid payment is available for surgical procedures and/or contraceptive devices that result in permanent sterilization, including tubal ligation (Current Procedural Terminology [CPT] codes 58600, 58605 and 58611) and vasectomy (CPT 55250) when all of the following conditions have been met:

- The recipient is at least 21 years old at the time consent is obtained
- The recipient is neither mentally incompetent nor institutionalized
- The recipient is not in labor (childbirth)
- The recipient is not under the influence of alcohol or other drugs
- The recipient is not seeking or obtaining an abortion
- The recipient has voluntarily given informed consent and signed the Sterilization Consent Form (FA-56)

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- At least 30 days, but not more than 180 days have passed between the date of informed consent and the date of sterilization.

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

1. Premature delivery: The sterilization consent form must have been signed at least 30 calendar days before the expected date of delivery and at least 72 hours before the sterilization is performed.
2. Emergency abdominal surgery: The sterilization consent form must have been signed at least 72 hours before the sterilization is performed.
    - In the case of premature delivery, the physician must state the expected date of delivery.
    - In the case of emergency abdominal surgery, the physician must describe the emergency.

Before the recipient signs the Sterilization Consent Form, you must orally inform him or her:

- About the procedure
- About alternative methods of family planning and birth control
- That sterilization is considered irreversible
- About the discomforts and risks of the surgery
- About the benefits or advantages of sterilization
- That no federal benefits will be withdrawn if he or she decides not to be sterilized

You must effectively communicate this information to any individual, regardless of any handicaps or language barriers. If the recipient does not understand any part of the Sterilization Consent Form or the oral explanation as discussed above, you must provide an interpreter or another means for them to understand this information.

Tubal Ligation

When a tubal ligation is performed at the time of obstetric delivery, be sure to submit a Sterilization Consent Form with your claim. Failure to provide this form will result in claim denial when a copy of the form is not on file with Nevada Medicaid.

Prior authorization requirements

Prior authorization is not required for sterilization procedures; however, an inpatient *admission* specifically for a sterilization procedure must be prior authorized.

Covered services

Use ICD-10 diagnosis code Z302 to bill for sterilization.

The table below shows covered CPT codes for sterilization.

Code	Description
54690	Laparoscopy, surgical; orchiectomy
55200	Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)
55250	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)
55450	Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)
58600	Ligation or transaction of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58605	Ligation or transaction of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)

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Code	Description
58611	Ligation or transaction of fallopian tube(s), when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)
58615	Occlusion of fallopian tube(s) by device (e.g. band, clip, Falope ring) vaginal or suprapubic approach
58661	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure) with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58670	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure) with fulguration of oviducts (with or without transaction)
58671	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure) with occlusion of oviducts by device (e.g. band, clip or Falop ring)
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

Abortion

Abortion services are covered for pregnancy resulting from rape, incest, if the procedure is necessary to save the life of the mother, or when it has been determined by a provider to be otherwise medically necessary. This includes the treatment of incomplete, missed or septic abortions. Elective abortions are not a covered benefit.

Medically necessary abortions:

Medicaid will reimburse for abortion services provided they meet the criteria of medical necessity as outlined in Medicaid Services Manual (MSM) Chapter 100, Section 103.1. Prior Authorization must be requested using form prior to services being rendered. CPT codes for induced abortion services include 59840-59857 and 59866.

Pregnancy resulting from rape or incest:

Medicaid will reimburse for abortion services provided to terminate pregnancies resulting from rape or incest when the following procedures are followed:

The pregnant woman must sign a declaration attesting to the fact the pregnancy is the result of rape or incest. Use form FA-54 for rape and form FA-55 for incest.

The recipient must sign form FA-54 or FA-55 in the presence of two witnesses who must be employees of the physician, clinic or health facility where the abortion services are provided. The physician who performs the abortion must sign the bottom half of the form.

A copy of the declaration must be attached to the claim submitted to Nevada Medicaid. The physician is required to maintain the original copy of the form in their records.

Missed abortion and life threatening pregnancy:

When submitting a claim for a missed abortion or for an abortion to save the life of the mother, the physician must attach to the claim a signed certification stating that on the basis of the physician's professional judgment, and supported by adequate documentation, the mother's life would have been endangered if the fetus were carried to term and explain why the abortion was medically necessary to save the life of the mother. Providers must use form FA-57.

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Prior Authorization requirements

Prior authorization is required for medically necessary abortions. If an abortion is performed in an inpatient setting, prior authorization is required for pregnancy resulting from rape or incest, if the procedure is necessary to save the life of the mother, or when it has been determined by a provider to be otherwise medically necessary.

Authorization does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

Billing procedures

All claims submitted for induced abortion procedures must have the appropriate condition code indicating the reason for the abortion. Claims will be denied when no condition code is present.

Abortions that are the result of rape, incest or to save the life of the mother **must have a claims attachment with the appropriate form** (FA-54 for rape, form FA-55 for incest, and FA-57 for life endangerment).

See Provider Web Portal Chapter 3 Claims for billing instructions, including submitting attachments.

The following tables show covered codes/services. Use Table A1 when submitting professional claims and Table A2 when submitting institutional claims. **Table A3 indicates the condition codes that must be attached to to all claim types (professional and institutional).**

Table A1: Professional Claims

Code	Description
01964	Anesthesia for abortion procedures
59840	Induced abortion, by dilation and curettage
59841	Induced abortion, by dilation and evacuation
59850	Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines
59851	With dilation and curettage and/or evacuation
59852	With hysterectomy (failed intra-amniotic injection)
59855	Induced abortion, by one or more vaginal suppositories (e.g. prostaglandin) with or without cervical dilation (e.g. laminaria), including hospital admission and visits, delivery of fetus and secundines
59856	With dilation and curettage and/or evacuation
59857	With hysterotomy (failed medical evacuation)
59866	Multifetal pregnancy reduction(s)

Table A2: Institutional Claims

Code	Description
59812	Treatment of incomplete abortion, any trimester, completed surgically
59820	Treatment of missed abortion, completed surgically, first trimester
59821	Treatment of missed abortion, completed surgically, second trimester
59830	Treatment of septic abortion completed surgically

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Code	Description
59840	Induced abortion, by dilation and curettage
59841	Induced abortion, by dilation and evacuation
59850	Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines
59851	With dilation and curettage and/or evacuation
59852	With hysterectomy (failed intra-amniotic injection)
59855	Induced abortion, by one or more vaginal suppositories (e.g. prostaglandin) with or without cervical dilation (e.g. laminaria), including hospital admission and visits, delivery of fetus and secundines
59856	With dilation and curettage and/or evacuation
59857	With hysterotomy (failed medical evacuation)
59866	Multifetal pregnancy reduction(s)

Table A3 : Condition Codes (must be listed on claim)

Code	Description
AA	Abortion performed due to rape.
AB	Abortion performed due to incest.
AD	Abortion performed due to life endangering physical condition caused by, arising from or exacerbated by the pregnancy.
AE	Abortion performed due to physical health of the mother that is not life endangering.*
AF	Abortion performed due to emotional/physchological health of the mother.*

*Prior Authorization necessary for utilization of these condition codes.

Note: Use of any other condition codes will result in claim denial.