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# Sterilization

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This section includes instructions to bill for sterilization services.

## **Human Reproductive Sterilization Defined**

Under the regulations, human reproductive sterilization is defined as any medical treatment, procedure or operation for the purpose of rendering an individual permanently incapable of reproducing. Sterilizations which are performed because pregnancy would be life threatening to the mother (so-called “therapeutic” sterilizations) are included in this definition. The term sterilization, as used in Medi-Cal regulations, means only human reproductive sterilization, as defined above.

**Note:** For hysterectomy policy, refer to the *Hysterectomy* section in this manual.

## **Coverage Conditions**

The conditions under which sterilization procedures for both inpatient and outpatient services are reimbursable by the Medi-Cal program conform to federal regulations.

A sterilization will be covered by Medi-Cal only if the following conditions are met:

1. The individual is at least 21 years old at the time written consent for sterilization is obtained.

**Note:** Under Medi-Cal regulations, a patient must be 21 years old to give consent to a sterilization. This is a federal requirement for *sterilizations only* and is not affected by state law regarding the ability to give consent to medical treatment generally. The age limit is an absolute requirement. There are no exceptions for marital status, number of children or for a therapeutic sterilization.

2. The individual is not mentally incompetent. A mentally incompetent individual is a person who has been declared mentally incompetent by the federal, state or local court of competent jurisdiction for any purposes which include the ability to consent to sterilization.
3. The individual is able to understand the content and nature of the informed consent process as specified in this section. A patient considered mentally ill or with intellectual disabilities may sign the consent form if it is determined by a physician that the individual is capable of understanding the nature and significance of the sterilizing procedure.

4. The individual is not institutionalized. For the purposes of Medi-Cal reimbursement for sterilization, an institutionalized individual is a person who is:
  - Involuntarily confined or detained under civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or
  - Confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.
5. The individual has voluntarily given informed consent in accordance with all the requirements prescribed in this section.
6. At least 30 days, but not more than 180 days, have passed between the date of the written and signed informed consent and the date of the sterilization, except in the following instances:
  - Sterilization may be performed at the time of emergency abdominal surgery if:
    - The patient consented to the sterilization at least 30 days before the intended date of sterilization, and
    - At least 72 hours have passed after written informed consent was given and the performance of the emergency surgery.
  - Sterilization may be performed at the time of premature delivery if the following requirements are met:
    - The written informed consent was given at least 30 days before the expected date of the delivery, and
    - At least 72 hours have passed after written informed consent to be sterilized was given.
7. A completed consent form must accompany all claims for sterilization services. This requirement extends to all providers, attending physicians or surgeons, assistant surgeons, anesthesiologists and facilities. However, only claims directly related to the sterilization surgery require consent documentation. Claims for presurgical visits and tests or services related to postsurgical complications do not require consent documentation.

## **Informed Consent Process**

The informed consent process may be conducted either by a physician or by the physician's designee.

An individual has given informed consent only if:

1. The person who obtained consent for the sterilization procedure:
  - Offered to answer any questions the individual may have had concerning the sterilization procedure, and
  - Provided the individual with a copy of the consent form and the booklet on sterilization published by the Department of Health Services, and
  - Provided orally all of the following information to the individual to be sterilized:
    - Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled.
    - A full description of available alternative methods of family planning and birth control.
    - Advice that the sterilization procedure is considered to be irreversible.
    - A thorough explanation of the specific sterilization procedure to be performed.
    - A full description of the discomforts and risks that may accompany or follow performing the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
    - A full description of the benefits or advantages that may be expected as a result of the sterilization.
    - Approximate length of hospital stay.
    - Approximate length of time for recovery.
    - Financial cost to the patient.
    - Information that the procedure is established or new.
    - Advice that the sterilization will not be performed for at least 30 days, except under the circumstances of premature delivery or emergency abdominal surgery.
    - The name of the physician performing the procedure; if another physician is to be substituted, the patient shall be notified of the physician's name and the reason for the change in physicians prior to administering preanesthetic medication.

2. Suitable arrangements were made to ensure that the information specified above was effectively communicated to any individual who is blind, deaf, or otherwise handicapped.
3. An interpreter was provided if the individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent.
4. The individual to be sterilized was permitted to have a witness of the individual's choice present when consent was obtained.
5. The sterilization operation was requested without fraud, duress, or undue influence.
6. The appropriate consent form was properly filled out and signed.
7. Informed consent may not be obtained while the individual to be sterilized is:
  - Under the influence of alcohol or other substances that affect the individual's state of awareness.
  - In labor or within 24 hours postpartum or postabortion.
  - Seeking to obtain or obtaining an abortion.
    - “Seeking to obtain” means that period of time during which the abortion decision and the arrangements for the abortion are being made.
    - “Obtaining an abortion” means that period of time during which an individual is undergoing the abortion procedure, including any period during which preoperative medication is administered.

Medi-Cal regulations prohibit the giving of consent to a sterilization at the same time a patient is seeking to obtain or obtaining an abortion. This does not mean, however, that the two procedures may never be performed at the same time. If a patient gives consent to sterilization, then later wishes to obtain an abortion, the procedures may be done concurrently. An elective abortion does not qualify as emergency abdominal surgery, and this procedure does not affect the 30-day minimum wait.

## **«Sterilization Consent Form (DHCS 8649): General Information**

The only sterilization consent form accepted by Medi-Cal is the Department of Health Services' *Consent Form* (DHCS 8649).

A sample DHCS 8649 and instructions for completing the form are included in this section.. These instructions must be followed exactly or the DHCS 8649 will be returned and reimbursement delayed. The DHCS 8649 form requirements are imposed by the Federal government and can be found in *California Code of Regulations*, Title 22, Section 51305.4.

### **Ordering Forms**

DHCS 8649 can be downloaded from the Forms page of the Medi-Cal website located at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov). For questions or assistance call the Telephone Service Center (TSC) at 1-800-541-5555.

Additional information can be found on the DHCS [Sterilization Materials](#) webpage.»

## **Sterilization Consent Form Instructions**

1. Name of physician or clinic. Name of the doctor, group, clinic or hospital. If the provider is a physician group, all names may appear (for example, Drs. Miller and Smith), the professional group name may be listed (for example, "Westside Medical Group") or the phrase "and/or his/her associates" may be used. This line may be pre-stamped or typed.
2. Name of procedure. Enter the full name of the procedure. «If completing the DHCS 8649 in Spanish, the name of the procedure may be written in Spanish. Must be consistent throughout DHCS 8649 (numbers 2, 6, 13 and 20) and must match name of procedure on the claim.» This line may be pre-stamped or typed.
3. Patient's birthdate. Month, day and year required and must match the patient's date of birth on the claim. The patient must be at least 21 years of age at the time consent is obtained.
4. Patient's name. «Must be consistent throughout the DHCS 8649 and must match the patient's name on the claim.» Print the last name first; use one letter per square.
5. Physician's name. If a group, all provider's names may be listed, or the phrase "and/or his/her associates." This line may be pre-stamped or typed.
6. Name of procedure. Enter the full name of the procedure. «If completing the DHCS 8649 in Spanish, the name of the procedure may be written in Spanish. Must be consistent throughout the DHCS 8649 (numbers 2, 6, 13 and 20).» This line may be pre-stamped or typed.
7. Patient's signature. If the patient signs the consent form with an "X", a symbol/character or in a non-Arabic alphabet, the signature must be countersigned by a witness. «Must be consistent throughout the DHCS 8649 (numbers 4, 7, 12 and 18).»
8. Date. Patient's signature must be dated with month/day/year. The required 30-day waiting period is calculated from this date.

## **Interpreter's Statement**

9. Language. Indicate the language in which the patient was counseled, if other than English or Spanish.
10. Interpreter's signature. A signature is required if an interpreter was used.
11. Date. Interpreter's signature must be dated with month/day/year.

## Statement Of Person Obtaining Consent

12. «Patient's name. Patient's name must be consistent throughout the DHCS 8649 (numbers 4, 7, 12 and 18) and must match the patient's name on the claim.
13. Name of procedure. Enter the full name of the procedure. If completing the *Consent Form* in Spanish, the name of the procedure may be written in Spanish. Must be consistent throughout the DHCS 8649 (numbers 2, 6, 13 and 20). This line may be pre-stamped or typed.»
14. Signature of person obtaining consent. Signature required from person providing sterilization counseling; it may be a physician or the physician's designee.
15. Date. Signature of the person obtaining consent must be dated with month/day/year.
16. Name of facility. Name of place where patient was given sterilization counseling, for example, a physician's office, clinic, etc. (Not necessarily the facility where the procedure was performed.) May be pre-stamped or typed.
17. Address of facility. Complete mailing address of facility identified in number 16. It must include a street address, city, state and ZIP code. Once this section is completed, the patient must be given a copy of the consent form. May be pre-stamped or typed.

## Physician's Statement

18. Patient's name. «Patient's name must be consistent throughout the DHCS 8649 (numbers 4, 7, 12 and 18) and must match the patient's name on the claim.»
19. Date. Enter month/day/year. This date must match the date of the procedure on the claim.
20. Name of procedure. Enter the full name of the procedure. «If completing the DHCS 8649 in Spanish, the name of the procedure may be written in Spanish. Must be consistent throughout the DHCS 8649 (numbers 2, 6, 13 and 20).» This line may be pre-stamped or typed.

21. Premature delivery. If the minimum waiting period of 30 days has not been met due to a premature delivery. Complete date of premature delivery and date delivery was expected.
22. Premature delivery date. Date of premature delivery with month/day/year. «This date must be at least 72 hours from the date consent was given by the patient and the date of the sterilization procedure and must be completed if box for premature delivery is marked.»
23. Individual's expected date of delivery. Date of patient's expected delivery with month/day/year as estimated by physician based on the patient's history and physical condition. This date must be at least 30 days from the date consent was given by the patient).
24. Emergency abdominal surgery. Mark the box if the minimum waiting period of 30 days was not met due to emergency abdominal surgery or if 72 hours has not passed between the date the patient gave consent and the date of the emergency abdominal surgery. Enter name of the operation performed and describe the circumstances.
25. Physician's signature. Signature of the physician who has verified consent and who actually performed the operation is required.
26. Date. Physician's signature must be dated with month/day/year. Date must be on or after the sterilization date.



## «Consent for Sterilization Form-DHCS 8649»

State of California – Health and Human Services Agency		Department of Health Care Services
<b>CONSENT FOR STERILIZATION</b>		
<b>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.</b>		
<b>CONSENT TO STERILIZATION</b>		
I have asked for and received information about sterilization from: (Doctor or Clinic): _____.		
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.		
<b>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.</b> I was told about temporary methods of birth control that 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 (Type of Operation):		
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 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. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health Care Services, or Employees of programs or projects funded by the Department but only for determining if State and Federal laws were observed. I have received a copy of this form.		
Print Name: _____		
Signature: _____	Date: _____	

Figure 1: Sample Sterilization Consent Form (DHCS 8649) –Consent Section

<b>INTERPRETER'S STATEMENT (If an interpreter is provided to assist the individual to be sterilized)</b>	
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 the individual the consent form in (Language) _____ and explained its contents to the individual. To the best of my knowledge and belief the individual understood this explanation.	
Printed Name: _____	
Interpreter's Signature: _____	Date: _____

**Figure 2:** Sample Sterilization Consent Form (DHCS 8649) –Interpreter's Statement

<b>STATEMENT OF PERSON OBTAINING CONSENT</b>		
Before (Name of Individual) _____ signed the consent form, I explained to the individual the nature of sterilization operation (Type of 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 the individual 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. The individual 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: _____

**Figure 3:** Sample Sterilization Consent Form (DHCS 8649) –Statement of Person Obtaining Content

PHYSICIAN'S STATEMENT		
Shortly before I performed a sterilization operation upon (Name of Individual): _____ on Date of Sterilization: _____ I explained to him/her the nature of the sterilization operation (Type of Operation) _____, the fact that it is intended to be a final and irreversible procedure, and the discomforts, risks and benefits associated with it.		
<ul style="list-style-type: none"><li>• I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary.</li><li>• I explained that sterilization is different because it is permanent.</li><li>• I informed the individual to be sterilized that the individual consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.</li><li>• To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. The individual knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.</li></ul>		
<p align="center"><b>(Instructions for use of alternative final paragraph:</b></p> <p>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.)</p> <p>(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.</p> <p>(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):</p>		
<input type="checkbox"/> Premature delivery- Individual's Expected Date of Delivery:	<input type="checkbox"/> Emergency abdominal surgery- Describe circumstances:	Signature: <div style="border: 1px solid red; height: 30px; width: 100%;"></div>
		Date: <div style="height: 30px; width: 100%;"></div>

**Figure 4:** Sample Sterilization Consent Form (DHCS 8649) –Physician's Statement

**California MMIS  
Fiscal Intermediary**  
  
P.O. Box 13029  
Sacramento, CA 95813-4029  
  
1.800.541.5555

Dear Medi-Cal Provider,

California Medicaid Management Information System (California MMIS) Fiscal Intermediary has received your claim for sterilization services performed under the Medi-Cal program. In reviewing the sterilization *Consent Form* accompanying your claim, we identified area(s) of insufficient or incorrect information. As this information is required by state and federal rules and regulations for sterilizations performed under the Medi-Cal program, we are unable to process your claim as it was submitted.

To facilitate the resolution of your denied claim, we have enclosed the materials necessary for properly completing the sterilization *Consent Form* in accordance with Medi-Cal specifications. These materials include the following:

- A copy of your original claim.
- A sample sterilization *Consent Form*, indicating the specific information required by the California MMIS Fiscal Intermediary for proper claim adjudication.

The sample sterilization *Consent Form* included with this letter shows the fields of information labeled numerically. To the right of the sample form is a corresponding explanation for each of these fields (numbers). We have marked on this sample form the fields (numbers) for which you must provide either corrected or additional information so that we can process your claim. These fields are marked with an "X."

Please provide the correct and/or additional information, designated with an "X" on the sample sterilization *Consent Form*, in the corresponding field on the copy of your original sterilization *Consent Form*. For example, is number 4, "Patient's Name," is designated with an "X" on the sample sterilization *Consent Form*, provide the appropriate information in the corresponding field on the copy of your original sterilization *Consent Form*.

Please return the following to the California MMIS Fiscal Intermediary, P.O. Box 15300, Sacramento, CA 95851-1300:

- The copy of your original claim.
- The corrected copy of your original sterilization *Consent Form*.
- A copy of the Remittance Advice Details (RAD) showing the denied claim.
- A completed *Claims Inquiry Form (CIF)*. (The CIF cannot be completed and sent to the California MMIS Fiscal Intermediary until the claim has actually appeared as denied on a RAD)

**NOTE**  
For more information, see the *Sterilization* section in your Inpatient/Outpatient or Medical Services Provider Manual.

For instructions about submitting the CIF and timeliness guidelines, refer to the CIF sections in your provider manual. If you need further assistance in filing claims for sterilization services rendered under the Medi-Cal program, refer to your provider manual or contact the Telephone Service Center (TSC) at 1-800-541-5555.

88-H-20 (9/18)

**Figure 5.** Sterilization Consent Form (88-H-20) Correction Letter.

## **Sterilization Consent Form Signature**

1. The *Consent Form* must be signed and dated by the:
  - individual to be sterilized,
  - interpreter, if one is provided,
  - individual who obtains the consent, and
  - physician who performed the sterilization procedure.
2. The person securing consent shall certify by signing the *Consent Form* that he or she:
  - advised the individual to be sterilized, before the individual to be sterilized signed the *Consent Form*, that no federal benefits may be withdrawn because of the decision not to be sterilized.
  - explained orally the requirements for informed consent to the individual to be sterilized as set forth on the *Consent Form* and in regulations.
  - determined to the best of his/her knowledge and belief that the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.
3. The physician performing the sterilization shall certify by signing the *Consent Form* that:
  - the physician, shortly before the performance of the sterilization, advised the individual to be sterilized that federal benefits shall not be withheld or withdrawn because of a decision not to be sterilized. (For the purposes of Medi-Cal regulations, the phrase “shortly before” means a period within 72 hours prior to the time the patient receives any preoperative medication.)
  - the physician explained orally the requirements for informed consent as set forth on the *Consent Form*.
  - to the best of the physician’s knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

- at least 30 days have passed between the date of the individual's signature on the *Consent Form* and the date the sterilization was performed, except in the following instances:
  - «Sterilization may be performed at the time of emergency abdominal surgery if the physician certifies that the patient consented to the sterilization at least 30 days before he/she intended to be sterilized; that at least 72 hours have passed after written informed consent to be sterilized was given; and the physician describes the emergency on the DHCS 8649»
  - Sterilization may be performed at the time of premature delivery if the physician certifies that the written informed consent was given at least 30 days before the expected date of the delivery. The physician shall state the expected date of the delivery on the *Consent Form*. At least 72 hours have passed after written informed consent to be sterilized was given

4. The interpreter, if one is provided, shall certify that he or she

- transmitted the information and advice presented orally to the individual to be sterilized
- «read the DHCS 8649 and explained its contents to the individual to be sterilized, and»
- determined to the best of his/her knowledge and belief that the individual to be sterilized understood what the interpreter told the individual

5. «A copy of the signed DHCS 8649 must be:»

- provided to the patient
- retained by the physician and the hospital in the patient's medical records, and
- attached to all claims for sterilization services. This requirement extends to all providers: attending physicians or surgeons, assistant surgeons, anesthesiologists and facilities. Only claims directly related to the sterilization surgery, however, require consent documentation. Claims for presurgical visits and tests or services related to postsurgical complications do not require consent documentation

«Before obtaining consent, the person who obtains consent must provide the individual to be sterilized with a copy of the informational brochure on sterilization, which can be downloaded and printed from the [Sterilization Material](#) page of the DHCS website.»

## **Sterilization Consent Form Corrections**

Providers whose claims are denied as a result of incorrectly completed sterilization *Consent Forms* will receive a package from the California MMIS Fiscal Intermediary, with the materials required for correcting the sterilization *Consent Form*. The package will include a letter explaining the process of correcting the sterilization *Consent Form* (see Figure 3), a sample sterilization *Consent Form* (see Figure 4) indicating the fields (numbers) on the form that were either completed incorrectly or contained insufficient information and a copy of the original claim.

The sample sterilization *Consent Form* (Figure 4), found on the reverse side of the letter, shows all of the fields on the form labeled numerically. An explanation of each field is presented to the right of the sample sterilization *Consent Form*. The field(s) marked with an “X” on the sample sterilization *Consent Form* is the field(s) that was either not completed or completed incorrectly on the original sterilization *Consent Form*.

The provider must make the appropriate correction(s) on his or her copy of the original sterilization *Consent Form*. For example, if the information for number 3, “Patient’s Birthdate,” is marked with an “X” on the sample sterilization *Consent Form*, the provider should enter the appropriate information in number 3 on their copy of the original sterilization *Consent Form*. All changed information should be initialed. Do not use correction fluid to blot out errors. Errors should be lined out.

The corrected copy of the original sterilization *Consent Form*, the copy of the original claim, a copy of the *Remittance Advice Details* (RAD) showing the denied claim, and a completed *Claims Inquiry Form* (CIF) should be returned to:

California MMIS Fiscal Intermediary  
P.O. Box 15300  
Sacramento, CA 95851-1300

The package received by the provider is an indication that the sterilization claim either has or will soon appear on a RAD as a denied claim. The CIF cannot be completed and sent to the California MMIS Fiscal Intermediary until the claim has actually appeared as denied on a RAD. All guidelines requiring timeliness and completion of the CIF should be followed.

## **Tubal Ligations**

A tubal ligation performed during the same hospitalization as a vaginal delivery (CPT® code 58605), or at the time of a cesarean section or intra-abdominal surgery (CPT code 58611), is covered by Medi-Cal as a separately reimbursable service. If the tubal ligation is performed at the time of a cesarean section or intra-abdominal surgery, providers must follow these guidelines.

Physicians must use:

- Modifier AG (primary physician) to bill for the C-section or intra-abdominal surgery
- Modifier 51 to bill for the tubal ligation (CPT code 58611)
- «A *Sterilization Consent Form* (DHCS 8649)»

**Note:** Assistant Surgeons must bill code 58611 with modifier 99. The *Additional Claim Information* field (Box 19) of the CMS-1500 claim must note that modifier 99 was used to signify “modifier 80 and modifier 51.”

## **Removal of Fallopian Tubes**

If a laparoscopy with removal of the adnexal structures (CPT code 58661), salpingectomy (CPT code 58700) or a salpingo-oophorectomy (CPT code 58720) is performed, the claim must clearly indicate whether the procedure was:

- A unilateral procedure that will not produce sterility
- A bilateral procedure that will produce sterility

«When one of the above procedures results in sterilization, the DHCS 8649 form and an approved *Treatment Authorization Request* (TAR) are required. If CPT codes 58661 and 58700 are elective sterilization procedures, there is no TAR requirement. *Consent Form* DHCS 8649 remains a requirement in elective sterilization procedures.» Refer to “Sterilization Consent Form Required” in this section for guidelines.

## **Subtotal or Total Hysterectomy After Cesarean Delivery**

Reimbursement for CPT code 59525 (subtotal or total hysterectomy after cesarean delivery) does not require informed consent but does require that a handwritten statement, signed by the physician certifying the nature of the emergency, accompany the claim. The certification of emergency must appear in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim form or on an attachment.

Refer to the *Hysterectomy* section in this manual for additional information.



## **Authorization for Interval Inpatient Sterilizations**

Authorization is required for most inpatient sterilizations, except those performed on a postpartum basis, such as a tubal ligation. Since sterilizations normally can be performed as an outpatient procedure, the TAR should clearly indicate why hospitalization is required. «TARs for the inpatient hospitalization need not include consent documentation, but the completed DHCS 8649 must accompany the claim for the procedure.»

## **Hysterosalpingogram**

A hysterosalpingogram (CPT code 74740) is not reimbursable if performed within three months following a tubal occlusion/transection/ ligation procedure.

## **Retroactive Coverage**

Sterilization is covered by Medi-Cal only if all the applicable requirements are met at the time the operation is performed. If a patient obtains retroactive Medi-Cal coverage, previously provided sterilization services cannot be billed to Medi-Cal unless the applicable requirements have been met. «If a patient receives a sterilization as a private patient and the provider later performs an eligibility verification transaction that proves the recipient has coverage for the month of service, the provider has no duty to bill the program unless all Medi-Cal requirements, including the signing of *Consent Form* DHCS 8649 were observed.»

## **Anesthesia Time**

Refer to the *Anesthesia* section in the appropriate Part 2 manual for instructions on billing for the anesthesia time associated with a tubal ligation.

## **Sterilization and Supplies Require Consent Forms**

To comply with federal requirements, a legible copy of a valid sterilization Consent Form (DHCS 8649) must accompany claims for sterilization services. This rule also extends to claims for supplies billed with modifiers UA or UB.

## **Codes Requiring Consent Forms**

«The following CPT and HCPCS codes require a sterilization *Consent Form* DHCS 8649 when the procedure will render the recipient sterile and unable to conceive.»

<b>CPT Code</b>	<b>Description</b>
55250	Vasectomy, unilateral or bilateral, including postoperative semen examination(s)
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)
58671	Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
58700	Salpingectomy, complete or partial, unilateral or bilateral
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral

## **ICD-10-PCS Codes Identifying Sterilization Procedures**

Sterilization services must be billed in conjunction with one of the following ICD-10-PCS codes:

0U550ZZ thru 0U578ZZ	0VBP3ZZ	0VLH0CZ thru 0VLH4ZZ
0UB50ZX thru 0UB78ZZ	0VBP4ZZ	0VLN0CZ thru 0VLN8ZZ
0UL50CZ thru 0UL78ZZ	0VBP8ZX	0VLP0CZ thru 0VLP8ZZ
0UT50ZZ thru 0UT7FZZ	0VBP8ZZ	0VLQ0CZ thru 0VLQ8ZZ
0V5N0ZZ thru 0V5Q8ZZ	0VBQ0ZZ	0VTN0ZZ
0VBN0ZZ	0VBQ3ZZ	0VTN4ZZ
0VBN3ZZ	0VBQ4ZZ	0VTP0ZZ
0VBN4ZZ	0VBQ8ZX	0VTP4ZZ
0VBN8ZX	0VBQ8ZZ	0VTQ0ZZ
0VBN8ZZ	0VLF0CZ thru 0VLF4ZZ	0VTQ4ZZ
0VBP0ZZ	0VLG0CZ thru 0VLG4ZZ	

## **Sterilization Consent Form Required**

When a sterilization procedure is performed for the purpose of rendering the recipient sterile and unable to conceive, the provider must bill the sterilization code in conjunction with ICD-10-CM diagnosis code Z30.2 (encounter for sterilization) and enter the appropriate family planning code in the *Condition Codes* field (Boxes 18 thru 24) on the *UB-04* claim or the *EPSDT/Family Planning* field (Box 24H) on the *CMS-1500* claim. «A completed sterilization *Consent Form* (DHCS 8649) must be submitted for all elective sterilizations».

«When CPT code 58661 (laparoscopy, surgical; with removal of adnexal structures [partial or total oophorectomy and/or salpingectomy]), 58700 (salpingectomy, complete or partial, unilateral or bilateral), 58720 (salpingo-oophorectomy, complete or partial unilateral or bilateral) or one of the following ICD-10-PCS codes 0U500ZZ thru 0U0524ZZ, 0U550ZZ thru 0U578ZZ, 0UB00ZX thru 0UB28ZZ, 0UB50ZX thru 0UB78ZZ, 0UT00ZZ thru 0UT2FZZ, 0UT50ZZ thru 0UT7FZZ (unilateral or bilateral destruction, excision or resection of fallopian tube and/or ovary) is performed for the purpose of rendering the recipient permanently incapable of reproducing, a DHCS 8649 and an approved TAR are required.»

## **Sterilization Consent Form Not Required**

If a code is billed that requires a PM 330 but the surgery was not performed for the purpose of rendering the recipient permanently incapable of reproducing, then a PM 330 is not required. However, the claim will be denied unless at least one of the following justifications is present in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim or on an attachment:

- The surgery was a unilateral procedure and did not result in sterilization.
- The surgery was unilateral or bilateral but the patient was previously sterile. (On a signed attachment to the claim, the physician must explain the cause of the sterility.)
- The procedure was not elective and was done for an acute condition.

## **Sterilization Services Inquiries**

Questions concerning sterilization services covered by Medi-Cal should be directed to:

Medi-Cal Benefits Division  
Department of Health Care Services  
MS 4601  
1501 Capitol Avenue, Suite 71.4001  
P.O. Box 997417  
Sacramento, CA 95899-7417  
(916) 552-9797

## **Inquiries for Non-Medi-Cal Patients**

Questions regarding sterilization service requirements for non-Medi-Cal patients should be addressed to:

Office of Family Planning  
California Department of Health Care Services  
MS 8400  
1615 Capitol Avenue, Suite 73.430  
P.O. Box 997413  
Sacramento, CA 95899-7413  
(916) 650-0414

## **Legend**

Symbols used in the document above are explained in the following table.

<b>Symbol</b>	<b>Description</b>
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
»	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.