

Washington Apple Health (Medicaid)

Sterilization Supplemental Billing Guide

August 14, 2019

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This publication takes effect August 14, 2019, and supersedes earlier billing guides to this program.

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Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

*This publication is a billing instruction.

What has changed?

Subject	Change	Reason for Change
<u>About Sterilization</u>	<p>Retroactive to claims with dates of service on or after January 1, 2018: When billing for salpingectomy (diagnosis code Z30.2), modifier FP must also be on the claim for Family Planning Only Pregnancy Related and Family Planning Only clients. Providers may resubmit previously denied claims for salpingectomy (dx code Z30.2 and modifier FP) for dates of service on and after January 1, 2018.</p>	<p>The January 1, 2019, publication of this billing guide was missing the requirement for the FP modifier for Family Planning Only Pregnancy Related and Family Planning Only.</p>
<u>Coverage Table</u>	<p>Added language to include using diagnosis code Z30.2 and modifier FP when using HCPCs code 58661 for Family Planning Only Pregnancy Related and Family Planning Only.</p>	<p>Policy change effective January 1, 2018.</p>
<u>Physician's statement</u>	<p>Removed tubal sterilization and laparoscopic tubal sterilization from the list of examples under line 20 of the Physician's Statement and added salpingectomy.</p>	<p>Correction.</p>
<u>Appendix C</u>	<p>Added language to common reasons why claims are denied. Salpingectomy (58661 or 58700) is billed as a sterilization but tubal ligation is listed as the specific type of operation on line 20 of the consent form.</p>	<p>Clarifying language to avoid denied claims.</p>

How can I get agency provider documents?

To access provider alerts, go to the agency's [provider alerts](#) webpage.

To access provider documents, go to the agency's [provider billing guides and fee schedules](#) webpage.

Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and provider's webpage, select [Forms & publications](#). Type the HCA form number into the **Search box** as shown below (Example: 13-835).

The screenshot shows the Washington State Health Care Authority website. The top navigation bar includes a search icon, Home, About HCA, and Contact HCA. Below this is a blue header for "Billers and providers" with a "ProviderOne" button. A secondary navigation bar contains "Forms & publications", "News", "Electronic Health Records (EHR)", and "Contact Us". The main content area is titled "Forms & publications" and features a search box with a magnifying glass icon, a "Search" button, and two dropdown menus set to "- Any -". A "Sort by" dropdown is set to "Name (A-Z)". A blue arrow points from the search box to the "Search" button.

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Resources Available

Topic	Resource
<p>Obtaining information regarding reproductive health or family planning programs, including questions about sterilization</p>	<p>Visit the agency's Family Planning Billing Guide.</p> <p>Visit the Apple Health Billers and Providers "contact us" webpage.</p> <p>Contact the Family Planning Program:</p> <p>PO Box 45506 Olympia, WA 98504-5530 Phone: 360-725-1652 Fax: 360-725-1152 familyplanning@hca.wa.gov</p>
<p>Agency-approved Sterilization Consent form</p>	<p>Visit U.S. Department of Health and Human Services to download English and Spanish versions of HHS-687.</p>
<p>Pharmacy information</p>	<p>See the agency's Pharmacy Information and the Prescription Drug Program Billing Guide.</p>
<p>Additional agency resources</p>	<p>See the agency's Billers and Providers webpage.</p>
<p>Billing and Claims</p>	<p>Providers must follow the billing requirements listed in the agency's ProviderOne Billing and Resource Guide.</p>
<p>For additional billing guidance</p>	<p>See the following billing guides:</p> <ul style="list-style-type: none"> • Outpatient Hospital Billing Guide • Physician-Related/Professional Services Billing Guide • Professional Administered Drugs Fee Schedule

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Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide.

Refer to [Chapter 182-500 WAC](#) and [WAC 182-532-001](#) for additional definitions.

Contraceptive – A device, drug, product, method, or surgical intervention used to prevent pregnancy.

Family Planning Only – The agency’s demonstration and research program approved by the federal government under a Medicaid program waiver to provide family planning services to people eligible according to [WAC 182-532-720](#).

Family Planning Only-Pregnancy Related program – The agency’s program providing an additional 10 months of family planning services to eligible clients at the end of their pregnancy. This benefit follows the 60-day post-pregnancy coverage for clients who received medical assistance benefits during the pregnancy.

Family planning services – Medically safe and effective medical care, educational services, and contraceptives that enable people to plan and space the number of their children and avoid unintended pregnancies.

Hysteroscopic sterilization – A permanent voluntary surgical procedure performed on females in which the Fallopian tubes are blocked with an implant. This procedure is done in a physician’s office using an instrument called a “hysteroscope” to access the Fallopian tubes. The procedure is less invasive than a tubal ligation and does not require the use of general anesthesia.

Hysterosalpingogram – An X-ray of the uterus and Fallopian tubes, using a dye that

identifies blockages in the Fallopian tubes confirming successful sterilization.

Informed consent – A person’s consent to a procedure after the provider who obtained a properly completed consent form has done all of the following:

- Disclosed and discussed the client's diagnosis
- Offered the client an opportunity to ask questions about the procedure and to request information in writing
- Given the client a copy of the consent form
- Communicated effectively using any language interpretation or special communication device necessary per 42 CFR 441.257
- Given the client oral information about all of the following:
 - ✓ The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure
 - ✓ Alternatives to the procedure including potential risks, benefits, and consequences
 - ✓ The procedure itself, including potential risks, benefits, and consequences

Sterilization Consent form – Unless otherwise specified in this billing guide, federal form [HHS-687](#).

Tubal sterilization – A permanent voluntary surgical procedure performed on females in which the Fallopian tubes are blocked, clamped, cut, burned, or removed to prevent pregnancy.

Vasectomy – A permanent voluntary surgical procedure performed on males in which the vas deferens (tubes that carry sperm from the testicles to the seminal vesicles) are cut, tied, burned or otherwise interrupted to prevent pregnancy.

Client Eligibility

Most Apple Health clients are enrolled in an agency-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See the agency's [Apple Health managed care page](#) for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. Verify the patient's eligibility for Apple Health. For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's [ProviderOne Billing and Resource Guide](#).

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. Verify service coverage under the Apple Health client's benefit package. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see the agency's [Program Benefit Packages and Scope of Services](#) webpage.

Note: Patients who are not Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at:
www.wahealthplanfinder.org
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to:
Washington Healthplanfinder
PO Box 946
Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's [Get Help Enrolling](#) page.
- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Behavioral Health Organization (BHO)

The Health Care Authority manages the contracts for behavioral health services (mental health and substance use disorder) for the following three Regional Service Areas (RSAs):

- **Great Rivers:** Includes Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties
- **Salish:** Includes Clallam, Jefferson, and Kitsap counties
- **Thurston-Mason:** Includes Thurston and Mason counties

To view a map and table of the integrated managed care plans available within each region, please see [Changes coming to Washington Apple Health](#). You may also refer to the agency's [Apple Health managed care webpage](#).

See the agency's [Mental Health Services Billing Guide](#) for details.

Apple Health – Changes for July 1, 2019

Effective July 1, 2019, HCA is continuing to shift to whole-person care to allow better coordination of care for both body (physical health) and mind (mental health and drug or alcohol treatment, together known as “behavioral health”). This delivery model is called Integrated Managed Care (formerly Fully Integrated Managed Care, or FIMC, which still displays in ProviderOne and Siebel).

Agency-contracted managed care organizations (MCOs) in certain Region Service Areas (RSAs) have expanded their coverage of behavioral health services (mental health and substance use disorder treatment), along with continuing to cover physical health services. The RSAs are outlined in the [Integrated Managed Care Regions](#) section.

Apple Health clients who are not enrolled in an agency-contracted MCO for their physical health services (e.g., dual-eligible Medicare-Medicaid clients) will still receive their behavioral health services through one of the agency-contracted MCOs. The MCO will provide only behavioral health services for the client.

Most clients will remain with the same health plan, except in regions where client's plan will no longer be available. HCA will auto-enroll these clients to one of the offered plans.

Clients can change their plan at any time by:

- Visiting the [ProviderOne Client Portal](#).
- Calling Apple Health Customer Service toll-free at 1-800-562-3022. This automated system is available 24 hours a day, 7 days a week.

- Requesting a change online through our secure [Contact us – Apple Health \(Medicaid\) client web form](#). Select the topic “Enroll/Change Health Plans.”

Visiting the [Washington Healthplanfinder](#) (only for clients with a Washington Healthplanfinder account).

Integrated managed care

For clients who live in an integrated managed care region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client’s agency-contracted MCO. The BHO will not provide behavioral health services in these-regions.

Clients living in an integrated managed care region will enroll with an MCO of their choice that is available in that region. If the client does not choose an MCO, the client will be automatically enrolled into one of the available MCOs, unless the client is American Indian/Alaska Native (AI/AN). Clients currently enrolled in one of the available MCOs in their region may keep their enrollment when the behavioral health services are added.

American Indian/Alaska Native (AI/AN) clients living in an integrated managed care region of Washington may choose to enroll in one of the agency-contracted MCOs available in that region or they may choose to receive all these services through Apple Health FFS. If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency’s [American Indian/Alaska Native webpage](#).

For more information about the services available under the FFS program, see the agency’s [Mental Health Services Billing Guide](#) and the [Substance Use Disorder Billing Guide](#).

For full details on integrated managed care, see the agency’s [Apple Health managed care webpage](#) and scroll down to “Changes to Apple Health managed care.”

Integrated managed care regions

Clients who reside in the following integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Specific details, including information about mental health crisis services, are located on the agency’s [Apple Health managed care webpage](#).

Region	Counties	Effective Date
North Sound	Island, San Juan, Skagit, Snohomish, and Whatcom	July 1, 2019 (new)
Greater Columbia	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman	January 1, 2019
King	King	January 1, 2019
Pierce	Pierce	January 1, 2019
Spokane	Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens	January 1, 2019
North Central	Grant, Chelan, Douglas, and Okanogan	January 1, 2018 January 1, 2019 (Okanogan)
Southwest	Clark, Skamania, and Klickitat	April 2016 January 1, 2019 (Klickitat)

Integrated Apple Health Foster Care (AHFC)

Effective January 1, 2019, children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington’s (CCW) Apple Health Foster Care program will receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as
“Coordinated Care Healthy Options Foster Care.”

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Administrative Services Organization (BH-ASO). For details, see the agency’s [Mental Health Services Billing Guide](#), under *How do providers identify the correct payer?*

About Sterilization

What is sterilization?

(WAC [182-531-1550\(1\)](#))

Sterilization is any medical procedure, treatment, or operation for the purpose of rendering a client permanently incapable of reproducing. This includes vasectomies and tubal sterilizations (including salpingectomies and hysteroscopic sterilizations).

When a salpingectomy is performed for sterilization only, all requirements in this billing guide must be met, including completing the federal consent form, and using diagnosis code Z30.2.

When salpingectomy is performed for sterilization only for Family Planning Only Pregnancy-Related and Family Planning Only programs, all requirements in this billing guide must be met, including completing the federal consent form, and using diagnosis code Z30.2 with modifier FP. A salpingectomy for sterilization when performed during a cesarean section must be billed using the add-on CPT code 58611.

A medically necessary salpingectomy performed to treat cancer, ectopic pregnancy, prophylaxis to prevent ovarian cancer in a high risk person, and other gynecological reasons is not considered a sterilization and is not subject to the requirements in this billing guide, including completing a sterilization consent form.

Note: Hysterectomy, oophorectomy, and urological procedures are not sterilization procedures. The agency does not pay for these procedures when performed solely for the purpose of sterilization. These procedures are covered only when medically necessary. A sterilization consent form is not required when these procedures are performed for medical necessity. The client must be informed as part of the surgical consent that the procedure will cause sterility. For more information about these procedures and billing guidelines, see the [Physician-Related Services/Health Care Professional Services Billing Guide](#). The Hysterectomy Consent and Patient Information Form ([HCA 13-365](#)) is required for approval and payment.

Note: Retroactive to claims with dates of service on and after January 1, 2018, salpingectomy is covered for sterilization . Providers may resubmit previously denied claims for sterilization that use salpingectomy as the procedure/technique. Family Planning Only Pregnancy-Related and Family Planning Only providers may resubmit previously denied claims for sterilization that use salpingectomy as the procedure/technique with the appropriate diagnosis code Z30.2 and modifier FP. The billing requirements listed in this guide, as well as the completion of the appropriate consent forms, must be met.

Who may perform sterilizations?

(WACs 182-531-1550(3))

Any Washington Apple Health (Medicaid) provider who is licensed to do sterilizations within their scope of practice may provide vasectomies and tubal sterilizations to any Washington Apple Health client, including Family Planning Only-Pregnancy Related and Family Planning Only clients.

For special qualifications for providers who perform hysteroscopic sterilizations, see [Provider qualifications specific to hysteroscopic sterilizations](#).

What are the consent requirements?

(WAC 182-531-1550(9))

Federal regulations (42 CFR Ch. IV, Subpart F, 441.256) prohibit payment for sterilization procedures until a federally approved and accurately completed sterilization consent form is received with a claim. For Washington Apple Health, the consent form is federal form [HHS-687](#). A [Spanish-language form](#) is also available. Information and instructions for accurately completing the HHS-687 consent form is included in Appendix A.

- To comply with this requirement, the following provider types must attach a copy of a completed [HHS-687](#) consent form to their claim:
 - ✓ Surgeons
 - ✓ Anesthesiologists and certified registered nurse anesthetists
 - ✓ Assistant surgeons
 - ✓ The facility in which the sterilization procedure was performed
- The surgeon must complete and sign the “physician statement” on the [HHS-687](#) consent form within 30 days of the sterilization procedure.
- The agency will deny a claim with a [HHS-687](#) consent form that is missing information or not completed according to instructions in Appendix A.
- The agency will deny a claim received without the [HHS-687](#) consent form.

Completion of [HHS-687](#) sterilization consent form for a client ages 18-20

- Use the HHS-687 consent form.
- Cross out “**age 21**” in the following three places on the form and write in the client’s age:
 - ✓ Section I: Consent to Sterilization: “**I am at least 21...**”
 - ✓ Section III: Statement of Person Obtaining Consent: “**To the best of my knowledge... is at least 21...**”
 - ✓ Section IV: Physician’s Statement: “**To the best of my knowledge... is at least 21...**”

Who completes the consent form?

- [Sections I, II, and III of the sterilization consent form](#) are completed by the client, interpreter (if needed), and a provider from the clinic or call/practice group performing the sterilization. This may be a physician, advanced registered nurse practitioner, or physician’s assistant. Once the sterilization consent form is signed by all parties, the client must undergo the procedure no sooner than the 31st day and no later than the 180th day after the signature date. The day the consent form is signed is considered day one.

Note: If less than 31 days, refer to [What are the exceptions to the usual consent requirements for sterilization?](#) and/or [section IV of the sterilization consent form.](#)

- [Section IV](#), the bottom right portion of the sterilization consent form, must be completed by the provider who performed the surgery within 30 days of the date of surgery.

Coverage and Payment

[\(WAC 182-531-1550\)](#)

Who is eligible for sterilizations?

- Washington Apple Health clients who meet the following criteria:
 - ✓ Men ages 18 and over.
 - ✓ Women ages 18-55. For a woman over 55, prior authorization is required. For information on how to submit a prior authorization request, see the [Physician-Related Services/Health Care Professional Services Billing Guide](#).
- Clients enrolled in the Family Planning Only-Pregnancy Related or Family Planning Only programs who meet these age requirements.

What does the agency cover for Family Planning Only-Pregnancy Related and Family Planning Only clients?

Coverage

Both Family Planning Only programs have limited coverage for family planning services. All services provided to Family Planning Only-Pregnancy Related and Family Planning Only clients must have a primary focus and diagnosis of family planning (contraception). Sterilization is a covered service for Family Planning Only-Pregnancy Related and Family Planning Only clients.

Drugs

When a client is enrolled in either of the Family Planning Only programs and undergoes sterilization, the agency covers a limited number of prescription anti-anxiety medications before the sterilization, and pain medications after the sterilization. For information on prescribing and billing limits for drugs related to sterilization procedures, see the agency's [Prescription Drug Program Billing Guide](#).

Payment

For clients in the Family Planning Only-Pregnancy Related and Family Planning Only programs, the agency does not pay for other medical services unless they are medically necessary for clients to safely and successfully use their chosen birth control method (including sterilization). See the [Family Planning Billing Guide](#) for more details.

For clients in the Family Planning Only-Pregnancy Related and Family Planning Only programs, only claims submitted with diagnosis and procedure codes related to family planning and contraception are processed for payment. The agency does not pay for diagnosis and procedure codes that are not related to family planning and contraception under the Family Planning Only-Pregnancy Related and Family Planning Only programs. For a list of covered codes, see the [Family Planning Fee Schedule](#).

Complications

For clients enrolled in either of the Family Planning Only programs, the agency covers complications resulting from sterilizations on a case-by-case basis. Contact the agency's [Family Planning Program](#).

When does the agency pay for sterilizations for clients enrolled in managed care plans?

The agency pays for sterilizations for clients age 18 through 20 who are enrolled in an agency-contracted managed care organization (MCO) under fee-for-service. This age group may self-refer to a fee-for-service provider who accepts Apple Health. All other managed care clients age 21 and older must obtain sterilization services from a provider contracted with their agency-contracted MCO.

For information on prescribing, coverage, and billing for drugs related to sterilization procedures when not contracted with an agency-contracted MCO, see the agency's [Prescription Drug Program Billing Guide](#).

When are sterilizations covered?

The agency covers sterilizations when all of the following apply:

- The client has voluntarily given informed consent.
- The client undergoes the procedure no sooner than the 31st day and no later than the 180th day after signing the consent. The day the consent form is signed is considered day one.
- The client is at least age 18 at the time an agency-approved consent form is signed. See Completion of [HHS-687](#) sterilization consent form for a client ages 18-20 and [Appendix A](#) for special instructions for clients 18-20.
- The client is mentally competent.
- The client participates in a Washington Apple Health program ([WAC 182-501-0060](#)).

When are sterilizations paid?

- The agency pays providers for the sterilization procedure only when a qualified provider submits a completed [HHS-687](#) consent form with the claim for reimbursement.
- The agency pays only after the procedure is completed.

Does the agency pay for an office visit related to a sterilization procedure?

Yes. The agency pays for an office visit that includes counseling associated with sterilization and obtaining the client's signature on the consent form. The agency pays for this visit even if after the visit the client chooses not to be sterilized. See the agency's [Physician-Related Services/Healthcare Professional Services Billing Guide](#) for how to bill for office visits.

For men in the Family Planning Only program, the initial preoperative sterilization office visit is payable when performed on the same day as a family planning preventive visit. For more information about Family Planning Only, see the agency's [Family Planning Billing Guide](#).

Does the agency pay anesthesia providers for sterilizations?

Yes. The agency pays for anesthesia necessary to perform sterilization. Follow the billing guidelines in the [Physician-Related Service/Health Care Professional Service Billing Guide](#).

- When sterilization is done in conjunction with a delivery, the agency pays as follows:
 - ✓ If the two procedures are performed during the same operative session, anesthesia time for the sterilization is added to the time for the delivery.
 - ✓ The agency pays for epidural anesthesia in excess of the six-hour limit when sterilization is performed in conjunction with or immediately following a delivery.
 - ✓ If the sterilization and delivery are performed during different operative sessions, the time for each procedure is calculated separately.
- If the consent form is missing or not filled out according to the instructions in [Appendix A](#), the agency will deny the portion of the claim related to sterilization. All other covered services on the claim will be processed.
- If section IV of the consent form is not complete, the agency will pay the claim if the anesthesia provider can provide the agency with evidence that the client gave consent for the sterilization procedure. Evidence includes **both**:
 - ✓ A hospital surgical consent that is signed by the client and surgeon for the same date of service as the submitted claim, and that indicates a sterilization procedure was performed;

AND

- ✓ A sterilization consent form that has sections I, II, and III correctly filled out but is not signed by the surgeon in section IV.

Does the agency pay assistant surgeons for sterilizations?

Yes. The agency pays for assistant surgeons to assist sterilization procedures when necessary. Follow the billing guidelines in the [Physician-Related Service/Health Care Professional Service Billing Guide](#).

- If the consent form is missing or not filled out according to the instructions in [Appendix A](#), the agency will deny the portion of the claim related to sterilization. All other covered services on the claim will be processed.
- If section IV of the consent form is not complete, the agency will pay the claim if the assistant surgeon can provide the agency with evidence that the client gave consent for the sterilization procedure. Evidence includes **both**:
 - ✓ A hospital surgical consent that is signed by the client and surgeon for the same date of service as the submitted claim, and that indicates a sterilization procedure was performed;

AND

 - ✓ A sterilization consent form that has sections I, II, and III correctly filled out but is not signed by the surgeon in section IV.

Does the agency pay the facility for sterilizations performed in a facility?

Yes. The agency pays facilities (ambulatory surgery centers and hospitals) for sterilizations performed in those facilities. Follow the billing guidelines in the [Outpatient Hospital Services Billing Guide](#), the [Inpatient Hospital Services Billing Guide](#), and the [Ambulatory Surgery Centers Billing Guide](#).

If the consent form is missing or not filled out according to the instructions in [Appendix A](#):

- The agency will deny sterilization and services related to sterilization on the facility claim. All other covered services on the claim will be processed.
- For inpatient claims, the hospital must indicate on the claim all charges that are associated with the sterilization on their own line with the appropriate revenue code as noncovered.

If section IV of the consent form is not complete:

- The agency will pay the claim if the facility can provide the agency with evidence that the client gave consent for the sterilization procedure. Evidence includes **both**:
 - ✓ A hospital or facility surgical consent that is signed by the client and surgeon for the same date of service as the submitted claim, and that indicates a sterilization procedure was performed;

AND

- ✓ A sterilization consent form that has sections I, II, and III correctly filled out but is not signed by the surgeon in section IV.

Does the agency pay for sterilizations performed in conjunction with another procedure?

Yes. The agency pays for these sterilizations as long as the services meet the requirements for sterilization. Submit an agency-approved sterilization consent form with the claim.

What are the additional coverage requirements for hysteroscopic sterilizations?

(WAC 182-531-1550(10-12))

- **Performed by agency-approved providers:** The sterilization must be performed by an agency-approved provider of hysteroscopic sterilizations. A list of these providers and their practice locations can be found on the Sterilization Supplemental Billing Guide [webpage](#). More information is available [in provider qualifications specific to hysteroscopic sterilizations](#) and [becoming a provider of hysteroscopic sterilizations](#).
- **Agency approved device:** An agency-approved device must be used. The agency has approved the ESSURE® device, which is placed at the time of the procedure.
 - ✓ To be paid for the device, the device must appear on the same claim as the procedure, by the provider that supplied the device. If the surgeon supplied the device, the device should be billed on the same claim as the professional service. If a facility supplied the device and includes it on their claim, the agency's reimbursement covers the cost of the device.
- **Performed in outpatient setting:** The procedure is performed in an outpatient clinical setting, such as a physician's office, outpatient hospital, or Ambulatory Surgery Center (ASC) without epidural, spinal, or general anesthesia and without the use of a surgical suite, anesthesiologist, or anesthetist. A para-cervical block or IV sedation is bundled in the procedure.
 - ✓ If a provider determines that it is medically necessary to perform the procedure in an inpatient setting or outpatient surgical suite, the provider must submit clinical notes with the claim, documenting the medical necessity.
- **Post-hysteroscopic sterilization:** The agency covers a post-hysteroscopic sterilization hysterosalpingogram to confirm complete blockage of the Fallopian tubes. Payment depends on the client's Medicaid eligibility at the time of service.
 - ✓ When a client's Family Planning Only-Pregnancy Related and Family Planning Only, or other Washington Apple Health coverage expires after having a hysteroscopic sterilization, the client must reapply for Washington Apple Health benefits and be eligible, in order for the agency to pay for a hysterosalpingogram.

Therefore, it's important to check the client's eligibility before doing the ESSURE procedure and again before doing the hysterosalpingogram.

- **Follow-up procedures due to complications:** The agency covers follow-up procedures if a client has complications due to side effects or allergies from the hysteroscopic sterilization or the occlusive device used. The agency does not require another sterilization consent form.
- **Discontinued before procedure:** When the hysteroscopic sterilization must be discontinued prior to completion, the provider may bill for the procedure and receive payment if there is a completed sterilization form submitted with the claim. The agency will also pay for the back-up procedure. A separate completed sterilization consent form must be submitted with the claim for the second procedure, indicating the type of procedure being done.

Note: Consider having the client sign two consent forms on the same day. One for the hysteroscopic sterilization and another for the back-up procedure that will be done if the hysteroscopic sterilization is unable to be completed due to medical, surgical, or anatomical complications. This will prevent the client from having to wait another 30 days for the back-up procedure.

Provider qualifications specific to hysteroscopic sterilizations

The hysteroscopic sterilization must be performed by an agency-approved provider who:

- Has a core provider agreement with the agency.
- Is nationally board certified in obstetrics and gynecology (OB-GYN).
- Is privileged to do hysteroscopies at a licensed hospital.
- Has successfully completed the manufacturer's training for the device covered by the agency.
- Has successfully performed a minimum of 20 hysteroscopies.
- Has established screening and follow-up protocols for clients being considered for hysteroscopic sterilization.

Becoming a hysteroscopic sterilization provider

To become an agency-approved provider for hysteroscopic sterilizations, interested providers must send the agency all of the following:

- Documentation of successful completion of the manufacturer's training
- Documentation demonstrating privilege to perform hysteroscopy at a licensed hospital
- Documentation attesting to having successfully performed 20 or more hysteroscopies
- Evidence of valid National Board Certification as an obstetrician or gynecologist
- Office protocols for screening and follow-up for hysteroscopic sterilizations

Submit documentation to:

Family Planning Program
familyplanning@hca.wa.gov

Once the agency has received all the required information from the provider, it will send an approval letter to the provider and add the provider's name to the approved-provider list. A provider will be able to perform and bill for the procedure only after receiving the agency's approval letter that provides additional billing details, including an expedited prior authorization (EPA) number.

The list of agency-approved hystereoscopic sterilization providers is posted on the [Sterilization Supplemental Billing Guide webpage](#) under the heading, Hysteroscopic Sterilization (ESSURE®) – Approved Providers. Only providers on this list may bill and be paid for hysteroscopic sterilizations.

When is sterilization covered for clients who are institutionalized or have been found mentally incompetent?

(WAC [182-531-1550](#)(7))

Providers must meet the following additional consent requirements before the agency will pay the provider for sterilizing institutionalized clients or clients who have been found mentally incompetent.

The agency requires the following to be attached to the claim:

- A court order including both:
 - ✓ A statement that the client is to be sterilized
 - ✓ The name of the client's legal guardian who will give consent for the sterilization
- The [HHS-687](#) consent form signed by the client's legal guardian at least 30 days before the procedure

What are the exceptions to the usual consent requirements for sterilization?

Allowing a 72-hour waiting period

(WAC [182-531-1550](#)(4))

In two circumstances, the agency requires at least a 72-hour consent waiting period rather than the 30-day waiting period for sterilization:

- At the time of premature delivery when the client gave consent at least 30 days before the expected date of delivery. The expected date of delivery must be documented on the [HHS-687](#) consent form. Premature delivery is a delivery that occurs less than 37 weeks gestation. See instructions for the sterilization consent form in [Appendix A](#).
- For emergency abdominal surgery, including medically-indicated cesarean sections. The nature of the emergency must be described on the [HHS-687](#) consent form. See instructions for the sterilization consent form in [Appendix A](#).

Waiving the 30-day waiting period

([WAC 182-531-1550\(5\)](#))

In three circumstances, the agency waives the 30-day waiting period for sterilization when the client requests that sterilization be performed at the time of delivery, and completes the agency-approved [HHS-687](#) consent form.

The required language listed below must be on the *Claim Note* section of the professional and facility claims. This language also must appear on the sterilization consent form. See instructions for the sterilization consent form in [Appendix A](#). Backup documentation may be requested if the reason for waiving the consent waiting period is not clearly identified.

For the waiver of the 30-day consent waiting period, one of the following circumstances may apply:

- The client became eligible for medical assistance during the last month of pregnancy.

Language required: “NOT ELIGIBLE 30 DAYS BEFORE DELIVERY.”
- The client did not obtain medical care until the last month of pregnancy.

Language required: “NO MEDICAL CARE 30 DAYS BEFORE DELIVERY.”
- The client was a substance abuser during pregnancy, but is not alcohol or drug-impaired at the time of delivery and consent.

Language required: “NO SUBSTANCE ABUSE AT TIME OF DELIVERY.”

When is a consent form invalid?

([WAC 182-531-1550\(6\)](#))

The agency considers a client incapable of informed consent when the client is in any of the following conditions:

- In labor or childbirth
- In the process of seeking to obtain or obtaining an abortion
- Under the influence of alcohol or other substances, including pain medications for labor and delivery, that affect the client’s state of awareness and ability to give informed consent

Under any of the conditions listed above, the agency will not accept a signed sterilization consent form.

Coverage Table

Note: Due to its licensing agreement with the American Medical Association, the agency publishes only the official, short CPT® code descriptions. To view the full descriptions, refer to a current CPT book.

HCPCS/ CPT Code	Short Description	Comments
00840	Anesthesia for intraperitoneal procedures in lower abdomen	May only to be used with 58670 or 58671
00851	Anesthesia for intraperitoneal procedure/tubal ligation	
00921	Anesth vasectomy	
55250	Removal of sperm duct(s)	Used for vasectomies performed by any method
58600	Division of fallopian tube	Abdominal or vaginal approach.
58605	Division of fallopian tube	Associated with a vaginal delivery
58611	Ligate oviduct(s) add-on	Associated with a cesarean delivery.
58615	Occlude fallopian tube(s)	For external occlusive devices only, such as band, clip, or <i>Falope</i> ring. Vaginal or suprapubic approach.

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58661	Laparoscopy remove adnexa	Only payable as a sterilization when the procedure is a salpingectomy when billed with diagnosis Z30.2 and *modifier FP. An oophorectomy is not payable when done only for the purpose of sterilization. *Modifier FP is needed only for billing under the Family Planning Only Pregnancy- Related and Family Planning Only programs.
58670	Laparoscopy, tubal cautery	
58671	Laparoscopy, tubal block	For external occlusive devices only, such as band, clip, or <i>Falope</i> ring.
58700	Removal of fallopian tube	
Hysteroscopic Sterilization with ESSURE		
58565	Hysteroscopy bi tube occlusion w/ perm implants	Requires EPA
A4264	Intratubal occlusion device	Must be billed with 58565 Requires EPA
58340	Catheter for hysteroigraphy	Must be billed with a sterilization diagnosis code
74740	Hysterosalpingography RS&I	Must be billed with a sterilization diagnosis code
<p>Office Visits: The agency pays for an office visit for the visit that includes counseling associated with sterilization and obtaining the client's signature on the HHS-687 consent form. The agency pays for this visit even if after the visit the client chooses not to be sterilized. See the agency's Physician-Related Services/Healthcare Professional Services Billing Guide for how to bill for evaluation and management visits.</p>		

Appendices

Appendix A: Consent form instructions

- The agency accepts [HHS-687](#) consent forms-completed according to the following instructions:
 - ✓ Do not use abbreviations on the form.
 - ✓ All signatures must be handwritten in ink. If an interpreter’s or the consenter’s signature is not legible, print the name legibly underneath the signature line.
- The Apple Health (ProviderOne) client identification number may be written on the form to help identify that the client on the consent matches the claim.
- Race and ethnicity are voluntary and not required for payment.
- The interpreter’s statement (Section III) is completed as needed for individual clients.
- All information on the [HHS-687](#) consent form **must be legible**. Do not cover up or obstruct portions of the form.
- Changes to Section I, II, and III of the consent form can only be made at the time of consent. Changes to Section IV may be made up to 30 days after the procedure.

What can and cannot be changed on a consent form

The agency recommends using the fill-in capability of the federal consent form to reduce the amount of handwritten information on the form. This makes the form more legible for review.

Clients can correct their entry on the consent form at the time of consent if they make a mistake on the date of birth (line 3) or printing their full name (line 4). Clients cannot correct any other line on the consent form. If a mistake is made, it is better to complete and sign a new consent form.

Providers can correct their miswritten entries by crossing out the incorrect information, initialing and dating next to the mistake, and writing in the correct information legibly. Items that can be corrected are:

- Printed name of clinic or provider
- Address of clinic
- Name of the procedure only if it is to make lines 2, 6, and 13 match for clarity. (Example: If “tubal ligation” was written in line 2 and “bilateral tubal ligation” was written on lines 6 and 13. The word “bilateral” could be added to line 2.)
- Name of person only if it is to make lines 4, 12, and 18 match for clarity. (Example: If “Mary Smith” was written on line 4 and “Mary E. Smith” was written on line 12 and 18. The initial “E” could be added to lines 12 and 18.)

Clients and providers cannot amend or correct the following items:

- Any signature
- Dates of consent by client, interpreter, and provider.

Instructions for the [HHS-687](#) consent form

(The actual federal consent form does not have section and line numbers. The example in Appendix B has section and line numbers to show where each instruction refers.)

Section I: Consent to Sterilization	
Line*	Instructions
1. Doctor or Clinic:	<p>Must be the full name of the health professional, clinic, or practice group that gave the client the federally required information regarding sterilization and informed consent.</p> <p>Can be a provider at a specific clinic/practice, a clinic name, or a provider on call with a specific clinic/practice. Does not have to be the same name as on line #24.</p> <p>The agency will not accept “physician on call” or abbreviations.</p> <p>Tip: There is less confusion if lines #1, #5 and #16 match.</p>
2. Specify Type of Operation:	<p>Indicate a <i>single</i> type of sterilization procedure. Procedure must be the same on lines #2, #6, #13. The client may consent to only one type of procedure.</p> <p>Abbreviations are not accepted. “Tubal” alone is not accepted.</p> <p>Examples of acceptable procedure names: <i>Vasectomy, tubal sterilization, tubal ligation, laparoscopic tubal ligation, laparoscopic tubal sterilization, salpingectomy, hysteroscopic sterilization, or ESSURE®. The terms bilateral or unilateral are acceptable as long as they are followed by a procedure name. The agency recognizes that there are various techniques used for sterilization and that the term “tubal ligation” is commonly used to refer to cautery, occlusion, ligation, and excision.</i></p>
3. Date:	<p>Must be the client’s birth date. The date must match the client’s birth date in ProviderOne.</p> <p>If the client is not 21 years of age, the age “21” next to the date of birth must be crossed out with a single line and the age of the client must be written in. The client must be at least 18 at the time of consent.</p>
4. Space for name of person being sterilized:	<p>Must be the client’s printed name as shown in ProviderOne. Must be the same name as lines #12 and #18 on this form.</p> <p>Tip: Check that the name the client is using is the same as in ProviderOne.</p> <p>Tip: Write the client’s ProviderOne ID on the form. An open space such as the upper left hand corner or near a patient sticker if that is put on the form.</p>
5. Doctor or Clinic:	See line #1.

*The line numbers correspond to those listed on the sample consent form in [Appendix B](#).

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Section I: Consent to Sterilization	
6. Specify Type of Operation:	See line #2.
7. Signature:	Client signature. Must be client's usual legal signature. Must be signed in ink.
8. Date:	<p>Date of consent. Must be the date that client was initially counseled regarding sterilization. Must be the same date as #11 and #15.</p> <p>Must be more than 30 days, but less than 181 days, from the date of sterilization (line #19). Note: This is true even of shorter months such as February.</p> <p>The sterilization may be done on the 31st through 180th day from the date of the client's signature.</p> <p>Example: <i>If the HHS-687 form was signed on 3/2/2016, the client has met the 30-day wait period and can have their sterilization on 4/1/2016.</i></p> <p>If less than 30 days, see What are the exceptions to the usual consent requirements for sterilization? and section IV of the form.</p>

Section II: Interpreter's Statement	
Line	Instructions
9. Space for client's language:	Must specify language into which the sterilization information statement has been translated to for the client.
10. Interpreter's Signature:	Must be interpreter's original signature in ink.
11. Date:	The date the interpreter translated for the client must be the same date the client signed. Must be the same date as lines #8 and #15.

Section III: Statement of Person Obtaining Consent	
Line	Instructions
12. Name of Individual:	See line #4.
13. Specify Type of Operation:	See line #2.
Age of client (middle of section IV)	If the client is not 21 years of age, the age "21" in the 1 st sentence of the 3 rd paragraph must be crossed out with a single line and the age of the client must be written in.

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14. Signature of Person Obtaining Consent:	Must be usual legal signature signed in ink.
15. Date:	Date consent was obtained. Must be the same as #8 and #11.
16. Facility:	See line #1. Tip: For legibility print the name of the person obtaining consent on line #16 below the signature.
17. Address:	Must be physical address of medical practice/group, clinic, or health professional's office where the consent was signed.

Section IV: Physician's Statement

Line	Instructions
18. Name of Individual:	See line #4.
19. Date of Sterilization:	<p>Must be more than 30 days, but less than 181 days, from client's signed consent date listed in line #8, #11, and #15.</p> <p>If less than 30 days, see What are the exceptions to the usual consent requirements for sterilization? and section IV of the form.</p> <p>Date must match the date of procedure on the submitted claim.</p>
20. Specify Type of Operation:	<p>Indicate the type of sterilization operation performed. It must match the type of operation on the claim submitted by the surgeon.</p> <p>Abbreviations are not accepted. "Tubal" alone is not accepted.</p> <p>Examples of acceptable operation names: <i>Vasectomy, salpingectomy, tubal ligation, laparoscopic tubal ligation, salpingectomy, hysteroscopic sterilization, or ESSURE®.</i> The terms <i>bilateral</i> or <i>unilateral</i> are acceptable as long as they are followed by a procedure name. The agency recognizes that there are various techniques used for sterilization and that the term "tubal ligation" is commonly used to refer to cauterization, occlusion, and ligation.</p>
Age of client (middle of section IV)	If the client is not 21 years of age, the age "21" in the 1 st sentence of the 4 th paragraph must be crossed out with a single line and the age of the client must be written in.

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Section IV: Physician's Statement	
21. Premature Delivery:	<p>Check if delivery is premature. Premature means a delivery occurring at less than 37 weeks gestation.</p> <p>Cross out the paragraph identified with (1) as instructed on the consent form.</p>
22. Expected Date of Delivery:	To be completed if there is a premature delivery. Enter the <i>expected</i> date of delivery. Do not use the actual date of delivery.
23. Emergency Abdominal Surgery:	<p>Check if emergency abdominal surgery is required.</p> <p>On line #24, list diagnoses codes if sterilization was done at the time of emergency abdominal surgery. This includes medically indicated cesarean sections. It is unnecessary to write descriptions if the diagnosis codes indicate what the emergency was.</p> <p>Cross out the paragraph identified with (1) as instructed on the consent form.</p>
24. [blank] Reason for waiving the 30 day waiting period:	<p>To be completed if the 30 day waiting period is waived.</p> <p>If it is emergency abdominal surgery see instruction for line 23.</p> <p>If it is one of the reasons listed in Waiving the 30-day waiting period write the required language here.</p>
25. [blank] Surgeon's printed name	Print the provider's name signed on line #25. To verify the claim for payment the provider's name must be printed above the signature or located nearby (may be on a patient sticker).
26. Physician's Signature:	Must be the provider who actually performed the sterilization procedure. Must be signed in ink. Name must be the same name as on the primary surgeon's claim submitted for payment.
27. Date:	<p>Date of provider's signature. Must be no later than 30 days after the sterilization procedure.</p> <p>Tip: It is best if Section IV is signed and dated on the date of the procedure to prevent delay in payment for other providers and facilities that are billing for the same procedure.</p>

Appendix C: Common reasons sterilization claims are denied

- A copy of the consent form is NOT attached.
- There are blank lines on the consent form. (All lines in sections [I](#), [II](#), and [IV](#) must be completed, except lines 21, 22, and 23 which are required only in certain cases.)
- Lines are not completed correctly on the consent form, or inaccurate information is included rather than what is needed.
- On the consent form, there are fewer than 30 days from the date of the client's signature (line 8) to the date of the sterilization operation (line 19).
- The sterilization date on the consent form (line 19) is not the same as the sterilization date on the claim.
- The provider who signs the consent form (line 24) is not the provider listed on the claim as performing the sterilization procedure.
- The provider's signature is illegible on the consent form and the provider's name is not printed above his or her signature (line 24).
- The handwriting on the consent form is illegible or the photocopy quality is too poor to read.
- No expected date of delivery is listed with a premature delivery (line 22).
- The client consents to surgical sterilization and a hysteroscopic sterilization on the same consent form (tubal ligation and ESSURE).
- Salpingectomy (procedure code 58661 or 58700) is billed as a sterilization but tubal ligation is listed as the specific type of operation (line 20).