Clinical Policy: Sterilization Illinois

Reference Number: IL.CP.MP.519
Last Review Date: 09/23

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description:

Sterilization: Any medical procedure, treatment, or operation for the purpose of rendering a beneficiary (male or female) permanently incapable of reproducing. Surgical procedures performed solely to treat an injury or pathology is not considered sterilizations under Medicaid's definition of sterilization, even though the procedure may result in sterilization (e.g., oophorectomy). Most female sterilization procedures are performed either hysteroscopically or laparoscopically. Prophylactic salpingectomy may offer clinicians the opportunity to prevent ovarian cancer in their patients. Hysterectomy as a form of female sterilization is not considered medically necessary thus is not a covered benefit in either state.

Policy/Criteria

I. It is the policy of MeridianHealth affiliated with Centene Corporation® that sterilization is **medically necessary** for the following indications:

A. Sterilizations are covered in accordance with Medicaid and 42 CFR 441.253 and 42 CFR 441.254 when **all** of the following conditions have been met:

i. Recipient is at least 21 years of age;
ii. The recipient is not legally declared mentally incompetent at the time informed consent was obtained;
iii. The recipient is not institutionalized in a corrective, penal, or mental rehabilitation facility;
iv. The procedure is performed at least 30 days but no more than 180 days after signing the appropriate consent form(s), with the exception of cases of premature delivery or emergency abdominal surgery as described below; and
v. A recipient may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since he or she gave informed consent for the sterilization and, in the case of premature delivery, if the informed consent was given at least 30 days before the expected date of delivery.
vi. In cases of abdominal surgery, the emergency nature of the surgery must be clearly identified, e.g. diagnosis, physician's statement, or hospital summary. The nature of the emergency must be included on the consent form.
vii. Informed consent is obtained on the state specific form. Requesting providers are responsible for obtaining the signed Consent for Sterilization (MSA-1959/HHS 687) 30 days prior to surgery.

B. Regarding Informed Consent

i. Suitable arrangements should be made to ensure that the information given during informed consent was effectively communicated to any patient who is blind, deaf, or otherwise handicapped.
ii. An interpreter should be provided if the patient to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent;
iii. The patient to be sterilized should be permitted to have a witness of his or her choice present when consent was obtained.

Absolute Contraindications

iv. Informed consent may not be obtained while the individual to be sterilized is:

a. In labor or childbirth
b. Seeking to obtain or obtaining an abortion, ***or***
c. Under the influence of alcohol or other substances that affect the individual's state of awareness

C. Regarding guardianship

i. A guardian of the person shall not consent to the sterilization of the ward without first obtaining an order from the court granting the guardian the authority to provide consent**.**
ii. Must be in compliance with Illinois state law regarding guardianship - **Illinois General Assembly (755 ILCS 5/11a-17.1) con.**

Illinois General Assembly - Illinois Compiled Statutes (ilga.gov)

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description

HCPCS ®* Codes	Description

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description

Reviews, Revisions, and Approvals	Revisions Date	Approval Date
Original approval date		2/11/13
Annual Review	09/2021	09/2021
Annual Review	09/2022	09/2022
Annual Review	09/2023	09/2023

1. For **Medicaid/Medicaid Expansion Plan** members, this policy will apply. Coverage is based on medical necessity criteria being met and the codes being submitted and considered for review being included on the Illinois Medicaid Fee Schedule (http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx). If there is a discrepancy between this policy and the Illinois Medicaid Provider Manual (located at: http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx) the applicable Medicaid Provider Manual will govern.

State specific special instructions:
IL: Medicaid
Physicians are responsible for obtaining the signed Consent for Sterilization (https://www.illinois.gov/hfs/SiteCollectionDocuments/hfs2189.pdf) 30 days prior to surgery.

References

1. Illinois Department of Healthcare and Family Services, Handbook for Practitioners Rendering Medical Services. Chapter A-200. Sec. A-223.1.4 Sterilization Issued: 3/1/17. Referenced 6/16/2021
2. Centers for Medicare & Medicaid Services. National Coverage Determination Number for Sterilization (230.3). Publication number 3100.3-3.
3. Illinois General Assembly - Illinois Compiled Statutes (ilga.gov)

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence

of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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