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## **1.0 Description of the Procedure**

Hysterectomy is defined as the operation of excising the uterus either through the abdominal wall or through the vagina.

## **2.0 Eligible Recipients**

### **2.1 General Provisions**

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

### **2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if the service is medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination\*\* (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**\*\*EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

**Basic Medicaid Billing Guide:** <http://www.ncdhhs.gov/dma/medbillcaguide.htm>

**EPSDT provider page:** <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

### 3.0 When the Procedure Is Covered

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

#### 3.1 General Criteria

Medicaid covers hysterectomy procedures when the procedure is medically necessary, and:

- a. the procedure is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the level of service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

#### 3.2 Medical Necessity

Medicaid accepts the following diagnoses as validation of medical necessity for hysterectomies:

- a. Malignant and pre-malignant lesions of the female reproductive tract
- b. Endometriosis
- c. Adenomyosis
- d. Leiomyomas or fibroids
- e. Salpingitis and oophoritis
- f. Cervical dysplasia
- g. Mild to moderate cervical dysplasia, when prior conservative procedures failed

- h. Hyperplasia of the endometrium
- i. Dysfunctional uterine bleeding, severe idiopathic menorrhagia and/or metrorrhagia
- j. Inflammatory peritonitis
- k. Intractable procidentia (prolapsed uterus)
- l. Perforation of the uterus by IUD
- m. Class IV or V pap smear
- n. Prophylactic oophorectomy for positive family history of BRCA-1 (breast cancer gene)
- o. Traumatic injury to the uterus with irreparable damage
- p. Complications of childbirth such as uterine rupture or intractable hemorrhage

#### 4.0 When the Procedure Is Not Covered

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

##### 4.1 General Criteria

Medicaid does not cover hysterectomy procedures when:

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure is experimental, investigational or part of a clinical trial;
- d. the procedure is a component of a more comprehensive procedure already paid for the same date of service (Medicaid does not allow a component procedure to be paid on the same date of service as a comprehensive procedure.); or
- e. the hysterectomy is performed for the purpose of sterilization.

#### 5.0 Requirements for and Limitations on Coverage

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

### **5.1 Informed Consent**

Except when designated an emergency abdominal surgery, the recipient must be informed orally and in writing prior to the surgery as to the nature of the surgery and of the fact that the surgery will render the recipient permanently incapable of reproducing. The recipient or her representative, if any, must sign a written acknowledgement of receipt of that information.

### **5.2 Emergency Situations**

When a recipient requires a hysterectomy due to a life-threatening emergency situation, the requirement to obtain informed consent is waived if the physician determines that prior acknowledgement is not possible. The physician who performs the hysterectomy must certify in writing that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgment was not possible. The certification must include the following:

- a. a description of the nature of the emergency
- b. the recipient's name
- c. the recipient's address
- d. the physician's dated signature
- e. all relevant medical records

### **5.3 Previous Sterilization**

When a recipient who is already sterile requires a hysterectomy, the physician who performs the hysterectomy must certify in writing that the recipient was already sterile at the time of the hysterectomy. The certification must include the following:

- a. the cause of the sterility (e.g. age, congenital disorder, previous sterilization, post-menopausal)
- b. the recipient's name
- c. the recipient's address
- d. the physician's dated signature

### **5.4 Hysterectomy Performed During a Retroactive Eligibility Period**

If a recipient receives retroactive eligibility after a hysterectomy is performed, a valid hysterectomy statement must be submitted as indicated in **Sections 5.1, 5.2, or 5.3** for coverage.

### **5.5 Hysterectomy Statement**

One of three federally approved hysterectomy statements (see **Attachment B**) must be completed, as applicable, with the following information indicated on the statement:

- a. the recipient's Medicaid identification number
- b. the recipient's name and address
- c. the recipient's signature and date
- d. the witness's signature

- e. the date of surgery
- f. the surgeon's signature, if applicable

### **5.5.1 Improper Hysterectomy Statements**

According to federal regulations, improperly worded, incomplete, altered, or traced hysterectomy statements cannot be accepted.

### **5.5.2 Witness Signatures**

- a. If the recipient signs with an "X", two people must witness and sign the hysterectomy statement.
- b. If the recipient is mentally incompetent, the recipient's legal guardian and one other person must witness and sign the hysterectomy statement.
- c. If the recipient is under the age of 21, the recipient's legal guardian and one other person must witness and sign the hysterectomy statement.

### **5.5.3 Name Changes**

If the recipient name on the claim and the name on the hysterectomy consent form are different, a signed name change statement (see **Attachment C**) that verifies the recipient whose name appears on the claim and statement are the same person, must be included.

### **5.5.4 Submitting Hysterectomy Statements**

The hysterectomy statement must be on file with Medicaid's fiscal agent in order to process the claim.

**Note:** The hysterectomy statement may be submitted with the claim if the claim is submitted on paper. When a claim is submitted electronically but no hysterectomy statement is on file, the claim will suspend for two weeks to allow time for the statement to be received and processed. Refer to **Attachment B** for additional information on submitting the hysterectomy statement.

## **5.6 Medical Necessity Documentation**

Medical record documentation must support the medical necessity for the hysterectomy procedure. Medical records must be submitted for the following individuals and/or diagnoses:

- a. individuals under the age of 21
- b. pelvic inflammatory disease
- c. mild to moderate cervical dysplasia, when prior conservative procedures failed
- d. carcinoma in situ of unspecified organs
- e. uterine hemorrhage from placenta previa

Medical record documentation must include:

- a. history and physical
- b. operative notes
- c. pathology report
- d. discharge summary
- e. reports for treatments performed prior to the hysterectomy (e.g., laparoscopic procedures, dilations and curettage, conizations or cervical biopsies)

### 5.7 Dilation and Curettage

Medicaid covers a dilation and curettage when performed at the time of an abdominal hysterectomy. A dilation and curettage is not covered when performed in conjunction with a vaginal hysterectomy.

### 5.8 Outpatient Hysterectomies

Medicaid covers outpatient hysterectomies. Observation charges for hysterectomies are not routinely covered. These charges are covered only in situations where a recipient exhibits an uncommon or unusual reaction, or other postoperative complications that require monitoring or treatment beyond the usual services provided in the immediate post-operative period. When observation charges are billed, medical record documentation supporting medical necessity must be submitted with the claims. The records must include the following:

- a. history and physical
- b. operative notes
- c. pathology report
- d. discharge summary

### 5.9 Recovery Room Services

Routine recovery room services are not to be billed as observation services.

### 5.10 Limitations

Hysterectomy procedures are covered for an individual once in a lifetime.

## 6.0 Providers Eligible to Bill for the Procedure

Providers who meet Medicaid's qualifications for participation and are currently enrolled with the N.C. Medicaid program are eligible to bill for hysterectomy procedure when the procedure is within the scope of their practice.

## 7.0 Additional Requirements

There are no additional requirements.

## 8.0 Policy Implementation and Revision Information

Original Effective Date: January 1, 1985

### Revision Information:

Date	Section Updated	Change
5/1/07	Attachment A	Added UB-04 as an accepted claims form.

## Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

### A. Claim Type

#### 1. CMS-1500 Claim Form

Physician providers must submit a CMS-1500 claim form.

#### 2. UB 92 or UB-04 Claim Form

Inpatient hospitals and outpatient hospitals must submit a UB-92 or UB-04 claim form.

### B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

### C. Procedure Code(s)

#### 1. CPT for the CMS-1500 claim form

51925	58150	58152	58180	58200	58210	58240
58260	58262	58263	58267	58270	58275	58280
58285	58290	58291	58292	58293	58294	58550
58552	58553	58554	59135	59525		

#### 2. ICD-9-CM for the UB-92 claim form

68.3	68.4	68.41	68.49	68.5	68.51	68.6
68.61	68.69	68.7	68.71	68.79	68.8	

All physicians (primary, assistant, etc.) must bill the same hysterectomy procedure code for the same recipient, same date of service. All providers must use the correct procedure code for the type of hysterectomy performed to eliminate recoupments.

### D. Modifiers

Providers are required to follow applicable modifier guidelines.

### E. Place of Service

Inpatient hospital  
Outpatient hospital  
Office


### F. Reimbursement Rate


Providers must bill their usual and customary charges.


### Attachment B: Examples of Hysterectomy Consent Statements

These examples should be recreated on professional letterhead – exact wording must be used.

MID: \_\_\_\_\_

 ***If the patient signs the hysterectomy statement prior to surgery:***  
I HAVE BEEN INFORMED ORALLY AND IN WRITING THAT A HYSTERECTOMY WILL RENDER ME PERMANENTLY INCAPABLE OF BEARING CHILDREN:  
Patient's Signature \_\_\_\_\_  
Patient's Address \_\_\_\_\_  
Date Signed \_\_\_\_\_ Witness Signature \_\_\_\_\_

 ***If the provider fails to obtain the patient's statement prior to surgery, however has informed her that she would be incapable of bearing children (this is an exception, not a rule, and will be reviewed as such):***  
PRIOR TO MY SURGERY ON \_\_\_\_\_ (Date of Surgery) \_\_\_\_\_, I WAS INFORMED ORALLY AND IN WRITING THAT A HYSTERECTOMY WOULD RENDER ME PERMANENTLY INCAPABLE OF BEARING CHILDREN  
Patient's Signature \_\_\_\_\_  
Patient's Address \_\_\_\_\_  
Date Signed \_\_\_\_\_ Witness Signature \_\_\_\_\_

 ***If the patient is sterile due to age, a congenital disorder, a previous sterilization or if the hysterectomy was performed on an emergency basis because of life-threatening circumstances (life-threatening should indicate that the patient is unable to respond to the information pertaining to the acknowledgement agreement. Federal regulations do not recognize metastasis of any kind as life threatening or an emergency):***  
Patient's Name \_\_\_\_\_  
Patient's Address \_\_\_\_\_  
The above named patient was sterile prior to the hysterectomy due to:  
\_\_\_\_\_  
or  
A hysterectomy was performed on the above named patient on an emergency basis and was unable to respond because of the following life-threatening circumstances: \_\_\_\_\_  
Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

### Attachment C: Example of Name Change Statement

Dr. Any Provider  
101 Any Hwy  
Any City NC 22222

Medicaid ID Number: 88888888T

To Whom It May Concern:

Jane Recipient has changed her name to Jane Doe.

Dr. Any Provider (Signature of representative at provider's office is required)