Gynecology

Gynecologic services include:

- Pelvic examinations;
- Papanicolaou testing for cervical cancer;
- Screening mammography;
- Contraceptive implants;
- Intrauterine contraceptive system;
- Saline infusion sonohysterography or hysterosalpingography;
- Hysterectomies; and
- Sterilizations.

Pelvic Examinations

Routine pelvic examinations are included in the reimbursement for the evaluation and management service. Therefore, routine pelvic examinations are not to be billed as separate procedures.

Pelvic examinations under anesthesia may be medically necessary for certain populations and must be prior authorized. The beneficiary's medical record must indicate the medical justification for the pelvic examination under anesthesia.

Papanicolaou Testing for Cervical Cancer

Papanicolaou testing (also called a Pap test) is a screening procedure for cervical cancer. The Pap test detects the presence of precancerous or cancerous cells on the cervix. In alignment with American College of Obstetricians and Gynecologists guidelines (ACOG), it is not considered medically necessary to screen beneficiaries younger than 21 years of age if they do not meet eligibility criteria. Therefore, Medicaid will not routinely reimburse testing for beneficiaries under 21 years of age.

Eligibility Criteria

Medicaid considers cervical cancer screening (including repeat screening) medically necessary for beneficiaries under 21 years of age if they meet the following criteria:

- Were exposed to diethylstilbestrol before birth;
- Have Human Immunodeficiency Virus;
- Have a weakened immune system;
- Have a history of cervical cancer or abnormal cervical cancer screening test; or
- Meet other criteria subsequently published by ACOG.

Providers of beneficiaries who meet any of the criteria above must submit hard copy supporting documentation to the fiscal intermediary. Required documentation includes but is not limited to:

- Initial abnormal Pap test result and subsequent abnormal Pap test results;
- History and Physical; and
- Procedure note.

Reimbursement

Collection of Pap test specimens is included in the reimbursement of the evaluation and management service.

A claim for a Pap test may be submitted only if the provider submitting the claim has the necessary laboratory equipment to perform the test in their office or facility.

For those beneficiaries under the age of 21, it is the responsibility of the treating provider to submit the required documentation needed for billing to the laboratory provider.

Providers of these services must submit hard copy supporting documentation to the fiscal intermediary to have the age restriction bypassed for a specific clinical situation.

Claims filed with hard copy supporting documentation to the fiscal intermediary will pend to medical review for confirmation of the conditions that are considered medically necessary. The following claims processing conditions will also apply:

- If the hard copy documentation is not present, the claim for the test will be denied.

- If the hard copy supporting documentation is present and meets the clinical criteria, the claim will be allowed to continue normal processing.

Screening Mammography

Louisiana Medicaid allows payment for one screening mammogram (either film or digital) per calendar year for beneficiaries at least 40 years of age. Providers should perform the most clinically appropriate method (film or digital) specific to the beneficiary.

Contraceptive Implants

Louisiana Medicaid reimburses the insertion and removal of all FDA-approved contraceptive implants.

Intrauterine Contraceptive Systems

Louisiana Medicaid reimburses the insertion and removal of all FDA-approved intrauterine contraceptive systems.

Saline Infusion Sonohysterography or Hysterosalpingography

Claims for catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography must be submitted with hardcopy and attachments indicating the purpose for, and the radiological interpretation of, the procedure.

Reimbursement for this procedure is limited to the assessment of fallopian tube occlusion or ligation following a sterilization procedure.

To meet payment requirements for anesthesia during a hysterosalpingogram, the above criteria must be met.

Hysterectomy

Federal regulations governing Medicaid payment of hysterectomies prohibit payment under the following circumstances:

- If the hysterectomy is performed solely for the purpose of terminating reproductive capability; or

- If there is more than one purpose for performing the hysterectomy, but the procedure would not be performed except for the purpose of rendering the individual permanently incapable of reproducing.

Medicaid guidelines only allow payment to be made for a hysterectomy when:

- The person securing authorization to perform the hysterectomy has informed the individual and their representative (if any), both orally and in writing, that the hysterectomy will make the individual permanently incapable of reproducing; and

- The individual or their representative (if any) has signed a written acknowledgement of receipt of that information. (See Appendix B for information on obtaining a copy of the "Acknowledgement of Receipt of Hysterectomy Information," BHSF Form 96-A).

These regulations apply to all hysterectomy procedures, regardless of the beneficiary's age, fertility, or reason for surgery.

Consent for Hysterectomy

The hysterectomy consent form must be signed and dated by the beneficiary on or before the date of the hysterectomy. The consent must include signed acknowledgement from the beneficiary stating that the beneficiary has been informed that the hysterectomy will result in permanent loss of reproductive ability.

The primary surgeon's claim requires hard-copy submission with a valid consent form and the primary surgeon is expected to share copies of the completed consent forms to facilitate ancillary provider billing for hysterectomy services. Ancillary providers include the assistant surgeon, anesthesiologist, hospital, and/or ambulatory surgical center.

If an ancillary provider submits a claim for hysterectomy services without the appropriate consent form, the claim will be paid only if the primary surgeon's claim has been approved.

The ancillary provider's claim may be held for up to 30 days pending review of the primary surgeon's claim. If the primary surgeon's claim has not been approved during this timeframe, Medical Review will deny the ancillary provider's claim. If the claim is denied, ancillary providers may resubmit after allowing additional time for the primary surgeon's claim to be paid or submit the claim hard-copy with the appropriate consent form.

~~The physician who obtains the consent must share the consent form with all providers involved in that beneficiary's care, (e.g., attending physician, hospital, anesthesiologist, and assistant surgeon)~~

~~as each of these claims must have the valid consent form attached. To avoid a system denial, the consent must be attached to any claim submission related to a hysterectomy.~~

When submitting claims for services that require a hysterectomy consent form, the name on the Medicaid file for the date of service in which the form was signed must be the same as the name signed at the time consent was obtained. If the beneficiary's name is different, the provider must attach a letter from the physician's office from which the consent was obtained. The letter must be signed by the physician and must state that the beneficiary's name has changed and include the beneficiary's social security number and date of birth. This letter must be attached to all claims requiring consent upon submission for claims processing.

A witness signature is needed on the hysterectomy consent form when the beneficiary meets one of the following criteria:

- Beneficiary is unable to sign and must indicate "x" on the signature line; or
- There is a diagnosis on the claim that indicates mental incapacity.

If a witness signs the consent form, the signature date must match the date of the beneficiary's signature. If the dates do not match, or the witness does not sign and date the form, claims related to the hysterectomy will deny.

Exceptions

Obtaining consent for a hysterectomy is unnecessary in the following circumstances:

- The individual was already sterile before the hysterectomy, and the physician who performed the hysterectomy certifies in writing that the individual was already sterile at the time of the hysterectomy and states the cause of sterility.
- The individual required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible, and the physician certifies that the hysterectomy was performed under these conditions and includes a description of the nature of the emergency.
- The individual was retroactively certified for Medicaid benefits, and the physician who performed the hysterectomy certifies that the individual was informed before the operation that the hysterectomy would make the patient permanently incapable of reproducing. In addition, if the individual was certified retroactively for benefits, and the hysterectomy was performed under one of the two other conditions listed above, the physician must certify that the hysterectomy was performed under one of those

conditions and that the beneficiary was informed, in advance, of the reproductive consequences of having a hysterectomy**.**

The written certification from the physician must be attached to the hard copy of the claim for the claim to be considered for payment.

Sterilizations

In accordance with Federal regulations, Medicaid payment for sterilization requires:

- The individual is at least 21 years of age at the time the consent is obtained;
- The individual is not a mentally incompetent individual;
- The individual has voluntarily given informed consent in accordance with all federal requirements; and
- At least 30 days, but no more than 180 days, have passed between the date of the informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual 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. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

Sterilization Consent Form Requirements

Providers must use the current sterilization consent form~~s~~ (OMB No. 0937-0166/HHS-687)~~HHS 687~~ available in English and ~~HHS 687-1 available in~~ Spanish~~)~~ from the Health and Human Services, Office of Population Affairs website. (See Appendix B for information on obtaining and completing these forms).

The consent form must be signed and dated by:

- The individual to be sterilized;
- The interpreter, if one was provided;
- The person who obtained the consent; and
- The physician performing the sterilization procedure.

NOTE: If the physician who performed the sterilization procedure is the one who obtained the consent, that physician must sign both statements.

The primary surgeon's claim requires hard-copy submission with a valid consent form and the primary surgeon is expected to share copies of the completed consent forms to facilitate ancillary provider billing for sterilization services. Ancillary providers include the assistant surgeon, anesthesiologist, hospital, and/or ambulatory surgical center.

If an ancillary provider submits a claim for sterilization services without the appropriate consent form, the claim will be paid only if the primary surgeon's claim has been approved.

The ancillary provider's claim may be held for up to 30 days pending review of the primary surgeon's claim. If the primary surgeon's claim has not been approved during this timeframe, Medical Review will deny the ancillary provider's claim. If the claim is denied, ancillary providers may resubmit after allowing additional time for the primary surgeon's claim to be paid or submit the claim hard-copy with the appropriate consent form.

Consent Forms and Name Changes

When submitting claims for services that require a sterilization consent form, the name on the Medicaid file for the date of service in which the form was signed must be the same as the name signed at the time consent was obtained. If the beneficiary's name is different, the provider must attach a letter from the physician's office from which the consent was obtained. The letter must be signed by the physician and must state that the beneficiary's name has changed and include the beneficiary's social security number and date of birth. This letter must be attached to all claims requiring consent upon submission for claims processing.

Correcting the Sterilization Consent Form

The informed consent must be obtained and documented prior to the performance of the sterilization.

Errors in the following sections can be corrected, but only by the person over whose signature they appear:

- "Consent to Sterilization";
- "Interpreter's Statement";
- "Statement of Person Obtaining Consent"; and

- "Physician's Statement".

If either the beneficiary, the interpreter, or the person obtaining consent returns to the office to make a correction to the relevant portion of the consent form, the medical record must reflect that person's presence in the office on the day of the correction.

To make an allowable correction to the form, the person making the correction must line through the mistake once, write the corrected information above or to the side of the mistake, and initial and date the correction. Erasures, "write-overs," or use of correction fluid in making corrections are unacceptable.

Only the beneficiary can correct the date of signature. The same applies to the interpreter, to the person obtaining consent, and to the physician. Corrections by the beneficiary, the interpreter, and the person obtaining consent must be made before the claim is submitted.

The date of the sterilization may be corrected either before or after submission by the physician over whose signature it appears. However, the operative report must support the corrected date.

An invalid consent form will result in denial of all claims associated with the sterilization.

Consent forms will be considered invalid if:

- Errors have been made in correctable sections, but have not been corrected;
- Errors have been made in blanks that cannot be corrected; or
- The consent form shows evidence of erasures, "write-overs," or use of correction fluid.