WAC 182-531-1550 Sterilization physician-related services. (1) For purposes of this section, sterilization is any medical procedure, treatment, or operation for the purpose of rendering a client permanently incapable of reproducing.

Hysterectomy results in sterilization and is not covered by the medicaid agency solely for that purpose. (See WAC 182-531-0150 and 182-531-0200 for more information about hysterectomies.)

STERILIZATION

(2) The medicaid agency covers sterilization when all of the following apply:

(a) The client is at least eighteen years of age at the time an agency-approved consent form is signed;

(b) The client is a mentally competent individual;

(c) The client participates in a medical assistance program (see WAC 182-501-0060);

(d) The client has voluntarily given **informed consent**; and

(e) The date the client signed a sterilization consent is at least thirty days and not more than one hundred eighty days before the date of the sterilization procedure.

(3) Any medicaid provider who is licensed to do sterilizations within their scope of practice may provide vasectomies and tubal ligations to any medicaid client. (See subsections (10), (11), and (12) of this section for additional qualifications of providers performing hysteroscopic sterilizations.)

(4) The medicaid agency requires at least a seventy-two hour waiting period rather than the usual thirty-day waiting period for sterilization in either of the following circumstances:

(a) At the time of a premature delivery when the client gave consent at least thirty days before the expected date of delivery. (The expected date of delivery must be documented on the consent form.)

(b) For emergency abdominal surgery. (The nature of the emergency must be described on the consent form.)

(5) The medicaid agency waives the thirty-day consent waiting period for sterilization when the client requests that sterilization be performed at the time of delivery and completes a sterilization consent form. One of the following circumstances must apply:

(a) The client became eligible for **medical assistance** during the last month of pregnancy;

(b) The client did not obtain medical care until the last month of pregnancy; or

(c) The client was a substance abuser during pregnancy, but is not using alcohol or illegal drugs at the time of delivery.

(6) The medicaid agency does not accept informed consent obtained when the client is:

(a) In labor or childbirth;

(b) In the process of seeking to obtain or obtaining an abortion; or

(c) Under the influence of alcohol or other substances, including pain medications for labor and delivery, that affects the client's state of awareness.

(7) The medicaid agency has certain consent requirements that the provider must meet before the agency reimburses sterilization of an institutionalized client or a client with mental incompetence. The agency requires both of the following:

(a) A court order, which includes both a statement that the client is to be sterilized, and the name of the client's legal guardian who will be giving consent for the sterilization; and

(b) A sterilization consent form signed by the legal guardian, sent to the agency at least thirty days before the procedure.

(8) The medicaid agency reimburses epidural anesthesia in excess of the six-hour limit for deliveries if sterilization procedures are performed in conjunction with or immediately following a delivery.

(a) For reimbursement, anesthesia time for sterilization is added to the time for the delivery when the two procedures are performed during the same operative session.

(b) If the sterilization and delivery are performed during different operative sessions, the anesthesia time is calculated separately.

(9) The medicaid agency reimburses all attending providers for the sterilization procedure only when the provider submits an agency-approved and complete consent form with the claim for reimbursement. (See subsections (10), (11), and (12) of this section for additional coverage criteria for hysteroscopic sterilizations.)

(a) The physician must complete and sign the physician statement on the consent form within thirty days of the sterilization procedure.

(b) The agency reimburses attending providers after the procedure is completed.

HYSTEROSCOPIC STERILIZATIONS

(10) The medicaid agency pays for hysteroscopic sterilizations when the following additional criteria are met:

(a) A device covered by the agency is used.

(b) The procedure is predominately performed in a clinical setting, such as a physician's office, without general anesthesia and without the use of a surgical suite; and is covered according to the corresponding agency fee schedule.

(c) If determining that it is medically necessary to perform the procedure in an inpatient rather than outpatient setting, a provider must submit clinical notes with the claim, documenting the medical necessity.

(d) The client provides informed consent for the procedure.

(e) The hysteroscopic sterilization is performed by an approved provider who:

(i) Has a core provider agreement with the agency;

(ii) Is nationally board certified in obstetrics and gynecology (OB-GYN);

(iii) Is privileged at a licensed hospital to do hysteroscopies;

(iv) Has successfully completed the manufacturer's training for the device covered by the agency;

(v) Has successfully performed a minimum of twenty hysteroscopies; and

(vi) Has established screening and follow-up protocols for clients being considered for hysteroscopic sterilization.

(11) To become approved for hysteroscopic sterilizations, interested providers must send the medicaid agency-approved vendor, identified in the agency's billing instructions, the following:

(a) Documentation of successful completion of the manufacturer's training;

(b) Documentation demonstrating privilege at a licensed hospital to perform hysteroscopies;

(c) Documentation attesting to having successfully performed twenty or more hysteroscopies;

(d) Evidence of valid National Board Certification; and

(e) Office protocols for screening and follow-up.

(12) The provider will not be paid to perform the hysteroscopic procedure until the medicaid agency sends written approval to the provider.

[Statutory Authority: RCW 41.05.021, 74.09.520, 74.09.657, 74.09.659, and 74.09.800. WSR 13-16-008, § 182-531-1550, filed 7/25/13, effective 9/1/13. WSR 11-14-075, recodified as § 182-531-1550, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-24-071, § 388-531-1550, filed 11/30/10, effective 1/1/11. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-1550, filed 12/6/00, effective 1/6/01.]