310-L HYSTERECTOMY

EFFECTIVE DATES: 10/01/94, 10/01/18, 11/27/18

REVISION DATES: 05/01/97, 10/01/01, 10/01/06, 05/01/11, 07/01/11, 09/27/18

I. PURPOSE

This Policy applies to AHCCCS Complete Care (ACC), ALTCS E/PD, DCS/CMDP (CMDP), DES/DDD (DDD), and RBHA Contractors; Fee-For-Service (FFS) Programs as delineated within this Policy including: Tribal ALTCS, American Indian Health Program (AIHP); and all FFS populations, excluding Federal Emergency Services (FES). (For FES, see AMPM Chapter 1100). This Policy establishes requirements for hysterectomy services in accordance with 42 CFR 441.250 et seq.

II. DEFINITIONS

HYSTERECTOMY  A medical procedure or operation for the purpose of removing the uterus.

INSTITUTIONALIZED INDIVIDUAL  As specified in 42 CFR 441.251, an individual who is:
1. Involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital, or
2. Other facility for the care of treatment of mental illness.

MENTALLY INCOMPETENT  An individual who has been declared mentally incompetent by a Federal, State, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purpose which include the ability to consent to sterilization as specified in 42 CFR 441.251.

STERILIZATION  Any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

III. POLICY

Coverage of hysterectomy services is limited to those cases in which medical necessity has been established by careful diagnosis. Exclusions are specified below. Prior to performing a hysterectomy, documentation relating to the trial of medical or surgical therapy which has not been effective in treating the member’s condition shall be documented.
A. EXAMPLES OF CONDITIONS WHEN HYSTERECTOMY MAY BE INDICATED

1. Dysfunctional Uterine Bleeding or Benign Fibroids associated with Dysfunctional Bleeding: A hysterectomy may be indicated for members for whom medical and surgical therapy has failed, and for which the member has confirmed childbearing is not a consideration.

2. Endometriosis: A hysterectomy may be indicated for members with severe disease when the member has confirmed childbearing is not a consideration, and when disease is refractory to medical or surgical therapy.

3. Uterine Prolapse: A hysterectomy may be indicated for the symptomatic woman for whom the member has confirmed childbearing is not a consideration and for whom non-operative and/or surgical correction, i.e., suspension or repair, will not provide the member adequate relief.

B. CONDITIONS WHERE THERAPY IS NOT REQUIRED PRIOR TO HYSTERECTOMY

Hysterectomy services may be considered medically necessary without prior trial of therapy in the following cases:

1. Invasive carcinoma of the cervix,

2. Ovarian carcinoma,

3. Endometrial carcinoma,

4. Carcinoma of the fallopian tube,

5. Malignant gestational trophoblastic disease,

6. Life-threatening uterine hemorrhage, uncontrolled by conservative therapy, or

7. Potentially life-threatening hemorrhage as in cervical pregnancy, interstitial pregnancy, or placenta abruption.

C. PRIOR ACKNOWLEDGMENT AND DOCUMENTATION

Except as described in Section D, providers shall comply with the following requirements prior to performing the hysterectomy:

1. The member shall be at least 21 years old at the time consent is obtained,

2. The member is not a mentally incompetent individual or an institutionalized individual,
3. Inform the member and member’s representative, if any, both orally and in writing that the hysterectomy will render the member incapable of reproducing (i.e. result in sterility), and

4. Obtain from the member or member’s representative, if any, a signed dated written acknowledgment stating that the information above has been received and that the member has been informed and understands that the hysterectomy will result in sterility. This documentation shall be kept in the member’s medical record. A copy shall also be kept in the member’s medical record maintained by the PCP if enrolled with a Contractor.

A hysterectomy consent and acknowledgement form shall be completed by the Contractor or FFS Providers and allow for a 30 day waiting period as specified in 42 CFR 441.258. Contractors shall use the Hysterectomy Consent and Acknowledgement Form as specified in AMPM Policy 820, Attachment A.

D. EXCEPTIONS FROM PRIOR ACKNOWLEDGEMENT

Providers are not required to complete AMPM Policy 820, Attachment A prior to performing hysterectomy procedures and/or the 30 day waiting period required for sterilization if the physician performing the hysterectomy determines:

1. The member was already sterile before the hysterectomy. In this instance the physician shall certify in writing that the member was already sterile at the time of the hysterectomy and specify the cause of sterility. If the cause of sterility is unknown, specify tests run to determine sterility and test results, or

2. The member requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgement is not possible. In this circumstance the physician shall certify in writing that the hysterectomy was performed under a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible.

E. LIMITATIONS

1. AHCCCS does not cover a hysterectomy procedure if:
   a. It is performed solely to render the individual permanently incapable of reproducing, or
   b. There was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

Refer to AMPM Chapter 800 for prior authorization requirements for FFS providers.