

#### Overview

The Plan provides reimbursement to participating providers for inpatient or outpatient hospital services. Care provided to eligible members includes those services which are necessary for the diagnosis or treatment of disease, illness or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort.

WellCare establishes reimbursement limitations as required by the Ohio state contract to ensure medical necessity of services rendered and utilization control.

#### **Medically-necessary services are those that are:**

- Generally accepted standards of medical practice;
- Appropriate to the illness or injury for which it is performed as to type of service and expected outcome;
- Appropriate to the intensity of service and level of setting;
- Unique, essential and provide appropriate information when used for diagnostic purposes;
- The lowest cost alternative that effectively addresses and treats the medical problem;
- In compliance with general principles regarding reimbursement for Medicaid-covered services found in rule 5101:3-1-02 of the Administrative Code.

Preventive health care, though not customarily thought of as a medically-necessary service, is available through Early and Periodic Screening, Diagnosis and Treatment (EPSDT), also known as the Healthchek program.

A hospital must have a current, valid provider agreement in order to participate in the Medicaid program.

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A *provider agreement* is a contractual agreement whereby the provider agrees to adhere to conditions of participation as outlined in rule 5101:3-1-172 of the Administrative Code.

Coverage is provided for eligible members for preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. Care must be rendered under the direction of a doctor or by an institution which is certified by the Ohio Department of Health for participation under Medicare (Title XVIII) and are eligible to participate in the Ohio Medicaid (Title XIX) program upon execution of a provider agreement.

Also considered to be eligible is a hospital, which is currently determined to meet the requirements for Title XVIII participation and has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Title XIX.

In compliance with Section 1902 (a) (57) of the Social Security Act, hospitals must:

- Provide written information to patients regarding their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
- Provide written information to individuals regarding the institution's or program's written policies respecting the implementation of the right to formulate advance directives;
- Document in the patient's medical record whether or not an advance directive has been executed;
- Comply with all requirements of state law respecting advance directives;
- Provide (individually or with others) education for staff and the community on issues concerning

advance directives;

- Not condition the provision of care or otherwise discriminate against an individual who has executed an advance directive.

WellCare defines an *inpatient* as a patient who is admitted to a hospital on recommendation of a physician or dentist and whose inpatient stay lasts more than 23 hours.

WellCare defines an *outpatient* as a patient who receives outpatient services at a hospital or at a hospital's offsite unit which has been extended accreditation by The Joint Commission, the American Osteopathic Association and/or is certified under Medicare.

*Outpatient* also includes a patient admitted as an inpatient whose inpatient stay does not extend beyond midnight of the day of admission except in instances when, on the day of admission, a patient dies or is transferred to another inpatient unit within the hospital, to another hospital or to a state psychiatric facility.

### **Documentation and Coding Requirements**

WellCare's requirements for documentation and coding dictate that written records must be maintained which fully disclose the extent, medical necessity and appropriateness of the setting for services provided. The records must identify the member, support the diagnosis, justify the treatment and document the course of care and results accurately. Written records are subjected to audit by WellCare.

Medical records must be maintained in accordance with 42 CFR 482.24. Medical records must be maintained for every individual evaluated or treated in the hospital.

Medical records for WellCare members must include the following:

- Identity of the patient;

- Medical history of the patient;
- Report of relevant physical examination;
- Diagnostic and therapeutic orders;
- Evidence of appropriate informed consent;
- Clinical observations, including the results of therapy;
- Reports and results of procedures and tests;
- Conclusions at termination of hospitalization, evaluation or treatment;
- Condition of the patient upon discharge and instructions given to the patient and family;
- Signature and date for each entry.

Inpatient medical care records must contain at least the following, as appropriate:

- Information justifying admission and continued hospitalization, information supporting the diagnosis and describing the patient's progress and response to medications and services;
- The identification of the author of each entry. The author must authenticate his/her entry (authentication may include signatures, written initials or computer entry);
- Admitting diagnosis;
- Identification data including the patient's name, address, date of birth, next of kin and a number that identifies the patient and the patient's medical record;
- A medical history and physical examination report completed no more than seven days prior to admission or within 48 hours after admission that

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includes:

- Chief complaint
- Details of the present illness
- Relevant past, social and family histories
- An inventory of body systems
- Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient;
- Relevant obstetrical records and prenatal information;
- Documentation of complications, hospital-acquired infections and unfavorable reactions to drugs and anesthesia;
- Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by federal or state law if applicable, to require written patient consent;
- All practitioners orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports and vital signs and other information necessary to monitor the patient's condition;
- Discharge summary with outcome of hospitalization, disposition of case and provisions for follow-up care;
- Final diagnosis with completion of medical records (within 30 days of discharge).

WellCare requires all participating hospitals to properly code all relevant diagnoses and surgical and obstetrical procedures on all inpatient and outpatient claims submitted. WellCare utilizes the International Classification

of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) for all coding.

In addition, the Physicians' Current Procedural Terminology, Fourth Edition (CPT-4) coding and/or HCFA Common Procedure Coding System (HCPCS) is required for all outpatient surgical, obstetrical, injectable drugs, diagnostic laboratory and radiology procedures. WellCare does not accept certain codes from these schemes.

When coding, the hospital must select the code(s) that most closely describe(s) the diagnosis(es) and procedure(s) performed. When a single code is available for reporting multiple tests or procedures, that code must be utilized rather than reporting the tests or procedures individually.

WellCare tracks billing codes and providers who repeatedly use incorrect codes resulting in the need for a positive adjustment and may be subject to adverse action.

WellCare utilizes the National Uniform Billing Form (UB-04) for billing (inpatient and outpatient) hospital services. See the Claim Submission Guidelines for details on how to file a claim for hospital services.

**Inpatient Services**

Hospitals should use inpatient-qualifying criteria such as InterQual™ to determine the appropriateness of an inpatient admission as well as conduct concurrent review of the patient's condition. The patient should remain hospitalized until the same criteria indicate hospitalization is no longer necessary.

In determining if a member's condition requires inpatient care, WellCare looks to the medical necessity using inpatient-qualifying criteria such as those published by InterQual™.

There is no limit on the number of days Medicaid allows for medically-necessary inpatient hospital care. If a member is re-admitted to the hospital for the same or related problem within one day of discharge, it is considered the same

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admission. All admissions are subject to medical justification and WellCare may request documentation to substantiate medical necessity and appropriateness of setting. Documentation must be provided upon request in pre-payment or post-payment review. Failure to show appropriate medical justification may be cause for denial, reduction or recoupment of reimbursement.

WellCare defines *inpatient emergency medical services* as those that are medically necessary as a result of a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person could reasonably expect that the absence of immediate medical attention would result in any of the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

For additional reimbursement for cost outliers or unusually expensive admissions, WellCare follows state of Ohio guidelines with each request determined on a case-by-case basis.

Hospital admission for diagnostic purposes is covered only when the services cannot be performed on an outpatient basis. Certain services may only be reimbursed when performed on an outpatient basis unless medical necessity for an inpatient admission is documented and pre-certified.

If a hospital determines that an outpatient hospital setting would have met the medical needs of a member after the services were provided in an inpatient setting, the services may be billed to WellCare as outpatient if the claim is received within six months of the ending date of the service month. If the claim is received more than six months after the ending date, the services are not covered.

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If the claim is paid prior to the determination, the inpatient claim must be voided from the WellCare claims processing system prior to the processing of the new outpatient claim. To substantiate the determination, a physician's order must document the member's status at the time of admission and any changes in the member's status.

Reimbursement for psychiatric services is limited to short-term acute care.

If a member is admitted as an inpatient for less than 24 hours in duration, the admission is subject to a medical necessity of admission review by WellCare. A length of stay less than 24 hours is considered observation and is therefore outpatient service.

Outpatient services billed as inpatient are subject to recoupment after review for medical necessity.

## Observation

WellCare defines *observation services* as those services furnished by a hospital, including the use of beds and periodic monitoring by a hospital's nursing or other staff.

Observation services are covered when it is determined they are reasonable and necessary to evaluate an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized to admit patients to the hospital or to order outpatient tests.

Observation services usually do not exceed 24 hours. However, some patients may require 48 hours of outpatient observation services. To receive payment for a third consecutive date of service, the patient must have been discharged and, for medically necessary reasons, readmitted as an outpatient.

When a member is placed under observation by a hospital, the patient is considered an outpatient until the patient is admitted as an inpatient. While under observation, the hospital may determine the patient needs further care as

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an inpatient admission or the patient may improve and be released. The maximum time for observation services is 48 hours. If a member has not been admitted after 48 hours of observation, further observation services will be denied. Observation status begins on the first hour after Emergency department evaluation and initial treatment.

Payment for observation services will be made in accordance with 5101:3-2-21 – Appendix F of the Administrative Code which reflects how to pay an observation.

WellCare does not cover outpatient observation services in the following situations:

- Complex cases requiring inpatient care, post-operative monitoring during the standard recovery period;
- Routine preparation services furnished prior to diagnostic testing in the hospital outpatient department and the recovery afterwards;
- Observation billed concurrently with therapeutic services such as chemotherapy, physical therapy, etc.

A member may only transfer from outpatient status to inpatient status if it is determined that that inpatient services are medically necessary. In order for the services to be covered, certification must be obtained within one business day of the beginning date of this episode of care. To receive certification for inpatient admission, WellCare must receive documentation indicating the admission is medically necessary and appropriate.

The date of the inpatient admission will be the actual date the patient is formally admitted as an inpatient and will count as the first inpatient day. When a patient is admitted to the hospital from outpatient observation, all observation charges must be combined and billed with the inpatient charges. Outpatient observation services should not be used for services for which an overnight stay is normally

expected. Services, such as complex surgery, clearly requiring inpatient care may not be billed as outpatient.

WellCare will deny any request for updates to the prior authorization file and retroactive authorization for inpatient admissions if it is clear that an inpatient level of care should have been initially requested.

WellCare only covers services that are medically appropriate and necessary. Medical appropriateness and necessity including that of the medical setting must be clearly substantiated in the member's medical record. Services provided for the convenience of the member or physician and are not reasonable or medically necessary for the diagnosis are not covered.

#### **Hospital-Based Physicians, Certified Registered Nurse Anesthetists, and Nurse Practitioners**

All inpatient and outpatient professional services must be billed on the physician's claim form.

Hospital-based physicians, CRNAs and specified nurse practitioners may designate the hospital as payee by agreement. The hospital must maintain each agreement authorizing such payments on file.

Services rendered to eligible members by hospital-based physicians, CRNAs, designated nurse practitioners will be covered both on an inpatient and outpatient basis as long as the services are medically necessary and within the contractual or financial agreement with the hospital. These services are subject to retrospective review by WellCare or its authorized agents.

#### **Transplant Services**

WellCare covers all services and supplies related to Medicaid-covered transplant services for eligible members. All non-investigational, medically-necessary transplantation services are covered, if covered by Medicaid. Prior authorization is required for all transplants.

**Dialysis**

Services for dialysis require prior approval and prior authorization and must be obtained at a contracted facility.

*End-stage renal disease clinic services* are defined as diagnostic, therapeutic, rehabilitative or palliative services that are furnished by a free-standing clinic that is not supervised, managed, owned or controlled by a hospital or long-term care facility, but is organized and operated independently (both fiscally and administratively) to provide medical care.

The term includes the following services:

- Services furnished at the clinic by or under the direction of a physician;
- Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

Medicaid is the payer of last resort. Any provider must determine whether Medicare or another third-party insurer covered the recipient's dialysis treatment for the date of treatment.

Members with acute renal failure are covered for inpatient dialysis services.

**Rehabilitation Services**

Rehabilitation services related to chemical dependency is limited to coverage of services for detoxification. Coverage is not available for days of inpatient care which occur solely for the provision of rehabilitation services related to chemical dependency.

- However, short-term medical rehabilitation services are covered by WellCare for members.

#### **Hospitalist Program**

WellCare may utilize Hospitalists at certain contracted hospitals. Hospitalists provide attending physician coverage in selected markets for members admitted to contracted facilities.

Hospitalists provide the following services:

- Emergency room assessment of a member;
- Direct admissions to facilities where the Primary Care Provider (PCP) may not provide that service;
- Manage care as needed throughout the inpatient medical admission for members 16 years of age and older excluding obstetrical and gynecological cases;
- Refer members to the PCP upon discharge for follow-up care and communicating the treatment/discharge plan verbally within 24 hours and in writing within seven days.

#### **Emergency Room and Outpatient Services**

Emergency services shall be available 24 hours a day, seven days a week to treat an emergency medical condition.

There is no requirement for prior authorization for emergency services. WellCare provides an aggressive Emergency Room Follow-up program to provide continuity of care among the ER, the PCP and other agencies. The Emergency Services department will provide WellCare with the treatment and discharge instructions as well as any current contact information, if requested.

This will enable the coordination of the member's health care needs after he/she is discharged from the emergency room. The member will also be assessed for WellCare's Emergency Room Diversion program.

An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms. An *emergency medical condition* is a medical or behavioral

health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious harm to self or others due to an alcohol or drug abuse emergency;
- Injury to self or bodily harm to others; or
- With respect to a pregnant woman having contractions: (i) that there is not adequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

WellCare provides payment for emergency services when furnished by a qualified provider, regardless of whether that provider is in the WellCare network. These services are not subject to prior authorization requirements. WellCare will pay for all emergency services that are medically necessary until the member is stabilized. WellCare will also pay for any screening examination services conducted to determine whether an emergency medical condition exists.

### **Non-Covered Inpatient Services**

WellCare does not cover the services and procedures listed below:

(In addition, any services related to, required in preparation for, or as a result of non-covered services are also not covered.)

- Services and supplies, which are inappropriate or not medically necessary, as determined by WellCare or other authorized agent;
- Services or procedures performed which are not in compliance with the policies and procedures contained in this manual;
- Rehabilitation services related to chemical dependencies: Coverage of inpatient days for treatment of a chemical dependency is limited to coverage of services for detoxification. Coverage is not available for days of inpatient care which occur solely for the provision of rehabilitation services related to a chemical dependency;
- Miscellaneous and non-specific charges;
- Non-acute levels of care;
- Utilization review;
- Late charges defined as a portion of the charges for a given service omitted from the original billing, which included some of the charges for that given service, are non-covered. If the total charges for a given service were omitted from the original billing, a positive adjustment may be requested;
- Services mandated to be performed only on an outpatient basis;
- Clinic services while the member is an inpatient;
- Leave of absence;
- Services provided free of charge to the public by the hospital or county health departments, state laboratory or other state agencies; i.e., immunizations, metabolic screens for members under one year of age, etc;
- Nursing services, including services traditionally accepted as nursing care even though provided by

other ancillary departments;

- Service charges for individual areas within the hospital; e.g., pharmacy dispensing fee, IV admixture fee (except for hyperalimentation), cover charge for central supply, charges for handling and distribution of supplies, transportation within the hospital, equipment installation, specimen collection, venipuncture, standby equipment, staff time and evaluations;
- Resuscitation, code, CPR (cardiopulmonary resuscitation), etc. are non-covered. However, supplies associated with this service will be reimbursed;
- Investigational items and experimental services, drugs or procedures;
- Any services or items furnished for which the hospital does not normally charge;
- Services provided by an institution for mental disease or special disorders;
- Separately billed equipment and supplies which are integral parts of hospital care and the area in which care is being provided; e.g., cardiac monitor in intensive care unit (ICU), light source in operating room (OR), call system, blood pressure cuffs and monitors, specimen collection devices and containers, etc;
- Private rooms are non-covered services. However, if the member has a condition that requires an isolation room or special care unit (ICU, coronary care unit (CCU), these are reimbursable. All other accommodations are reimbursed at the semiprivate room rate;
  - Upon admission, members should be notified that private rooms are non-covered services. Members who request a private room after

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being informed of WellCare's policy will be responsible for the difference between the hospital's semi-private and private room rates.

- If the member has a condition that requires an isolation room or special care unit, or if the hospital only offers private rooms or only has private rooms available, the member cannot be billed for the difference between the semi-private room rate paid by WellCare and the private room rate.
- Intermediate care (i.e., step-down units) are reimbursable at the semi-private room rate;
- Services which are not medically necessary to the patient's well-being; e.g., television, telephone, combs, brushes, guest meals, cots, etc.
- Non-consumable multiple supply items; e.g., bath basins, admission kits, disposable pillows, etc;
- Take-home prescription drugs, medical supplies, durable medical equipment, artificial limbs and appliances are non-covered;
- Cosmetic surgery or mammoplasties for aesthetic purposes;
- Infertility procedures and related services;
- Some situations concerning abortions, sterilizations and hysterectomies. See **Limits to Abortions, Sterilizations and Hysterectomy Coverage** for details;
- Tubal reanastomosis procedures pertaining to sterilizations and vasectomies;
- Preventive health care. Members under age 21 may receive this care through the EPSDT screening

process;

- Days waiting for placement and custodial care, including days waiting for transfer to a long-term care facility, days of inpatient care unnecessary due to unnecessary delays in applying for court-ordered commitment, grace periods, administrative days and custodial care.

This exclusion also includes days spent as an inpatient at a transferring hospital on or after the effective date of a court commitment to another facility and inpatient days resulting from a hospital's failure to timely request or perform necessary diagnostic studies, medical-surgical procedures or consultations.

**Non-Covered  
Emergency  
Room and  
Outpatient  
Services**

Not all emergency room and outpatient services are covered benefits for WellCare members. Those listed below as well as any services related to these services are also non-covered.

- Services or procedures performed which are not in compliance with the policies and procedures contained in this manual;
- Routine physical examinations;
- Investigational items and experimental services, drugs or procedures;
- Services provided free of charge to the public by the hospital, county health departments, state laboratory or other state agencies; i.e., immunizations, metabolic screens for members under one year of age, etc.;
- Any services and supplies which WellCare or an authorized agent deems as inappropriate or not medically necessary;
- Any services or items furnished for which the hospital does not normally charge;

- Services non-covered or denied by WellCare because they were provided on an inpatient basis;
- Non-acute levels of care;
- Separately billed equipment and supplies which are integral parts of hospital care and the area in which care is being provided, e.g., cardiac monitor in ICU, light source in OR, call system, blood pressure cuffs and monitors, specimen collection devices and containers, etc.;
- Late charges defined as a portion of the charges for a given service omitted from the original billing, which included some of the charges for that given service, are non-covered. If the total charges for a given service were omitted from the original billing, a positive adjustment may be requested;
- Take-home prescription drugs, medical supplies, appliances and durable medical equipment are also non-covered;
- Differential service charges; e.g., "STAT" or priority, after-hours or call-back fees;
- Resuscitation, code, CPR (cardiopulmonary resuscitation), etc. are non-covered. However, supplies associated with this service will be reimbursed;
- Service charges for individual areas within the hospital; e.g., pharmacy dispensing fee, IV admixture fee (except for hyperalimentation), cover charge for central supply, charges for handling and distribution of supplies, transportation within the hospital, equipment installation, specimen collection, venipuncture, standby equipment, staff time and evaluations;
- Nursing services, including services traditionally accepted as nursing care even though provided by

other ancillary departments;

- Some situations concerning abortions, sterilizations and hysterectomies. See **Limits to Abortions, Sterilizations and Hysterectomy Coverage** for details;
- Tubal reanastomosis procedures pertaining to sterilizations and vasectomies;
- Artificial insemination, Infertility procedures and related services;
- Acupuncture;
- Treatment of obesity, including gastroplasty, gastric stapling or ileo-jejunal shunt; (unless it is determined to be medically necessary and the procedure is prior authorized)
- Plastic or cosmetic surgery when the surgery is performed for aesthetic purposes; for example: rhinoplasty, ear piercing, or mammary augmentation or reduction, tattoo removal; Excision of keloids, facio-plasty, osteoplasty (prognathism and micrognathisms, dermabrasion, skin grafts and lipectomy).

**Out-of-State Providers and Service Limitations**

Out-of-state hospital providers not contracted with WellCare will be reimbursed for covered services provided to eligible WellCare members while out-of-state if the claim is received within six months from the month of service, and if at least one of the following conditions is met:

- The hospital provider pre-authorized the service through WellCare; or
- The service was provided to the WellCare member as a result of an emergency or life-endangering situation occurring out of state (If the out-of-state provider believes the medical record supports the existence of an emergency situation but the diagnosis does not justify an emergency, the claim

must be submitted with a copy of the medical record).

While out-of-state providers are eligible for reimbursement, the Medicaid program does not reimburse providers located outside the continental United States.

Routine health care or elective surgery provided by out-of-state providers is not covered.

**Requests for prior authorization or questions regarding out-of-state services must be directed to WellCare's Utilization Management department. See the Quick Reference Guide for contact information.**

If services are pre-authorized, a copy of the authorization letter from WellCare must be attached to out-of-state claims submitted for reimbursement. Services rendered due to an emergency or life-endangering situation do not have to be pre-authorized.

### **Limits to Abortion, Sterilization and Hysterectomy Coverage**

#### **Abortion**

Reimbursement for abortions is restricted to the following circumstances when appropriate certification is obtained:

- Instances in which the woman suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed;
- Instances in which the pregnancy was the result of an act of rape and the patient, the patient's legal guardian or the person who made the report to the law enforcement agency, certifies in writing that a report was filed, prior to the performance of the abortion, with a law enforcement agency having the requisite jurisdiction, unless the patient was physically unable to comply with the reporting requirement and that fact is certified by the

physician performing the abortion; or

- Instances in which the pregnancy was the result of an act of incest and the patient, the patient's legal guardian or the person who made the report certifies in writing that a report was filed, prior to the performance of the abortion, with either a law enforcement agency having the requisite jurisdiction, or, in the case of a minor, with a county children services agency established under Chapter 5153 of the Revised Code, unless the patient was physically unable to comply with the reporting requirement and that fact is certified by the physician performing the abortion.

Abortions are not covered if used for family planning purposes.

A certification must be made on the Ohio Department of Job & Family Services (ODJFS) Abortion Certification Form JFS 03197 and submitted to WellCare with the provider's claim.

The physician's signature must be in the physician's own handwriting. All certifications must contain the name and address of the patient. The certification form must be attached to the provider's claim. See the **Forms** section of this manual for a copy of this form.

Claims for payment will be denied if the required documentation is not attached or if incomplete or inaccurate documentation is submitted. WellCare does not accept documentation meant to satisfy informed consent requirements, which has been completed or altered after the service was performed.

Reimbursement will not be made for associated services when the abortion procedure itself is not eligible for reimbursement, regardless of whether or not the abortion procedure is itself billed to the department. The member may sign the consent form either before or after the surgery as long as she was informed of the consequences of the procedure verbally and in writing prior to surgery.

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### Sterilizations

Sterilization procedures will be reimbursed only if the following requirements are met:

- The sterilization must be the result of a voluntary request for such services by a member legally capable of consenting to such a procedure;
- The individual is at least 21 years old at the time consent is obtained;
- The individual is not mentally competent. For program purposes, *mentally incompetent individual* is defined as a person who has been declared mentally incompetent by a federal, state or local court of jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization;
- The individual is not institutionalized. For program purposes, *institutionalized individual* is defined as an individual who is:
  - (a) Involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or
  - (b) Confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.
- The individual has been given a thorough explanation of all elements of the department's approved Consent to

Sterilization Form JFS 03198<sub>1</sub>, prior to giving consent for the procedure to be performed. In addition, the member must have been made fully aware that he/she is free to withhold consent to the procedure at any time before the sterilization, without affecting the right to future care or treatment and without loss or withdrawal of any federally-funded program benefits to which the individual might be otherwise entitled. In instances where the individual is blind, deaf or otherwise handicapped, arrangements must be made to ensure that all information is effectively communicated. Similarly, an interpreter must be provided if the individual to be sterilized did not understand the language of the consent form or of the person obtaining the consent. The individual must also be permitted to have a witness of his/her choice present when consent is made; and

- At least 30 days, but not more than 180 days, have passed between the date of the informed consent and the date of the 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/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. It should be noted that the above waiver does not apply to cases of unanticipated abortions, since, unlike situations involving emergency abdominal surgery or premature delivery, an abortion in the first trimester of pregnancy is not generally considered a major surgical procedure with consequent double exposure

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to the risks of major surgery.

However, all claims submitted to WellCare for sterilization, whether performed as a primary or secondary procedure or for medical procedures directly related to such sterilizations, must include a copy of the signed consent form.

Reimbursement will not be made for associated services when the sterilization procedure itself is not eligible for reimbursement, regardless of whether or not the procedure is itself billed to the department. The physician may sign and date the consent to sterilization form either before or after the date the procedure is performed. The date the physician signs the form cannot be prior to the date that the member signs the form.

Informed consent must not be obtained while the individual to be sterilized is:

- In labor or childbirth; or
- Seeking to obtain or obtaining an abortion; or
- Under the influence of alcohol or other substances that affect the individual's state of awareness.

#### **Sterilization by Hysterectomy**

- Reimbursement cannot be made for hysterectomy procedures when the primary intent of the hysterectomy is for fertility control. Payment will only be made for those hysterectomies performed for medical reasons, such as a diseased uterus and only if the recipient has been advised verbally and in writing prior to surgery that sterility will result. Acknowledgment of the receipt of this information must be obtained by completing section II of the department's approved

#### Consent to Hysterectomy form JFS 03199.

The primary physician performing the hysterectomy is normally responsible for securing the recipient's consent to the procedure. Should a member change physicians between the time a physician secures the recipient's consent and the date of the sterilization, it is not necessary for the physician performing the sterilization procedure to complete a second consent form if the initial consent form is available. However, as in the case of sterilizations, all claims submitted to WellCare for hysterectomies, whether performed as a primary or secondary procedure, or for medical procedures directly related to such hysterectomies, must include a copy of the signed approved consent form.

Reimbursement will not be made for associated services when the hysterectomy procedure itself is not eligible for reimbursement, regardless of whether or not the hysterectomy procedure is itself billed to the department. The member may sign the consent form either before or after the surgery as long as she was informed of the consequences of the procedure verbally and in writing prior to surgery.

- Payment can be made for a hysterectomy without obtaining signed acknowledgment of the hysterectomy consent form in the following circumstances:
  - (a) The individual was already sterile before the hysterectomy;
  - (b) The individual was post-menopause; or
  - (c) The individual requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior

acknowledgment is not possible.

In either situation, where the exceptions apply, a physician meeting the conditions must certify by completing section III on the JFS 03199 that the individual was already sterile at the time of the hysterectomy and state the cause of the sterility; or, certify that the hysterectomy was performed under a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible. The primary physician must also include a description of the nature of the emergency.

- Reimbursement is also available for hysterectomies performed during a period of an individual's retroactive eligibility if the physician certifies that all the requirements are met by completing section IV on the JFS 03199. In a case where signed acknowledgment by the recipient or her representative is required, section II of the JFS 03199 must also be completed.
- If a recipient requiring a hysterectomy is eligible for both Medicaid and Medicare, an acknowledgment statement or certification of exception must be obtained. The properly completed JFS-03199 form must not be attached to the Medicare claim form, but must be forwarded separately to the department. If the claim is rejected by Medicare, the provider should submit a separate claim to the department with the Medicare rejection attached. The date that the JFS 03199 form was sent to the department should be entered in the provider remarks section of the Medicaid claim.
- All claims for abortions, sterilizations and sterilizations by hysterectomy must be billed on a paper claim. Electronic claims will not

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be accepted.

Claims received for abortions, sterilizations and sterilizations by hysterectomy must comply with the requirements of this rule if they are to be eligible for reimbursement. Claims that are not in compliance with the requirements of this rule will be denied and returned to providers.

- See the **Forms** section of this manual for a copy of the required consent forms. WellCare will deny any provider claims submitted without the required documentation or with incomplete or inaccurate documentation.

**Prior  
Authorization  
Requirements**

For details on notification and prior authorization processes, refer to the **Quick Reference Guide** and the **Utilization Management** sections of this manual.