

HYSTERECTOMY CONSENT FORM

PART I

This hysterectomy (is not being) (was not) performed solely for the purpose of rendering _____ permanently incapable of reproducing, and
(patient's name)
this hysterectomy (would be) (would have been) performed even without the purpose of rendering _____ permanently incapable of reproducing
(patient's name)
because of: _____.

Physician's Signature

Date

A hysterectomy consent form was not obtained because:

1. The patient _____ was sterile before this procedure because of:
(patient's name)
_____.

2. It was a life-threatening emergency and prior acknowledgement could not be obtained.

The emergency was: _____.

Physician's Signature

Date

PART II

I told _____ and her representative _____ both
(patient's name) (if one is present)
orally and in writing, that a hysterectomy will render her permanently incapable of reproducing.

Signature: _____
Person Obtaining Surgical Consent

Date

PART III

I have received and understood both oral and written information explaining that a woman undergoing a hysterectomy will be permanently incapable of having children after the operation.
I was informed of this before my surgery was performed.

Signature: _____
Patient

Date

CERTIFICATE OF MEDICAL NECESSITY

Patient Name	Medicaid ID Number
Date Billed	Description of Item/Service
Procedure Code	
Reason for Item/Service/Equipment/Supplies	
Date Prescribed	Diagnosis
Prognosis	
Attending/Prescribing Physician Name/Medicaid Contract ID/NPI <div style="text-align: right; margin-right: 100px;"> _____ Signature </div>	
Provider Name, Address, Medicaid Contract ID and NPI	
Provider Signature	Title

Please attach this form to all claims requiring documentation of medical necessity.

STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ . When I first asked for
(doctor or clinic)

the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide to not be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected those alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____
Month Day Year
I, _____, hereby consent
of my own free will to be sterilized by _____
(doctor)

by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human services or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Signature Date Month Day Year

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- | | |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black (not of Hispanic origin) |
| <input type="checkbox"/> Asian or Pacific Island | <input type="checkbox"/> Hispanic |
| | <input type="checkbox"/> White (not of Hispanic origin) |

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter (Signature) Date

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the
name of individual
consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of person obtaining consent Date

Facility

Address

■ PHYSICIAN'S STATEMENT ■ (TO BE COMPLETED FOLLOWING SURGERY)

Shortly before I performed a sterilization operation upon _____ on _____
Name of individual to be sterilized Date of sterilization

_____, I explained to him/her the nature of the operation

sterilization operation _____, the fact that
specify type of operation
it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Premature delivery
Individual's expected date of delivery: _____
(Date)
- Emergency abdominal surgery:
(describe circumstances): _____

(Signature) Physician Date

ALL APPLICABLE BLANKS MUST BE COMPLETED.
STAMPED SIGNATURES ARE NOT ACCEPTABLE.

CERTIFICATE TO REQUEST FEDERAL (MEDICAID) FUNDS FOR ABORTION

Effective November 13, 1997, Congress passed another revision of the Hyde Amendment pertaining to federally funded Medicaid abortions. The provision states that federal funds are available for an abortion only "(1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a 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."

(Recipient's Full Name)

(Recipient's Medicaid Identification Number)

had an abortion procedure performed on ____/____/____.
(Mo. / Day / Year)

Indicate the circumstance that applies below:

I certify that prior to performing the abortion procedure on the above patient to terminate her pregnancy, I obtained a non-notarized signed statement from the patient that her pregnancy was the result of an act of rape or incest. That statement is now part of the patient's medical record.

I certify that in my professional judgement, the abortion procedure on the above patient was performed due to physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion was performed, based on full consideration of all factors as described in the attached operative report.

(Signature of Recipient's Attending Physician)

M.D.

D.O.

____/____/____
(Month / Day / Year)

(Date of Physician's Signature)

This certificate to request federal (Medicaid) funds for an abortion must be personally signed and dated by the recipient's attending physician. A facsimile signature or signature of the physician's authorized representative is not acceptable. Each provider submitting a claim for abortion services (e.g., physician, inpatient hospital, outpatient hospital) must attach a completed certificate bearing an original signature of the recipient's attending physician. The signature requirement will not be waived for resubmission.

Appendix A
Select Diagnoses and Procedures Pre–certification List
Effective January 1, 2010*

DIAGNOSES/SYMPTOMS REQUIRING PRE–CERTIFICATION
FOR ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES MEDICAL ASSISTANCE RECIPIENTS

Diagnosis	ICD–9 CM Diagnosis Code	LOCATION		REVIEW METHOD	
		Inpatient	Outpatient	Telephonic /Fax	Clinical Records
Gastroenteritis	001.1, 002.0, 002.9, 003.0, 004.9, 005.0, 005.1, 005.9, 006.0 through 006.2, 006.9, 007.1, 007.2, 007.8, 007.9 008.00 through 008.04, 008.09, 008.1, 008.2, 008.3, 008.5, 008.8, 008.41 through 008.47, 008.49, 008.61 through 008.69, 008.8, 009.0, through 009.3, 014.80-014.86, 112.85, 487.8, 536.8, 556.0 through 556.9, 557.0, 557.1, 557.9, 558.1, 558.2, 558.3, 558.41, 558.9, 564.9, 569.9	✓		✓	
Cellulitis	682.0 through 682.9	✓		✓	
Respiratory Illness Bronchitis	466.0 through 466.19 (Children under the age of five (<i>1825 days</i>) are excluded from pre–certification. Continued Stay Review is required after day 3, as are all hospital stays.)	✓		✓	
Pneumonia	480.9 through 486 (Children under the age of five (<i>1825 days</i>) are excluded from pre–certification. Continued Stay Review is required after day 3, as are all hospital stays.)	✓		✓	
Physical Rehabilitation	V57.0, V57.1, V57.21, V57.22, V57.3, V57.4, V57.81, V57.89, V57.9	✓		✓	
All Admissions to Long Term Acute Care Facilities (LTAC)		✓		✓	

All categories on this page require the facility’s Utilization Review Department to notify Qualis Health of urgent/emergent admits within 24 hours or the next business day. The attending physician is responsible for pre-certifying any non-urgent/emergent admissions for the above diagnoses/symptoms.

PROCEDURES REQUIRING PRE-CERTIFICATION
FOR ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES MEDICAL ASSISTANCE RECIPIENTS

Procedure	ICD-9 CM Procedure Code	CPT® Code	LOCATION		REVIEW METHOD	
			Inpatient	Outpatient	Telephonic /Fax	Clinical Records
Alcohol Detoxification	94.62	90899	✓		✓	
Drug Detoxification	94.65	90899	✓		✓	
Combined Alcohol & Drug Detoxification	94.68	90899	✓		✓	
Cochlear device implantation	20.95, 20.96, 20.97, 20.98, 20.99	69930	✓	✓	✓	
Cholecystectomy	51.21 through 51.24	47562, 47563, 47564, 47600, 47605, 47610, 47612, 47620	✓	✓	✓	
Gastric Bypass for Obesity	44.31	43644, 43645, 43775 , 43845, 43846, 43847, 43848, 43850, 43886, 43887, 43888, 47740, 47741				
Laparoscopic Gastroplasty/Gastric Bypass	44.68	43645, 43843	✓	✓		✓
Gastric Adjustable Band	44.95	43845, 43770, 43771, 43772, 43773, 43774, 43842				
Duodenal Switch	43.89, 45.91	43845				
Hysterectomy (All Hysterectomies must have informed consent and meet the following criteria: <ul style="list-style-type: none"> • Patient must be over 21 years of age • Patient must be mentally competent) 						
Abdominal	68.39, 68.49, 68.69	58150, 58152, 58180, 58200, 58951, 58953, 58954, 58956, 59135, 59525	✓	✓	✓	
Vaginal	68.51, 68.59, 68.71, 68.79	58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294	✓	✓	✓	
Laparoscopic	68.31, 68.41, 68.51, 68.61, 68.71	58550, 58552, 58553, 58554, S2078, 58541, 58542, 58543, 58544, 58548, 58570, 58571, 58572, 58573, 58578	✓	✓	✓	
Radical	68.8	58210, 58240, 58548	✓	✓	✓	
Laminectomy/Diskectomy	03.02, 03.09, 80.50, 80.51	63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63050, 63051, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102, 63103, 63170, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200, 63250, 63251, 63252, 63265, 63266, 63267, 63268, 63270, 63271, 63272, 63273, 63275, 63276, 63277, 63278, 63280, 63281, 63282, 63283, 63285, 63286, 63287, 63290, 63295	✓	✓	✓	

PROCEDURES REQUIRING PRE-CERTIFICATION
FOR ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES MEDICAL ASSISTANCE RECIPIENTS

Procedure	ICD-9 CM Procedure Code	CPT® Code	LOCATION		REVIEW METHOD	
			Inpatient	Outpatient	Telephonic /Fax	Clinical Records
Division of intra-spinal nerve root-Rhizotomy	03.1	63185, 63190, 0090T, 0091T, 0092T, 0093T, 0095T, 0096T, 0098T	✓	✓	✓	
Internal fixation of bone without fracture reduction	78.59	22841	✓		✓	
Spinal Fusion (arthrodesis)	81.00 through 81.08, 81.30 through 81.39, 84.51, 84.52, 81.62, 81.63, 81.64	22585, 22614, 22632, 22800, 22802, 22804, 22808, 22810, 22812, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 22851, 27280	✓		✓	
Cervical including revision	81.01, 81.02, 81.03, 81.31, 81.32, 81.33	22548, 22554, 22590, 22595, 22600	✓	✓	✓	
Dorsal/Thoracic including revision	81.04, 81.05, 81.34, 81.35	22532, 22556, 22610	✓	✓	✓	
Lumbar/Lumbosacral including revision	81.06, 81.07, 81.08, 81.36, 81.37, 81.38	22533, 22534, 22558, 22612, 22630	✓	✓	✓	
Insertion of Spinal disc prosthesis	84.60	22851, 22852, 22855, 22857, 22862, 22864, 22865, 0090T, 0092T, 0163T				
Revision or Replacement	84.69					
Cervical						
Insertion of partial spinal disc prosthesis	84.61					
Insertion of total spinal disc prosthesis	84.62					
Revision, Replacement or Removal	84.66					
Dorsal/Thoracic						
Insertion of partial spinal disc prosthesis	84.63					
Revision or Replacement	84.67					
Lumbar/Lumbosacral						
Insertion of partial spinal disc prosthesis	84.64					
Insertion of total spinal disc prosthesis	84.65					
Revision or Replacement	84.68					
Mastopexy	85.6, 85.70, 85.71, 85.72, 85.73, 85.74, 85.75, 85.76, 85.79					
Mastectomy	85.4, 85.41	19300, 19301, 19302, 19303, 19304, 19305, 19306, 19307				
Mammoplasty (reduction)	85.31 (unilateral) 85.32 (bilateral)	19318				
Mammoplasty	85.5, 85.50	19324				
Unilateral injection to breast for augmentation	85.51	19324				

PROCEDURES REQUIRING PRE-CERTIFICATION
FOR ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES MEDICAL ASSISTANCE RECIPIENTS

Procedure	ICD-9 CM Procedure Code	CPT® Code	LOCATION		REVIEW METHOD	
			Inpatient	Outpatient	Telephonic /Fax	Clinical Records
Bilateral injection to breast for augmentation	85.52	19324				
Unilateral prosthetic implant	85.53	11970, 19325, 19340, 19342				
Bilateral prosthetic implant	85.54	19325, 19340, 19342				
Removal of prosthetic implant	85.94	19328, 19330				
Revision of implant of breast	85.93	19342				
Breast reconstruction with insertion of breast tissue expander	85.95	19357				
Removal of breast tissue expander	85.96	19357				
Other	85.99, 85.85, 85.87	19350, 19355, 19361, 19364, 19366, 19367, 19368, 19369, 19396				
Revision of reconstructed breast	85.53, 85.89	19342, 19380				
Unlisted procedure, breast	85.99	19499				
Unilateral Subcutaneous mastectomy with implant	85.33	19304				
Unilateral Subcutaneous mastectomy NEC	85.34	19304				
Bilateral Subcutaneous mastectomy with implant	85.35	19304				
Other bilateral subcutaneous mastectomy	85.36	19304				
Breast DIEP Flap Reconstruction	85.85	S2068				
Panniculectomy/Abdominoplasty	86.83	15830, 15847	✓	✓		✓
Total Knee Replacement	81.54	27440, 27441, 27442, 27443, 27445, 27446, 27447				
Revision of Knee Replacement	81.55, 81.59, 00.80, 00.81, 00.82, 00.83, 00.84	27486, 27487	✓		✓	
Meniscectomy, Knee (<i>Inpatient only</i>)	80.6	27332, 27333, 29880, 29881	✓		✓	
Total Hip Replacement	81.51	27130	✓		✓	
Revision-Total or Partial	81.53, 81.59, 00.70, 00.71, 00.72, 00.73, 00.74, 00.75, 00.76, 00.77, 00.85, 00.86, 00.87	27132, 27134, 27137, 27138	✓		✓	
Partial Hip Replacement	81.52	27125	✓		✓	
Total Ankle Replacement including revision	81.56, 81.59	27700, 27702, 27703	✓		✓	
Video/telemetric EEG Monitoring	89.19	95950, 95951, 95953, 95956	✓		✓	

PROCEDURES REQUIRING PRE-CERTIFICATION
FOR ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES MEDICAL ASSISTANCE RECIPIENTS

IMPORTANT COVERAGE INFORMATION ABOUT TRANSPLANTS

- **Alaska Medicaid Regulations provide for limited coverage of transplants.**
- All transplants must be medically necessary.
- Kidney/cornea/skin/bone transplants do not require preauthorization from Qualis Health
- All other covered transplants listed below require preauthorization from Qualis Health.
- Multiple organ transplants including any of the procedures below require preauthorization.

TRANSPLANTS NOT LISTED BELOW ARE NOT COVERED BY ALASKA MEDICAID.

Transplant Procedures Requiring Special Review

Procedure	ICD-9 CM Procedure Code	CPT® Code	LOCATION		REVIEW METHOD	
			Inpatient	Outpatient	Telephonic /Fax	Clinical Records
Bone Marrow Transplant (includes stem cell transplant) Autologous	41.00, 41.01, 41.04, 41.07, 41.09	38241	} Commonly performed for many leukemia's, however some cases require special review, depending on clinical circumstances.	✓	✓	✓
Allogenic	41.02, 41.03, 41.05, 41.06, 41.08	38240 38242				
Liver Transplant (Cadaver)	50.51, 50.59	47135, 47136				
Liver Transplant (Living Donor)	50.59	47135, 47136	✓			✓
Heart Transplant, including Artificial Heart (All ages covered, effective 8/26/08)	37.51, 37.52, 37.53, 37.54	33945	✓			✓
Lung Transplant (All ages covered, effective 8/26/08)	33.50, 33.51, 33.52	32851, 32852, 32853, 32854	✓			✓
Heart/Lung Transplant (All ages covered, effective 8/26/08)	33.6	33935	✓			✓

Other Surgical Procedures Requiring Special Review

Gastric Neurostimulator	04.92, 86.94	43647, 43648, 43881, 43882, 64590, 64595	✓	✓		✓
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