

Blue Cross Blue Shield of Michigan
Medicare Advantage Private Fee-for-Service

Sterilization

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STERILIZATION

Sterilization is defined as the process of rendering barren. This is accomplished by surgical removal of testes or ovaries (castration) or inactivation by irradiation or by tying off or removing a portion of reproductive ducts (ductus deferens or uterine tubes).

ORIGINAL MEDICARE¹

Original Medicare provides limited coverage for sterilization.

Covered conditions:

- Payment may be made only where sterilization is a necessary part of the treatment of an illness or injury, e.g., removal of a uterus because of a tumor, removal of diseased ovaries.
- Sterilization of a mentally retarded beneficiary is covered if it is a necessary part of the treatment of an illness or injury (bilateral oophorectomy), or bilateral orchidectomy in a case of cancer of the prostate. Claims are denied when the pathological evidence of the necessity to perform any such procedures to treat an illness or injury is absent; and
- Monitor such surgeries closely and obtain the information needed to determine whether in fact the surgery was performed as a means of treating an illness or injury or only to achieve sterilization.

Noncovered conditions:

- Elective hysterectomy, tubal ligation, and vasectomy, if the stated reason for these procedures is sterilization.
- A sterilization that is performed because a physician believes another pregnancy would endanger the overall general health of the woman is not considered to be reasonable and necessary for the diagnosis or treatment of illness or injury within the meaning of §1862(a) (1) of the Social Security Act. The same conclusion would apply where the sterilization is performed only as a measure to prevent the possible development of, or effect on, a mental condition should the individual become pregnant; and sterilization

¹ CMS Medicare national coverage determinations manual – Chapter 1, part 4, section 230.3

of a mentally retarded person where the purpose is to prevent conception, rather than the treatment of an illness or injury.

MEDICARE ADVANTAGE

Coverage for elective hysterectomy, tubal ligation, and vasectomy, is provided to members under select Medicare Advantage private fee-for-service plans as an enhanced benefit. The member's cost-sharing and coverage conditions are determined by the group.

Conditions for Payment

BCBSM Medicare Advantage private fee-for-service plans use the Centers for Medicare & Medicaid Services deemed provider² concept for group specific benefits. The table below specifies payment conditions for sterilization:

Conditions For Payment	
Eligible providers	Consistent with Original Medicare
Deemed provider	See terms and conditions on bcbsm.com/ma
Payable locations	Consistent with Original Medicare
Frequency	
CPT codes	55250, 58565, 58600, 58605, 58611, 58615, 58670, 58671, 58700
Diagnosis restrictions	Consistent with Original Medicare
Age restrictions	

Reimbursement

The maximum payment amount for the sterilization is consistent with Original Medicare. The provider will be paid the lesser of Medicare's allowable amount or the provider's charge, minus the member's cost-share. This represents payment in full and providers are not allowed to balance bill the member for the difference between the allowed amount and the charge.

Member Cost-sharing

- Deemed providers must agree to collect from the member only the cost-sharing amounts described in the table below. They may not otherwise charge or bill the member.
- If the member elects to receive a noncovered service, he or she is responsible for the entire charge associated with the noncovered service.

The cost-sharing chart below identifies members with sterilization coverage.

² 2008 Terms and conditions

Member Cost-Sharing Responsibilities								
Group Name and Number	Annual Deductible		Coinsurance				Out-of-Pocket Maximum	
			Professional Claim		Institutional Claim			
	2007	2008	2007	2008	2007	2008	2007	2008
BCBSM Retirees ³ 80311, 80312	No MA PFFS plan	\$250	No MA PFFS plan	5%	No MA PFFS plan	SOB ⁴	No MA PFFS plan	\$1000
City of Detroit Option F ⁵ 54731, 81097	\$175 Waived	\$175	10%		SOB ⁶	\$825		
City of Detroit Option G ⁷ 04436		\$0	None			Does not apply		
State of MI Retirees ⁸ 81820, 81821, 81828	No MA PFFS plan	\$200	No MA PFFS plan	None	No MA PFFS plan	No MA PFFS plan	Does not apply	

Billing Instructions

1. Bill services on the CMS 1500 (8/05) claim form, UB-04 or the 837 equivalent claim.
2. Use the Medicare Advantage private fee-for-service unique billing requirements.
3. Report CPT/HCPCS codes and diagnosis codes to the highest level of specificity.
4. Report your National Provider Identifier number on all claims.
5. Submit claims to your local BCBS plan.
6. Use electronic billing:
 - a. Michigan providers:

³ BCBSM Retirees Benefit grid

⁴ 2008 Summary of benefits

⁵ City of Detroit - Option F Benefit grid

⁶ 2007 Summary of benefits

⁷ City of Detroit Option - G Benefit grid

⁸ State of Michigan Retirees Benefit grid

- A copy of the ANSI ASC X12N 837 and 835 Institutional Health Care Claim and Health Care Claim Payment/Advice (BCBSM Electronic Data Interchange (EDI) Institutional 837/835 Companion Document) is available at:
http://www.bcbsm.com/pdf/837_835_institutional_companion.pdf
 - A copy of the BCBSM EDI Professional 837/835 Companion Document is available at:
http://www.bcbsm.com/pdf/systems_resources_prof_837_835.pdf
- b. Providers outside of Michigan should contact their local BCBS plan.