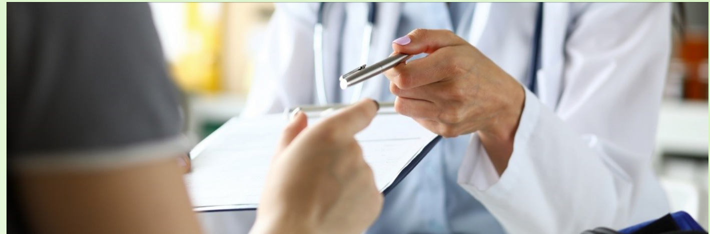
IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT202471 MAY 28, 2024

IHCP updates Consent for Sterilization form instructions

A properly completed *Consent for Sterilization* form (HHS-687 or HHS-687-1) must accompany all claims for voluntary sterilization and related services. Effective immediately, the Indiana Health Coverage Programs (IHCP) is updating the *Consent for Sterilization* form instructions.



Previously published guidance in *IHCP Bulletin BT202427* is being revised. If an in-person interpreter is used, the interpreter must hand-write their signature and date in month, day and year format on the consent form. If an interpreter was used via teleconference (phone or video), the person obtaining the consent must write the interpreter's name and ID number (if applicable). The person obtaining the consent must initial, date and provide the method used (phone or video).

The form instructions are in the *Family Planning Services* provider reference module. The updated instructions as shown in this bulletin will be included in the module's next review.

Consent for Sterilization form instructions

All providers (attending physicians and surgeons, assistant surgeons, anesthesiologists, inpatient and outpatient hospital facilities, and other providers of related services) must attach a copy of the *Consent for Sterilization* form to each claim for voluntary sterilization and related services.

Providers may download the current version of the *Consent for Sterilization* form (HHS-687), and its Spanish-language equivalent (HHS-687-1), from the *Forms* page at in.gov/medicaid/providers. An expiration date appears in the upper-right corner of the form. Completed consent forms that are not the current version available will cause full claim denial.

When providers properly complete the *Consent for Sterilization* form, the IHCP receives all the necessary information regarding consent, interpreter's statement, statement of person obtaining consent and physician's statement.

Federal regulations require that certain elements of the consent form be handwritten. If providers or members make an error on the form, they must complete a new form rather than submitting the form with a strikethrough.

The IHCP contractor must receive a properly completed *Consent for Sterilization* form before making payment. To ensure timely payment to related service providers, the primary service provider should forward **exact** copies of the properly completed consent form to the related service providers.

Table 1 provides instructions for each item on the *Consent for Sterilization* form. Fields marked with an asterisk must be completed with exactly the same wording and must match the procedure billed on the claim.

Table 1 – Instructions for the Consent for Sterilization form (HHS-687)

Field	Description
Consent to Sterilization	
Doctor or Clinic	Enter the name of the doctor or clinic providing information to the patient. If the provider is a physician group, the professional group name can be listed (such as “Westside Medical Group”) or all individual names can be listed (such as “Drs. Miller and Smith” or “Dr. Miller and/or Dr. Smith”). Alternatively, one or more names can be listed followed by the phrase *and/or associates*.
*Specify Type of Operation	Enter the name of the operation to be performed. If the name of the operation is lengthy, providers can use an abbreviation with an asterisk. Providers must then write out the full name of the operation at the bottom of the form.
Date	Enter the patient’s birth date in month, day and year format. The IHCP requires this information, and it must match the birth date on the claim.
[Name of Individual]	Enter the patient’s name in this blank field. The name must be identical to the patient name appearing on the claim form.
Doctor or Clinic	Enter the name of the doctor or clinic where the procedure will be performed. If the provider is a group, providers can list the professional group name, all names, or one or more names followed by the phrase *and/or associates*.
*Specify Type of Operation	Enter the name of the operation to be performed. If the name of the operation is lengthy, providers can use an abbreviation with an asterisk. Providers must then write the full name of the operation on the bottom of the form.
Signature	The patients must sign their full name here. If the patient is illiterate, the IHCP permits **X** as the signature with a witness to countersign. The signature must match the name on the claim and consent form.
Date	Enter, in month, day and year format, the date the consent form was signed. This date must be more than 30 days and less than 180 days before the date the sterilization is performed. If it is less than 30 days, see instructions for “alternative final paragraphs.”. The IHCP calculates the waiting period from this date.
Ethnicity and Race Designation	The information is voluntary and should be completed only by the patient.
Interpreter’s Statement	
[Language]	If an interpreter was used, use this field to indicate the language in which the patient was counseled.
Interpreter’s Signature	If an in-person interpreter was used, the handwritten signature of the interpreter must be entered in this field. If an interpreter was used via teleconference (phone or video), the person obtaining the consent must write the interpreter’s name and ID number (if applicable). The person obtaining the consent must initial, date, and provide the method used (phone or video).
Date	Enter, in month, day and year format, the date the interpreter translated the consent form to the patient. The date must be on or before the patient’s signature date.
Statement of Person Obtaining Consent	
Name of Individual	Enter the patient’s name here. The name must be identical to the name listed on the consent form and on the claim.
*Specify Type of Operation	Enter the name of the operation to be performed. If the name of the operation is lengthy, providers can use an abbreviation with an asterisk. Providers must then write the full name of the operation at the bottom of the form.
Signature of Person Obtaining Consent	The handwritten signature of the person obtaining consent must be entered in this field. The person providing sterilization counseling can be a physician or the physician’s designee, such as an office nurse.
Date	Enter, in month, day and year format, the date consent was taken. The signature date of the person obtaining the consent must be the same as the patient’s signature date.
Facility	Enter the name of the physician’s office or clinic where the patient signed the sterilization consent form. This location may not necessarily be the facility where the operation is performed.
Address	Enter the address of the facility where the patient signed the sterilization consent form. After the *Statement of Person Obtaining Consent* section is completed, the provider gives the patient a copy of the form.

Table 1 – Instructions for the Consent for Sterilization form (HHS-687) (Continued)

Field	Description
Physician's Statement	
Name of Individual	Enter the patient's full name. The name must be identical to the names listed on the consent form and the claim.
Date of Sterilization	Enter, in month, day and year format, the specific date of the sterilization procedure. This date must be at least 30 days, and not more than 180 days, following the patient's signing the consent form (with previously noted exceptions for premature delivery or emergency abdominal surgery). The date on the claim must match the date entered here.
*Specify Type of Operation	Enter the name of the operation to be performed. If the name of the operation is lengthy, providers can use an abbreviation with an asterisk. Providers must then write the full name of the operation at the bottom of the form.
Instructions for use of alternative final paragraphs	The form provides two options: paragraph (1) or (2). Cross out the paragraph not used.
Premature delivery	Check this item if alternative paragraph 2 was selected due to premature delivery. If providers check this item, they must also enter a date of expected delivery (see the next item).
Individual's expected date of delivery	The patient's physician estimates the date based on the patient's history and physical.
Emergency abdominal surgery	Check this item if alternative paragraph 2 was selected due to emergency abdominal surgery. If providers check this box, they must indicate the operation performed (see the next item).
Describe circumstances	Indicate the emergency operation performed and any relevant information about the circumstances requiring the emergency operation.
Physician's Signature	The physician who has verified consent and who actually performed the operation must complete this field after the sterilization operation. Signature stamps are **not** acceptable.
Date	Enter, in month, day and year format, the date the physician signed the consent form. The physician's signature date must be on or within 30 days after the sterilization date.

** All "Type of Operation" fields must be worded **exactly the same** and must match the procedure billed on the claim.*

When a sterilization consent form is not required

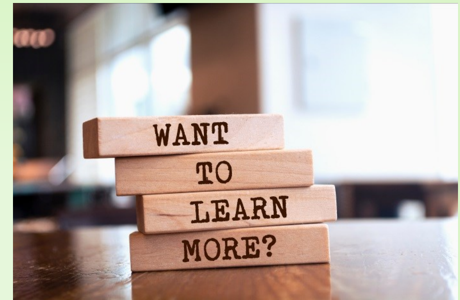
A sterilization consent form is not required in these situations:

- The provider renders the patient sterile as a result of an illness or injury, when prior acknowledgement was not possible.
- The patient was already sterile prior to the procedure.
- The patient is not rendered sterile by the procedure (for example, because the procedure was performed unilaterally rather than bilaterally).

In these situations, when billing codes that would otherwise require a *Consent for Sterilization* form, the provider must include appropriate documentation to prevent the claim from denying. Such documentation may be either an operative report or a statement attesting that one of the preceding exceptions applies. The following items should be included in the documentation:

- Patient name
- Explanation of the exception
- Physician signature

For more information



Questions regarding coverage for all fee-for-service (FFS) IHCP-enrolled members, billing and reimbursement should be directed to Gainwell Technologies at 800-457-4584. Questions about FFS PA should be directed to Acentra Customer Service at 866-725-9991.

Questions about managed care coverage, PA, billing and reimbursement should be directed to the managed care entity (MCE) with which the member is enrolled.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 800-457-4584.

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