Sterilization
Applies to:

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

☐ Medicare Plus Blue PPO℠ ☒ Medicare Plus Blue Group PPO℠ ☐ Both

Sterilization

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

Original Medicare

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
- Monitors 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.

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

Medicare Plus Blue Group PPO Enhanced Benefit

Medicare Plus Blue is a Medicare Advantage plan, which provides at least the same level of benefit coverage as Original Medicare (Part A and Part B) and may provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Blue Cross to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

Coverage for elective hysterectomy, tubal ligation, and vasectomy, is provided to members under select Medicare Plus Blue Group PPO plans. This enhanced benefit paper applies to groups that selected this benefit. The reimbursement methodology, maximum payable amounts, and member cost sharing are determined by the group.

Conditions for payment

The table below specifies payment conditions for elective sterilization.

Conditions for payment	
Eligible provider	Consistent with Original Medicare
Payable location	Consistent with Original Medicare
Frequency	
CPT codes	55250, 58565, 58600, 58605, 58611, 58615, 58670, 58671, 58700
Diagnosis restrictions	Restrictions apply
Age restrictions	Consistent with Original Medicare

Reimbursement

Medicare Plus Blue Group PPO plan's maximum payment amount for sterilization is consistent with Original Medicare. The provider will be paid the lesser of Medicare's allowed 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

- Medicare Plus Blue Group PPO providers should collect the applicable cost–sharing from the member at the time of the service when possible. Cost–sharing refers to a flat–dollar copayment, a percentage coinsurance or a deductible. Providers can only collect the appropriate Medicare Plus Blue Group PPO cost–sharing amounts from the member.
- If the member elects to receive a non–covered service, he or she is responsible for the entire charge associated with the non–covered service.

To verify benefits and cost–share, providers may utilize web–DENIS call 1–866–309–1719.

Billing instructions for providers

1. Bill services on the CMS 1500 (02/12) claim form, UB 04 or the 837 equivalent claim.
2. Use the Medicare Advantage PPO 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
      — Copies of the ANSI ASC X 12N 837 and 835 Institutional Health Care Claim and Health Care Claim Payment/Advice (BCBSM Electronic Data Interchange (EDI) Institutional 837/835 Companion Documents) are available on the BCBSM website under the reference library section at: ***http://www.bcbsm.com/providers/help/faqs/electronic-connectivity-edi.html***.
   b. Providers outside of Michigan should contact their local BCBS plan.

Revision History

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08/17/2015: Updated formatting, updated provider billing instructions, updated hyperlinks, removed reference to CAREN, added revision history section.