New York State
UB-04 Billing Guidelines

INPATIENT HOSPITAL

Version 2011 - 01

6/1/2011

eMedNY is the name of the New York State Medicaid system. The eMedNY system allows New York Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible members.

eMedNY offers several innovative technical and architectural features, facilitating the adjudication and payment of claims and providing extensive support and convenience for its users. CSC is the eMedNY contractor and is responsible for its operation.

The information contained within this document was created in concert by eMedNY DOH and eMedNY CSC. More information about eMedNY can be found at www.emedny.org.

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***For eMedNY Billing Guideline questions, please contact the eMedNY Call Center** 1-800-343-9000.*

1. Purpose Statement

The purpose of this document is to assist the provider community in understanding and complying with the New York State Medicaid (NYS Medicaid) requirements and expectations for:

- Billing and submitting claims.
- Interpreting and using the information returned in the Medicaid Remittance Advice.

This document is customized for Inpatient Hospital providers and should be used by the provider as an instructional, as well as a reference tool.

2. Claims Submission

Clinics can submit their claims to NYS Medicaid in electronic format only.

2.1 Electronic Claims

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, which was signed into law August 12, 1996, the NYS Medicaid Program adopted the HIPAA-compliant transactions as the sole acceptable format for electronic claim submission, effective November 2003.

eMedNY will process both 4010 and 5010 transaction types between July 21, 2011 and December 31, 2011. All Trading Partners will be required to employ the 5010 standards in accordance with federal mandates as of January 1, 2012.

Inpatient hospital providers must use the HIPAA 837 Institutional (837I) transaction.

Direct billers should refer to the sources listed below in order to comply with the NYS Medicaid requirements.

- 5010 Implementation Guides (IGs) explain the proper use of 837I standards and other program specifications. These documents are available at store.X12.org.
- The eMedNY 5010 Companion Guide provides specific instructions on the NYS Medicaid requirements for the 837I transaction. This document is available at www.emedny.org by clicking on the link to the web page as follows: eMedNY Transaction Information Standard Companion Guide.
- eMedNY Trading Partner Information CG provides technical information needed to successfully transmit and receive electronic data. Some of the topics put forth in this CG are error report information and communication specifications. This document is available at www.emedny.org by clicking: eMedNY Trading Partner Information Companion Guide.

Further information on the 5010 transaction is available at www.emedny.org by clicking: eMedNYHIPAASupport.

2.2 General Inpatient Procedures

The following information details billing instructions and related information for hospital inpatient claims in the following main categories:

- Reporting Covered and Non Covered Days
- Reporting Present on Admission (POA) Information

2.2.1 Reporting Covered and Non-covered Days

When calculating the number of days to be reported on a claim, Medicaid counts the date of admission, but not the date of discharge, transfer or death.

The calculation of the number of days in the billing period is impacted by the status of the member on the statement through date. When the patient status is "30" – Still A Patient, the through date is included in the calculation of days. When the status is a "Discharged" on the through date of service, the through date is not included in the calculation of the number of days. For status codes, please refer to the NUBC UB-04 Manual. The UB-04 manual is available at www.nubc.org.

The sum of the days reported in the following fields ***must*** equal the days in the statement from-through period of the claim or one less day if the status is discharged as described above:

- Medicare Full Days (Loop 2320 MIA01 when Loop 2320 SBR09 = 'MA')
- Medicaid Full Days (Loop 2300 Value Code HI - HI0x-5 when HI0x-2 = '80')
- Medicaid Non Covered Days (Loop 2300 Value Code HI - HI0x-5 when HI0x-2 = '81')
- Other Insurance Covered Days (Loop 2320 MIA01 when Loop 2320 SBR09 not 'MA')

Days billed as covered and non-covered, by the various payers, are reported in the 837 Institutional Segments with appropriate qualifiers.

NOTE: The maximum number of days cannot exceed 9999 on any inpatient claim.

2.2.2Reporting Present on Admission (POA) Information

NYSDOH requires this information to be reported for all reported diagnoses on all hospital inpatient claims. Present On Admission is defined as the diagnosis that is present at the time the order for inpatient admission occurred.

One of the following POA Codes must be submitted with the Primary Diagnosis and each Other Diagnosis. POA is not required for the admitting diagnosis. Valid values and definitions follow:

- Y – Yes

  Present at the time of inpatient admission
- N – No

  Not present at the time of inpatient admission
- U – Unknown

  Documentation is insufficient to determine if condition is present at time of inpatient admission
- W – Clinically undetermined

  Provider is unable to clinically determine whether condition was present at time of inpatient admission or not
- If exempt from POA reporting, this field is not used.

2.3 Claim Submission Procedures

This section includes instructions and descriptions for the following:

- Inpatient Billing Procedures for APR DRG Claims
- Inpatient Billing Procedures Non-DRG Claim
- Medicaid as Payer of Last Resort
- Special Instructions for Other Inpatient Claims
- Medicaid Policy when Medicare Coverage Begins During an Inpatient Admission

2.3.1Inpatient Billing Procedures for APR DRG Claims

This section details instructions for APR DRG claims that are effective for claims with discharge dates on or after December 1, 2009. Instructions for claims submitted (including adjustments to previously paid claims) with discharge dates prior to December 1, 2009 are in the DRG section of this manual.

APR DRG billing classifies inpatient hospital stays into one of approximately 1,200 groups, also referred to as APR DRGs. A "grouper" program assigns an APR DRG by utilizing data submitted on the claim such as ICD-9-CM diagnoses, procedures, member age, sex, and other information.

The Principle Diagnosis and up to 24 Other Diagnosis Codes are processed through the APR DRG Grouper. Up to 25 ICD-9 Procedure Codes are also processed through the APR DRG Grouper.

Associated with each APR DRG is an average length of stay, which will only be applied to claims with a Transfer Discharge Status Code. Service Intensity Weights are applied to APR DRG payment calculations. See definitions in Exhibit 2.4.1-1 which may or may not be applicable to the APR DRG payment methodology:

Exhibit 2.4.1-1

Term	Definition
High Trim	**Maximum** number of days the patient is expected to be hospitalized based on the assigned DRG
Low Trim	**Minimum** number of day the patient is expected to be hospitalized for the assigned DRG
Inlier	Portion of the inpatient stay from the date of admission through and including the high trim point

2.3.1.1 APR DRG Rate Codes

A claim is classified as an APR DRG claim based on the submitted rate code. The rate code is sent in the 837 Institutional Claim in loop 2300, in the Value Information Segment. DRG claims are identified by the Rate Codes shown in Exhibit 2.4.1.1-1

Exhibit 2.4.1.1-1

Type of Claim	Rate Code
New York State	2946
GME Claim	3130
Out-of-state	2953

NOTE: A Direct Medical Education (DME) rate code (2589) will be used for calculating DME add-ons. This rate code is not to be submitted on a claim but may appear on retro-active rate adjustment remittances.

2.3.1.2 APR DRG Payment Calculations

The following describes the calculations used to price Inpatient APR DRG claims.

The ***claim calculation*** is as follows:

CPD (x) SIW (as determined by the Severity of Illness Code assigned) (+) Capital add-on (+) DME add-on = Payment Amount

The Graduate Medical Expense (GME) payment ***calculation*** is as follows:

Per Discharge Rate Adjusted for Facility Specific Labor and IME (x) APR DRG Weight (+) Direct Medical Education add-on = GME Payment

Transfer claims will pay the lesser of the two ***calculations***:

Rate (X) SIW (+) Capital Add on (+) DME add on = Payment Amount
OR
Rate (X) SIW divided by ALOS (X) the number of days (+) Capital Add on (+) DME add on = Payment Amount

NOTE: Capital add-on amounts are not applicable to GME claims.

Rule 1 – Timely Submission of Claims

For APR DRG claims, the NYS Medicaid 90-day timely filing requirement is based on the Through Statement Date reported on the claim.

Rule 2 – Discharge Date

An APR DRG claim cannot be billed until the member is discharged. All APR DRG claims must include the discharge date regardless of the status code of the member.

NOTES:

- ***See ALC rule 6 in the "Special Instructions for Other Inpatient Claims" section below.***
- ***When the Discharge Date is different than the Statement Through Date, the Discharge date is reported using Occurrence Code 42.***

Rule 3 - Newborns

APR DRG claims for newborns, 28 days or younger, must contain the birth weight in grams. The birth weight is reported using Value Code 54 in the Value Information segment.

2.3.2Non-DRG Claim Procedures

For non-DRG claims the 90 day timely filing regulation applies to the statement through date entered on the claim.

Non-DRG claims can be billed from admission to discharge or they can be billed as interim claims. If a Non-DRG claim is billed as an interim bill, the patient status code submitted is 30 – Still A Patient, and no discharge date is entered on the claim.

2.3.3Special Instructions for Other Inpatient Claims

This section of the manual explains billing requirements for the following types of claims:

- Alternate Level of Care (ALC) Claims
- Alternate Level of Care - Medicare Non-covered
- Graduate Medical Expense (GME) Claims
- Pass Days Claims
- Cost Outlier Claims

2.3.3.1 Alternate Level of Care (ALC)

ALC Rule 1 – Patient Cannot be Admitted Directly to ALC Status

All patients MUST be admitted as acute care patients. A claim submitted indicating the member was admitted on ALC will be denied.

ALC Rule 2 – Split Billing

ALC claims are per diem claims. The ALC claims can be split-billed. Split-billing means submission of multiple date range claims that when compiled represent the period from Admit to Discharge.

ALC Rule 3 – Discharge Date

The discharge date and time of discharge is only reported on an ALC claim if the patient status is a discharge or transfer status code.

ALC Rule 4 – Occurrence Span Code

The claims for ALC must contain Occurrence Span Code 75 with the date range the member was on ALC.

ALC Rule 5 – Admission Date

The admission date on the ALC claim will be the acute care admission date.

ALC Rule 6 – Transferred and Discharged ALC

If the member is transferred to ALC and is discharged while on ALC, then the APR DRG claim is billed from the date of admission to the last day the member was acute care, with status code 30 – Still A Patient. The APR DRG claim must include the discharge date (Value Code 42) and occurrence span code 75 with the date span the member was on ALC.

Refer to Scenario 2 – Patient Discharged on ALC in the section below.

ALC Rule 7 – Transferred to and From ALC Multiple Times

If the member is transferred to and from ALC multiple times during the stay, each ALC time period is a separate claim, with no discharge date and a patient status code 30 – Still A Patient; except for the discharge claim.

The occurrence span code 75 with the date span the member was on ALC must be reported.

The date range used as the statement covers period in the header on the APR DRG claim will include the dates of service the member was on ALC.

The APR DRG claim will have an occurrence span code 75 with the date range of each of the ALC time periods.

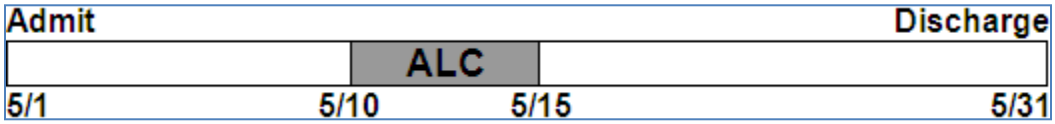
Refer to Scenario 3 – Multiple ALC periods in the section below.

2.3.3.2 APR DRG and ALC Billing Scenarios

Scenario 1 – ALC Period Occurs During the Stay

See Exhibit 2.4.2.2-1 for the APR DRG Timelines related to this scenario.

Exhibit 2.4.2.2-1



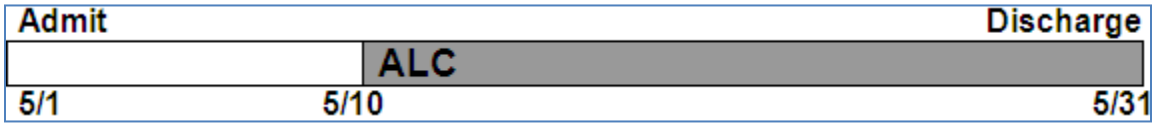
The APR DRG and the ALC claims are billed as follows:

- Submit the acute care claim for the entire stay (admit to discharge). In the above exhibit 5/1 through 5/31. Include occurrence code 75 and the date range the member was on ALC.
- Submit the ALC claim with from – through dates 5/10 to 5/15 with discharge status code 30 (Still a patient) and no discharge date.

Scenario 2 – Patient Discharged on ALC

See Exhibit 2.4.2.2-2 for the APR DRG Timelines related to this scenario.

Exhibit 2.4.2.2-2



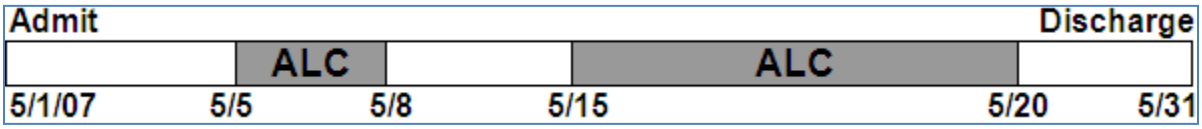
The APR DRG and ALC claims are billed as follows:

- Submit acute care claim from the admit date to the last day the member was acute care. In the above exhibit 5/1 to 5/9. Include occurrence code 75 and the date range the member was on ALC. This claim cannot be submitted until the member is discharged.
- Submit the ALC claim from the first day of ALC. Note that an ALC claim can be interim billed with status code 30 (Still a patient) and no discharge date. If the ALC is billed through the discharge date, use the appropriate discharge status code and include the discharge date. In the above exhibit 5/10 to 5/31.

Scenario 3 – Multiple ALC periods

See Exhibit 2.4.2.2-3 for the APR DRG Timelines related to this scenario.

Exhibit 2.4.2.2-3



The APR DRG and ALC claims can be billed as follows:

- Submit the acute care claim for the entire stay (admit to discharge). In the above exhibit 5/1 to 5/31, include occurrence code 75 and the date range the member was on ALC.
- Submit the ALC claims for each of the ALC periods. In the above exhibit 5/5 to 5/8 and another claim for dates 5/15 to 5/20.Each claim must include an occurrence span code 75 and the date span the member was on ALC with no discharge date and discharge status 30 (Still a patient).

2.3.3.3 Alternate Level of Care After Medicare

When ALC occurs during the inpatient hospital stay and ***Medicare does not cover the ALC period(s)***, 0FILL must be represented within the Medicare information.

Note for programmers and software developers: 0FILL is represented in the electronic claim in Loop 2320, AMT02 where AMT01 equals A8.

2.3.3.4 Graduate Medical Education (GME) Claims

GME payments are made to cover the GME expenses related to an Inpatient stay on behalf of a Medicaid member enrolled in a Medicaid Managed Care plan on the Date of Admission.

The GME payment is determined by the GME rate code entered on the claim.

2.3.3.5 Pass Day Claims

Pass day claims are submitted when the member was readmitted within 31 days of the original discharge for the same or a related condition in accordance with 10 NY CRR, Section 86-1.54(m). Claims should be submitted as follows:

- Admission date submitted is from the first stay.
- Discharge date submitted is from the second stay.
- Date of service "From" is the first Admission date.
- Dates between the first discharge and 2nd admission are included in the dates of service.
- Days between the first discharge and 2nd admission are submitted as Medicaid Non-covered days.

2.3.3.6 Cost Outlier Claims

Hospitals can request additional reimbursement for an inpatient, DRG hospitalization by requesting Cost Outlier consideration. Each cost outlier case must undergo Peer Review. The 837I must include rate code 2946 or 2953 (whichever code appears on the provider's file) and condition code 61 in the Loop 2300 HI - Condition Information segment.

Please note:

1. Medicaid must be the primary inpatient coverage to qualify for a cost outlier consideration, and
2. Transfer cases, as defined in 10 NY CRR, Section 86-1.50, do not qualify for cost outlier consideration.

NOTES:

- ***Cost outlier claims are submitted as adjustments to a previously paid DRG claim.***
- ***The Cost Outlier payment is for the entire acute care stay.***
- ***ALC periods are not paid as part of the Cost Outlier, therefore ALC claims can be billed in addition to the Cost Outlier claim.***

2.3.4 Medicaid Policy When Medicaid Coverage Begins During an Inpatient Admission

If a member is not Medicaid eligible on the date of admission, but becomes eligible during or for part of the service period, the claim will pend for manual review. If DOH determines payment is warranted, payment will be calculated and remitted. If DOH determines payment is not warranted, the claim will be denied.

For additional details, refer to the Inpatient Policy Guidelines available at www.emedny.org by clicking on the link to the web page as follows: Policy Guidelines.

2.3.5Medicare Part A Coverage Begins During Inpatient Admission

Special processing is required if a member is covered by Medicaid at admission and becomes eligible for Medicare Part A during that stay. To be paid by Medicaid, submit a paper claim (currently UB-04) to the NYS Department of Health at the address listed below. Include an Explanation of Benefits from all other payers.

Rate Based Provider Bureau
Office of Health Insurance Programs
NYS Department of Health
150 Broadway, Suite 6E
Albany, NY 12204-2736

For additional details, refer to the Inpatient Policy Guidelines available at www.emedny.org by clicking on the link to the web page as follows: Policy Guidelines.

2.3.6Medicaid as Payer of Last Resort

All other sources of payments must be exhausted before billing Medicaid. The following section of the manual explains billing procedures for patients with other sources of coverage. The main topics are as follows:

- Instructions for the Submission of Medicare Crossover Claims
- Medicare as Primary – Medicaid as Secondary
- Other Third party Insurance as Primary – Medicaid as Secondary

2.3.6.1 Instructions for the Submission of Medicare Crossover Claims

This subsection is intended to familiarize the provider with the submission of crossover claims. Providers can bill claims for Medicare/Medicaid patients to Medicare. When Medicare adjudication is complete, any Part A or Part B claims found on the Medicaid enrollment files with a patient responsibility remaining will be forwarded to Medicaid for processing. The provider's Medicare remittance will indicate that the claim has been crossed over to Medicaid. ***Medicare Part-C*** (Medicare Managed Care) and ***Medicare Part-D*** claims are ***not*** part of this process.

Providers must review Medicare remittances to determine whether claims have been crossed over to Medicaid for processing. Any claim indicated as a crossover by Medicare should not be submitted to Medicaid. If the Medicare remittance does not indicate the claim has been crossed over to Medicaid, the provider should submit the claim directly. Claims for services not covered by Medicare should continue to be submitted directly to Medicaid as policy allows.

If a claim is submitted directly by the provider to Medicaid and subsequently paid prior to receipt of the Medicare crossover claim, both claims will be paid. The provider submitted claim will then be voided automatically. Providers may submit adjustments to Medicaid for their crossover claims.

Electronic remittances from Medicaid for crossover claims will be sent to the default ETIN when the default is set to electronic. If there is no default ETIN, the crossover claims will be reported on a paper remittance. The ETIN application is available at www.emedny.org by clicking on the link to the webpage as follows: Default Electronic Transmitter Identification Number (ETIN) Selection Form.

2.3.6.2 Medicare as Primary – Provider Submitted

If Medicare covered the entire stay (and there is no ALC), the only payment due is the Deductible/Coinsurance or Life Term Reserve (LTR) amounts – the claim must be billed from Admission to Discharge.

All days are reported as Full-Covered Medicare days.

If some, or all, days are covered as Coinsurance Days or Life Time Reserved (LTR) Days, those Coinsurance and/or LTR days are included in the Total Covered Medicare Days and are repeated in the Coinsurance or LTR Days fields.

The system will pay the reported Part A deductible, which is entered in the CAS Segment and the Coinsurance and/or LTR amounts.

Claims must include all adjustment information as reported in the prior payer's remittance advice.

If Medicare ***Part A has covered*** the claim, the ***Part B patient responsibility*** may be claimed.

If Medicare ***Part A has not covered*** the claim, ***Medicare Part B patient responsibility will not be paid*** and the ***Medicare Part B payment must be reported and deducted*** from the Medicaid payment.

Medicare Coverage Begins After the Admission Date

For billing instruction in this scenario, please see the Inpatient Policy Guidelines available at www.emedny.org by clicking: Inpatient Manual.

2.3.6.3 Other Third Party Insurance as Primary – Medicaid as Secondary

If another insurance deductible is being claimed it is entered in the CAS Segment of the electronic claim record, eMedNY will calculate the Medicaid payment and, subtract the reported other Insurance payment, then compare that balance to the deductible claimed. eMedNY will pay the lower of the reported deductible or the balance after subtracting the other insurance payment from the amount Medicaid would pay.

Claims must include all adjustment information as reported in the prior payer's remittance advice.

2.4 Supplemental Inpatient Billing Information

This section of the manual contains information on the following topics:

- Inpatient Services Paid "Offline"
- Replacement/Void of Previously Paid Claims
- Medicaid Managed Care Clients
- Hospital Responsibility For Outside Care
- Patient Status Codes

2.4.1Inpatient Services Paid "Off-Line"

Information about Inpatient Services Paid "Off-Line" can be found in the Policy Guidelines section of the Inpatient Manual. This document is available at www.emedny.org by clicking on the link to the web page as follows: Inpatient Manual.

2.4.2Replacement/Void of Previously Paid Claims

Do not use the Payer Claim Control Number Segment (Loop 2300) when submitting an original claim or a resubmission of a denied claim.

If submitting an adjustment or a void, enter the appropriate ***Transaction Control Number (TCN)*** in the Payer Claim Control Number Segment (Loop 2300). A TCN is a 16-digit identifier that is assigned to each claim document or electronic record regardless of the number of individual claim lines (service date/procedure combinations) submitted in the document or record.

- If submitting an adjustment (replacement) to a previously paid claim, enter '7' for the Claim Frequency Type Code in the Claim Information Segment (Loop 2300 – CLM05-3).
- If submitting a void to a previously paid claim, enter '8' for the Claim Frequency Type Code in the Claim Information Segment (Loop 2300 – CLM05-3).

NOTE: Once a claim is voided, any re-billed claim is subject to the 90 day timely filing policy.

Adjustments

An adjustment may be submitted to correct any information on a previously paid claim other than:

- Billing Provider ID
- Member ID

Voids

A void is submitted to nullify the original claim in its entirety.

When submitting a void, please follow the instructions below:

- The void must be submitted on a new claim form (copy of the original form is unacceptable).
- The void must contain the TCN and the originally submitted Billing Provider ID and Member ID.

2.4.3Medicaid Managed Care Members

If a member is enrolled in a Medicaid Managed Care Plan on the day of admission, the managed care plan should be billed and is responsible to pay the claim. Even in cases where the member is disenrolled from the managed care plan during the stay, the managed care plan is responsible for payment.

2.4.4Hospitality Responsibility for Outside Care: Reimbursement Policy

Please see the Policy Guidelines section of the Inpatient manual for information. This document is available at www.emedny.org by clicking on the link to the web page as follows: Policy Guidelines.

3. Remittance Advice

The Remittance Advice is an electronic, PDF or paper statement issued by eMedNY that contains the status of claim transactions processed by eMedNY during a specific reporting period. Statements contain the following information:

- A listing of all claims (identified by several items of information submitted on the claim) that have entered the computerized processing system during the corresponding cycle
- The status of each claim (denied, paid or pended) after processing
- The eMedNY edits (errors) that resulted in a claim denied or pended
- Subtotals and grand totals of claims and dollar amounts
- Other pertinent financial information such as recoupment, negative balances, etc.

The General Remittance Advice Guidelines contains information on selecting a remittance advice format, remittance sort options, and descriptions of the paper Remittance Advice layout. This document is available at www.emedny.org by clicking: General Remittance Billing Guidelines.

APPENDIX A
STERILIZATION CONSENT FORM – LDSS-3134

A copy of the New York State Sterilization Consent Form (DSS-3134) must be given to the patient to be sterilized and completed copies must be submitted with all surgeon, anesthesiologist and facility claims for sterilizations.

The physician who performs the sterilization must sign the Sterilization Consent Form after the procedure has been performed, certifying that all Federal requirements have been met. Hospitals and Article 28 clinics submitting claims electronically must maintain a copy of the completed DSS-3134 in their files.

A supply of these forms, available in English and in Spanish [LDSS-3134(S)], can be obtained from the NYS DOH website by clicking: Local Districts Social Service Forms

When completing the LDSS-3134, please follow the guidelines below:

- An illegible or altered form is unacceptable and will cause a paper claim to deny
- Ensure that all five copies are legible.
- Each required field must be completed in order to ensure payment.
- If a woman is not Medicaid eligible at the time she signs the LDSS-3134 [or LDSS-3134(S)] form but becomes eligible prior to the procedure and is 21 years of age when the form was signed, the 30 day waiting period starts from the date the LDSS form was signed regardless of the date the woman becomes Medicaid eligible.

A sample Sterilization Consent Form and step-by-step instructions follow on the next pages.

LDSS-3134 (2/01)

STERILIZATION CONSENT FORM

PATIENT NAME	CHART NO.	RECIPIENT ID NO.
1.		
HOSPITAL/CLINIC		

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 2. (doctor or clinic). When I asked for 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 not to 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 these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation know as a 3. 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 4. (Month Day Year)

I, 5., hereby consent of my own free will to be sterilized by 6. (Doctor)

by a method called 7.. 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, Education, and Welfare 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.

8. (Signature) Date: 9. (Month Day Year)

You are requested to supply the following information, but it is not required: 10.

Race and ethnicity designation (please check)

☐ 1 American Indian or Alaska Native
☐ 2 Asian or Pacific Islander
☐ 3 Black (not of Hispanic origin)
☐ 4 Hispanic
☐ 5 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 11. language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

12. (Interpreter) _____ (Date)

■ STATEMENT OF PERSON OBTAINING CONSENT■

Before 13. (Name of Individual) signed the consent form, I explained to him/her the nature of the sterilization operation 14., 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 knowlingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

15. (Signature of person obtaining consent) _____ (Date)

16. (Facility)

17. (Address)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon 18. (Name of individual to be sterilized) on 19. (Date of sterilization) 20. (Operation), I explained to him/her the nature of the sterilization operation 21. (Specify type of operation), the fact that it is intended to be a final 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 a least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared 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 sterilization was performed.

(2) This sterilization was preformed 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 and fill in information requested): 22.

☐ 1. Premature delivery
Individual's expected date of delivery: 23.

☐ 2. Emergency abdominal surgery: 24.
(describe circumstances): 25.

26. (Physician) _____ (Date)

THE FOLLOWING MUST BE COMPLETED FOR STERILIZATIONS PERFORMED IN NEW YORK CITY -- WITNESS CERTIFICATION

I, 27. do certify that on 28. I was present while the counselor read and explained the consent form to 29. (patient's name) and saw the patient sign the consent form in his/her handwriting.

SIGNATURE OF WITNESS	TITLE	DATE
X 30.	31.	32.

REAFFIRMATION (to be signed by the patient on admission for Sterilization)

I certify that I have carefully considered all the information, advice and explanations given to me at the time I originally signed the consent form. I have decided that I still want to be sterilized by the procedure noted in the original consent form, and I hereby affirm that decision.

SIGNATURE OF PATIENT	DATE	SIGNATURE OF WITNESS	DATE
X 33.	34.	35. X	36.

DISTRIBUTION: 1 – Medical Record File 2 – Hospital Claim 3- Surgeon Claim 4 – Anesthesiologist Claim 5 – Patient

STERILIZATION CONSENT FORM – LDSS-3134 AND 3134(S) INSTRUCTIONS

Patient Identification

Field 1

Enter the member's name, Medicaid ID number, and chart number.

The hospital or clinic name of is optional.

Consent to Sterilization

Field 2

Enter the name of the individual doctor or clinic obtaining consent. If the sterilization is to be performed in New York City, the physician who performs the sterilization (26) cannot obtain the consent.

Field 3

Enter the name of sterilization procedure to be performed.

Field 4

Enter the member's date of birth. Check to see that the member is at least 21 years old. If the member is not 21 on the date consent is given (9), Medicaid will not pay for the sterilization.

Field 5

Enter the member's name.

Field 6

Enter the name of the doctor expected to perform the sterilization. It is understood this may not be the doctor who eventually performs the sterilization (26).

Field 7

Enter the name of sterilization procedure.

Field 8

The member must sign the form.

Field 9

Enter the date of member's signature. This is the date on which the consent was obtained.

The sterilization procedure must be performed no less than 30 days, nor more than 180 days, from this date.

Exceptions to the 30 day rule include:

- instances of premature delivery (23), or
- emergency abdominal surgery (24/25), when at least 72 hours (three days) have elapsed.

Except in instances of premature delivery (23), or emergency abdominal surgery (24/25) when at least 72 hours (three days) must have elapsed.

Field 10

Completion of the race and ethnicity designation is optional.

Interpreter's Statement

Field 11

If the person to be sterilized does not understand the language of the consent form, the services of an interpreter will be required. Enter the language employed.

Field 12

The interpreter must sign and date the form.

Statement of Person Obtaining Consent

Field 13

Enter the member's name.

Field 14

Enter the name of the sterilization operation.

Field 15

The person who obtained consent from the member must sign and date the form. If the sterilization is to be performed in New York City, this person cannot be the operating physician (26).

Field 16

Enter the name of the facility with which the person who obtained the consent is associated. This may be a clinic, hospital, Midwife's, or physician's office.

Field 17

Enter the address of the facility.

Physician's Statement

The physician should complete and date this form after the sterilization procedure is performed.

Field 18

Enter the member’s name.

Field 19

Enter the date the sterilization procedure was performed.

Field 20

Enter the name of the sterilization procedure.

Instructions for Use of Alternative Final Paragraphs

If the sterilization was performed at least 30 days from the date of consent (9), then cross out the second paragraph and sign (26) and date the consent form.

If less than 30 days but more than 72 hours has elapsed from the date of consent as a consequence of either premature delivery or emergency abdominal surgery, complete the following fields:

Field 21

Specify the type of operation.

Field 22

Select one of the check boxes as necessary.

Field 23

If the sterilization was scheduled to be performed in conjunction with delivery but the delivery was premature, occurring within the 30-day waiting period, check box one (22) and enter the expected date of delivery (23).

Field 24

If the member was scheduled to be sterilized but within the 30-day waiting period required emergency abdominal surgery and the sterilization was performed at that time, then check box two (22) and describe the circumstances(25).

Field 25

Describe the circumstances of the emergency abdominal surgery.

Field 26

The physician who performed the sterilization must sign and date the form.

The date of the physician's signature should indicate that the physician's statement was signed after the procedure was performed, that is, on the day of or a day subsequent to the sterilization.

For Sterilizations Performed In New York City

New York City local law requires the presence of a witness chosen by the member when the member consents to sterilization. In addition, upon admission for sterilization, the member is required to review his/her decision to be sterilized and to reaffirm that decision in writing.

Witness Certification

Field 27

Enter the name of the witness.

Field 28

Enter the date the witness observed the consent to sterilization. This date will be the same date of consent to sterilization (9).

Field 29

Enter the member's name.

Field 30

The witness must sign the form.

Field 31

Enter the title, if any, of the witness.

Field 32

Enter the date of witness's signature.

Reaffirmation

Field 33

The member must sign the form.

Field 34

Enter the date of the member's signature. This date should be shortly prior to or same as date of sterilization in field 19.

Field 35

The witness must sign the form for reaffirmation. This witness need not be the same person whose signature appears in field 30.

Field 36

Enter the date of witness's signature.

APPENDIX B
ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION FORM – LDSS-3113

An Acknowledgment of Receipt of Hysterectomy Information Form, LDSS-3113, must be completed for each hysterectomy procedure. A supply of these forms, available in English and in Spanish, can be obtained from the New York State Department of Health's website by clicking on the link to the webpage as follows: Local Districts Social Service Forms

Claims for hysterectomy procedures must be submitted on paper forms, and a copy of the completed and signed LDSS-3113 must be attached to the claim.

When completing the LDSS-3113, please follow the guidelines below:

- Be certain that the form is completed so it can be read easily. An illegible or altered form is unacceptable (will cause a paper claim to deny).
- Each required field must be completed in order to ensure payment.

A sample Hysterectomy Consent Form and step-by-step instructions follow on the next pages.

DSS-3113 (Rev. 4/84)

ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION
(NYS MEDICAID PROGRAM)

1. RECIPIENT ID NO.	2. SURGEON'S NAME

EITHER PART I OR PART II MUST BE COMPLETED

Part I: RECIPIENT'S ACKNOWLEDGEMENT STATEMENT AND SURGEON'S CERTIFICATION

RECIPIENT'S ACKNOWLEDGEMENT STATEMENT

It has been explained to me, 3. _____ (RECIPIENT NAME), that the hysterectomy to be performed on me will make it impossible for me to become pregnant or bear children. I understand that a hysterectomy is a permanent operation. The reason for performing the hysterectomy and the discomforts, risks and benefits associated with the hysterectomy have been explained to me, and all my questions have been answered to my satisfaction prior to the surgery.

4. RECIPIENT OR REPRESENTATIVE SIGNATURE	5. DATE	6. INTERPRETER'S SIGNATURE (If required)	7. DATE
X		X	

SURGEON'S CERTIFICATION

The hysterectomy to be performed for the above mentioned recipient is solely for medical indications. The hysterectomy is not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing.

8. SURGEON'S SIGNATURE	9. DATE
X	

Part II: WAIVER OF ACKNOWLEDGEMENT AND SURGEON'S CERTIFICATION

The hysterectomy performed on 10. _____ (RECIPIENT NAME) was solely for medical reasons. The hysterectomy was not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing. I did not obtain Acknowledgement of Receipt of Hysterectomy information from her and have her complete Part I of this form because (please check the appropriate statement and describe the circumstances where indicated):

11 1. She was sterile prior to the hysterectomy.
(briefly describe the cause of sterility)_____

_____

12 2. The hysterectomy was performed in a life threatening emergency in which prior acknowledgement was not possible. (briefly describe the nature of the emergency)

_____

_____

13 3. She was not a Medicaid recipient at the time the hysterectomy was performed but I did inform her prior to surgery that the procedure would make her permanently incapable of reproducing.

14. SURGEON'S SIGNATURE	15. DATE
X	

DISTRIBUTION: File patient's medical record; hospital submit with claim for payment; surgeon and anesthesiologist submit with claims for payment; patient

ACKNOWLEDGEMENT RECEIPT OF HYSTERECTOMY INFORMATION FORM – LDSS-3113 INSTRUCTIONS

Either Part I or Part II must be completed, depending on the circumstances of the operation. In all cases, Fields 1 and 2 must be completed.

Field 1

Enter the member's Medicaid ID number.

Field 2

Enter the surgeon's name.

Part I: Recipient's Acknowledgement Statement and Surgeon's Certification

This part must be signed and dated by the member or her representative unless one of the following situations exists:

- The member was sterile prior to performance of the hysterectomy;
- The hysterectomy was performed in a life-threatening emergency in which prior acknowledgment was not possible; or
- The member was not a Medicaid member on the day the hysterectomy was performed.

Field 3

Enter the member's name.

Field 4

The member or her representative must sign the form.

Field 5

Enter the date of signature.

Field 6

If applicable, the interpreter must sign the form.

Field 7

If applicable, enter the date of interpreter's signature.

Field 8

The surgeon who performed or will perform the hysterectomy must sign the form to certify that the procedure was for medical necessity and not primarily for family planning purposes.

Field 9

Enter the date of the surgeon's signature.

Part II: Waiver of Acknowledgement

The surgeon who performs the hysterectomy must complete this Part of the claim form if Part I, the member's Acknowledgment Statement, has not been completed for one of the reasons noted above. This part need not be completed before the hysterectomy is performed.

Field 10

Enter the member's name.

Field 11

If the member's acknowledgment was ***not*** obtained because she was sterile prior to performance of the hysterectomy, check this box and briefly describe the cause of sterility, e.g., postmenopausal. This waiver may apply to cases in which the woman was not a Medicaid member at the time the hysterectomy was performed.

Field 12

If the member's Acknowledgment was ***not*** obtained because the hysterectomy was performed in a life-threatening emergency in which prior acknowledgment was not possible, check this box and briefly describe the nature of the emergency. This waiver may apply to cases in which the woman was not a Medicaid member at the time the hysterectomy was performed.

Field 13

If the member's Acknowledgment was ***not*** obtained because she was not a Medicaid member at the time a hysterectomy was performed, but the performing surgeon did inform her before the procedure that the hysterectomy would make her permanently incapable of reproducing, check this box.

Field 14

The surgeon who performed the hysterectomy must sign the form to certify that the procedure was for medical necessity and not primarily or secondarily for family planning purposes and that one of the conditions indicated in Fields 11, 12, and 13 existed.

Field 15

Enter the date of the surgeon's signature.