# Clinical Policy: Sterilization Procedures

Reference Number: WNC.CP.226 Coding Implications
Last Review Date: Revision Log

**See** Important Reminder **at the end of this policy for important regulatory and legal information.**

**Note:** When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

## Description[1]

Sterilization means any medical procedure, treatment, or an operation for the sole purpose of rendering an individual permanently incapable of reproducing and not related to the repair of a damaged or dysfunctional body part.

## Policy/Criteria[1]

**I.** WellCare of North Carolina® shall cover voluntary tubal sterilization procedure or vasectomy for members that meet all the following criteria:
- **A.** Is at least 21 years of age at time of the informed consent is signed;
- **B.** Is **not** legally declared to be mentally incompetent;
- **C.** Is **not** one of following:
  1. Involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility of the care and treatment of mental illness; **or**
  2. Confined, under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness in a corrective, penal, or mental rehabilitation facility; **and**
- **D.** Gave informed consent.

**II.** WellCare of North Carolina® shall cover opportunistic salpingectomy when the member meets all the requirements listed in Criteria I., above and has tested positive for BRCA1 or BRCA2.

**III.** WellCare of North Carolina® **shall not** cover sterilization when:
- **A.** When the requirements listed in Criteria I or Criteria II have not been met;
- **B.** The member is mentally incompetent, as defined under 42 CFR 441.251;
- **C.** The member is an institutionalized individual, as defined under 42 CFR 441.251; **and**
- **D.** For permanent birth control system by bilateral occlusion of the fallopian tubes or hysteroscopic tubal sterilization/transcervical sterilization (Essure).

***Note**: If a judicial court orders a sterilization procedure for a Medicaid member who is a ward of the county and mentally incompetent, the member is not eligible for sterilization procedures.*

**IV.** WellCare of North Carolina® **shall not** cover procedures for the reversal of sterilization. Sterilization reversal procedures include:
- **A.** Reverse bilateral fallopian tube trans-section by means of bilateral salpingoplasty, **AND**
- **B.** Reversal of a bilateral vasectomy by means of a bilateral vasovasostomy.

## Background[1]

### I. Definitions

**A. Tubal Sterilization Procedure**

Female sterilization, also called tubal occlusion or ligation, is a permanent contraceptive method for Members who do not want to become pregnant. The method requires a simple surgical procedure that prevents the egg from passing down the fallopian tubes into the uterus. A physician can block the fallopian tubes several different ways. They can be clipped closed with bands or rings. They can be cut and tied closed, or they can be cauterized with an electric needle. Once the fallopian tubes are cauterized, scar tissue forms, which blocks them. A surgical cut must be made in either the abdomen just above the pubic hair, in the belly button and lower abdomen, or in the back wall of the vagina. The procedure can be done using a local anesthetic to numb the area, or a general anesthetic. The two most common female sterilization approaches are mini laparotomy, which is usually performed under local anesthesia with light sedation, and laparoscopy, which requires general anesthesia.

**B. Opportunistic Salpingectomy**

Opportunistic salpingectomy is the surgical removal of the fallopian tube(s), so the risk of ovarian cancer is reduced. This procedure can be performed independently or in conjunction with another abdominal surgery, such as a hysterectomy.

**C. Vasectomy**

A vasectomy is the surgical division or resection of all or part of the vas deferens to induce sterility.

**D. Preterm Delivery**

Preterm delivery is a delivery that occurs at less than 37 weeks gestation

### II. Requirements for and Limitations on Coverage:

**A. Sterilization Consent**

Consent is required for all voluntary sterilizations. The member shall provide voluntary informed consent according to the requirement found in Medicaid policy and the federal regulations listed in 42 CFR 441.253, 42 CFR 441.257 and 42 CFR 441.258.

**B. Date of Consent:**
Consent must be obtained at least 30, but not more than 180, consecutive days prior to the date of the sterilization, except under the following circumstances:
1. Preterm Delivery: Informed consent must have been given at least 30 consecutive days before the expected date of delivery (EDD), and at least 72 hours must have passed since the informed consent was given.
2. Emergency Abdominal Surgery: At least 72 hours must have passed since the informed consent was given.

**C. Obtaining Informed Consent:**
Informed consent for sterilization **may not** be obtained while the member to be sterilized is:
1. In labor or childbirth;
2. Seeking to obtain or obtaining an abortion; or
3. Under the influence of alcohol or other substances that affect the member's state of awareness.
4. Under anesthesia or any other substance that affects the member's ability to provide informed consent.

***Note:*** *Any state or local requirements for obtaining consent, except those requiring spousal consent, must be followed.*

**D. Expected Date of Delivery:**
The EDD must be documented on the sterilization consent form in cases of preterm delivery.

**E. Consent Form Requirements:**
Providers shall ensure that a valid sterilization consent form has been completed prior to rendering a sterilization procedure. The sterilization consent form is a federally mandated document and must be completed according to the **detailed** instructions listed in NC Policy *1E-3 Sterilization Procedures Attachment B* located at Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov)

**F. Consent for Sterilization Form** is not required when a member tests positive for BRCA1 or BRCA2 and requires a risk-reduction salpingo-oophorectomy.

**G. Claims Submission:**
**To process the claim for payment,** WellCare of North Carolina® can accept the consent form along with the claim via the *275 Claim Attachment Transactions via EDI*. Additional information can be located at https://www.wellcare.com/North-Carolina/Providers/Bulletins.

**Coding Implications**
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted

| CPT®* Codes | Description |
|---|---|
| 55250 | Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s) |
| 58600 | Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral |
| 58605 | Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral, or bilateral, during same hospitalization |
| 58611 | Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery |
| 58615 | Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach |
| 58661 | Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy) |
| 58670 | Laparoscopy, surgical; with fulguration of oviducts (with or without transection) |
| 58671 | Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, Falope ring) |
| 58700 | Salpingectomy, complete or partial, unilateral, or bilateral |

**ICD-10-CM Diagnosis Codes that Support Coverage Criteria**
+ Indicates a code(s) requiring an additional character

| ICD-10-CM Code | Description |
|---|---|
| Z30.2 | Encounter for sterilization |
| Z15.01 | Genetic susceptibility to malignant neoplasm of breast |
| Z15.02 | Genetic susceptibility to malignant neoplasm of ovary |
| Z15.04 | Genetic susceptibility to malignant neoplasm of endometrium |

***NOTE:*** *The only diagnosis code to be considered strictly for elective sterilization is Z30.2, "Encounter for sterilization."*

***NOTE:*** *When an opportunistic salpingectomy procedure is performed and the member has tested positive for BRCA1 or BRCA2, claims must be billed with diagnosis code Z15.01, Z15.02, or Z15.04*

| Reviews, Revisions, and Approvals | Reviewed Date | Approval Date |
|---|---|---|
| Original Approval date. | 04/21 | 05/21 |
| Added definitions to Background. Updated punctuation under "Date of Consent." | 07/21 | 08/21 |
| Reviewed CPT and ICD-10-CM codes. | 06/22 | 08/22 |
| Annual review. NCHC verbiage removed from NC Guidance Verbiage. Description Updates: Sterilization definition consistent with CMS. Changed "premature delivery" to "preterm delivery" throughout. Criteria Added: II. "Medicaid shall cover opportunistic salpingectomy when the member meets all of the requirements listed in section I, above and has tested positive for BRCA1 or BRCA2." Criteria Changes: I. "WellCare of North Carolina shall cover voluntary tubal sterilization procedure or vasectomy for Members that meet all of the following criteria:" III. "the requirements listed in Criteria I or Criteria II have not been met." Criteria Deleted: I. & III.A. Reference to the CFR. Background Updates: Tubal Sterilization Procedure: "for women who do not want more children" to "for Members who do not want to become pregnant." Changed "prophylactic bilateral salpingectomy" to "opportunistic salpingectomy" Definition updated for "Opportunistic Salpingectomy" "vasectomy" and "Preterm delivery." Headings changed "Obtaining Consent to Obtaining Informed Consent." and "Date of Confinement" to "Expected Date of Delivery." Added "Under anesthesia or any other substance that affects the member's ability to provide informed consent." Under Consent Form Required, "NC Policy IE-3 Sterilization Procedures Attachment B located at Added "Program Specific Clinical Coverage Policies \| NC Medicaid (ncdhhs.gov)" and "A Consent for Sterilization Form is not required when a member tests positive for BRCA1 or BRCA2 and requires a risk-reduction salpingo-oophorectomy." Background Deleted: Consent Required: "including prophylactic bilateral salpingectomy," ICD-10-CM Table Notes Added: "The only diagnosis code to be considered strictly for elective sterilization is Z30.2, "Encounter for sterilization." "When an opportunistic salpingectomy procedure is performed and the member has tested positive for BRCA1 or BRCA2, claims must be billed with diagnosis code Z15.01, Z15.02, or Z15.04." "Note: All claims must be billed with ICD-10-CM diagnosis code Z30.2 as the primary or secondary diagnosis code on the claim." Added Z15.01 Genetic susceptibility to malignant neoplasm of breast; Z15.02 Genetic susceptibility to malignant neoplasm of ovary; Z15.04 Genetic susceptibility to malignant neoplasm of endometrium. | 05/23 | 05/23 |
| Annual Review. | 05/24 | 05/24 |

| | | |
|---|---|---|
| Annual Review. Criteria II. Changed 'Medicaid' to 'WellCare of NC" HCPCS code box removed. Removed "Medicaid and health choice' text from References. Under NC Guidance/Claims related information, updated state web address. | 05/25 | 05/25 |
| Annual Review. | | |

**References**

1. State of North Carolina Medicaid Clinical Coverage Policy No: 1E-3 Sterilization Procedures. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov).. Published April 15, 2023. Accessed December 31, 2025.

**North Carolina Guidance**

*Eligibility Requirements*

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

*EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age*

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure:

1. that is unsafe, ineffective, or experimental or investigational.

2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   *NCTracks Provider Claims and Billing Assistance Guide*:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   *EPSDT provider page*: https://medicaid.ncdhhs.gov/

*Provider(s) Eligible to Bill for the Procedure, Product, or Service*
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

*Compliance*
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state, and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

*Claims-Related Information*
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:

Professional (CMS-1500/837P transaction)
Institutional (UB-04/837I transaction)
Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
   *Unlisted Procedure or Service*
   CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
   HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service
d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/meetingsnotices/medicaid-state-plan-public-notices

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in

developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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