KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Sterilization Consent	**Policy #**	2.19-P
Policy Owner	Quality Improvement	**Original Effective Date**	08/1997
Revision Effective Date	1/2025	**Approval Date**	4/18/2025
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

To define federal and state mandated requirements and coverage conditions pertaining to the provision sterilization procedures as appropriate for Kern Health Systems (KHS) female and male members undergoing sterilization.

II. POLICY

A. KHS will abide by State Medi-Cal and Centers for Medicare & Medicaid Services (CMS) Federal requirements and conditions pertaining to Sterilization procedures for both inpatient and outpatient services.

B. KHS contracted providers are required to obtain and abide by Medi-Cal sterilization consent form requirements for sterilization procedures (tubal sterilization, vasectomy and hysterectomy) prior to performing such procedures.

C. KHS members undergoing sterilization procedures must meet specific criteria as outlined in the California Department of Health Care Services (DHCS) guidelines established for sterilization.

D. KHS contracted providers must confirm that all the applicable requirements for sterilization are met at the time the procedure is performed, to receive reimbursement for performing such procedures.

III. DEFINITIONS

TERMS	DEFINITIONS
Human Reproductive Sterilization	Any medical treatment, procedure, or operation for the purpose of rendering an individual permanently incapable of reproducing. Sterilizations that are performed because pregnancy would be life threatening to the mother (so-called "therapeutic" sterilizations) are included in this definition. The term sterilization, as used in Medi-Cal regulations, means only human

	reproductive sterilization, as defined above.
Form PM330	California Department of Health Care Services (DHCS) form entitled "Consent Form" PM 330 is the only sterilization consent form accepted by Medi-Cal for sterilization. The sterilization Consent Form requirements are imposed by the Federal government and are followed by CA DHCS and can be found in California Code of Regulations, Title 22, Section 51305.4.
Hysterectomy Consent Form	Patients undergoing therapy that is not for, but results in, sterilization (formerly referred to as secondary sterilization) are not required to complete the Department of Health Care Services sterilization Consent Form (PM 330). Instead, it will require a hysterectomy consent form. A Hysterectomy Consent Form may be a hospital form, a physician-designed form or a written statement by the person who secures authorization. To be acceptable, however, the form must include the following: A. A statement that the procedure will render the patient permanently sterile and, B. The patient's signature and date of signing. The date of signing must be on or before the date of surgery. A sterilization consent form is not required if an individual has previously been sterilized as the result of a prior surgery, menopause, prior tubal ligation, pituitary or ovarian dysfunction, pelvic inflammatory disease, endometriosis or congenital sterility.
Mentally Incompetent	A person who has been declared mentally incompetent by the federal, state or local court of competent jurisdiction for any purposes which include the ability to consent to sterilization.

IV. PROCEDURES

A. Criteria For Eligibility of Sterilization Procedure - Member Specific Criteria

1. All the following criteria must be met for a sterilization procedure to be performed and reimbursed by KHS:

    a. Members who have procedures performed for the purpose of tubal sterilization or vasectomy shall receive adequate information to make an informed decision.

    b. This decision shall be reflected by a properly executed DHCS Consent Form PM 330.

    c. The individual is at least 21 years old at the time written consent for sterilization is obtained.

        i. This is a federal requirement for sterilizations only and is not affected by state law regarding the ability to give consent to medical treatment in general. **The age limit is an absolute requirement.** There are no exceptions for marital status, number of children, or for a therapeutic sterilization.

    d. The individual is not mentally incompetent.

        i. A mentally incompetent individual is a person who has been declared mentally incompetent by the federal, state, or local court of competent jurisdiction for any purposes unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

e. The individual can understand the content and nature of the informed consent process as specified in this section. A patient considered mentally ill or mentally retarded may sign the consent form if a physician determines that the individual can understand the nature and significance of the sterilizing procedure.

f. The individual is not institutionalized. For the purposes of reimbursement for sterilization, an institutionalized individual is a person who is:

   i. Involuntarily confined or detained under civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or

   ii. Confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

g. The individual has voluntarily given informed consent in accordance with all the federal requirements.

h. At least thirty (30) days, but not more than 180 days, have passed between the date of the written and signed informed consent and the date of the sterilization, except in the following instances:

   i. Sterilization may be performed at the time of emergency abdominal surgery if the patient consented to the sterilization at least 30 days before the intended date of sterilization, and at least 72 hours have passed after written informed consent was given and the performance of the emergency surgery.

   ii. Sterilization may be performed at the time of premature delivery if the written informed consent was given at least 30 days before the expected date of delivery, and at least 72 hours have passed after written informed consent to be sterilized was given.

i. The sterilization operation must be requested without fraud, duress, or undue influence. Consent may not be obtained while the member is in labor, within 24 hours postpartum or postabortion, seeking to obtain or obtaining an abortion, or under the influence of substances that affect the member's state of awareness.

B. Sterilization Consent Form - DHCS Form

1. A completed consent form must accompany all claims for sterilization services.
   a. This requirement extends to all providers, attending physicians or surgeons, assistant surgeons, anesthesiologists, and facilities.
2. The only sterilization consent form accepted is the most current Department of Health Care Services' Consent Form (PM 330) **(See Attachment A)**.
   a. Claims submitted with a computer-generated form, or any other preprinted forms are not reimbursed.
   b. However, the doctor or clinic name, and the name and address of the facility where the consent form is signed, may be stamped or typed in the appropriate fields of the PM 330.
   c. The form may then be photocopied prior to being completed and signed. Photocopies will

only be acceptable if the entire form is legible.

3. Sterilization Consent forms and a patient's information booklet can be downloaded for printing, in English or Spanish.
   a. Booklet is located: https://www.dhcs.ca.gov/Pages/PermanentBirthControl.aspx
   b. Consent Form **Attachment A**- Consent Form (PM 330).
   c. DHCS Provider Portal PDF mcweb.apps.prd.cammis.medi-cal.ca.gov for DHCS Billing Tips

C. Completion of the Sterilization Consent Form

1. The sterilization consent form must be signed and dated by the individual to be sterilized and include:
   a. Interpreter, if one is provided,
   b. Individual who obtains the consent, and
   c. Physician who will perform the sterilization procedure.
      i. The member must be permitted to have a witness of his/her choice present when consent is obtained.

D. Individual who Obtains Consent

1. Before obtaining consent, the person who obtains consent must provide the individual to be sterilized with a copy of the booklet on sterilization provided by DHCS in English and Spanish, offer to answer any questions the patient may have regarding the sterilization procedure, and provide all the following information, orally to the patient to be sterilized:
   a. Advice that the patient is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the patient might be otherwise entitled.
   b. A full description of available alternative methods of family planning and birth control. This includes all the following provisions:
      i. Advice that the sterilization procedure is considered to be irreversible,
      ii. A thorough explanation of the specific sterilization procedure to be performed,
      iii. A full description of the discomforts and risks that may accompany or follow performance of the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
      iv. A full description of the benefits or advantages that may be expected as a result of the sterilization,
      v. Approximate length of hospital stay,
      vi. Approximate length of time for recovery,
      vii. Financial cost to the patient (no cost for Medi-Cal members),

viii. Information as to whether the procedure is established or new,

ix. Advice that the sterilization will not be performed for at least 30 days from the time the consent form is signed, except under the circumstances of premature delivery or emergency abdominal surgery.

c. The name of the physician performing the procedure,

i. If another physician is substituted, it must be documented on the consent form and the patient shall be notified of the physician's name and the reason for the change in physicians prior to administering pre-anesthetic medication.

d. Suitable arrangements must be made to ensure that the information specified above was effectively communicated to any member who is blind, deaf, or otherwise handicapped. The person securing the consent shall certify by signing the consent form that he or she:

i. Advised the individual to be sterilized that no federal benefits may be withdrawn because of the decision not to be sterilized (before the individual to be sterilized signed the consent form).

ii. Explained orally the requirements for informed consent to the individual to be sterilized as set forth on the consent form and in regulations.

iii. Determined to the best of his/her knowledge and belief that the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

E. Translation Services

1. Translation and interpretation services will be provided if the Member to be sterilized does not understand the language used on the consent form or the verbal language used to obtain consent. Linguistic services are provided by KHS at no cost to monolingual, non-English speaking or Limited English Proficiency (LEP) Medi-Cal beneficiaries as well as eligible Members with sensory impairment. These services include written translations, qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters, use of California Relay Services for hearing impaired or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries

F. Physician who Performs Sterilization

1. The physician performing the sterilization shall certify by signing the consent form that:

a. The physician (shortly before the performance of the sterilization) advised the individual to be sterilized that federal benefits should not be withheld or withdrawn because of a decision not to be sterilized.

i. For purposes of regulations, the phrase "shortly before" means a period within 72 hours prior to the time the patient receives any preoperative medication.

b. The physician explained orally the requirements for informed consent as set forth on the consent form.

c. To the best of the physician's knowledge and belief the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

d. At least thirty (30) days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed, except in the following instances:

i. Sterilization may be performed at the time of emergency abdominal surgery if the physician certifies that the patient consented to the sterilization at least thirty (30) days before he/she intended to be sterilized; and that at least 72 hours have passed after written informed consent to be sterilized was given; and the physician describes the emergency on the consent form.

2. Sterilization may be performed at the time of premature delivery if the physician certifies that the written informed consent was given at least 30 days before the expected date of delivery. The physician shall state the expected date of the delivery on the consent form. At least 72 hours have passed after written informed consent to be sterilized was given.

G. Interpreter

1. An interpreter must be provided if the member does not understand the language used on the consent form or the language used by the person obtaining consent. The interpreter, if one is provided, shall certify that he or she:
   a. Transmitted the information and advice presented orally to the individual to be sterilized.
   b. Read the consent form and explained its contents to the individual to be sterilized, and
   c. Determined to the best of his/her knowledge and belief that the individual to be sterilized understood what the interpreter told the individual.

H. Distribution of Completed Consent Forms

1. A copy of the signed consent form must be:
   a. Provided to the patient,
   b. Retained by the physician and the hospital in the patient's medical records, and attached to all claims for sterilization services,
      i. Requirement "b" extends to all providers including attending physicians or surgeons, assistant surgeons, anesthesiologists, and facilities.

I. Hysterectomy Informed Consent

1. A hysterectomy is not covered under the Medi-Cal program if performed, or arranged, solely for the purpose of rendering the patient permanently sterile; or, if there is more than one purpose for the operation, if the hysterectomy would not be performed except for the purpose of sterilization.
   a. Informed consent is not required if an individual has previously been sterilized as the result of prior surgery, menopause, prior tubal ligation, pituitary or ovarian dysfunction, pelvic inflammatory disease, endometriosis, or congenital sterility. When submitting a claim for a patient previously sterilized, the provider must state the cause of sterility. This statement must be handwritten and signed by a physician.

b. There is no waiting period for a hysterectomy. There is no informed consent requirement if a hysterectomy is performed in a life-threatening emergency in which the physician determines prior acknowledgment was not possible. In this case, a statement handwritten and signed by the physician, certifying the nature of the emergency must accompany the claim. A diagnosis alone will not justify this service as an emergency.

c. A physician may perform or arrange for a hysterectomy only if:

   i. The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representative, if any, orally and in writing that the hysterectomy will render the individual permanently sterile. The person who secures authorization may transmit the written information to the patient on a hospital form, a physician-designed form, or a written statement.

   ii. The individual or the individual's representative, if any, has signed a written acknowledgment of the receipt of the preceding information. The consent must be dated prior to the date of surgery. Although the consent form for sterilization (PM 330) is not ideal for hysterectomy patients because the age and the waiting period are inapplicable, these forms are adequate so long as the name of the operation is clearly denoted as "hysterectomy". A consent form signed previously for tubal ligation, however, is not acceptable.

   iii. The individual has been informed of the rights to consultation by a second physician.

d. A copy of the written acknowledgment signed by the patient must be:

   i. Provided to the patient.

   ii. Retained by the physician and the hospital in the patient's medical records.

   iii. Attached to claims submitted by the physician, assistant surgeons, anesthesiologists, and hospitals.

J. Sterilization Consent Form (Pm 330) Corrections

1. Providers whose claims are denied with a result of incorrectly completed sterilization Consent Form will receive a package with the materials required for correcting the sterilization Consent Form. The package will include a Sterilization Consent Form Corrections letter explaining the process of correcting the sterilization Consent Form **(see Attachment B)**, a sample sterilization Consent Form **(see Attachment C)** indicating the fields (numbers) on the form that were either completed incorrectly or contained insufficient information and a copy of the original claim. The provider then may resubmit the corrected form according to the instructions in the letter **(Attachment B)**.

V. ATTACHMENTS

Attachment A: Consent Form (PM 330)
Attachment B: Sterilization Consent Form Corrections letter
Attachment C: Sample Sterilization Consent Correction form

Attachment D: DHCS Billing Tips

VI. REFERENCES

Reference Type	Specific Reference
Regulatory	22 California Code of Regulations §51305.l(b)(l), §51305.3(a) (2), (4), (5), (b) (3), (c)
Regulatory	DHCS COB Letter 87-1 §3.0
Regulatory	DHCS Provider Manual Part 2 -Sterilization updated 08/2022
Regulatory	42 CFR Part 441 Subpart F -- Sterilizations
DHCS Contract (Specify Section)	5.2.8 Specific Requirements for Access to Programs and Covered Services

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revised	01/2025	Revised per annual routine review.	M.H. QI
Revised	01/2020	Reviewed by Director of Quality Improvement. Added clarification of sterilization procedures and of completion of the PM330 Sterilization Consent Form.	Director of Quality Improvement
Revised	12/2016	Reviewed by QI Supervisor. Updated link to PM 330.	QI Supervisor
Revised	07/2015	Routine review performed by Quality Improvement Supervisor.	Quality Improvement Supervisor
Revised	01/2012	Revisions provided by Claims Manager. Address and websites updated. New Section 5.0 adds information to correct a sterilization consent form	Claims Manager
Revised	05/2010	No revision required per Director of Quality Improvement, Health Education & Disease Management. Titles updated.	-
Revised	07/2009	Reviewed by Director of Quality Improvement, Health Education & Disease Management. No revision needed, signature lines updated. Not reviewed by the AIS Compliance Department.	-
Revised	09/2006	Revised per DHS Workplan comments (04/26/06)	-
Revised	08/2005	Policy reviewed by QI/UM Manager April	-

		2004 and July 2005	
Revised	08/2002	Revised per DHS Comment 05/13/02	-
Effective	08/1997	-	-

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Department of Health Care Services (DHCS)		

Chief Executive Leadership Approval *		
Title	**Signature**	**Date Approved**
Chief Executive Officer		
Chief Medical Officer		
Chief Operating Officer		
*Signatures are kept on file for reference but will not be on the published copy		

KERN HEALTH SYSTEMS

Policy and Procedure Review

KHS Policy & Procedure: 2.19-P Sterilization Consent

Last approved version: 01/2020

Reason for revision: Revised per annual routine review.

Director Approval		
Title	**Signature**	**Date Approved**
Dr. John Miller Medical Director of Quality Improvement		
Christine Pence Senior Director of Health Services		
Magdee Hugais Director of Quality Improvement		
Michelle Curioso Director of Population Health Management		
Amanda Gonzalez Director of Utilization Management		
Robin Dow-Morales Senior Director of Claims		

Date posted to public drive: _____

Date posted to website ("P" policies only) : _____

State of California -- Health and Human Services Agency

CONSENT FORM
PM 330

Department of Health Services

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 (1) _____ (doctor or clinic). When I first 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 known as a (2) _____ (Name of procedure). The discomforts, risks and benefits associated with the operation have been explained to me. All of 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 (3) ___/___/___ (Mo Day Yr).

(4) I, _____ (Last) _____ (First) _____ (M.I.)

hereby consent of my own free will to be sterilized by (5) _____ (Doctor's name) by a method called (6) _____ (Name of procedure).

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 and Human Services.**
- **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.

(7) _____ Date: (8) ___/___/___
Signature of individual to be sterilized (Mo Day Yr)

■ 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 (9) _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ Date: (11) ___/___/___
Signature of Interpreter (Mo Day Yr)

PM 330 (1/99)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before (12) _____ (Name of individual to be sterilized) signed the consent form, I explained to him/her the nature of the sterilization operation (13) _____ (Name of procedure) 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 anytime 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 knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ Date: (15) ___/___/___
Signature of person obtaining consent (Mo Day Yr)

(16) _____
Name of Facility where patient was counseled

(17) _____
Address of Facility where patient was counseled City State Zip Code

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon (18) _____ (Name of individual to be sterilized) on (19) ___/___/___ (Date of Sterilization). I explained to him/her the nature of the sterilization operation (20) _____ (Name of procedure), the fact that it is intended to be 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 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 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 when 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 below which is not used.

(21) (1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(22) (2) This sterilization was performed 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 box below and fill in information requested**.)

(23) A. ☐ Premature delivery date: (24) ___/___/___ (Mo Day Yr) **Individual's expected date** of delivery: (25) ___/___/___ (Mo Day Yr) (Must be 30 days from date of patient's signature).

(26) B. ☐ Emergency abdominal surgery; describe circumstances: _____

(27) _____ Date: (28) ___/___/___
Signature of Physician performing surgery (Mo Day Yr)

Figure 1: Sample Sterilization Consent Form (PM 330) – English Side.

State of California – Health and Human Services Agency **CONSENT FORM - PM 330** Department of Health Services

NOTA: NINGUNO DE LOS BENEFICIOS QUE RECIBO DE LOS PROGRAMAS O PROYECTOS SUBSIDIADOS CON FONDOS FEDERALES SE ME CANCELARÁ O SUSPENDERÁ EN CASO DE QUE YO DECIDA NO ESTERILIZARME.

■ CONSENTIMIENTO PARA ESTERILIZACIÓN ■

Declaro que he solicitado y obtenido información sobre esterilización de (1) _____ (nombre o iniciales). Al solicitar información se me dijo que yo soy la única persona que puede decidir esterilizarme o no y que estoy en mi derecho a negarme a ser esterilizado. Mi decisión de no esterilizarme no afectará mi derecho a recibir atención o tratamiento médico en el futuro, y tampoco dejaré de recibir ningún tipo de asistencia o beneficios que recibo actualmente de los programas subsidiados con fondos federales, tales como A.F.D.C. o Medicaid o de aquellos a los que pudiera tener derecho en el futuro.

ENTIENDO QUE LA ESTERILIZACIÓN DEBE SER CONSIDERADA **PERMANENTE E IRREVERSIBLE**. DECLARO QUE ES MI DECISIÓN EL NO QUERER VOLVER A EMBARAZARME, DAR A LUZ O SER PADRE NUEVAMENTE.

Declaro que se me ha informado acerca de la existencia de otros métodos anticonceptivos temporales que están a mi disposición y que me permitirían en un futuro tener hijos o ser padre nuevamente. Sin embargo, he rehusado estos métodos alternativos y he decidido esterilizarme.

Entiendo que se va a esterilizar mediante un método conocido como: (2) _____ (Nombre del procedimiento).

Declaro que se me explicaron los malestares, riesgos y beneficios asociados con la operación, y que se respondió a todas mis preguntas satisfactoriamente.

Entiendo que la operación no se llevará a cabo hasta por lo menos treinta (30) días después de que firme este formulario, y que puedo cambiar de parecer en cualquier momento y decidir no esterilizarme. Si decido no esterilizarme, no dejaré de recibir ninguno de los beneficios o servicios médicos ofrecidos por los programas subsidiados con fondos federales.

Declaro tener al menos 21 años de edad y que nací en (3) ___/___/___ Mes Día Año

(4) Cuidado / Nombre

por medio de la presente doy mi consentimiento libre y voluntario para ser esterilizado/a por (5) _____ (Nombre del Doctor)

utilizando un método conocido como (6) _____ (Nombre del procedimiento).

Mi consentimiento es válido sólo por un plazo de **180 días** a partir de la fecha en que firmé este formulario como se muestra abajo.

Asimismo, doy mi consentimiento para que este formulario y otros expedientes médicos sobre la operación se den a conocer a:

- **Representantes del Departamento de Salud y Servicios Humanos.**
- **Empleados de los programas o proyectos que reciben fondos de dicho Departamento, pero únicamente para determinar si se cumplieron las leyes federales.**

He recibido copia de este formulario.

(7) _____ Fecha (8) ___/___/___

Firma de la persona a ser esterilizada Mes Día Año

■ DECLARACIÓN DEL INTÉRPRETE ■

Si se requiere de un intérprete para asistir a la persona que va a ser esterilizada: Declaro que he traducido la información y los consejos verbales que la persona que recibe este consentimiento le ha dado a la persona que va a ser esterilizada. También le he leído a la persona el contenido de este formulario de consentimiento en idioma (9) _____ y le he explicado su contenido. A mi mejor saber y entender dicha persona ha comprendido las explicaciones que se le dieron.

(10) _____ Fecha: (11) ___/___/___

Firma del intérprete Mes Día Año

PM 330 (1/99) (Sp)

■ DECLARACION DE LA PERSONA QUE RECIBE EL CONSENTIMIENTO ■

Declaro que antes de que (12) _____ (Nombre de la persona a ser esterilizada) firmara el formulario de consentimiento, le expliqué la naturaleza del método de esterilización conocido como (13) _____ (Nombre del procedimiento).

También le expliqué que dicha operación es final e irreversible, y le informé sobre los malestares, riesgos y beneficios asociados con dicho procedimiento.

Declaro que le he explicado a la persona a ser esterilizada acerca de la existencia de otros métodos anticonceptivos temporales y que a diferencia de estos, el método de esterilización es irreversible.

Declaro que le he informado a la persona a ser esterilizada que puede desistir en cualquier momento a este consentimiento y que esto no traerá como consecuencia la pérdida de ningun servicio médico o beneficio subsidiado con fondos federales.

Declaro que, a mi mejor saber y entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece estar en su sano juicio. Dicha persona, de forma voluntaria y con conocimiento de causa, ha solicitado ser esterilizada y parece entender la naturaleza y las consecuencias del procedimiento.

(14) _____ Fecha (15) ___/___/___

Firma de quien recibe el consentimiento Mes Día Año

(16) _____

Nombre del lugar donde el paciente recibió la información

(17) _____

Dirección del lugar donde el paciente recibió la información Ciudad Estado Código Postal

■ DECLARACIÓN DEL MÉDICO ■

Declaro que poco agrilas de operar a (18) _____ (Nombre de la persona a ser esterilizada) en (19) ___/___/___ (Fecha de esterilización) le explique la naturaleza del método de esterilización conocido como (20) _____ (Nombre del procedimiento), también le expliqué que este método es final e irreversible y le informé de los malestares, riesgos y beneficios asociados con este procedimiento.

Declaro que le he explicado a la persona a ser esterilizada acerca de la existencia de otros métodos anticonceptivos temporales y que ha diferencia de estos, el método de esterilización es irreversible.

Declaro que le he informado a la persona a ser esterilizada que puede desistir en cualquier momento a este consentimiento y que esto no traerá como consecuencia la pérdida de ningun servicio médico o beneficios subsidiado con fondos federales.

Declaro que, a mi mejor saber y entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece estar en su sano juicio. Dicha persona, de forma voluntaria y con conocimiento de causa, ha solicitado ser esterilizada y parece entender la naturaleza y las consecuencias del procedimiento.

Instrucciones para el Uso Alternativo de los Párrafos Finales: Use el primer párrafo de abajo excepto en caso de parto prematuro o cirugía del abdomen de emergencia cuando la esterilización se lleva a cabo antes de que se cumplan treinta (30) días desde que la persona firmó este consentimiento. En dichos casos se debe usar el segundo párrafo. Tachar el párrafo de abajo que no es usado.

(21) (1) Han pasado por lo menos treinta (30) días desde que la persona firmó este consentimiento y la fecha en que se realizó la esterilización.

(22) (2) La esterilización se realizó en menos de 30 días, pero después de 72 horas desde que la persona firmó este consentimiento debido a lo siguiente: (Marque la casilla correspondiente de abajo y escriba la información que se solicita.)

(23) A ☐ Fecha de parto prematuro: (24) ___/___/___ Mes Día Año **Fecha anticipada del parto** (25) ___/___/___ Mes Día Año (Debe ser 30 días a partir de la firma de la persona).

(26) B ☐ Cirugía del abdomen de emergencia; describa las circunstancias: ____

(27) _____ Fecha (28) ___/___/___

Firma del Doctor a cargo de la cirugía Mes Día Año

Figure 2: Sample Sterilization Consent Form (PM 330) – Spanish Side

KERN HEALTH SYSTEMS

Dear Kern Health Systems Provider,

In reviewing the sterilization **Consent Form PM 330** accompanying your claim, we identified an area (s) of insufficient or incorrect information. As this information is required by State and Federal rules and regulations for sterilizations performed under the Medi-Cal program, we are unable to process your claim as it was submitted.

To facilitate the resolution of your denied claim, we have enclosed the materials necessary for properly completing the sterilization **Consent Form PM 330** in accordance with Medi-Cal specifications. These materials include the following:

- A copy of your original claim
- A sample sterilization **Consent Form PM 330**, indicating the specific information required by KHS for proper claim adjudication.

This sample sterilization **Consent Form PM 330** enclosed with this letter shows the fields of information labeled numerically. To the right of the sample form is a corresponding explanation for each of these fields (numbers). We have marked on this sample form the fields (numbers) for which you must provide either corrected or additional information so that we can process your claim. These fields are marked with an "X".

Please provide the correct and or additional information, designated with an "X" on the sample sterilization **Consent Form PM 330**, in the corresponding field on the copy of your original sterilization **Consent Form PM 330**. For example, if number 4, "Patient's Name", is designated with an "X" on the sample sterilization **Consent Form PM 330**, provide the appropriate information in the corresponding field on the copy of your original sterilization **Consent Form PM 330**. All changed information should be initialed. Do not use correction fluid or tape to blot out errors. Errors should be lined out and initialed.

Please return the following to KHS, P.O. Box 85000 Bakersfield, CA 93380-9998

- The copy of your original claim.
- The corrected copy of your original sterilization **Consent Form PM 330**.
- A copy of the Explanation of Benefits showing the denied claim.

If you need further assistance in submitting a corrected **Consent Form PM 330**, please contact your provider relations representative at (661) 632-1590.

2900 Buck Owens Blvd, Bakersfield, CA 93308
(661) 632-1590 • Fax (661) 664-5151
www.kernfamilyhealthcare.com

Sample Sterilization Consent Form for Medi-Cal Billing

CCN: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Recipient's Last Name: _____

State of California – Health and Human Services Agency — CONSENT FORM PM 330 — Department of Health Services

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

(1) _____

(Name of doctor)

Before I first asked for the sterilization, I was told that the decision to be sterilized is completely up to me. I was told that I could change my mind at any time. My decision 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 choose to be sterilized.

I understand that I will be sterilized by an operation known as a

(2) _____

(Name of operation)

The discomforts, risks and benefits associated with the operation have been explained to me. All of 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 (3) ___/___/___ (Mo Day Yr)

I, (4) _____ (Patient's name)

hereby consent of my own free will to be sterilized by

(5) _____ by a

(Physician's name)

(6) _____ (Name of operation)

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 and Human Services.
- 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.

(7) _____ (Signature of individual to be sterilized) Date: (8) ___/___/___ (Mo Day Yr)

■ INTERPRETER'S STATEMENT ■

I am competent to translate the information 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 (9) _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood that explanation.

(10) _____ Date: (11) ___/___/___

(Signature of interpreter) (Mo Day Yr)

PM 330 (1/89)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before (12) _____ signed the consent form, I explained to (13) _____ (Name of individual to be sterilized) (Name of interpreter, if any) whether the nature of the sterilization operation (14) _____ (Name of operation) 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 on 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 knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ Date: (15) ___/___/___ (Mo Day Yr)

(Signature of person obtaining consent)

(16) _____ (Name of facility where patient was counseled)

(17) _____ (Address of facility where patient was counseled) (City) (State) (Zip Code)

■ PHYSICIAN'S STATEMENT ■

I (Physician) (18) _____ on (15) ___/___/___ (Mo Day Yr) (Name of individual to be sterilized) I explained to him/her the nature of the sterilization operation (20) _____ (Name of procedure) the fact that it is intended to be 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 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 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 when 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 below which is not used.

(21) ☐ (1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(22) ☐ (2) This sterilization was performed 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 box below and fill in information concerning)

(23) A ☐ Premature delivery date: (24) ___/___/___ Individual's expected date of delivery: (25) ___/___/___ (Must be 30 days from date of patient's signature).

(Mo Day Yr)

(26) B ☐ Emergency abdominal surgery; describe circumstances: _____

(27) _____ (Signature of Physician performing surgery) Date: (28) ___/___/___ (Mo Day Yr)

Sample Sterilization Consent Form Instructions

CONSENT TO STERILIZATION

(1) **Name of physician or clinic.**
Name of physician or clinic must be present.

(2) **Name of procedure.**
Name of procedure must be present and must be consistent throughout the consent form (2, 6, 13, 20).

(3) **Patient's birthdate.**
Date must be present (month/day/year) and must match the date of birth on the claim form.

(4) **Patients name.**
Name must be present and consistent throughout the consent form (4, 7,12, 18). It must also be consistent with the patients name on the claim form.

(5) **Physician's name.**
The name of the physician, group, clinic, or hospital must be present.

(6) **Name of procedure.**
The name of the procedure must be present and consistent throughout the consent form (2, 6, 13, 20).

(7) **Patient's signature.**
If the patient signs the consent form with an "X", a symbol/character or in a non-Arabic alphabet, the signature must be countersigned by a witness. Must be consistent throughout the *Consent Form* (numbers 4, 7, 12 and 18).

(8) **Date.**
The date must be present (month/day/year).

INTERPRETER'S STATEMENT

(9) **Language.**
Language in which the patient was counseled (if other than English or Spanish) must be completed.

(10) **Interpreter's signature.**
The signature of the interpreter must be complete and present.

(11) **Date.**
The date must be present (month/day/year).

STATEMENT OF PERSON OBTAINING CONSENT

(12) **Patients name.**
Name must be present and consistent throughout the consent form (4, 7, 12, 18). It must also be consistent with the patients name on the claim form.

(13) **Name of procedure.**
Name of procedure must be present and must be consistent throughout the consent form (2, 6, 13, 20).

(14) **Signature of person obtaining consent.**
Full signature of person who counseled patient must be present.

(15) **Date.**
The date must be present (month/day/year).

(16) **Name of facility.**
Name of facility where counseling was given to patient must be present.

(17) **Address of facility.**
Address of facility where counseling was given to patient must be present (street address, city, state, and ZIP code)

PHYSICIAN'S STATEMENT

(18) **Patients name.**
Name must be present and consistent throughout the consent form (4, 7, 12, 18). It must also be consistent with the patients name on the claim form.

(19) **Date.**
The date must be present (month/day/year).

(20) **Name of procedure.**
Name of procedure must be present and must be consistent throughout the consent form (2, 6, 13, 20).

(21) **Paragraph one.**
a. Paragraph one is not crossed off when at least 30 days has passed between the date the patient gave consent (8) and the date the procedure was performed (19); cross off paragraph two (22) if the minimum waiting period of 30 days has been met.
b. Consent is invalid because more than 180 days passed between date patient gave consent (8) and date of procedure (19).

(22) **Paragraph two.**
a. Paragraph two is not crossed off when less than 30 days has passed between the date the patient gave consent (8) and the date of the procedure (19); cross off paragraph one (21) if the minimum waiting period of 30 days has not been met.

(23) **Premature delivery.**
Box A is selected when less than 30 days passed between date patient gave consent (8) and date of procedure (19) due to premature delivery.

(24) **Premature delivery date.**
a. Date of premature delivery must be present (month/day/year).
b. Claim denied because less than 72 hours passed between date patient gave consent (8) and date of procedure (19).

(25) **Individual's expected date of delivery.**
a. Date of patient's expected date of delivery must be present (month/day/year).
b. Claim denied because there must be at least 30 days between date patient gave consent (8) and patient's expected date of delivery.

(26) **Emergency abdominal surgery.**
a. Box B is selected when less than 30 days passed between date patient gave consent (8) and date of procedure (19) due to an emergency abdominal surgery.
b. Comments regarding the circumstance of emergency abdominal surgery must be included.
c. Claim denied because less than 72 hours passed between date patient gave consent (8) and the date of the emergency abdominal surgery (19).

(27) **Physician's signature.**
Physician's full signature must be present and complete.

(28) **Date.**
a. Date must be present (month/day/year).
b. Date must be on or after the date which sterilization was performed (19).

For more information, refer to your Medi-Cal provider manual or call 1-800-541-5555.

HP Enterprise Services/Medi-Cal 88-H-20 (4/10)

Sample Sterilization Consent Correction Form.

PM-330 *Sterilization Consent Form*
Tips & Reminders for Successful Billing

☑ **Name of procedure.** **Fields 2, 6, 13 and 20** require the name of the procedure. The name of the procedure must be present and must be **consistent** throughout the form and **must** match name of procedure on the claim.

☑ **Patient's name.** **Fields 4, 7, 12 and 18** require the name of the patient to be consistent throughout the form.

Tip: Use the name as reflected on the BIC or the name used when determining Family PACT eligibility.

☑ **Field 21 and 22 (Alternative Final Paragraphs).** The paragraph that does not apply **must be crossed out** (an **'X'** through the paragraph that does not apply is required).

(21) Paragraph one. **Do not** cross off paragraph one if the minimum waiting period of 30 days has been met.

(22) Paragraph two. **Do not** cross off paragraph two if the minimum waiting period of 30 days **has not** been met.

☑ **Physician's signature.** **Field 27** requires full signature of the Physician who has verified consent and who actually performed the operation.

☑ **Date.** **Field 28** must be present (month/day/year). Date must be on or after the sterilization date.

Note: These instructions must be followed **exactly** or the *Consent Form* will be returned and reimbursement delayed.

A completed PM 330 *Sterilization Consent Form* must accompany all claims directly related to the sterilization surgery. This requirement extends to all providers, attending physicians, surgeons, assistant surgeons, anesthesiologists and facilities.

The above tips are being provided to assist in the prevention of common RAD code denials:
105 – This service requires a valid sterilization consent form.
115 – Sterilization Consent Form is incomplete. A letter has been sent that indicates needed correction.

Provider Manual Reference – Part 2: *Sterilization* section