Summit COMMUNITY CARE

Arkansas | Medicaid

Reimbursement Policy
Hysterectomy

Policy Number: **G-06164**
Policy Section: **Surgery**
Last Approval Date: **06/08/2026**
Effective Date: **06/08/2026**

Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://provider.summitcommunitycare.com**.

Policy

The health plan allows reimbursement of non-elective and medically necessary hysterectomy procedures for covered members unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Reimbursement is based on the applicable fee schedule or contracted/negotiated rate and receipt of a valid Consent/Acknowledgment of Hysterectomy form.

The health plan considers reimbursement for a hysterectomy only when the following criteria are met:

- The hysterectomy is medically necessary to treat an illness or injury.
- The member has given informed consent.
- The member or authorized representative is fully aware that the hysterectomy will render the member permanently incapable of reproducing and has verbally and in writing expressed this understanding.
- The member or authorized representative has signed and dated an applicable state-approved Consent/Acknowledgment of Hysterectomy form. The form is required regardless of the member's diagnosis or age.

Note: If the member was already sterile before the hysterectomy or if the individual required a hysterectomy because of a life-threatening emergency situation in which the physician determined that prior consent/acknowledgment was not possible:

- The Consent/Acknowledgment of Hysterectomy form with the physician's certification will be required; and
- The member's informed Consent/Acknowledgement of Hysterectomy will not be required.

Claims for professional and/or facility services for a hysterectomy submitted without the valid informed Consent/Acknowledgment of Hysterectomy form may not be reimbursed. A "valid" Consent/Acknowledgment of Hysterectomy form has to be properly executed and include all required signatures:

- Member, except as noted
- Person obtaining the member's consent
- The physician performing the hysterectomy

If a hysterectomy is performed in conjunction with a delivery, then multiple surgery guidelines apply (refer to our Modifiers 50 and 51: Multiple and Bilateral Surgery policy).

Nonreimbursable:
The health plan does not allow reimbursement of a hysterectomy in the following circumstances:

- The hysterectomy is performed for the sole purpose of rendering the member permanently incapable of reproduction.
- There is more than one reason for the hysterectomy, but the primary reason is to render the member permanently incapable of reproduction.
- The hysterectomy is performed for the purpose of cancer prophylaxis.

Related Coding
Standard correct coding applies.

Definitions
General Reimbursement Policy Definitions

Related Policies and Materials
- Claims Requiring Additional Documentation
- Modifier 50 and 51: Multiple and Bilateral Surgery

References and Research Materials
This policy has been developed through consideration of the following:

- American College of Obstetricians and Gynecologists (ACOG)
- CMS
- Code of Federal Regulations (CFR), Subpart F - Sterilizations §441.250-§441.258
- State contract
- State Medicaid

Policy History
- **06/08/2026 -** Review approved and effective: no changes
- **07/17/2024 -** Review approved and effective: no changes
- **06/29/2022 -** Review approved and effective
- **07/13/2020 -** Review approved and effective: updated policy language
- **03/01/2019 -** Initial approval and effective

Disclaimer
These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed.

Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

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