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June 3, 2020

MEMORANDUM

MEMO NO.
QI-2019

TO: QUEST Integration Health Plans

FROM: Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

SUBJECT: UPDATED DHS 1145 - HYSTERECTOMY ACKNOWLEDGEMENT FORM AND RESCINDING DHS 1146 - STERILIZATION - CONSENT FORM CHANGE

DHS 1145 - Hysterectomy Acknowledgement Form

Please find the attached updated form DHS 1145 and instructions. The requirement for the form to be signed remains but the form has been updated to reflect reference to the Clinical Standards Office. Also, the original will not be required to be submitted with the claim.

DHS 1146 - Sterilization Consent Form

Effective July 1, 2020, the Med-QUEST Division (MQD) is transitioning to federal form HHS 687 - Consent for Sterilization for the required documentation for the consent to sterilization.

Currently the QUEST Integration (QI) contract specifies providers are required to use the DHS 1146 Sterilization Required Consent form. With the issuance of this Provider Memorandum, the requirement to use the DHS 1146 will no longer be required. In its place please have providers use the federal form (HHS 687).

Transition period: Either the HHS 687 or DHS 1146 form will be acceptable forms to use up to December 31, 2020, in order to comply with the federal requirement. After that date, MQD will deactivate DHS 1146 and it will not be acceptable documentation.

Form template: The HHS 687 form may be found at the U.S. Department of Health and Human Services Office of Population Affairs website at https://www.hhs.gov/opa/sites/default/files/consent-for-sterilization-english-updated.pdf.

This change is in response to community input and is another MQD action to increase efficiency and reduce confusion in the provider community as language in the DHS and federal forms are the same except for additional information on the top of the State form.

Should you have any questions regarding this memorandum, please contact Leslie K Tawata, Clinical Standards Office Administrator, at 692-8116 or via email at ltawata@dhs.hawaii.gov.

Attachments

State of Hawaii
Department of Human Services

Med-QUEST Division

HYSTERECTOMY ACKNOWLEDGEMENT

Identification Number	Name of Health Plan	Patient's Full Name (Last, First, M.I.)	Sex M F ( ) ( )	Birthdate / /

I have informed _____
Name of Person to have Hysterectomy

or _____ orally and by this statement that the
Name of Her Representative, If Applicable

Hysterectomy she is to have will render her permanently incapable of reproducing.

_____ _____
Signature of Person Obtaining Authorization to Perform the Hysterectomy — Date

TO BE COMPLETED BY PATIENT OR HER REPRESENTATIVE

I acknowledge that I received the above information,

_____ _____
Signature of Person Having the Hysterectomy — Date

Or, if applicable:

_____ _____
Signature of Her Representative — Date

INSTRUCTIONS
DHS 1145 (Rev. 06/20)

HYSTERCTOMY ACKNOWLEDGEMENT

PURPOSE:

The DHS 1145, "Hysterectomy Acknowledgement" form shall be completed prior to the procedure between the beneficiary/Authorized Representative, acknowledging that the procedure is medically necessary, and the Health Care Provider performing the hysterectomy.

GENERAL INSTRUCTIONS:

1. All identifying information must be completed on this form

2. All other information pertaining to the doctor or clinic, dates, names of individuals/authorized representative, and individual obtaining consent must be completed on the form.

SPECIFIC INSTRUCTIONS:

For Health Care Provider:

The procedure to be performed and reimbursed by the Medicaid program must be medically necessary (e.g. uterine fibroids, endometriosis, and cancer).

The provider shall inform the woman of all options, the purpose of the procedure and that the result will be that the woman will no longer be able to reproduce.

For Beneficiary/Authorized Representative:

The beneficiary or her Authorized Representative must sign the form acknowledging the procedure to be performed and understands the procedure will result in the individual not being able to reproduce.

FILING/DISTRIBUTION INSTRUCTIONS:

The provider shall keep the signed original in the medical records and provide a copy of the signed form to the beneficiary/Authorized Representative.