Beyond Healthcare. A Better You.

Clinical Policy: Therapeutic and Non-Therapeutic Abortions

Reference Number: WNC.CP.271
Last Review Date: 04/23

Coding Implications
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]

This policy describes North Carolina Medicaid coverage for therapeutic and non-therapeutic abortions.

Policy/Criteria[1]

I. It is the policy of North Carolina Medicaid that therapeutic and non-therapeutic abortions are covered when the procedure is provided in accordance with federal and state laws and regulations.

A. *Therapeutic Abortions* – Coverage is provided when:
   1. A woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed; **or**
   2. The pregnancy is the result of an alleged act of incest; **or**
   3. The pregnancy is the result of an alleged act of rape.

B. *Non-Therapeutic Abortions* – Coverage is provided when:
   1. The termination of a pregnancy occurs without any manual or surgical interruption of that pregnancy (missed, incomplete, spontaneous, etc.).

C. *When an Abortion Is Not Unlawful*
   1. Refer to NCGS 14-45.1 for established provisions that govern the coverage of abortions.

II. It is the policy of North Carolina Medicaid that therapeutic and non-therapeutic abortions are **not covered** when the procedures, products, and services related to this policy do not meet the federally mandated requirements.

Background[1]

A *therapeutic abortion* is the termination of a pregnancy where fetal heart tones are present at the time of the abortive procedure. The termination of a pregnancy may be induced medically (prostaglandin suppositories, etc.) or surgically (dilation and curettage, etc.). This includes the delivery of a non-viable (incapable of living outside the uterus) but live fetus, if labor was augmented by Pitocin drip, laminaria suppository, etc.

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Life-Threatening Conditions - Federal regulations require Medicaid agencies to obtain certification in writing from the physician performing the abortion attesting to the fact that in his/her professional judgment that the life of the mother would be endangered if the fetus were carried to term.

- if the abortion was necessary to save the life of the mother—regardless of whether the pregnancy was a result of rape or incest—the medical diagnosis and health records must support the certification.
- an appropriate diagnosis code, legally induced abortion, must be indicated on the claim.
- health records supporting the certification must be submitted to DHHS fiscal contractor, along with the abortion statement. Health record documentation may include history, physical, operative report, office admission history notes and physical, discharge summary, ultrasound report, consult reports and pathology reports.
- the requirements of parental consent for a minor do not apply when a medical emergency exists that so complicates the pregnancy as to require an immediate abortion.

Incest - Medicaid requires the physician performing the abortion to submit certification in writing attesting to the fact that in his/her professional judgment the beneficiary was a victim of incest.

- when submitting a claim for an abortion performed due to incest, an ICD-10-CM diagnosis code must be billed indicating the perpetrator of the assault, in addition to a diagnosis code indicating rape.
- the health record documentation supporting the certification must be available for review, if necessary.
- the requirements of parental consent for a minor (refer to Subsection 5.4) do not apply when a medical emergency exists that so complicates the pregnancy as to require an immediate abortion.

Rape - Medicaid requires the physician performing the abortion to submit certification in writing attesting to the fact that in his/her professional judgment the beneficiary was a victim of rape.

- an appropriate ICD-10-CM diagnosis codes for rape, must be indicated on the claim.
- the health record documentation supporting the certification must be available for review, if necessary.
- the requirements of parental consent for a minor do not apply when a medical emergency exists that so complicates the pregnancy as to require an immediate abortion.

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The Abortion Statement – Please see **Attachments B and C** of State of North Carolina Medicaid and Health Choice *Clinical Coverage Policy No: 1E-2 Therapeutic and Non-therapeutic Abortions* located at https://medicaid.ncdhhs.gov/obstetrics-and-gynecology-clinical-coverage-policies for instructions on form completion, as well as a link to the form.

A *non-therapeutic abortion* is any termination of a pregnancy where there has been no manual or surgical interruption of that pregnancy (missed, incomplete, spontaneous, etc.).

Qualified physician means the same as found in NCGS 14-45.1(g).

Parental Consent for a Minor - Providers shall comply with requirements for parental consent as found in NCGS 90- 21.7.

Note: The requirements of parental consent do not apply when a medical emergency exists, as indicated in NCGS 90-21.9.

Note: By submitting the abortion statement for a minor, the physician is verifying that the requirements in this section have been met.

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 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Non-Therapeutic Abortions			
Claim Type	**Procedure**	**Diagnosis**	**Abortion Statement Required**
Physician (CMS-1500)	59870	O01.0, O01.1, O01.9	No
	59812, 59820, 59821, 59830, 01965, 88305	O02.1, O03.39, O03.4, O03.89, O03.9	No
Hospital (UB-04)	0UC90ZZ, 0UC93ZZ, 0UC94ZZ, 10D17ZZ, 10D18ZZ, 0UDB7ZZ, 0UDB8ZZ	O01.0, O01.1, O0.19	No
	10D17ZZ, 10D18ZZ 10D17Z9, 10D18Z9	O02.1, O03.39, O03.4, O03.89, O03.9	No

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Therapeutic Abortions			
Claim Type	**Procedure**	**Diagnosis**	**Abortion Statement Required**
Physician (CMS-1500)	59200, 59830, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 01966, 88304	O04.80, O04.89, O07.30, O07.39, O07.4, Y07.11 Y07.13, Y07.410, Y07.430, Y07.435, Y07.490, Y07.499, T7421XA, T7422XA	Yes (Diagnosis for Life-threatening conditions require an abortion statement and records)
Hospital (UB-04)	10A07ZZ, 10A08ZZ, 10A00ZZ, 10A03ZZ, 10A07ZX, 10A04ZZ, 10A07ZW, 10A07Z6	O04.80, O04.89, O07.30, O07.39, O07.4, Y07.11 Y07.13, Y07.410, Y07.430, Y07.435, Y07.490, Y07.499, T7421XA, T7422XA	Yes (Diagnosis for Life-threatening conditions require an abortion statement and records)

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	06/22	08/22
Annual Review. NCHC verbiage removed from NC Guidance Verbiage.	04/23	

References

1. State of North Carolina Medicaid and Health Choice Clinical Coverage Policy. No: 1E-2 Therapeutic and Non-therapeutic Abortions. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). . Published December 20, 2019. Accessed April 5, 2023.

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]

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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;

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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.

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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/get-involved/nc-health-choice-state-plan

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

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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.

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