

Abortions

This section contains information about billing for abortions and the medical services and supplies incidental or preliminary to an abortion.

Abortion Services

The Medi-Cal program covers abortion performed as a physician service.

- Abortion is a covered benefit regardless of the gestational age of the fetus.
- Medical justification and authorization for abortion are not required.
- Inpatient hospitalization for the performance of an abortion requires prior authorization under the same criteria as other medical procedures (see *California Code of Regulations* [CCR], Title 22, Section 51327).

Medicare Denial Required for Abortion Procedures

Medicare covers abortion in limited situations. Therefore, a Medicare denial is required prior to billing Medi-Cal for abortion procedures (CPT-4 codes 59840, 59841, 59850 – 59852 and 59855 – 59857).

Surgical Pathology Gross and Microscopic Examination of Materials

If abortion materials are sent to a pathology laboratory, a separate billing by the laboratory may be submitted, using only CPT-4 code 88300 (Level I – surgical pathology, gross examination only) or 88304 (Level III – surgical pathology, gross and microscopic examination). Claims with code 88300 or 88304 submitted for surgical pathology examination purposes should be billed with V61.7.

Codes 88300 and 88304 are not separately reimbursable if billed in conjunction with an induced abortion procedure (CPT-4 codes 59840, 59841, 59850 – 59852 and 59855 – 59857) by the same provider, for the same female recipient, on the same date of service.

Two or more surgical pathology specimens from different sites are separately reimbursable only when billed on separate claim lines on the same claim form. The *Service Units/Days or Units* must be “1” for each claim line.

**Elective Abortion:
Incidental or Preliminary
Services**

The following instructions are for providers billing medical services incidental or preliminary to an elective abortion:

- Services performed on the same date as the elective abortion

Providers are requested to bill services incidental or preliminary to an elective abortion (such as office visits* or laboratory tests) on the same claim form as the elective abortion procedure (CPT-4 codes 59840 – 59852) only if those services were performed on the same date as the abortion.

* Most pre-operative office visits are included in the listed value of the surgical procedure and are not reimbursable. Under some circumstances, however, office visits may be reimbursable. These circumstances are outlined in the *CPT-4 Surgery Guidelines*.

- Services performed on an earlier date than the abortion

Medical services provided on an earlier date than the abortion itself that are directly related to the abortion should be billed on a separate claim from the abortion procedure. Such services must be identified with ICD-9-CM diagnosis code V61.7 (when a diagnosis is required), or a written diagnosis of “elective abortion,” as appropriate.

The provider should exercise professional judgment in determining whether a particular service is directly related to an abortion, or whether it would have been performed regardless of the abortion.

- Services performed on an earlier date unrelated to the abortion

Medical services that are not performed on the same date as an abortion not directly related to an abortion should also be billed on a separate claim form. This claim form should indicate the appropriate diagnosis as required. For example, a physician office visit to discuss various alternatives for family planning should be billed separately and identified as a family planning service, even if the patient subsequently, or during the visit, chooses to undergo an elective abortion at some later date.

- Abortions performed in connection with other surgery

Providers are requested to list the written diagnosis of elective abortion (with ICD-9-CM diagnosis code V61.7 where required) as the secondary diagnosis when an abortion is provided in connection with other surgery. As a result, the Department of Health Care Services (DHCS) will be better able to identify services eligible for matching federal funds while excluding abortions that are not eligible for these funds.

Cervical Dilation With Hygroscopic Agents

The HCPCS procedure code for cervical dilation billing is as follows:

HCPCS Code	Description
A4649	Surgical supply; miscellaneous

Under the Medi-Cal program, the procedure of inserting hygroscopic sticks into the cervix to gain dilation prior to abortion is considered a part of the abortion procedure and is not separately reimbursable. However, the cost of the hygroscopic sticks is reimbursable.

For providers billing on the CMS-1500 claim: Use HCPCS code A4649 with the following modifiers in addition to ICD-9-CM diagnosis codes 632, 634.00 – 634.92, 635.00 – 635.92 and V61.7.

- Modifier U1 to indicate the use of natural laminaria, maximum 12 units per day
- Modifier U2 to indicate the use of synthetic laminaria, maximum 4 units per day

For facility claims (UB-04): Use HCPCS code A4649 with the following modifiers in addition to ICD-9-CM diagnosis codes 632, 634.00 – 634.92, 635.00 – 635.92, V61.7 and revenue code 0272.

- Modifier U1 to indicate the use of natural laminaria, maximum 12 units per day
- Modifier U2 to indicate the use of synthetic laminaria, maximum 4 units per day

The number of sticks used should be indicated in the *Service Units/Days or Units* box of the claim. The fetal gestational age and surgical procedure code used to perform the abortion (for example, suction, curettage, evacuation) should be indicated in the *Remarks* field (Box 80)/*Reserved for Local Use* field (Box 19) of the claim. Claims submitted for hygroscopic sticks using codes other than HCPCS code A4649 are subject to denial.

Ultrasound

An ultrasound performed prior to an induced abortion is reimbursable with CPT-4 codes 76801 – 76812, 76815 and 76817 when billed in conjunction with ICD-9-CM diagnosis code V61.7.

Fetal Age Determination

CPT-4 code 76815 (ultrasound, pregnant uterus, limited) is billed for ultrasound when the age of the fetus cannot be determined by the patient's history or physical examination.

**Dilation and Curettage/
Dilation and Evacuation**

The following definitions outline the differences between the methods used in surgical procedures for removing uterine contents. The procedure performed should be indicated on a recipient's medical record.

<u>CPT-4 Code</u>	<u>Description</u>
59840	Dilation and Curettage – used to induce a first trimester abortion, for termination of a pregnancy in the first 12 – 14 weeks of gestation. A vacuum source, a vacuum curette and sometimes a sharp curette are used to confirm complete evacuation of uterine contents.
59841	Dilation and Evacuation – used to induce a second trimester abortion, for termination of a pregnancy after 12 – 14 weeks of gestation. A greater degree of cervical dilation is required, and suction curettage alone is inadequate. Long, heavy forceps are frequently required, as well as additional time for completion.

Operative Report

An operative report documenting the name of the procedure performed should accompany all claims for Dilation and Evacuation (D&E) (CPT-4 code 59841). If the operative report documents that a Dilation and Curettage (D&C) was performed, but the claim is for a D&E, reimbursement will be reduced to the rate of a D&C.

**Simultaneous Sterilization
and Abortion:
Restricted Conditions**

Sterilization and abortion procedures can be performed at the same time if separate arrangements for the procedures are made.

California Code of Regulations, Title 22, Section 51305.3(b), states that informed consent for a sterilization could not be given when an individual was seeking to obtain or obtaining an abortion. This section also defines the terms “seeking to obtain” and “obtaining an abortion.” Under these defined terms, both procedures can be performed at the same time only if sterilization arrangements are made prior to arrangements for an abortion procedure.

The definitions are:

- “Seeking to obtain” means that period of time during which the abortion decision and the arrangements for the abortion are being made.
- “Obtaining an abortion” means that period of time during which an individual is undergoing the abortion procedure, including any period during which pre-operative medication is administered.

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**Abortion-Related
Supplies/Services Not
Separately Reimbursable**

The following supplies or services are included in the reimbursement for an elective abortion and are not reimbursed separately:

- Emergency room miscellaneous drugs and medical supplies (HCPCS code Z7610)
- Supplies and materials provided by the physician over and above those usually included in the office visit or other services rendered (CPT-4 code 99070)
- Comprehensive office visit (CPT-4 code 99215)
- Dilation of cervical canal, instrumental (separate procedure) (CPT-4 code 57800)

Medical Abortion

Medical abortion of intrauterine pregnancies through the 63rd day from the first day of the patient's last menstrual period is a reimbursable benefit when billed with the following HCPCS codes:

<u>HCPCS Code</u>	<u>Description</u>
S0199	Medical abortion
<u>S0190</u>	Mifepristone <u>200 mg</u> (RU-486)
<u>S0191</u>	Misoprostol <u>200 mcg</u>

Mifepristone (RU-486)
Requirements

The Food and Drug Administration (FDA) mandates that mifepristone (RU-486) will be supplied only to licensed physicians who sign and return a Prescriber's Agreement to Danco Laboratories, LLC, documenting the following:

- Ability to determine the duration of the gestation and detect ectopic (tubal) pregnancy
- Ability to provide or arrange immediate, appropriate intervention in cases of medical and/or surgical complications, ectopic (tubal) pregnancy, incomplete abortion, infection or severe bleeding
- Commitment to FDA-required recipient education and follow-up inclusive of postabortion ultrasonographic studies to ensure complete evacuation of all products of conception and to document a negative pregnancy test

Reimbursement Requirements

Providers will only be reimbursed for mifepristone (S0190) and misoprostol (S0191) when administered in a clinic or medical office or when self-administered by a recipient in an outpatient setting after physician consultation. Mifepristone and misoprostol must be administered by a physician or under the supervision of a physician. Mifepristone is administered in a single dose and is followed by misoprostol, which is administered in a single dose on the third day.

Services rendered to a recipient for a medical abortion (S0199) are performed over a 14- to 18-day period and include all office visits, pelvic ultrasounds, laboratory studies, urine pregnancy tests and recipient education. Therefore, providers must bill for code S0199 using the “from-through” method.* Duplicate claims submitted for any of these services rendered individually during the global billing period for a medical abortion will be denied.

* For recipients who do not show up for follow-up visits, modifier 52 (reduced services) must be billed with code S0199-52 using the “from-through” method with the “no show” date as the “through” date.

Note: Providers must maintain documentation of patient informed consent for all procedures and documentation of all recipient education.

Providers must document the gestational age of the fetus, based on ultrasound measurements, in the *Remarks* field (Box 80)/*Reserved for Local Use* field (Box 19) of the claim when billing for medical abortion (S0199). Claims for medical abortions performed after the 63rd day following the first day of the patient’s last menstrual period will be denied. Reimbursement of code S0199 is restricted to once in five weeks.

Alternative Protocols

Medically accepted and documented alternative protocols for medical abortion may be substituted. Alternative protocols may include, but are not limited to, at-home recipient self-administration of misoprostol (S0191) in lieu of the second office visit for physician administration of misoprostol. Self-administration of misoprostol may occur only after the physician consultation and appropriate informed consent of the physician or other person lawfully authorized to administer the initial dosage of mifepristone (S0190).

Alternative protocols must include the following:

- A first-day visit to establish the presence of an intrauterine pregnancy.
- A postabortion follow-up visit within 14 to 16 days after the administration of misoprostol, regardless if that administration was at home or not. The purpose of this final visit is to ensure complete evacuation of the uterine contents.

Laboratory and ultrasonographic studies will be performed on each of these two visits as required by the above-referenced protocol.