Sentara Health Plans

Commercial

Elective Termination of Pregnancy, OB 01

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Effective Date	7/1/2026
Next Review Date	3/2027
Coverage Policy	OB 01
Version	9

Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details *.

Description & Definitions:

Elective termination of pregnancy is a procedure that ends a pregnancy by removing the fetus before the fetus is considered viable.

Criteria:

Elective termination of pregnancy is considered medically necessary for **1 or more of the following**:

- Individual is in the first trimester or less gestation and has **all of the** following:
  - Individual has benefit coverage
- Individual is over first trimester gestation and has **All** of the following:
  - The individual or fetus have 1 or more of the following:
    - The life of the mother would be endangered if the fetus were carried to term
    - There is documented evidence of major fetal organ abnormalities
  - The abortion has been approved by an Sentara Health Plan Medical Director
- Individual is subsequent to the second trimester of pregnancy with **all of the** following:
  - Three physicians agree the continuation of the pregnancy is likely to result in the death of the individual or substantially and irremediably impair the mental or physical health of the individual.

There is insufficient scientific evidence to support the medical necessity of this procedure for uses other than those listed in the clinical indications for procedure section.

Document History:

Revised Dates:

- 2025: May – Implementation date of August 1, 2025. Updated coding. Placed in new format.
- 2023: March, July
- 2022: June
- 2021: July
- 2020: January
- 2019: October
- 2016: April
- 2015: August

- 2014: July
- 2012: March
- 2008: August

Reviewed Dates:

- 2026: March – Implementation date July1, 2026. No change to criteria. References updated.
- 2024: June – no changes references updated
- 2020: August
- 2019: May
- 2018: April
- 2013: July
- 2012: July
- 2011: August
- 2010: August
- 2009: August

Origination Date: December 2007

Coding:

Medically necessary with criteria:

Coding	Description
59840	Induced abortion, by dilation and curettage

59841	Induced abortion, by dilation and evacuation.
59850	Induced abortion, by 1 or more intra-amniotic injections (amniocentesis injections), including hospital admission and visits, delivery of fetus and secundines
59851	Induced abortion, by 1 or more intra-amniotic injections (amniocentesis injections), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation.
59852	Induced abortion, by 1 or more intra-amniotic injections (amniocentesis injections), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed intra-amniotic injection)
59855	Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines
59856	Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation
59857	Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed medical evacuation)
59866	Multifetal pregnancy reduction(s) (MPR)
S0199	Medically induced abortion by oral ingestion of medication including all associated services and supplies (e.g., patient counseling, office visits, confirmation of pregnancy by HCG, ultrasound to confirm duration of pregnancy, ultrasound to confirm completion of abortion) except drugs
S2260	Induced abortion, 17 to 24 weeks
S2265	Induced abortion, 25 to 28 weeks
S2266	Induced abortion, 29 to 31 weeks
S2267	Induced abortion, 32 weeks or greater

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Special Notes: *

- Coverage: See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to Products: Policy is applicable to Sentara Health Plan Commercial products.
    - NOTE: This policy does not apply to removal of products of conception due to fetal demise.
- Authorization Requirements:
    - Pre-certification by the Plan is required.
- Special Notes:
    - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving, and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
    - Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Keywords:

Elective termination pregnancy, abortion, obstetrics 01, ob, endangered, fetus, mother, gestation