Sentara Health Plans

Medicaid

Elective Termination of Pregnancy

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Effective Date	2/1992
Next Review Date	1/15/2024
Coverage Policy	Obstetrics 01
Version	6

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Purpose:

This policy addresses Elective Termination of Pregnancy.

NOTE: This policy does not apply to removal of products of conception due to fetal demise. The procedure for an elective and non-elective termination of pregnancy are the same. Ensure the service is an elective before utilizing this policy.

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 when the woman's life would be endangered by carrying the fetus to term for **1 or more** of the following:

- Individual meets **All** of the following:
  - Any elective termination of pregnancy must be authorized by a Sentara Health Plan Medical Director.
  - There would be a substantial danger to the life of the mother.
  - An abortion certification form, MAP-3006, must be submitted at time of authorization for induced (elective) abortion.
- 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

Elective termination of pregnancy is considered **not medically necessary** for uses other than those listed in the clinical criteria.

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

Considered Not Medically Necessary:

Coding	Description
	None

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

Document History:

Revised Dates:

- 2023: July
- 2023: March
- 2022: June
- 2021: July
- 2020: January
- 2019: October

- 2016: April
- 2015: August
- 2014: July
- 2012: March
- 2008: August

Reviewed Dates:

- 2020: August
- 2019: May
- 2018: April
- 2013: July
- 2012: July
- 2011: August
- 2010: August
- 2009: August

Effective Date:

- December 2007

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

(2023). Chapter 4. Article 9. Abortion. Virginia Law. Virginia.gov. (2023). Retrieved 6.13.2023. https://law.lis.virginia.gov/vacodefull/title18.2/chapter4/article9/

Virginia Department of Medical Assistance Services, Practitioner Manual (8/28/2023), Chapter IV: Covered Services and Limitations, Page 6. Retrieved 1.10.2024. https://vamedicaid.dmas.virginia.gov/sites/default/files/2023-08/Practitioner%20Chapter%20IV%20%28updated%208.28.23%29_Final.pdf

Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

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.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

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