State of Maryland PT6-99

MEDICAL CARE POLICY ADMINISTRATION
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201

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October 26, 1998

MARYLAND MEDICAL ASSISTANCE PROGRAM
General Provider Transmittal No. 50

Clinics
Hospitals
Managed Care Organizations
Nurses
Physicians

FROM: Joseph M. Millstone, Director
Medical Care Policy Administration

NOTE: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

Abortion Services for HealthChoice Enrollees

A recent change in federal law prohibits Medicaid managed care contracts from including any abortion services in their capitation payments. As a result, Managed Care Organizations are not financially responsible for providing abortion services to their members effective March 9, 1998. All abortion services rendered to eligible Maryland Medicaid recipients will be reimbursed by the Program on a fee-for-service basis. Please note that the Family Planning Program does not cover abortion services. The Medicaid Program and not the MCO will provide coverage for:

1) abortion procedures,
2) related services provided at a hospital on the day of the procedure or during an inpatient stay, or
3) an abortion package as may be provided by a free-standing clinic.

The MCO, however, is financially responsible for any related services not indicated above which may be performed as part of a medical evaluation prior to the

actual performance of an abortion for which the physician who performs the procedure completes a DHMH 521 Certification for Abortion Form. In addition, the MCO is responsible for referring its members, who require or express a need for an abortion, to a Medicaid participating service provider.

A copy of the "Certification for Abortion" form (see attached) signed by the physician who performs the procedure must accompany any invoice submitted to the Medical Assistance Program by a practitioner, hospital, clinic or agency when such invoice is for services related to a termination of pregnancy (except spontaneous abortion or treatment of ectopic pregnancy) or for medical procedures necessary to voluntarily terminate a pregnancy for victims of rape or incest (Procedure codes 59840-59841, 59850-59852, 59855-59857, 59866). The Program will accept copies of this completed form. The abortion form and the accompanying invoice must be submitted to:

Medical Care Operations Administration
P.O. Box 1935
Baltimore, MD 21203

FFS claims for the abortion procedure must reflect one of the following appropriate diagnosis and procedure codes in order to be paid:

Physicians and Clinics (HCFA-1500)

CPT Procedure codes: **59840**, **59841**, **59850**, **59851**, **59852**, **59855**, **59856**, **59857** and **59866**
ICD-9-CM Primary Diagnosis codes: **635.00** through **635.92** and **637.00** through **638.92**

Hospital (UB-92)

ICD-9-CM Procedure codes: **6901**, **6951**, **7491**

ICD-9-CM Primary Diagnosis codes: **635.00** through **635.92** and **637.00** through **638.92**

COVERAGE CRITERIA FOR ABORTIONS

Abortions have special requirements which must be met in order for them to be covered by the Medical Assistance Program. The Program will reimburse providers for abortions provided that one of the conditions listed below exists:

1. The abortion is necessary because the life of the mother would be endangered if the fetus were carried to term;

2. The abortion is necessary because, based on the professional judgment of the physician who performs the procedure, continuation of the pregnancy is likely to result in the death of the woman;

3. The physician who performs the procedure certifies that, within a reasonable degree of medical certainty, based upon his/her professional judgment, termination of pregnancy is medically necessary because there is a substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical health;

4. The physician who performs the procedure certifies that, in his/her professional judgment, there exists medical evidence that continuation of the pregnancy is creating a serious effect on the woman's present mental health and, if carried to term, there is substantial risk of a serious or long lasting effect on the woman's future mental health;

5. The physician who performs the procedure certifies that, within a reasonable degree of medical certainty, based on his/her professional judgment, this abortion is necessary because the fetus is affected by genetic defect or serious deformity or abnormality; and

6. The physician who performs the procedure certifies that this procedure is necessary for a victim of rape, sexual offense or incest, and the incident has been reported to a law enforcement agency or to a public health or social agency. Documentation of the incident must include the following information:

a. name and address of victim,
b. name and address of person making report (if different from the victim),
c. date of the rape or incest incident,
d. date of the report,
e. statement that the report was signed by the person making it, and
f. name and signature of the person at the law enforcement agency or public health service who took the rape or incest report.

It is also necessary that the medical record reflect the medical necessity for the therapeutic abortion as determined by the certifying physician. The specific condition for which the abortion was performed must be documented in this record. Such documentation must explicitly state, at the time of service, the physician's findings which indicate the basis on which the medical necessity for the abortion was determined. Completion of the certification form DHMH 521 alone is not sufficient to serve as documentation, nor is it sufficient to render a clinical opinion and/or

diagnosis without supporting evidence in the medical record. Lack of acceptable documentation in the medical record will cause the Program to deny payment, or in those cases where payment has been made, the Program will require repayment from the provider.

Billing questions should be directed to 410-767-5457 or 5361.

Policy questions should be directed to 410-767-1455.

Attachment

JMM:jg

MARYLAND MEDICAL ASSISTANCE PROGRAM
CERTIFICATION FOR ABORTION

A COPY OF THIS FORM MUST BE ATTACHED TO ALL INVOICES FOR ABORTION SERVICES.

Please Print or Type

PATIENT'S NAME

PHYSICIAN COMPLETING FORM

PATIENT'S ADDRESS

PHYSICIAN'S MEDICAL ASSISTANCE PROVIDER NUMBER

PATIENT'S ADDRESS

PLACE OF SERVICE

PATIENT'S MEDICAL ASSISTANCE NUMBER

DATE OF SERVICE

PART I - Check one of the blocks if applicable and sign the certification.

☐ G. I certify that this abortion is necessary because the life of the mother would be endangered if the fetus were carried to term.

DATE

PHYSICIAN'S SIGNATURE

☐ Attached is a document submitted by an official of a law enforcement agency or public health service where the rape or incest was reported. The document includes the following information:

1. Name and address of victim;
2. Name and address of person making the report (if different from the victim);
3. Date of the rape or incest incident;
4. Date of the report (may not exceed 60 days after the incident);
5. Statement that the report was signed by the person making it;
6. Name and signature of person at law enforcement agency or public health service who took the rape or incest report.

DATE

PHYSICIAN'S SIGNATURE

PART II - You must check one of the following blocks and sign the certificate, unless you have checked "I" in Part I, above.

☐ R. I certify that this abortion is necessary because, based on my professional judgement, continuation of the pregnancy is likely to result in the death of the woman.

DATE

PHYSICIAN'S SIGNATURE

S. I certify that, within a reasonable degree of medical certainty, based on my professional judgement, termination of pregnancy is medically necessary because there is substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical health.

DATE

PHYSICIAN'S SIGNATURE

☐ T. I certify that, in my professional judgement, there exists medical evidence that continuation of the pregnancy is creating a serious effect on the woman's present mental health and, if carried to term, there is substantial risk of a serious or long lasting effect on the woman's future mental health.

DATE

PHYSICIAN'S SIGNATURE

☐ V. I certify that, within a reasonable degree of medical certainty, based on my professional judgement, this abortion is necessary because the fetus is affected by genetic defect or serious deformity or abnormality.

DATE

PHYSICIAN'S SIGNATURE

☐ W. I certify that this procedure is necessary for a victim of rape, sexual offense, or incest, and the incident has been reported to a law enforcement agency or to a public health or social agency.

DATE

PHYSICIAN'S SIGNATURE

DHMH 521 (9/80/25,000)