U of M – Pregnancy terminations medical and surgical

Applies to:

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

☐ **Medicare Plus Blue℠ PPO** ☒ **Medicare Plus Blue℠ Group PPO** ☐ **Both**

Pregnancy terminations - medical and surgical

Pregnancy termination is the removal of pregnancy tissue, products of conception or the fetus and placenta (afterbirth) from the uterus. In general, the terms fetus and placenta are used after eight weeks of pregnancy. This policy includes medical abortion, surgical abortion and labor-inducing abortion.

Original Medicare

Original Medicare doesn't cover pregnancy termination unless:

- The pregnancy is the result of an act of rape or incest.
- 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.

Medicare Plus Blue℠ PPO enhanced benefit

Medicare Plus Blue is a Medicare Advantage plan that provides at least the same level of benefit coverage as Original Medicare (Part A and Part B) and may provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Blue Cross to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

Coverage for pregnancy terminations – medical and surgical is provided to members under the University of Michigan Medicare Plus Blue Group PPO plan. Since Original Medicare limits coverage of pregnancy terminations – medical and surgical, the group determines the scope of the benefit, reimbursement methodology, maximum allowed payment amounts and member cost sharing.

Inclusionary and exclusionary guidelines (clinically based guidelines that may support individual consideration and prior authorization decisions)

Coverage of elective abortions, both medically and surgically induced, are considered an exclusion unless the benefit is offered through an optional rider.

Inclusions:

- Confirmation of pregnancy must be documented.
- Gestational age must be verified.
- All legal requirements have been fulfilled. (For example, documents required by current Michigan law must be provided to the woman seeking an abortion at least 24 hours prior to the abortion procedure.)
- The patient must be instructed about the importance of follow-up within 14 days to confirm the abortion is complete.
- Provider must include information regarding emergency contacts on a 24-hour basis in case of complications such as heavy bleeding, pain or infection.

- The administration of medications to induce abortion must follow specific guidelines set by the National Abortion Federation (the professional association of abortion providers in the United States and Canada).

Conditions for payment

The table below specifies payment conditions for pregnancy terminations – medical and surgical.

Conditions for payment	
Eligible provider	Consistent with Original Medicare
Payable location	Consistent with Original Medicare
Frequency	No restrictions
CPT/HCPCS codes	Elective or voluntary (when not paired with one of the medically necessary diagnosis codes): 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S0190, S0191, S0199, S2260, S2265, S2266, S2267 Note: For medically necessary pregnancy terminations, please reference Original Medicare guidance.
Diagnosis restrictions	No restrictions
Age restrictions	No restrictions

Reimbursement

Medicare Plus Blue plan's maximum payment amount for pregnancy terminations – medical and surgical is available on our provider website on the Medicare Plus Blue enhanced benefits fee schedule. The provider will be paid the lesser of the allowed amount or the provider's charge, minus the member's cost share. This represents payment in full and providers aren't allowed to bill the member for the difference between the allowed amount and the charge..

Member cost sharing

- Medicare Plus Blue providers should collect the applicable cost sharing from the member at the time of the service when possible. Cost sharing refers to a flat dollar copayment, a percentage coinsurance or a deductible. Providers can only collect the appropriate Medicare Plus Blue cost-sharing amounts from the member.
- If the member elects to receive a noncovered service, he or she is responsible for the entire charge associated with that service.
- Providers may not have members sign an Advance Beneficiary Notice to accept financial responsibility for noncovered items or services. If there is any question about whether an item or service is covered, seek a coverage determination from Blue Cross before providing the item or service to the member. If a provider provides a noncovered item or service to a member without first obtaining a coverage determination, the member must be held harmless for all charges except for any applicable cost share.

To verify benefits and cost share, providers may utilize our provider portal or call 1-866-309-1719.

Billing instructions for providers

1. Bill services on the CMS 1500 (02/12) claim form for all payable locations, except for Federally Qualified Health Center (FQHC) providers; which should be billed on the CMS UB-04 claim form.
2. Use the Medicare Advantage PPO unique billing requirements.
3. Report CPT/HCPCS codes and diagnosis codes to the highest level of specificity.
4. Report your National Provider Identifier number on all claims.
5. Submit claims to your local Blue Cross plan.
6. Use electronic billing:
   a. Michigan providers
   Copies of the ANSI ASCX 12N 837 and 835 Institutional Health Care Claim Payment/Advice (Blue Cross Electronic Data Interchange (EDI) Institutional 837/835 Companion Documents) are available on the Blue Cross website under the reference library section at ***bcbsm.com/providers/help/edi***.

b. Providers outside of Michigan should contact their local Blue Cross plan.

References

CMS National Coverage Determinations (NCDs)
NCD 140.1 Abortion*

CMS Benefit Policy Manual
Chapter 1: 20.1 Health Care Associated with Pregnancy, Termination of Pregnancy*
Chapter 15: 90 Physician Expenses for Surgery, Childbirth and Treatment for Infertility*

CMS Benefit Processing Manual
Chapter 3: Billing for Abortion Services*

Revision history

Policy number: MAPPO 1045

Effective: 01/01/2024

Reviewed: 11/06/2023

Revised:

*Clicking this link means that you're leaving the Blue Cross Blue Shield of Michigan and Blue Care Network website. While we recommend this site, we're not responsible for its content.