Priority Health

MEDICAL POLICY
No. 91000-R10

TERMINATION OF PREGNANCY

Effective Date: June 1, 2025	**Review Dates: 1/93, 12/94, 10/97, 12/99, 12/01, 2/02, 1/03, 1/04, 1/05, 12/05, 12/06, 6/07, 4/08, 4/09, 4/10, 4/11, 4/12, 4/13, 5/14, 5/15, 5/16, 5/17, 5/18, 5/19, 5/20, 5/21, 5/22, 5/23, 5/24, 5/25**
Date Of Origin: June 30, 1988	**Status: Current**

Summary of Changes

- I.A.1-2: Updated language regarding applicable laws and regulations, and associated coverage criteria
- I.B: Updated language for Medicaid; refers to the MDHHS Provider Manual for coverage and prior authorization criteria

I. POLICY/CRITERIA

Coverage is subject to the terms of a member's benefit plan documents, and any federal or state laws or regulations applicable to the location where the procedure or services are performed, all of which supersedes the information in this policy.

A. For fully funded commercial members (individual and group):

1. Consult individual plan documents for specific terms, conditions, limitations, riders, or supplemental coverage.
2. Exclusions shall not apply to terminations of pregnancy when performed to:
   a. Protect the mother's life when it is endangered by continuation of the pregnancy.
   b. Increase the probability of a live birth or to preserve the life or health of the child after birth. An example would include selective abortion for multiple gestations.
   c. Remove a fetus that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant mother.
   d. When a fetal condition diagnosed in-utero is incompatible with life post-delivery.
   e. When the pregnancy is the result of rape or incest.

B. For Medicaid/Healthy Michigan Plan members

Consult the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual for coverage and prior authorization requirements.

C. For Self-funded members

Consult individual plan documents.

II. MEDICAL NECESSITY REVIEW

Prior authorization for certain drug, services, and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service, or procedure is medically necessary. For more information, please refer to the Priority Health Provider Manual.

III. APPLICATION TO PRODUCTS

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- **HMO/EPO:** ***This policy applies to insured HMO/EPO plans.***
- **POS:** ***This policy applies to insured POS plans.***
- **PPO:** ***This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.***
- **ASO:** ***For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.***
- **INDIVIDUAL:** ***For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.***
- **MEDICARE:** ***Coverage is determined by the Centers for Medicare and Medicaid Services (CMS) and/or the Evidence of Coverage (EOC); if a coverage determination has not been adopted by CMS, this policy applies.***
- **MEDICAID/HEALTHY MICHIGAN PLAN:** ***For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.***

V. CODING INFORMATION

ICD-10 Codes that may support medical necessity
Not specified

CPT/HCPCS Codes
Covered (*Inpatient service must be pre-authed)*
59100 Hysterotomy, abdominal (e.g., for hydatidiform mole, abortion)

59812 Treatment of incomplete abortion, any trimester, completed surgically
59820 Treatment of missed abortion, completed surgically; first trimester
59821 Treatment of missed abortion, completed surgically; second trimester
59830 Treatment of septic abortion, completed surgically

Covered with Rider only:

59840 Induced abortion, by dilation and curettage
59841 Induced abortion, by dilation and evacuation
59850 Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines;
59851 Induced abortion, by one 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 one 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 (e.g., prostaglandin) with or without cervical dilation (e.g., laminaria), including hospital admission and visits, delivery of fetus and secundines;
59856 Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g., 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 (e.g., prostaglandin) with or without cervical dilation (e.g., laminaria), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed medical evacuation)
59866 Multifetal pregnancy reduction(s) (MPR)
S0190 Mifepristone, oral, 200 mg
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

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