Easy Choice Health Plan

Harmony Health Plan of Illinois

Missouri Care

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona

OneCare (Care1st Health Plan Arizona, Inc.)

Staywell of Florida

WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)

WellCare Prescription Insurance

WellCare Texan Plus (Medicare – Dallas & Houston markets)

Abortion Services (Nebraska)

Policy Number: HS-233

Original Effective Date: 10/6/2016

Revised Date(s): 3/2/2017; 6/1/2017; 5/3/2018

APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans. The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this CCG. When a conflict exists between the two documents, the Member's Benefit Plan always supersedes the information contained in the CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any. All links are current at time of approval by the Medical Policy Committee (MPC). Lines of business (LOB) are subject to change without notice; current LOBs can be found at www.wellcare.com – select the Provider tab, then "Tools" and "Clinical Guidelines".

BACKGROUND

Over the past three decades, medical methods of abortion have been developed throughout the world and are now a standard method of providing abortion care in the United States. Medical abortion, which involves the use of medications rather than a surgical procedure to induce an abortion, is an option for women who wish to terminate a first-trimester pregnancy. Although the method is most commonly used up to 63 days of gestation (calculated from the first day of the last menstrual period), the treatment also is effective after 63 days of gestation. The Centers for Disease Control and Prevention (CDC) estimates that 64% of abortions are performed before 63 days of gestation. Medical abortions currently comprise 16.5% of all abortions in the United States and 25.2% of all abortions at or

before 9 weeks of gestation. Mifepristone, combined with misoprostol, is the most commonly used medical abortion regimen in the United States and Western Europe; in parts of the world, mifepristone remains unavailable.[1]

Types of abortion procedures include surgery and medication. Surgery can be performed in a health care provider's office, clinic, or hospital. The most common type of surgical abortion is called vacuum aspiration and can be performed up to 14 weeks of pregnancy. After 14 weeks of pregnancy, the abortion procedure is called a dilation and evacuation (D&E). This procedure takes longer to perform and may require more than one visit and the patient can usually go home within a few hours after the procedure is completed. In a medical abortion, certain drugs are taken to cause an abortion. For this option, a woman usually must be ≤ 9 weeks pregnant.[2]

While abortion is a low-risk procedure, women should be informed of risks and complications. These depend on how early the abortion is done and the method that is used. Fewer than 1 in 100 women have complications from an abortion performed before 14 weeks of pregnancy. For later abortions, up to 2 in 100 women have complications. In most cases, the risks from an abortion are less than the risks of giving birth to a baby. Most health care providers agree that having one abortion does not affect later pregnancies or a woman's future health. However, the longer a woman waits to have an abortion, the more risk it carries for her. [2]

State of Nebraska Legislature[3]

The State of Nebraska Legislature states the following:

1. That the following provisions were motivated by the legislative intrusion of the United States Supreme Court by virtue of its decision removing the protection afforded the unborn. Sections 28-325 to 28-345 are in no way to be construed as legislatively encouraging abortions at any stage of unborn human development, but are rather an expression of the will of the people of the State of Nebraska and the members of the Legislature to provide protection for the life of the unborn child whenever possible;
2. That the members of the Legislature expressly deplore the destruction of the unborn human lives which has and will occur in Nebraska as a consequence of the United States Supreme Court's decision on abortion of January 22, 1973;
3. That it is in the interest of the people of the State of Nebraska that every precaution be taken to insure the protection of every viable unborn child being aborted, and every precaution be taken to provide life-supportive procedures to insure the unborn child its continued life after its abortion;
4. That currently this state is prevented from providing adequate legal remedies to protect the life, health, and welfare of pregnant women and unborn human life;
5. That it is in the interest of the people of the State of Nebraska to maintain accurate statistical data to aid in providing proper maternal health regulations and education;
6. That the existing standard of care for pre-abortion screening and counseling is not always adequate to protect the health needs of women;
7. That clarifying the minimum standard of care for pre-abortion screening and counseling in statute is a practical means of protecting the well-being of women and may better ensure that abortion doctors are sufficiently aware of each patient's risk profile so they may give each patient a well-informed medical opinion regarding her unique case; and
8. That providing right to redress against non-physicians who perform illegal abortions or encourage self-abortions is an important means of protecting women's health.

American College of Obstetricians and Gynecologists

The American College of Obstetricians and Gynecologists (ACOG) clinical guidelines related to abortion and additional information are contained in applicable Practice Bulletins, Committee Opinions, and other College

documents. Visit the ACOG website at http://www.acog.org/Womens-Health/Abortion for additional information. Highlights from ACOG's published policy on abortion are noted below:[4]

- Like all medical matters, decisions regarding abortion should be made by patients in consultation with their health care providers and without undue interference by outside parties. Like all patients, women obtaining abortion are entitled to privacy, dignity, respect, and support.
- The College continues to affirm the legal right of a woman to obtain an abortion prior to fetal viability. ACOG is opposed to abortion of the health fetus that has attained viability in a healthy woman.
- ACOG states that health care providers should not impose their personal beliefs upon their patients nor allow personal beliefs to compromise patient, health, access to care, or informed consent.
- A pregnant woman who may be ambivalent about her pregnancy should be fully informed in a balance manner about all options (e.g., raising the child herself; adoption; or abortion). The information conveyed should be appropriate to the duration of the pregnancy. There is an ethical obligation to provide accurate information that is required for the patient to make a fully informed decision.
- If abortion is to be performed, it should be performed safely and as early as possible.
- ACOG opposed the harassment of abortion providers and patients.
- ACOG strongly supports those activities which prevent unintended pregnancy.

The College has published two practice bulletins – highlights of the College's recommendations are below.

Abortion in the First Trimester

The following recommendations are based primarily on good and consistent scientific evidence (Level A):[5]

- Based on efficacy and adverse effect profile, evidence-based protocols for medical abortion are superior to the FDA-approved regimen. Vaginal, buccal, and sublingual routes of misoprostol administration increase efficacy, decrease continuing pregnancy rates, and increase the gestational age range for use as compared with the FDA-approved regimen.
- Regimens that use low doses of mifepristone (200 mg) have similar efficacy and lower costs compared with to those that use mifepristone at 600 mg.
- Women can safely and effectively self-administer misoprostol at home as part of a medical abortion regimen.
- Medical abortion also can be provided safely and effectively by non-physician clinicians.
- Follow-up after receiving mifepristone and misoprostol for medical abortion is important, although an in-clinic evaluation is not always necessary.
- Misoprostol-only medical abortion regimens are significantly less effective than those that use a combination of mifepristone and misoprostol.

The following recommendations are based primarily on limited scientific evidence (Level B): [5]

- Because teratogenicity of medical abortifacients becomes an important issue if the pregnancy continues, patients must be counseled before medical abortion treatment of the need for a surgical abortion in the event of a continuing pregnancy.
- Before medical abortion is performed, gestational age should be confirmed by clinical evaluation or ultrasound examination.
- Nonsteroidal anti-inflammatory drugs, such as ibuprofen, are not contraindicated in women who undergo a medical abortion and are appropriate first-line agents for pain management.
- Buccal administration of misoprostol may result in a lower risk of serious infection compared with vaginal administration.
- Medical abortion can be provided safely and effectively via telemedicine with a high level of patient satisfaction; moreover, the model appears to improve access to early abortion in areas that lack a physician health care provider.

The following recommendations are based primarily on consensus and expert opinion (Level C): [5]

- Women who undergo medical abortion may need to access emergency surgical intervention, and it is medically appropriate to provide referral to another health care provider. However, state or local laws may have additional requirements.
- Clinicians who wish to provide medical abortion services either should be trained in surgical abortion or should be able to refer to a clinician trained in surgical abortion.
- No strong data exist to support the universal use of prophylactic antibiotics for medical abortion.
- Rh testing is standard of care in the U.S., and RhD immunoglobulin should be administered if indicated.

Abortion in the Second Trimester

The following recommendations/conclusions are based on good and consistent scientific evidence (Level A):[6]

- Cervical preparation is recommended before D&E to decrease risk of cervical trauma.
- Mifepristone followed in 24–48 hours by misoprostol is the most effective regimen for second-trimester medical abortion.
- Misoprostol as a single agent is effective for medical abortion.
- Administration of prophylactic antibiotics decreases the risk of infection after surgical abortion and, therefore, should be provided to all patients undergoing D&E.
- Except for hysteroscopic sterilization, diaphragm, or cervical cap, all forms of contraception can be considered after second-trimester abortion and initiated on the day of the procedure.

The following recommendations/conclusions are based on limited or inconsistent scientific evidence (Level B): [6]

- D&E is associated with fewer complications than medical abortion involving misoprostol regimens.
- When there is a suspicion of abnormal placentation, D&E is the preferred abortion method, and preparations should be made for possible hemorrhage by ensuring the procedure is performed at an appropriate facility with accessibility to blood products, interventional radiology, and the capability to perform a hysterectomy if necessary.
- The use of vasopressin in the paracervical block may decrease blood loss from D&E.
- Methylergonovine maleate is an appropriate first-line uterotonic agent unless contraindicated, as in patients with hypertension. Misoprostol is an effective agent in the setting of post-abortion hemorrhage, and doses of 800–1,000 micrograms are recommended.
- If refractory bleeding is thought to be due to atony or lower uterine segment bleeding, a Foley catheter or intrauterine balloon should be inserted to tamponade the endometrial cavity.
- Because the risk of uterine rupture associated with prior cesarean delivery is similar to the risk among women without a prior cesarean delivery, guidelines support the safety of misoprostol specifically and medical abortion generally in women with one prior cesarean delivery.

The following recommendations are based primarily on consensus and expert opinion (Level C): [6]

- In order to ensure access to D&E, residency training programs should offer integrated abortion training that includes second-trimester D&E.
- All physicians should facilitate timely referrals for abortion care to reduce delays in accessing services.
- Interventions to improve and facilitate early identification of pregnancy should be encouraged, including efforts to educate women about the signs and symptoms of pregnancy.

POSITION STATEMENT

Applicable To:

☑ Medicaid – Nebraska

Exclusions

Items not meeting the medical necessity criteria below are also **not covered.** No other abortions, regardless of funding, can be provided as a benefit. WellCare will not make payment for any core benefit or service under the contract to a network or non-network provider if any abortion performed hereunder violates Federal regulations.

Coverage[3]

Abortion services **is a covered benefit** when the following are met:

1. Approved in writing by a WellCare medical director **AND** the MLTC Medical Director before the services is rendered to ensure compliance with Federal and State regulations; **AND**
2. Pregnancy is the result of:
   - An act of rape or incest; **OR**
   - 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.

   AND

   A physician has certified in his/her writing, that, on the basis of his/her professional judgment, the life of the pregnant woman would be endangered if the fetus were carried to term. The provider must attach the certification statement to the claim form that must be retained by WellCare. The certification statement must contain the diagnosis or medical condition that makes the pregnancy life endangering.

AND

3. Member is before **or** at the beginning of the 20th week of gestation;[5] **AND**
4. Member has received state-directed counseling.

* In accordance with 42 CFR 441.202 and the Consolidated Appropriations Act of 2008

An abortion may be performed at or after 20 weeks post-fertilization (22 weeks after the woman's last menstrual period) only if the woman's life is endangered or if her physical health is severely compromised, based on the spurious assertion that a fetus can feel pain at that point.[7]

Per the Nebraska Department of Health and Human Services (as indicated by federal law 42 CFR 441.202), prior authorization shall be obtained, with the exception of when the physician certifies in the pregnant woman's record that a medical emergency exists and there is insufficient time to obtain authorization. All authorizations shall be directed for medical necessity review by a WellCare medical director **and** the MLTC Medical Director. Once approval is received, WellCare will obtain approval from the State of Nebraska. WellCare will complete the review and fax an authorization to the Provider upon receiving approval from the State. Please note, In cases of documented emergencies, authorization may be requested after the service has been provided.

Consent Requirements. Per the state of Nebraska's abortion law - Except in the case of a medical emergency, no person shall perform an abortion upon a pregnant woman unless, in the case of a woman who is less than eighteen years of age, he or she first obtains the notarized written consent of both the pregnant woman and one of her parents or a legal guardian or, in the case of a woman for whom a guardian has been appointed pursuant, he or she first obtains the notarized written consent of her guardian. In the case of a woman under the age of 18 with

evidence of abuse, sexual abuse, or child abuse or neglect the court may issue an order authorizing the pregnant woman to consent to the abortion without the consent of her parent or legal guardian. In deciding whether to grant such consent, a pregnant woman's parent or guardian shall consider only his or her child's or ward's best interest.[8]

Waiting Period. Voluntary and informed consent of woman 24 hours before abortion, except in emergency (woman must receive state-directed counseling on abortion and other options at least 24 hours prior to the procedure). [8]

CODING

Covered CPT®* Codes
(Codes May Not Be All-Inclusive)
(*Inpatient service must be pre-authed)*
59200 Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure)
59414 Delivery of placenta (separate procedure)
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 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (e.g., laminaria), including hospital admission and visits, delivery of fetus and secundines;
59856 Induced abortion, by 1 or more vaginal suppositories (eg, 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 1 or more vaginal suppositories (eg, 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)

Covered ICD-10-PCS Codes
(*Inpatient service must be pre-authed)*
Please note that ICD10PCS categories and ranges may be used.
(Codes May Not Be All-Inclusive)
10A00ZZ Abortion of Products of Conception, Open Approach
10A03ZZ Abortion of Products of Conception, Percutaneous Approach
10A07ZZ Abortion of Products of Conception, Via Natural or Artificial Opening
10A07ZW Abortion of Products of Conception, Laminaria, Via Natural or Artificial Opening
10A07ZX Abortion of Products of Conception, Abortifacient, Via Natural or Artificial Opening
10A04ZZ Abortion of Products of Conception, Percutaneous Endoscopic Approach
10A07Z6 Abortion of Products of Conception, Vacuum, Via Natural or Artificial Opening
10A08ZZ Abortion of Products of Conception, Via Natural or Artificial Opening Endoscopic
10D17ZZ Extraction of Products of Conception, Retained, Via Natural or Artificial Opening

Covered HCPCS Code
(Codes May Not Be All-Inclusive)
J8610 Methotrexate, oral, 2.5 mg
J9250 Methotrexate sodium, 5 mg
J9260 Methotrexate sodium, 50 mg
S0190 Mifepristone, oral, 200 mg (may be billed up to 3 times each procedure; total of 600 mg)
S0191 Misoprostol, oral, 200 mcg

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

Covered ICD-10-CM Diagnosis Codes
(Codes May Not Be All-Inclusive)
O00.1 Tubal pregnancy (code range)
O00.8-O00.9 Ectopic pregnancy (code range)
O04.5-O04.89 Induced termination of pregnancy with complications (code range)
Z33.1 Pregnant state, incidental
Z33.2 Encounter for elective termination of pregnancy
Z64.0 Problems related to unwanted pregnancy

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES

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2. Pregnancy choices: raising the baby, adoption, or abortion. American College of Obstetricians and Gynecologists Web site. http://www.acog.org/Patients/FAQs/Pregnancy-Choices-Raising-the-Baby-Adoption-and-Abortion. Published February 2013. Accessed April 9, 2018.
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8. Nebraska Legislature. Chapter 71 Section 6902. Nebraska Legislature Web site. http://nebraskalegislature.gov/laws/statutes.php?statute=71-6902. Accessed April 9, 2018.

MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	Action
5/3/2018	• Approved by MPC. No changes.
6/1/2017	• Approved by MPC. Added verbiage to consent and prior authorization sections.
3/2/2017	• Revised section on consent.
10/6/2016	• Approved by MPC. New.