



MEDICAL POLICY STATEMENT GEORGIA MARKETPLACE

Policy Name	Policy Number	Date Effective
Abortion	MM-0916	01/01/2022-08/31/2022
Policy Type		
MEDICAL	Administrative	Pharmacy
		Reimbursement

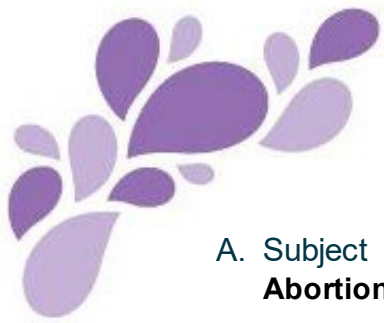
Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject
Abortion

B. Background

Abortion is **not** a covered benefit except in the case of a medical emergency.

C. Definitions

- **Abortion** - The use or prescription of any instrument, medicine, drug, or any other substance or device with the intent to terminate the pregnancy of a female known to be pregnant. The term "abortion" does not include the use or prescription of any instrument, medicine, drug, or any other substance or device employed solely to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead unborn child who died as the result of a spontaneous abortion. The term "abortion" does not include the prescription or use of contraceptives.
- **Medical emergency**- Any condition which, in reasonable medical judgment, complicates the medical condition of a pregnant female as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial or irreversible impairment of a major bodily function of the pregnant woman or death of the unborn child. No such condition is to be deemed to exist if it is based on a diagnosis or claim of a mental or emotional condition of the pregnant woman or that the pregnant woman will purposefully engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function.

D. Policy

- I. Abortion is **NOT** a covered benefit except in the case of a medical emergency.
- II. Prior authorization (PA) is required for all abortions. Due to the emergency nature these will be submitted as a retro-authorization.
 - A. Retro-authorization submitted must include medical documentation that supports that the abortion is a medical emergency and the informed consent.
- III. Reimbursement will not be made for associated services such as anesthesia, laboratory tests, or hospital services if the abortion service itself is not approved.

E. Conditions of Coverage

NA

F. Related Policies/Rules

Evidence of Coverage And Health Insurance Contract Georgia



G. Review/Revision History

DATE		ACTION
Date Issued	01/01/2020	
Date Revised	04/01/2020 12/16/2020 09/29/2021	Clarified when to submit medical documentation; removed PA and consent Clarified PA with an emergency, informed consent and retro-authorization Reviewed policy and references
Date Effective	01/01/2022	
Date Archived	08/31/2022	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. Official Code of Georgia. § 31-9A-2 *Definitions*. (n.d.) Retrieved September 8, 2021 from www.advance.lexis.com

The Medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.