MEDICAL POLICY STATEMENT
INDIANA MARKETPLACE

Policy Name		Policy Number	Date Effective
Abortion		MM-0914	03/01/2021-12/31/2021
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.

Table of Contents

A. Subject

Abortion

B. Background

CareSource covers medically necessary Therapeutic Abortions as defined in this policy.

C. Definitions

- **Therapeutic Abortion** - An abortion performed to save the life or prevent substantial and irreversible impairment of a major bodily function of a mother, or as a result of incest or rape.

D. Policy

I. A prior authorization is required for all therapeutic abortions.
   A. The Indiana State Department of Health Abortion Informed Consent Certification must be submitted with the request for prior authorization.

II. 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 Polices/Rules

Evidence of Coverage And Health Insurance Contract Indiana

G. Review/Revision History

	DATE	ACTION
Date Issued	01/30/2020	
Date Revised	12/16/2020	
Date Effective	03/01/2021	Clarified intent of policy in D.
Date Archived	12/31/2021	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. Indiana State Department of Health. Abortion Informed Consent Certification State Form 55320. (2020, June). Retrieved December 1, 2020 from www.forms.in.gov

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