



MEDICAL POLICY STATEMENT ARKANSAS PASSE

Policy Name	Policy Number	Date Effective
Abortion	MM-1138	01/01/2022-08/31/2022
Policy Type		
MEDICAL	Administrative	Pharmacy
		Reimbursement

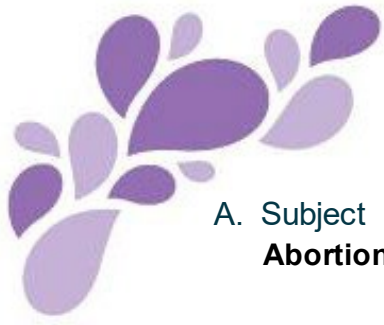
Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. 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

CareSource covers medically necessary elective abortions as described in this policy.

C. Definitions

D. Policy

- I. CareSource covers medically necessary elective abortions if:
 - A. The pregnancy is the result of incest or rape; or
 - B. The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition that manifests during pregnancy, which would, as certified by a physician, place the woman in danger of death unless an abortion is performed.
- II. All medically necessity reviews must include the following:
 - A. A completed Certification Statement for Abortion (DMS-2698); and
 - B. Member history and physical documentation.

E. Conditions of Coverage

F. Related Policies/Rules

Provider-Led Arkansas Shared Savings Entity (PASSE) Provider Agreement

G. Review/Revision History

DATE		ACTION
Date Issued	12/02/2020	
Date Revised		
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. Arkansas Medicaid. (2007, April). Division of Medical Services Certification Statement for Abortion. Retrieved November 11, 2020 from www.medicaid.mmis.arkansas.gov

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