

Abortions

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This section contains information about billing for abortions and the medical services and supplies incidental or preliminary to an abortion.

Abortion Services

The Medi-Cal program covers an abortion performed as a physician service. In addition to physicians, abortion services may be performed by other licensed, non-physician practitioners, including Physician Assistants (see California Business and Professions Code [BPC] Section 3502.4), Nurse Practitioners (see BPC Section 2725.4[a]), and Certified Nurse Midwives (see BPC Section 2725.4[b]) acting within their scope of practice as defined by the appropriate state licensing board.

- Abortion is a covered benefit regardless of the gestational age of the fetus.
- Medical justification and authorization for abortion are not required.
- «A denial from Medicare is not required for abortion services to be covered by Medi-Cal.»
- Inpatient hospitalization for the performance of an abortion requires prior authorization under the same criteria as other medical procedures (see California Code of Regulations [CCR], Title 22, Section 51327).
- Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Indian Health Service-Memorandum of Agreement (IHS-MOA), and Tribal FQHC providers may provide abortion services described in this section of the manual if they meet Medi-Cal requirements for abortion services reimbursement and comply with Medi-Cal policies, fee-for-service policies, and code and claim submission procedures. Refer to the respective provider manual pages for FQHCs, RHCs, IHS-MOA, and Tribal FQHC providers for additional information on abortion services.

Note: The Hyde Amendment, most recently enacted version in Public Law (P.L.) 117-103, Div. H, Tit. V, sections 506-507, and renewed annually, states that abortion services cannot be directly or indirectly funded by federal funds, except in cases of rape, incest, or when a pregnant person would be in danger of death if an abortion is not performed. Accordingly, abortion services are outside the scope of Medicare, Medicaid, IHS, and HRSA federal grant funds. FQHCs, RHCs, IHS-MOAs, Tribal FQHCs can provide abortions. As such, FQHCs, RHCs, IHS-MOAs and Tribal FQHCs can provide abortions as long as they do not use federal funds. To ensure compliance with these requirements, FQHCs, RHCs, IHS-MOAs and Tribal FQHCs will need to establish a separate line of business.

Surgical Pathology Gross and Microscopic Examination of Materials

If abortion materials are sent to a pathology laboratory, a separate billing by the laboratory may be submitted, using only CPT code 88300 (Level I – surgical pathology, gross examination only) or 88304 (Level III – surgical pathology, gross and microscopic examination). Claims with code 88300 or 88304 submitted for surgical pathology examination purposes should be billed with ICD-10-CM diagnosis code Z64.0.

Codes 88300 and 88304 are not separately reimbursable if billed in conjunction with an induced abortion procedure (CPT codes 59840, 59841, 59850 through 59852 and 59855 through 59857) by the same provider, for the same female recipient, on the same date of service.

Two or more surgical pathology specimens from different sites are separately reimbursable only when billed on separate claim lines on the same claim form. The *Service Units/Days or Units* must be “1” for each claim line.

Elective Abortion: Incidental or Preliminary Services

The following instructions are for providers billing medical services incidental or preliminary to an elective abortion.

- Services performed on the same date as the elective abortion: Providers are requested to bill services incidental or preliminary to an elective abortion (such as office visits* or laboratory tests) on the same claim form as the elective abortion procedure (CPT codes 59840 through 59852) only if those services were performed on the same date as the abortion. **
- Services performed on an earlier date than the abortion: Medical services provided on an earlier date than the abortion itself that are directly related to the abortion should be billed on a separate claim from the abortion procedure. Such services must be identified with ICD-10-CM diagnosis code Z64.0 (when a diagnosis is required), or a written diagnosis of “elective abortion,” as appropriate.
- The provider should exercise professional judgment in determining whether a particular service is directly related to an abortion, or whether it would have been performed regardless of the abortion.

- Services performed on an earlier date unrelated to the abortion: Medical services that are not performed on the same date as an abortion not directly related to an abortion should also be billed on a separate claim form. This claim form should indicate the appropriate diagnosis as required. For example, a physician office visit to discuss various alternatives for family planning should be billed separately and identified as a family planning service, even if the patient subsequently, or during the visit, chooses to undergo an elective abortion at some later date.
- Abortions performed in connection with other surgery: Providers are requested to list the written diagnosis of elective abortion (with ICD-10-CM diagnosis code Z64.0 where required) as the secondary diagnosis when an abortion is provided in connection with other surgery. As a result, the Department of Health Care Services (DHCS) will be better able to identify services eligible for matching federal funds while excluding abortions that are not eligible for these funds.

Cervical Dilation with Hygroscopic Agents

The HCPCS procedure code for cervical dilation billing is as follows:

Table of Cervical Dilation Billing

HCPCS Code	Description
A4649	Surgical supply; miscellaneous

Under the Medi-Cal program, the procedure of inserting hygroscopic sticks into the cervix to gain dilation prior to abortion is considered a part of the abortion procedure and is not separately reimbursable. However, the cost of the hygroscopic sticks is reimbursable.

For providers billing on the CMS-1500 claim: Use HCPCS code A4649 with the following modifiers in addition to ICD-10-CM diagnosis codes O02.1, O03.0 through O03.9, O04.5 through O04.89, Z33.2 and Z64.0.

- Modifier U1 to indicate the use of natural laminaria, maximum 12 units per day.
- Modifier U2 to indicate the use of synthetic laminaria, maximum four units per day.

For facility claims (UB-04): Use HCPCS code A4649 with revenue code 0272 and the following modifiers in addition to ICD-10-CM diagnosis codes O02.1, O03.0 through O03.9, O04.5 through O04.89, Z33.2 and Z64.0.

- Modifier U1 to indicate the use of natural laminaria, maximum 12 units per day.
- Modifier U2 to indicate the use of synthetic laminaria, maximum four units per day.

The number of sticks used should be indicated in the *Service Units/Days or Units* box of the claim. The fetal gestational age and surgical procedure code used to perform the abortion (for example, suction, curettage, evacuation) should be indicated in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim.

Claims submitted for hygroscopic sticks using codes other than HCPCS code A4649 are subject to denial.

Ultrasound

An ultrasound performed prior to an induced abortion is reimbursable with CPT codes 76801 thru 76812, 76815 and 76817 when billed in conjunction with ICD-10-CM diagnosis codes O99.511 thru O99.891 and Z64.0.

Fetal Age Determination

CPT code 76815 (ultrasound, pregnancy uterus, real time with image documentation, limited, one or more fetuses) is billed for ultrasound when the age of the fetus cannot be determined by the patient's last menstrual period date or clinical evaluation.

Dilation and Curettage/Dilation and Evacuation

The following definitions outline the differences between the methods used in surgical procedures for removing uterine contents. The procedure performed should be indicated on a recipient's medical record.

Table of Surgical Procedures for Removing Uterine Contents Codes

CPT Code	Description
59840	Dilation and Curettage – used to induce a first trimester abortion, for termination of a pregnancy in the first 12 thru 14 weeks of gestation. A vacuum source, a vacuum curette and sometimes a sharp curette are used to confirm complete evacuation of uterine contents.
59841	Dilation and Evacuation – used to induce a second trimester abortion, for termination of a pregnancy after 12 thru 14 weeks of gestation. A greater degree of cervical dilation is required, and suction curettage alone is inadequate. Long, heavy forceps are frequently required, as well as additional time for completion.

«**Note:** Providers billing with CPT codes 58940 and 59841 should list the appropriate ICD-10-CM diagnosis code on the claim.»

Simultaneous Sterilization and Abortion: Restricted Conditions

Sterilization and abortion procedures can be performed at the same time if separate arrangements for the procedures are made.

California Code of Regulations, Title 22, Section 51305.3(b), states that informed consent for a sterilization could not be given when an individual was seeking to obtain or obtaining an abortion. This section also defines the terms “seeking to obtain” and “obtaining an abortion.” Under these defined terms, both procedures can be performed at the same time only if sterilization arrangements are made prior to arrangements for an abortion procedure.

The definitions are:

- “Seeking to obtain” means that period of time during which the abortion decision and the arrangements for the abortion are being made.
- “Obtaining an abortion” means that period of time during which an individual is undergoing the abortion procedure, including any period during which pre-operative medication is administered.

Abortion-Related Supplies/Services Not Separately Reimbursable

The following supplies or services are included in the reimbursement for an elective abortion and are not reimbursed separately:

- Emergency room miscellaneous drugs and medical supplies (HCPCS code Z7610)
- Supplies and materials provided by the physician over and above those usually included in the office visit or other services rendered (CPT code 99070)
- Comprehensive office visit (CPT code 99215)
- Dilation of cervical canal, instrumental (separate procedure) (CPT code 57800)

Medical Abortion

Medical abortion of intrauterine pregnancies through the 70th day from the first day of the recipient's last menstrual period is a reimbursable benefit when billed with the following HCPCS codes:

Table of Billing for Medical Abortion

HCPCS Code	Description
S0190	Mifepristone, oral, 200 mg (RU-486)
S0191	Misoprostol, buccal, 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 human chorionic gonadotropin (hCG), ultrasound to confirm duration of the pregnancy, ultrasound to confirm completion of abortion) except drugs.»

Note: Pregnancy and gestational age must be determined prior to the administration of medications to induce a medical abortion. Gestational age can be determined by the date of the woman's last menstrual period, clinical evaluation, and/or ultrasound examination. Providers should assess pregnancy by ultrasonographic scan if the duration of the pregnancy is uncertain, if the woman has significant medical risk factors or history (for example, unilateral pain and vaginal bleeding) or if ectopic pregnancy is suspected.

«Providers may use a dosing regimen for the medical termination of intrauterine pregnancy through 77 days of gestation:»

- Day 1: Mifeprex (mifepristone), one 200 mg tablet
- 24 to 48 hours after Mifeprex: Misoprostol, 800 mcg buccally

- «For medication abortion at 71 through 77 days, the regimen must include a second dose of misoprostol, 800 mcg, four hours after the first misoprostol dose. More information about dosing regimens is available in the National Abortion Federation Guidelines.

For more information, see the “FDA Approved Regimen for Medical Abortion” and the Coverage of Misoprostol-only Regimen” heading in this section.

Note: DHCS does not prohibit dispensing of mifepristone (S0190) and misoprostol (S0191) through the use of a mail-order pharmacy for purposes of medication induced abortion, and dispensing is done in compliance with other state and federal laws and regulations.

Mifepristone Requirements

The FDA mandates that mifepristone will be supplied only to licensed physicians who sign and return a Prescriber’s Agreement to Danco Laboratories, LLC, documenting the following:

- Ability to determine the duration of the gestation and detect ectopic (tubal) pregnancy.
- Ability to provide or arrange immediate, appropriate intervention in cases of medical and/or surgical complications, ectopic (tubal) pregnancy, incomplete abortion, infection or severe bleeding.
- Commitment to FDA-required recipient education and follow-up to confirm that complete termination of pregnancy has occurred and to evaluate the degree of bleeding. Termination can be confirmed by medical history, clinical examination, hCG testing or ultrasonographic scan.

Note: Mifepristone is contraindicated in patients with a confirmed or suspected ectopic pregnancy because mifepristone is not effective in terminating ectopic pregnancies. Providers should remain alert to the possibility that a patient who is undergoing a medication abortion could have an undiagnosed ectopic pregnancy given that some expected symptoms experienced with a medication abortion (abdominal pain, uterine bleeding) may be similar to those of a ruptured ectopic pregnancy. Women who became pregnant with an IUD in place should be assessed for ectopic pregnancy.

Reimbursement Requirements

Providers will only be reimbursed for mifepristone (S0190) and misoprostol (S0191) when administered in a clinic or medical office, or when self-administered by a recipient in an outpatient setting after provider consultation, (see the Alternative Protocols heading below).»

«Services rendered to a recipient for a medication abortion are billed with HCPCS code S0199. They are bundled billable services performed over a 14 to 18 days period and reimbursement includes all office visits, including a post-abortion assessment or follow-up, pelvic ultrasounds when clinically indicated, laboratory studies, urine pregnancy tests and recipient education. Therefore, providers must bill for code S0199 using the “from-through” method.

- Providers may bill S0199 without providing a pre-abortion ultrasound when a pre-abortion ultrasound is not clinically indicated.
- Providers may bill S0199 without providing a post-abortion ultrasound when a post-abortion ultrasound is not clinically indicated.
- Providers may bill S0199 when a post-abortion assessment is provided via telehealth, if clinically appropriate and if patient prefers assessment via telehealth. An in-person visit must be offered but is not required to bill S0199.
- For recipients who do not show up for follow-up visits, HCPCS code S0199 must be billed using the “from-through” method with the “no show” date as the “through” date and modifier 52 is not required.

Note: Providers must maintain documentation of patient informed consent for all procedures and services rendered, and documentation of all recipient education.

Providers must document the gestational age of the fetus, based on the date of the woman’s last menstrual period, clinical evaluation, or ultrasound examination, in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim when billing for a medication abortion (S0199). Claims for medication abortions performed after the 77th day following the first day of the recipient’s last menstrual period will be denied. Reimbursement of code S0199 is restricted to once every five weeks.

Alternative Protocols

Medically accepted and documented alternative protocols for a medication abortion may be substituted. Alternative protocols may include, but are not limited to, at-home recipient self-administration of one or more doses of misoprostol (S0191) in lieu of an office visit for the provider administration of misoprostol. Self-administration of misoprostol may occur only after the provider consultation and appropriate informed consent of the provider or other person lawfully authorized to administer the initial dosage of mifepristone (S0190).»

Alternative protocols must include the following:

- A first-day visit to establish the presence of an intrauterine pregnancy.
- A postabortion assessment or a follow-up visit within 14 to 16 days after the administration of misoprostol, regardless if that administration was at home or not. The purpose of this final visit is to ensure complete evacuation of the uterine contents.

Laboratory and/or ultrasonographic studies may be performed on each of these two visits as required by the above-referenced protocol.

«Healthcare providers should remain alert to the possibility that a patient who is undergoing a medication abortion could have an undiagnosed ectopic pregnancy, given that some expected symptoms experienced with a medication abortion (abdominal pain, uterine bleeding) may be similar to those of a ruptured ectopic pregnancy.»

FDA Approved Regimen for Medication Abortion

The FDA first approved mifepristone in 2000. Mifepristone is a drug that blocks the hormone progesterone, which is needed for a pregnancy to continue. When used together with misoprostol, mifepristone may be used to terminate an early pregnancy.

On March 30, 2016, the FDA approved a supplemental application submitted by the drug company that markets mifepristone. This approval included changes in the dose and dosing regimen for taking mifepristone and misoprostol, a change in the administration of misoprostol from oral to buccal (in the cheek pouch), the interval between taking mifepristone and misoprostol, and the location in which a woman may take misoprostol.

The approval also modified the gestational age up to which mifepristone has been shown to be safe and effective, as well as the process for follow-up after administration of the drug. The labeling has also been revised to meet the current labeling requirements in the FDA's regulations. Changes were also made to the existing Risk Evaluation and Mitigation Strategies (REMS) to reflect the changes approved in the supplemental application, and to make the mifepristone REMS consistent with more recently approved REMS. The supplemental application for mifepristone was approved based on the review of data and information submitted by the drug manufacturer. The FDA determined that mifepristone is safe and effective when used to terminate a pregnancy in accordance with the revised labeling. «The FDA has approved mifepristone in a regimen with misoprostol to terminate a pregnancy through 70 days gestation (70 days or less from the first day of a woman's last menstrual period). Medi-Cal will reimburse providers for mifepristone to terminate a pregnancy through 77 days gestation.»

The currently approved mifepristone dosing regimen is:

- Day one: 200 mg of mifepristone taken by mouth.
- 24 to 48 hours after taking mifepristone: 800 mcg of misoprostol taken buccally at a location appropriate for the recipient.
- Within 7 to 14 days after taking mifepristone: a mandatory follow-up with the healthcare provider.

«The FDA has updated guidance in January 2023 that a REMS continues to be necessary to ensure the safe use of mifepristone.»

Under the REMS, mifepristone must be ordered, prescribed and dispensed by or under the supervision of a healthcare provider who meets certain qualifications.

- Providers who wish to prescribe mifepristone must complete a Prescriber Agreement Form prior to ordering and dispensing mifepristone.
- The provider must obtain a signed Patient Agreement Form before dispensing mifepristone.
- «Mifepristone may only be dispensed by or under the supervision of a certified prescriber, or by a certified pharmacy on a prescription issued by a certified prescriber. The FDA website has additional information about the modified FDA REMS Program.»

Healthcare providers who prescribe mifepristone are required under FDA regulations to provide the recipient with a copy of the Mifepristone Medication Guide (FDA-approved information for recipients).

«Coverage of Misoprostol-Only Regimen

The American College of Obstetricians and Gynecologists (ACOG) clinical guidelines regarding medication abortion up to 70 days of gestation (Practice Bulletin Number 225, as reaffirmed in 2023) recommend a combined mifepristone-misoprostol regimen as the preferred therapy for medication abortion. Guidelines also state that if access to a combined mifepristone-misoprostol regimen is disrupted, a misoprostol-only regimen is the recommended alternative regimen for medication abortion.

Medi-Cal covers misoprostol, billed with HCPCS code S0191, when substituted for a combined mifepristone-misoprostol regimen and administered consistent with clinical guidelines issued by ACOG.

Separately, Medi-Cal covers the bundle of services and supplies associated with medication abortion, billed with HCPCS code S0199. HCPCS S0199 is billable when a misoprostol-only regimen is substituted for a combined mifepristone-misoprostol regimen, when all clinically indicated services for medication abortion using a misoprostol-only regimen are provided, consistent with clinical guidelines issued by ACOG.»

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
»	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	Most pre-operative office visits are included in the listed value of the surgical procedure and are not reimbursable. Under some circumstances, however, office visits may be reimbursable. These circumstances are outlined in the <i>CPT Surgery Guidelines</i> .