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May 10, 2021

MEMO NO.
FFS 21-04
[Replaces FFS 15-12]

MEMORANDUM

TO: Physicians, Clinic Providers, Hospitals, and Free Standing Ambulatory Surgical Centers that Provide Intentional Termination of Pregnancy (ITOP) Services

FROM: Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

SUBJECT: UPDATED GUIDELINES FOR SUBMITTAL AND PAYMENT OF INDUCED/INTENTIONAL TERMINATION OF PREGNANCY (ITOP) CLAIMS

This Memorandum replaces Memo No. FFS 15-12 dated September 28, 2015. In issuing this memorandum, the Med-QUEST Division clarifies policies on induced/intentional termination of pregnancy (ITOP) and ITOP-related services.

**GENERAL**

1. With few exceptions, medical services provided to persons eligible for Medicaid in Hawaii are funded by both the federal government and the State of Hawaii. However, Hawaii Medicaid has elected to cover ITOPs with 100% State funds and is carved out of the QUEST Integration (QI) plans. Therefore, ITOPs need to be billed to our Fee-For-Service program rather than the QI plan.

2. Hawaii Medicaid limits the coverage of ITOP services to those services directly related to the surgical and non-surgical methods for inducing an abortion. Examples of services that should **not** be billed on ITOP claims are:

   - Contraceptive management;
   - LARC (long-acting reversible contraception) - intrauterine devices (IUDs) and birth control implants;
   - Missed abortions;
   - Threatened abortions;
   - Incomplete abortions;
   - Follow-up evaluation and management (E&M) services after the surgical follow-up period or fourteen (14) days after the medical ITOP;
   - Routine (E&M) visits during the surgical follow-up period or medical ITOP follow-up period;
   - Pregnancy tests, genetic testing, complete blood counts, hemoglobin and hematocrits performed more than two (2) days prior to a woman's decision to have an ITOP;
   - Complications related to the ITOP after the ITOP surgical follow-up period or fourteen (14) days after the medical ITOP; and
   - Immunizations such as the influenza vaccine.

3. All ITOPs and services covered by Medicaid that are directly connected to the ITOP procedure for women in QI and the Medicaid FFS program must be billed to Medicaid's Fiscal Agent, Conduent, at the following address:

   Hawaii Medicaid Fiscal Agent
   P.O. Box 1220
   Honolulu, Hawaii 96807-1220

   Drugs for the ITOPs should be billed separately to our Pharmacy Benefits Manager found in Section H below.

4. Recognizing the Hawaii 2021 ACT 003 signed April 12, 2021, Medicaid enrolled Advanced Practice Registered Nurse's (APRN) who have prescriptive authority and are practicing within scope of their specialty are eligible for reimbursement of first trimester medical or surgical ITOP services outlined in this memorandum.

5. All claims for ITOPs and ITOP-related professional services must be submitted with the primary diagnosis (diagnosis A) identified in Section A below electronically or hard copy in CMS 1500 claim format.

6. To expedite claims processing and to avoid denials of payment, the ITOP procedure and all ITOP-related services performed by a provider should be submitted on the same claim.

7. Services not directly related to the ITOP should be submitted to the member's QI health plan and not included in the ITOP claim. (Examples are birth control pills, implants, injectable contraceptives, intrauterine devices).

8. Services prior to a member's decision to terminate pregnancy, including but not limited to pregnancy testing, amniocentesis, ultrasound studies, alpha-fetoprotein, and chromosome analysis remain the responsibility of her health plan.

9. If a woman has a private health insurance that covers ITOPs, this insurer must be billed prior to submitting a claim to Medicaid. Claims billed to Medicaid that were first submitted to a private health insurer must be submitted to Medicaid with the private health insurance explanation of benefits (EOB).

10. Inpatient hospital and hospital emergency room services for the treatment of surgical ITOP complications that occur within ten (10) days of the outpatient ITOP or fourteen (14) days after the medical ITOP are covered under the FFS program. Medically indicated services after the indicated follow-up period should be billed to the member's health plan with a primary diagnosis that is not related to an ITOP.

11. UB04 Form Locator (FL) block 66 (Principle Diagnosis) and FL block 69 (Admitting Diagnosis) must be consistent with a diagnosis found in Section A.

**DIAGNOSIS CODES FOR ITOPs**

1. To expedite the correct processing of ITOP claims by Hawaii Medicaid's Fiscal Agent, Conduent, an ITOP primary diagnosis must be entered in Form Locator (FL) 21.A. on the CMS 1500 claim form or FL 66 on the UB04 claim form.

2. ITOP claims must be submitted with ICD-10 using one of the ICD-10 diagnosis codes in the following table as the principal diagnosis.

| ICD-10 Diagnosis | Description |
|---|---|
| Z33.2 | Encounter for elective termination of pregnancy, uncomplicated |
| O04.5 | Genital tract infection following (induced) termination of pregnancy |
| O04.6 | Delayed or excessive hemorrhage following (induced) termination of pregnancy |
| O04.84 | Damage to pelvic organs following (induced) termination of pregnancy |
| O04.82 | Renal failure following (induced) termination of pregnancy |
| O04.83 | Metabolic disorder following (induced) termination of pregnancy |
| O04.81 | Shock following (induced) termination of pregnancy |
| O04.7 | Embolism following (induced) termination of pregnancy |
| O04.85 | Other venous complications following (induced) termination of pregnancy |
| O048.6 | Cardiac arrest following (induced) termination of pregnancy |
| O04.87 | Sepsis following (induced) termination of pregnancy |
| O04.88 | Urinary tract infection following (induced) termination of pregnancy |
| O04.8 | (Induced) termination of pregnancy with other and unspecified complications |
| O04.80 | (Induced) termination of pregnancy with unspecified complications |
| O04.89 | (Induced) termination of pregnancy with other complications |
| O07 | Failed attempted termination of pregnancy |
| O07.0 | Genital tract and pelvic infection following failed attempted termination of pregnancy |
| O07.1 | Delayed or excessive hemorrhage following failed attempted termination of pregnancy |
| O07.2 | Embolism following failed attempted termination of pregnancy |
| O07.3 | Failed attempted termination of pregnancy with other and unspecified complications |
| O07.30 | Failed attempted termination of pregnancy with unspecified complications |
| O07.31 | Shock following failed attempted termination of pregnancy |
| O07.32 | Renal failure following failed attempted termination of pregnancy |
| O07.33 | Metabolic disorder following failed attempted termination of pregnancy |
| O07.34 | Damage to pelvic organs following failed attempted termination of pregnancy |
| O07.35 | Other venous complications following failed attempted termination of pregnancy |
| O07.36 | Cardiac arrest following failed attempted termination of pregnancy |
| O07.37 | Sepsis following failed attempted termination of pregnancy |
| O07.38 | Urinary tract infection following failed attempted termination of pregnancy |
| O07.39 | Failed attempted termination of pregnancy with other complications |
| O07.4 | Failed attempted termination of pregnancy without complications |

## A. FIRST TRIMESTER SURGICAL ITOPS PERFORMED IN THE PHYSICIAN OFFICE AND CLINIC SETTINGS - PLACE OF SERVICE (POS) 11

1. Bill services with ITOP code 59840. This code has a follow-up period of ten (10) days. No routine post-operative/follow-up evaluation and management service should be billed to Medicaid during this period. Medically indicated services after the ten (10) day follow-up period should be billed to the member's health plan with a primary diagnosis that is not related to an ITOP.

2. One Surgical Tray is reimbursable using code A4550-52. This code includes sedative medications, routine antibiotics, anesthetic agents, over-the-counter medications, misoprostol, all sterile supplies provided before and after the procedure. The miscellaneous supply codes (A4649 and 99070) are not reimbursable. No separate reimbursement is allowed for laminaria and/or laminaria insertion (59200). The surgical tray includes all medications provided pre- and post-operatively. Medications such as antibiotics, local anesthetics, medications for pain, and misoprostol should not be billed on the ITOP claim or to Conduent, MQD's Pharmacy benefit manager (PBM). Administration of any medications is not separately payable.

    a. A paracervical block coded as 64435 is reimbursable.

    b. If the provider has access to a previous urine pregnancy test, ultrasound report confirming a first trimester pregnancy, and/or hemoglobin/hematocrit, they should not be repeated.

    c. If a pregnancy test or ultrasound report is not available, the MQD will pay for ONE but not both. A hemoglobin or hematocrit is payable if performed by the provider and if a hemoglobin/hematocrit report is not available to the provider.

    d. If performed by the provider in the office/clinic, transvaginal (76817) or limited abdominal ultrasounds (76815 or 76816) may be covered. Only one ultrasound is covered prior to the ITOP procedure.

3. If a woman is RH negative (D-negative), RHo(D) immune globulin is covered under the ITOP benefit and should be billed hard-copy on a CMS 1500 form or on a DHS Form 204 Drug Claim form to Conduent. Follow the billing instructions in Section H below.

4. Intraoperative ultrasounds are NOT covered unless medically indicated. An operative report must be submitted for consideration.

**B. FIRST TRIMESTER ITOPS PERFORMED IN THE OUTPATIENT HOSPITAL OR AMBULATORY SURGICAL CENTER (ASC) SETTINGS - POS 22 OR 24**

1. Bill services with ITOP code 59840. This code has a follow-up period of ten (10) days. No post-operative/follow-up evaluation and management service should be billed to Medicaid during this period. Medically indicated services after the ten (10) day follow-up period should be billed to the member's health plan with a primary diagnosis that is not related to the ITOP.

2. Surgical trays (A4550-52) and paracervical blocks (64435) are not covered.

3. Urine pregnancy testing, ultrasound, and other laboratory and imaging studies performed on the same day as the ITOP are included in the global payment to the hospital or ASC and not separately payable or billable by the physician.

4. Complicated ITOPs should be coded as 59840-22. An operative report must be submitted.

5. General anesthesia is covered and separately billable by the anesthesiologist.

6. The interpretation of intraoperative ultrasounds by the surgeon is not covered unless medically indicated. An operative report must be submitted for consideration. The technical component of the intraoperative ultrasound is included in the global payment to the hospital or ASC.

7. If a woman is RH negative (D-negative), RHo(D) immune globulin is covered under the ITOP benefit and should be billed to Conduent by the facility. The administration of RHo(D) immune globulin is not separately payable to either the surgeon or facility.

**C. ITOPS PERFORMED IN THE PHYSICIAN OFFICE/CLINIC SETTINGS FOR PREGNANCIES OF THIRTEEN (13) WEEKS OR MORE - POS 11**

1. The physician office/clinic must follow the American College of Obstetricians and Gynecologists (ACOG) guidelines for outpatient ITOP services. These guidelines require that the provider have a plan to provide prompt emergency services and a mechanism for transferring patients who require emergency treatment if complications occur. Thus, providers who elect to perform ITOPs in the office/clinic setting for pregnancies of thirteen (13) weeks gestation or more must have written policies and procedures to prevent complications. These policies and procedures shall include established careful selection criteria for ITOPs for women with pregnancies of thirteen (13) weeks or more to be performed in these outpatient settings, appropriate staff training, and adequate monitoring equipment. In addition, the provider shall keep a written record of complications that occurred.

2. Bill services with ITOP code 59841-22. This code has a follow-up period of ten (10) days. No post-operative/follow-up evaluation and management service should be billed to Medicaid during this period. Medically indicated services after the ten (10) day follow-up period should be billed to the member's health plan with a primary diagnosis that is not related to the ITOP.

3. ITOPs performed in this category have a reimbursement of 150% of the rate for 59841. Gestational age must be noted in Form Locator (FL) block 19 of the CMS 1500 claim form.

4. Coverage of surgical trays (A4550-52), paracervical blocks (64435), pregnancy test, ultrasound, and hemoglobin/hematocrit is the same as detailed in section B. FIRST TRIMESTER ITOPS IN THE OFFICE/CLINIC SETTING Numbers 3-7.

5. Laminaria insertion (59200) is covered. No surgical tray is covered for laminaria insertion. No separate reimbursement for laminaria is allowed.

**D. ITOPS PERFORMED IN THE OUTPATIENT HOSPITAL OR AMBULATORY SURGICAL CENTER (ASC) SETTING FOR PREGNANCIES OF THIRTEEN (13) WEEKS OR MORE - POS 22 OR 24**

1. The code 59841 should be used. If the procedure is complicated, the code 59841-22 should be used and an operative report submitted.

2. Surgical trays (A4550-52) and paracervical blocks (64435) are not covered.

3. If a gestational age of thirteen (13) weeks or more is noted in FL block 19, laminaria insertion (59200) performed on the day before the ITOP or on the day of the ITOP is payable. No surgical tray is covered for laminaria insertion.

4. Urine pregnancy testing, ultrasound, and other laboratory and imaging studies performed on the same day as the ITOP are included in the global payment to the hospital or ASC and not separately payable or billable by the physician.

5. General anesthesia is covered and separately billable by the anesthesiologist.

6. The interpretation of intraoperative ultrasounds by the surgeon is not covered unless medically indicated. An operative report must be submitted for consideration. The technical component of the intraoperative ultrasound is included in the global payment to the hospital or ASC.

7. If a woman is RH negative (D-negative), RHo(D) immune globulin is covered under the ITOP benefit and should be billed to Conduent by the facility. The administration of RHo(D) immune globulin is not separately payable to either the surgeon or facility.

**E. ITOPS IN THE INPATIENT SETTING - POS 21**

1. Codes 59850, 59851, 59852, 59855, and 59856 are induced ITOP codes that include hospital admission and visits. Thus, these must be performed in the inpatient hospital setting.

2. The follow-up period for these codes is ninety (90) days. No routine post-operative/follow-up evaluation and management service should be billed to Medicaid

during this period. The treatment of complication(s) in the ninety (90) day follow-up period is billable to Medicaid. Diagnosis A must be in the range of 635.X-635.9X (ICD-9) or one of the ICD-10 codes listed in Section A. Treatment codes must have diagnoses that identify the complication(s) listed as diagnoses B through L. Diagnosis pointer should include each applicable diagnosis per line. Medically indicated services after the ninety (90) day follow-up period should be billed to the member's health plan with a primary diagnosis that is not related to the ITOP.

## F. MEDICAL ITOPS

1. A "medical abortion/ITOP" uses orally administered drugs to terminate a pregnancy. It is covered by the MQD under the following conditions:
   - The pregnancy must be in the early first trimester within ten (10) weeks gestation.
   - The drugs used are mifepristone (S0190), one 200 mg tablet, in combination with misoprostol (S0191) up to four (4) 200 mcg tabs. These must be submitted as detailed below.

| 24. A. DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| N64875000103 Mifepristone (oral) 200 MG UN 1 | | | | | | | | | | | | | | | |
| MM | DD | YY | MM | DD | YY | 11 | | S0190 | | 1 | 103.50 | 1 | | NPI | |

| 24. A. DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| N00025145120 Misoprostol Oral 100 MCG UN 8 | | | | | | | | | | | | | | | |
| MM | DD | YY | MM | DD | YY | 11 | | S0191 | | 1 | 11.04 | 4 | | NPI | |

2. If the ITOP cannot be completed with the drugs listed above, a surgical ITOP using the code 59840 performed in the office/clinic or the outpatient hospital/ASC is covered.

3. A transvaginal (76817) ultrasound prior to administration of the drugs and a follow-up transvaginal ultrasound performed within fourteen (14) days to confirm that the pregnancy has been terminated are covered.

4. An office/clinic evaluation and management service provided on the date the drugs are administered and on the follow-up visit are covered.

## G. DRUGS RELATED TO ITOPS

Drugs that are included in the surgical tray, payable as a medical ITOP and not directly related to the ITOP are not reimbursable under the ITOP benefit. Drugs such as Rh immunoglobulins (MICRhoGAM, RhoGam, etc.) to prevent sensitization of a Rh-negative woman and given by the provider/facility on the day of the surgical/medical ITOP (but not included in a surgical tray) should be billed either on the CMS 1500 with the NDC#

and NCPDP units (using the format above) or on the DHS Form 204 Drug claim form. Clearly write ITOP on the top right-hand corner of the claim form if using the CMS 1500, do not bill the drug on the same claim as the ITOP and medical services/tray covered under the ITOP benefit. These drugs should not be billed to the woman's QI plan.

To expedite claims processing, address the claim as follows:

Hawaii Medicaid Fiscal Agent
Attn: ITOP PBM Claims
P.O. Box 1480
Honolulu, Hawaii 96806-1480

## H. TELEHEALTH SERVICES

Telehealth evaluation and management services performed prior to the dates of service (DOS) of surgical or prior to or on the date of medical ITOPs are covered. Codes in the range of 99201-99215 with modifiers 95, GQ, or GT are allowed.

Medications for medical ITOPS (mifepristone and misoprostol) are not covered when mailed to the patient. They must be provided by providers that meet the Federal Drug Administration (FDA) Risk Evaluation and Mitigation Strategy (REMS) requirements and dispense Mifepristone (Mifeprex) from their offices/clinics or hospitals.

The FDA REMS requirements for Mifepristone follows. See FFS-21-05 that details an exemption to this requirement only applicable during the federal COVID Public Health Emergency.:

- Mifepristone must be ordered, prescribed and dispensed by or under the supervision of a healthcare provider who prescribes and who meets certain qualifications;
- Health care providers who wish to prescribe Mifepristone must complete a Prescriber Agreement Form prior to ordering and dispensing Mifepristone;
- Mifepristone may only be dispensed in clinics, medical offices, and hospitals by or under the supervision of a certified healthcare provider; and
- The healthcare provider must obtain a signed Patient Agreement Form before dispensing Mifepristone.

## I. TRANSPORTATION, LODGING, AND MEALS

1. Arrangements for interisland air, ground transportation, lodging and meals for women on neighbor islands who need surgical ITOPs done on another island are made by the Med-QUEST Division's Clinical Standards Office (MQD/CSO). Ground transportation will be arranged only for members who travel to Oahu.

2. The interisland travel, ground transportation, lodging and meals must be requested by the referring provider on the DHS 208 form. The form is available on the MQD website: https://medquest.hawaii.gov/content/dam/formsanddocuments/provider-forms/208-prior-auth-request---air--lodging--meals---ground/DHS-208-FINAL-Rev-0715.pdf/_jcr_content?type=pdf&process=

3. After the form is completed by the provider, it should be faxed to MQD/CSO at (808) 692-8131.

4. The form is reviewed by the MQD's Medical Director. Upon approval, the MQD Finance Office will make applicable travel arrangements and will contact the member with travel arrangement information.

5. Should you need further clarification on this process, please contact MQD/CSO at (808) 692-8124 or (808) 692-8105.

Attached are the current rates for the services listed above and a summary of services covered in different places of service (Attachment A).

Attachment