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ACS MEMO NO.
ACS M12-09
[Replaces ACS M10-08 dtd 07/02/10, QUEST/QExA Memos ADM-0407 & ADM-0306 dtd 05/04/04, BEN-1001 & BENX-1002 dtd 07/02/10]

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

FROM: Kenneth S. Fink, MD, MGA, MPH
Med-QUEST Division Administrator

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

This Memorandum replaces ACS Memo M10-08, dated July 2, 2010, QUEST Memos ADM-0407 [and ADM-0306], dated May 4, 2004 and Memos BEN-1001 and BENX-1002, dated July 2, 2010. In issuing this memorandum, the Med-QUEST Division addresses provider concerns and questions and clarifies policies on ITOPs and ITOP related services.

GENERAL

Effective October 1, 2010, all ITOPs and services covered by Medicaid that are directly connected to the ITOP procedure for women in QUEST, QUEST Expanded Access (QExA) and the Medicaid fee-for-service (FFS) program must be billed to Medicaid's fiscal agent, Xerox, at the following address:

P.O. Box 1220
Honolulu, Hawaii 96807-1220

All claims for ITOPs and ITOP related professional services must be submitted with the primary diagnosis (diagnosis #1) in the diagnosis range 635.0X-635.9X electronically or hard copy in CMS 1500 claim format.

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.

Services not directly related to the ITOP should be submitted to the member's QUEST or QExA health plan and not included in the ITOP claim. (Examples are birth control pills, implants, injections, intrauterine devices.)

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

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).

Inpatient hospital and hospital emergency room services for the treatment of ITOP complications that occur within ten (10) days of the outpatient ITOP are covered under the Fee-For-Service (FFS) program. 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 in the range of 635.0X to 635.9X.

UB04 Form Locator (FL) block 67 (Principle Diagnosis) and FL block 69 (Admitting Diagnosis) must be in the range of 635.0X to 635.9X. The hospital must submit medical records that justify the facility service.

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 in the range of 635.0X to 635.9X.

2. One (1) Surgical Tray is reimbursable using code A4550-52. This code includes sedative medications, routine antibiotics, anesthetic agents, 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).

3. A paracervical block coded as 64435 is reimbursable.

4. 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.

5. 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.

6. 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.

B. FIRST TRIMESTER ITOPS PERFORMED IN THE OUTPATIENT HOSPITAL OR AMBULATORY SURGIAL 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 10 day follow-up period should be billed to the member's health plan with a primary diagnosis that is not in the range of 635.0X to 635.9X.

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.

C. ITOPS PERFORMED IN THE PHYSICIAN OFFICE/CLINIC SETTINGS FOR PREGNANCIES OF FOURTEEN (14) 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 14 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 14 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 in the range of 635.0X to 635.9X.

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.

D. ITOPS PERFORMED IN THE OUTPATIENT HOSPITAL OR ASC SETTING FOR PREGNANCIES OF FOURTEEN (14) 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 14 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.

E. ITOPS IN THE INPATIENT SETTING—POS 21

1. Codes 59850, 59851, 59852, 59855, 59856, and 59851 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 #1 must be in the range of 635.X-635.9X. Treatment codes must have diagnoses that identify the complication(s) listed as diagnoses #2 through #4. 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 in the range of 635.0X to 635.9X.

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 nine (9) weeks.

   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 such as Rh immunoglobulins (MICRhoGAM, RhoGam, etc.) to prevent sensitization of a Rh negative woman and given by the physician/clinic on the day of the surgical/medical ITOP (but not included in a surgical tray) should be billed on the CMS 1500 with the NDC# and NCPDP units (using the format above). Clearly write ITOP on the top right hand corner of the CMS 1500 form. These drugs should not be billed to the woman's QUEST/QExA plan.

H. TRANSPORTATION, LODGING , AND MEALS

1. Arrangements for interisland air and ground transportation and lodging and meals for women on neighbor islands who need surgical ITOPs done on another island are made by Community Case Management Corp. (CCMC).

2. The interisland travel, ground transportation, lodging and meals must be requested by the physician on the DHS 208 form. After the form is completed by the physician, it should be faxed to CCMC at (808) 792-1098.

3. The form is then reviewed by the MQD's Medical Director. Upon approval, CCMC coordinates travel.

4. For clarification on this process, please contact the CCMC Medical Coordinator at (808) 792-1051.

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

Attachment

SURGICAL ITOP CODES						
CODE	DESCRIPTION	CURRENT RATE	POS 11	POS 22 & 24	POS 21	CLARIFICATION
59840	INDUCED ABORTION, BY DILATION AND CURETTAGE	172.92	Yes	Yes	No	
59841	INDUCED ABORTION, BY DILATION AND EVACUATION	263.62	Yes*	Yes	No	*Payable at 150% in POS 11for pregnancies of 14 weeks gestation when coded as 59841-22
59850	INDUCED ABORTION, BY 1 OR MORE INTRA-AMNIOTIC INJECTIONS	273.77	No	No	Yes	Detailed description in table below
59851	NDUCED ABORTION, BY 1 OR MORE INTRA-AMNIOTIC INJECTIONS	284.58	No	No	Yes	Detailed description in table below
59852	INDUCED ABORTION, BY 1 OR MORE INTRA-AMNIOTIC INJECTIONS	383.33	No	No	Yes	Detailed description in table below
59855	INDUCED ABORTION, BY 1 OR MORE VAGINAL SUPPOSITORIES	292.02	No	No	Yes	Detailed description in table below
59856	INDUCED ABORTION, BY 1 OR MORE VAGINAL SUPPOSITORIES,	352.77				Detailed description in table below
59857	INDUCED ABORTION, BY 1 OR MORE VAGINAL SUPPOSITORIES	434.41				Detailed description in table below
SURGICAL ITOP RELATE CODES						
64435	INJECTION, ANESTHETIC AGENT; PARACERVICAL (UTERINE) NERVE	26.74	Yes	No	No	Paid at 50% of rate according to multiple surgery rules
59200	INSERTION OF CERVICAL DILATOR (EG, LAMINARIA, PROSTAGLANDIN) (SEPARATE PROCEDURE)	29.09		No	No	29.09 on the day before to ITOP; on the day of the ITOP paid at 50% of the rate; only payable for gestational age 14 weeks or more
A4550-52	SURGICAL TRAYS	20.80	Yes	No	No	
76815	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, LIMITED	84.72	Yes	No	No	Only one of these codes is payable prior to the ITOP; detailed description in table
76816	ULTRASOUND, PREGNANT UTERUS,	70.34	Yes	No	No	

	REAL TIME WITH IMAGE DOCUMENTATION, FOLLOW-UP (EG,					below
76817	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, TRANSVAGINAL	74.64	Yes	No	No	
81025	URINE PREGNANCY TEST, BY VISUAL COLOR COMPARISON METHODS	8.74	Yes	No	No	Not payable if done on same day as an ultrasound
85018	BLOOD COUNT; HEMOGLOBIN (HGB)	3.27	Yes	No	No	Only one of these is payable
85014	BLOOD COUNT; HEMATOCRIT (HCT)	3.25	Yes	No	No	
MEDICAL ITOP CODES						
S0190	MIFEPRISTONE, ORAL, 200 MG	81.05	Yes	No	No	Dispensing fee included in this rate; one tablet payable
S0191	MISOPROSTOL, ORAL, 200 MCG	2.36 per tablet	Yes	No	No	Up to 4 200mcg tablets payable; Dispensing fee included in this rate
76817	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, TRANSVAGINAL	74.64	Yes	No	No	

DETAILED DESCRITIONS

Code	Complete Description
59850	INDUCED ABORTION, BY 1 OR MORE INTRA-AMNIOTIC INJECTIONS (AMNIOCENTESIS-INJECTIONS), INCLUDING HOSPITAL ADMISSION AND VISITS, DELIVERY OF FETUS AND SECUNDINES;
59851	INDUCED ABORTION, BY 1 OR MORE INTRA-AMNIOTIC INJECTIONS (AMNIOCENTESIS-INJECTIONS), INCLUDING HOSPITAL ADMISSION AND VISITS, DELIVERY OF FETUS AND SECUNDINES; WITH DILATION AND CURETTAGE AND/OR EVACUATION
59852	INDUCED ABORTION, BY 1 OR MORE INTRA-AMNIOTIC INJECTIONS (AMNIOCENTESIS-INJECTIONS), INCLUDING HOSPITAL ADMISSION AND VISITS, DELIVERY OF FETUS AND SECUNDINES; WITH HYSTEROTOMY (FAILED INTRA-AMNIOTIC INJECTION)
59855	INDUCED ABORTION, BY 1 OR MORE VAGINAL SUPPOSITORIES (EG, PROSTAGLANDIN) WITH OR WITHOUT CERVICAL DILATION (EG, LAMINARIA), INCLUDING HOSPITAL ADMISSION AND VISITS, DELIVERY OF FETUS AND SECUNDINES;
59856	INDUCED ABORTION, BY 1 OR MORE VAGINAL SUPPOSITORIES (EG, PROSTAGLANDIN) WITH OR WITHOUT CERVICAL DILATION (EG, LAMINARIA), INCLUDING HOSPITAL ADMISSION AND VISITS, DELIVERY OF FETUS AND SECUNDINES; WITH DILATION AND CURETTAGE AND/OR

	EVACUATION
59857	INDUCED ABORTION, BY 1 OR MORE VAGINAL SUPPOSITORIES (EG, PROSTAGLANDIN) WITH OR WITHOUT CERVICAL DILATION (EG, LAMINARIA), INCLUDING HOSPITAL ADMISSION AND VISITS, DELIVERY OF FETUS AND SECUNDINES; WITH HYSTEROTOMY (FAILED MEDICAL EVACUATION)
76815	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, LIMITED (EG, FETAL HEART BEAT, PLACENTAL LOCATION, FETAL POSITION AND/OR QUALITATIVE AMNIOTIC FLUID VOLUME), 1 OR MORE FETUSES
76816	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FOLLOW-UP (EG RE-EVALUATION OF FETAL SIZE BY MEASURING STANDARD GROWTH PARAMETERS AND AMNIOTIC FLUID VOLUME, RE-EVALUATION OF ORGAN SYSTEM(S) SUSPECTED OR CONFIRMED TO BE ABNORMAL ON A PREVIOUS SCAN), TRANSABDOMINAL APPROACH, PER FETUS