Medicare
Intermediary Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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This revision manualizes Program Memorandum AB-99-15, Change Request 839 dated April 1999 and AB-99-87, Change Request 969 dated December 1999.

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MANUALIZATION--EFFECTIVE /IMPLEMENTATION DATE: Not Applicable

Section 3652, Billing for Abortion Services, provides billing instructions for hospital reporting of abortion services furnished on or after October 1, 1998. This information was previously released to you in Program Memorandum AB-99-15 and AB-99-87.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

CHAPTER VII
BILL REVIEW

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3652. BILLING FOR ABORTION SERVICES

Effective October 1, 1998**,** abortions are not covered under the Medicare program except for instances where the pregnancy is a result of an act of rape or incest; or the woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

A. "G" Modifier.--The "G7" modifier is defined as "the pregnancy resulted from rape or incest, or pregnancy certified by physician as life threatening."

Beginning July 1, 1999, providers should bill for abortion services using the new Modifier G7. This modifier can be used on claims with dates of services October 1, 1998 and after. CWF will be able to recognize the modifier beginning July 1, 1999.

B. Intermediary Billing Instructions.--

1. Hospital Inpatient Billing--Hospitals will bill you on Form HCFA-1450 using bill type 11X. Medicare will only pay when condition code A7 or A8 is used in FLs 24-30 of UB92 along with an appropriate ICD-9-CM principal diagnosis code that will group to DRG 380 or with an appropriate ICD-9-CM principal diagnosis code and one of the four appropriate ICD-9-CM operating room procedure codes listed below that will group to DRG 381.

69.01	69.02	69.51	74.91

Providers must use ICD-9-CM codes 69.01 and 69.02 to describe exactly the procedure or service performed.

You must manually review claims with the above ICD-9-CM procedure codes to verify that all of the above conditions are met.

2. Outpatient Billing--Hospitals will bill you on Form HCFA-1450 using bill type 13X, 83X and 85X. Medicare will pay only if one of the following CPT codes is used with the "G7" modifier.

59840	59851	59856
59841	59852	59857
59850	59855	59866

C. Common Working File (CWF) Edits.--For hospital outpatient claims, CWF will bypass its edits for a managed care beneficiary who is having an abortion outside their plan and the claim is submitted with the "G7" modifier and one of the above CPT codes.

For hospital inpatient claims, CWF will bypass its edits for a managed care beneficiary who is having an abortion outside their plan and the claim is submitted with one of the above ICD-9-CM procedure codes.

D. Medicare Summary Notices (MSN)/Explanation of Your Medicare Benefits (EOMB)/ Remittance Advice Message.--

If a claim is submitted with one of the above CPT procedure codes but no "G7" modifier, the claim should be denied. State on the MSN or the EOMB the following message:

"This service was denied because Medicare only covers this service under certain circumstances." (MSN Message 21.21, EOMB Message 21.32).

For the remittance advice use existing American National Standard Institute (ANSI) X12-835 claim adjustment reason code B5, "Claim/service denied/reduced because coverage guidelines were not met or were exceeded."