Summit COMMUNITY CARE

Arkansas | Medicaid

Reimbursement Policy
Abortion (Termination of Pregnancy)

Policy Number: **G-06057**
Policy Section: **Surgery**
Last Approval Date: **06/08/2026**
Effective Date: **02/01/2027**

Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://provider.summitcommunitycare.com**.

Policy

The health plan allows reimbursement of induced abortions unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Induced abortions are allowed only when the written, voluntary, and informed consent has been obtained from the woman upon whom the abortion is to be performed, and the provider performing the procedure certifies the following:

- The woman suffers from a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

Reimbursement is based on the applicable fee schedule or contracted/negotiated rate when the state-approved Certification of Medical Necessity abortion form and documentation are properly executed and submitted with the provider's claim.

Informed consent is not needed for the treatment of incomplete, missed, or septic abortions. These procedures are not considered induced or elective abortions and are allowed under the criteria of medical necessity.

Related Coding

Standard correct coding applies.

Definitions

- **Abortion, Induced/Elective -** One resulting from measures taken to intentionally end a pregnancy, using medications (medical abortion) or instrumentation (surgery)
- **Abortion, Incomplete -** Part of the product of conception has been retained in the uterus
- **Abortion, Missed -** A dead, nonviable fetus and other products of conception are retained in the uterus for two or more months

- **Abortion, Septic -** There is an infection of the product of conception and the endometrial lining of the uterus usually resulting from attempted interference during early pregnancy
- **Abortion, Spontaneous/Miscarriage -** Occurs when a natural cause ends a pregnancy prior to 20 weeks
- **Abortion, Threatened -** The appearance of signs and symptoms of possible loss of embryo
- **Stillborn -** Occurs when a natural cause ends a pregnancy after 20 weeks
- **Termination of Pregnancy -** Synonym for abortion
- **General Reimbursement Policy Definitions**

Related Policies and Materials

- Claims Requiring Additional Documentation
- Sterilization

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Code of Federal Regulations (CFR) Subpart E - Abortions §441.200-§441.208
- State contract
- State Medicaid

Policy History

- **06/08/2026 -** Review approved 06/08/2026 and effective 02/01/2027: removed language to allow a pregnancy as the result of an act of rape or incest
- **11/04/2024 -** Review approved and effective: no changes
- **06/29/2022 -** Review approved and effective: no changes
- **07/13/2020 -** Review approved and effective: updated language; updated Definitions section to add the words induced/elective for abortion definition
- **03/01/2019 -** Initial approval and effective

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

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