

DECEMBER 5, 1997

WISCONSIN MEDICAID UPDATE

UPDATE 97-41

TO:
Ambulatory Surgical Centers
Family Planning Clinics
HMOS and other Managed Care
Programs
Hospitals
Nurse Practitioners
Nurse Midwives
Physician Assistants
Physicians

Medicaid Abortion Policy

Coverage Policy

In accordance with Sections 20.927, Wis. Stats., Wisconsin Medicaid covers abortions when:

- The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests, based on his or her best clinical judgement, that the abortion meets this condition by signing a certification.
- In a case of sexual assault or incest, provided that prior to the abortion the physician attests to his or her belief that sexual assault or incest has occurred by signing a certification, and provided that the crime has been reported to the law enforcement authorities.
- Due to a medical condition existing prior to the abortion, the physician determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman, provided that prior to the abortion, the physician attests, based on his or her best clinical judgment, that the abortion meets this condition by signing a certification.

Attach certification

When filing a claim for reimbursement of an abortion with Wisconsin Medicaid, physicians must affix written certification attesting to one of the circumstances listed above. In the case of

What this Update is about

This Update summarizes current and new Medicaid abortion policy.

rape or incest, the physician's statement must indicate belief that sexual assault or incest has occurred. Attached are examples of abortion certification statements.

Covered services

When an abortion meets the state and federal requirements for Medicaid payment, Wisconsin Medicaid covers office visits and all other medically necessary related services. Wisconsin Medicaid covers treatment for complications arising from an abortion, regardless whether the abortion itself is a covered service, because the complications represent new conditions, and thus the services are not directly related to the performance of an abortion.

Noncovered Services

Services incidental to a noncovered abortion are not covered by Wisconsin Medicaid. Such services include, but are not limited to, any of the following services when directly related to the performance of a noncovered abortion: laboratory testing and interpretation, ultrasound services, recovery room services, routine follow-up visits, and transportation.

Services provided by provider of noncovered abortion

The following is new policy, effective January 1, 1998.

Wisconsin Medicaid requires the provider in the following situation to comply with the requirements below:

Situation:

A Medicaid provider performs a non-Medicaid covered abortion on a Medicaid recipient. The provider claims Medicaid reimbursement for other services that were provided to the same recipient between nine months prior to and six weeks after the noncovered abortion.

Requirements:

1. All such claims must be submitted on paper, not electronically.
2. Each such claim must have the attached following signed written statement:

"No service billed to Wisconsin Medicaid on the attached claim form was directly related to the performance of a non-Medicaid-covered abortion procedure. I understand that this statement is a representation of a material fact made in a claim for payment under Wisconsin Medicaid within the meaning of s. 49.49, Wis. Stats., and HFS 106.06 (17), Wis. Admin. Code. Accordingly, if this statement is false, I understand that I am subject to criminal prosecution for Medicaid fraud or termination as a Medicaid provider, or both."

Signed

Date

Provider Number

Wisconsin Medicaid

Examples of Abortion Certification Statements

Life of the Mother

I, _____, certify that on the basis of my best clinical judgement, abortion
(Provider Name)
is directly and medically necessary to save the life of _____ of
(Recipient Name)
_____, for the following reason(s): _____
(Recipient Address) (Specific physical condition/diagnosis)

Signature

Date

Victim of Rape or Incest

I, _____, certify that it is my belief that _____ of
(Provider Name) (Recipient Name)
_____, was the victim of rape (or incest).
(Recipient Address)

Signature

Date

Grave and Long-lasting Damage to Physical Health

I, _____, certify that on the basis of my best clinical judgement, due to an
(Provider Name)
existing medical condition, grave, long-lasting physical health damage to _____,
(Recipient Name)
of _____, would result if the pregnancy were carried to term. The following
(Recipient Address)
medical condition necessitates the abortion: _____
(Specific medical condition/diagnosis)

Signature

Date

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