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MEMORANDUM

DATE: March 28, 2011

TO: Senator Bettye Davis, Chair, Senate HSS Committee

FROM: Jon Sherwood, DHSS Medical Assistance Administrator

SUBJECT: Denali KidCare

Senator Davis, below is the Department's response to two issues that came up in the hearing on SB 5 on March 23, 2011.

First, we believe there may have been some confusion regarding regulations defining medical necessity as it related to abortion and the definition of therapeutic abortion. There are regulations defining therapeutic abortion at 7 AAC 47.290; however, these regulations only apply to the General Relief Medical program. This program was defunded by the Alaska Legislature in 1998. Prior to that time, abortions for Medicaid eligible women were covered under the General Relief Medical program. This defunding of the program that covered abortions for Medicaid eligible women is what triggered the court cases that currently govern state-funded abortions. Nothing in those court decisions applies the definition at 7 AAC 47.290 to the current requirement to pay for abortions nor provides a separate definition of medical necessity.

There is no specific definition of medical necessity for abortions in 7 AAC 105.100 or elsewhere in 7 AAC 105, the regulations that govern Medicaid services. Under 7 AAC 105.100(5), the general criteria for medical necessity if there is no specific definition for a service is "by the standards of practice applicable to the provider".

Given these facts, the Department believes its previous statement that there is no statute, regulation, or court decision that defines medical necessity as it applies to abortions paid for under Denali KidCare is accurate.

Second, questions arose about how the Department uses coding to determine that services are abortion-related, and if services for miscarriages or stillbirths might be included.

The Division of Health Care Services determines whether a claim is for an abortion related service based on a combination of procedure codes and diagnosis codes as follows:

If a claim comes in with one of several ICD-9 diagnosis codes related to pregnancy, the claim is pended for review. The reviewer then identifies the procedure code and determines if the procedure code - diagnosis code combination is an abortion-related service. If so, the claim is assigned a collocation code that will be charged against state funds only. In some cases, the reviewer may request medical case notes to make the final determination of whether or not the claim is for an abortion-related service.

While a multitude of procedure codes may be included in abortion-related services, use of diagnosis codes directs the reviewer to correctly exclude services related to miscarriage, stillbirths, or other circumstances not related to abortions when we identify abortion-related services.

Cc: William Streur, DHSS Commissioner