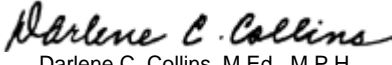
	MEDICAL ASSISTANCE BULLETIN COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE	
	SUBJECT Payment Policy for Abortion Services	BY  Darlene C. Collins, M.Ed., M.P.H. Deputy Secretary for Medical Assistance Programs
NUMBER:	99-95-09, 1141-95-01, 1163-95-02, 1221-95-01	
ISSUE DATE:	December 15, 1995	
EFFECTIVE DATE:	September 14, 1995	

PURPOSE:

This bulletin announces requirements applicable to abortion services for which reimbursement is sought under the Medical Assistance Program. These requirements, concerning the waiver provision for reporting requirements for rape and incest abortions and the second physician provision, are being implemented pursuant to the order of the Third Circuit Court of Appeals in the case Elizabeth Blackwell Health Center for Women v. Catherine Baker Knoll, No. 94-1954 (3rd Cir.) and are effective for abortion services provided on and after September 14, 1995. However, appeals are being pursued in this case and if successful, these requirements will become void and the payment for abortion services will resume as provided in Medical Assistance Bulletin dated April 22, 1988.

SCOPE:

This bulletin is applicable to all physicians, short procedure units, ambulatory surgical centers, independent medical/surgical clinics, hospital emergency rooms, general hospitals and managed care plans enrolled in the Medical Assistance Program.

DISCUSSION:

This bulletin implements the September 14, 1995 order of the Third Circuit Court of Appeals in the above-referenced case. Payment for abortion services will be made by the Medical Assistance Program only under the following conditions.

1. When a physician certifies that the abortion is necessary to avert the death of the woman. The decision as to whether the abortion is necessary to avert the death of the woman is a medical judgment to be made by the certifying physician. This certification may be made by a licensed physician whether or not he or she has a pecuniary or proprietary interest in the abortion.
2. The woman was the victim of rape or incest and prior to the performance of the abortion, she personally reported the incident to a law enforcement agency having the requisite jurisdiction. If the victim of incest is a minor, she personally reported the incident to the county child protective service agency. The identity of the offender must have been reported by the victim of rape or incest if the identity is known.

Note: A law enforcement agency means an agency or part of an agency that is responsible for the enforcement of the criminal laws, such as a local police department or sheriff's office.

Note: The requirement to report the crime of rape or incest may be waived when a physician certifies that in his or her medical judgment the woman is unable to report the crime for physical or psychological reasons.

PROCEDURE:

Payment for abortions that fulfill the conditions described in the preceding section of this bulletin will be made only if a participating physician submits along with the invoice the following information, as appropriate:

1. A completed duplicate of the "Physician Certification for an Abortion" (MA3) form specified in Attachment A to this bulletin.
2. If the recipient was the victim of rape or incest, a non-notarized, signed statement from the pregnant woman stating that she was a victim of rape or incest, as the case may be, and that she reported the incident, including the identity of the offender, if known, to a law enforcement agency having the requisite jurisdiction. In the case of incest, where a

pregnant minor is the victim, a statement that she reported the incident to the county child protective service agency. The statement must include the name of the law enforcement agency or child protective service agency to which the report was made and the date the report was made. Sample statements are included as Attachment B to this bulletin.

- i. The statement must bear the notice that any false statements made therein are punishable under the law and shall state that the pregnant woman is aware that false reports to law enforcement authorities are punishable by law.
 - ii. Physicians may use their own certification forms, however, they will be accepted by the Department only if they contain all of the information set forth on the sample statement.
3. If the recipient was the victim of rape or incest, but in the physician's medical judgment the woman is incapable of reporting the crime for physical or psychological reasons, the reporting requirement may be waived. The physician must set forth the reasons for the waiver on the "Physician Certification for an Abortion" form, Attachment A, and must obtain a non-notarized, signed statement from the pregnant woman stating that she was a victim of rape or incest, as the case may be, and that she did not report the crime. Sample statements (MA 368 and MA 369) are included as attachments to this bulletin.
 - i. Physicians may use their own certification forms, however, they will be accepted by the Department only if they contain all of the information set forth on the sample statement.

Providers affiliated with an HMO or HealthPASS who provide services to medical assistance recipients should contact the plan directly with questions.

Note: Effective January 1996, the attached abortion form will be available from the Medical Assistance forms contractor. Place your order by using the "Medical Assistance Provider Order Form" (MA 300X). Until available on the MA 300X, providers may photocopy the attached forms for their use.

ATTACHMENTS:

- Physician Certification for an Abortion Form (MA 3)
- Recipient Statement Form (MA 368)
- Recipient Statement Form (for victims of incest under age 18) (MA 369)

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Department of Public Welfare
P.O. Box 8045
Harrisburg, Pennsylvania 17105

or call the appropriate toll-free number for your provider type.

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap.

DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

PHYSICIAN CERTIFICATION FOR AN ABORTION

LEAVE THIS SPACE BLANK

*A COPY MUST BE ATTACHED TO
ALL INVOICES FOR ABORTION SERVICES*

1. RECIPIENT NUMBER

2. PATIENT'S NAME:	3. DATE OF SERVICE:
4. PATIENT'S ADDRESS:	

PLEASE COMPLETE EITHER PART I OR PART II

PART I

5. I certify that, on the basis of my professional judgment, this abortion was necessary to avert the death of the above-named woman.

6. _____
PHYSICIAN'S SIGNATURE

7. _____
STREET ADDRESS

8. _____ 9. _____
DATE PHONE NUMBER

_____ CITY STATE ZIP CODE

PART II - IF ONE OF THE BLOCKS BELOW IS CHECKED, A NON-NOTARIZED STATEMENT BY THE VICTIM MUST BE ATTACHED.

10. This patient is the alleged victim of RAPE INCEST

11. COMPLETE THIS SECTION ONLY IF APPLICABLE

I certify that, on the basis of my professional judgment, this patient was unable to report the crime of RAPE INCEST because the patient was: Physically unable Psychologically unable

12. I certify that prior to performing the abortion, I obtained the attached statement signed and dated by the patient.

13. _____
PHYSICIAN'S SIGNATURE

14. _____
STREET ADDRESS

15. _____ 16. _____
DATE PHONE NUMBER

_____ CITY STATE ZIP CODE

ALL INFORMATION WILL BE KEPT CONFIDENTIAL

DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

RECIPIENT STATEMENT FORM

		1. RECIPIENT NO.
2. NAME OF VICTIM	3. BIRTHDATE	4. TYPE OF INCIDENT <input type="checkbox"/> RAPE <input type="checkbox"/> INCEST
5. ADDRESS		6. DATE OF INCIDENT

PLEASE COMPLETE EITHER PART I OR PART II

PART I	
7. <input type="checkbox"/> I certify that I was the victim of the above-named incident and that I reported it to:	
8. NAME OF AGENCY:	9. DATE OF REPORT:
10. MY REPORT <input type="checkbox"/> DID <input type="checkbox"/> DID NOT INCLUDE THE IDENTITY OF THE OFFENDER	
11. I <input type="checkbox"/> DO <input type="checkbox"/> DO NOT KNOW THE IDENTITY OF THE OFFENDER	

PART II
12. <input type="checkbox"/> I certify that I was the victim of the above-named incident and that I did not report the crime.

I UNDERSTAND THAT ANY FALSE STATEMENTS MADE HEREIN ARE PUNISHABLE BY LAW AND THAT FALSE REPORTS TO LAW ENFORCEMENT AUTHORITIES ARE PUNISHABLE BY LAW.

13. _____
SIGNATURE OF VICTIM

14. _____
DATE

ALL INFORMATION WILL BE KEPT CONFIDENTIAL!

DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

RECIPIENT STATEMENT FORM

(FOR VICTIMS OF INCEST UNDER AGE 18)

		1. RECIPIENT NO.
2. NAME OF VICTIM	3. BIRTHDATE	4. TYPE OF INCIDENT <input type="checkbox"/> RAPE <input type="checkbox"/> INCEST
5. ADDRESS		6. DATE OF INCIDENT

PLEASE COMPLETE EITHER PART I OR PART II

PART I	
7. <input type="checkbox"/> I certify that I was the victim of incest and that I reported it to:	
8. NAME OF CHILD PROTECTION AGENCY:	9. DATE OF REPORT:
10. MY REPORT <input type="checkbox"/> DID <input type="checkbox"/> DID NOT INCLUDE THE IDENTITY OF THE OFFENDER	

PART II
11. <input type="checkbox"/> I certify that I was the victim of incest and that I did not report the crime.

I UNDERSTAND THAT ANY FALSE STATEMENTS MADE HEREIN ARE PUNISHABLE BY LAW AND THAT FALSE REPORTS TO LAW ENFORCEMENT AUTHORITIES ARE PUNISHABLE BY LAW.

12. _____
SIGNATURE OF VICTIM

13. _____
DATE

ALL INFORMATION WILL BE KEPT CONFIDENTIAL!