



<https://providers.amerigroup.com>

November 2017

Subject: Reimbursement for early elective deliveries

Dear Provider:

We appreciate the recent improvements in early elective delivery (EED) rates across the country. The collaborative efforts of state Medicaid agencies, the March of Dimes, CMS, The Joint Commission, the American Congress of Obstetricians and Gynecologists, and many others contributed to these improvements. Hospital hard-stop policies, describing the review of clinical indication and scheduling approval for EEDs, also increased awareness of the harm that can be caused by non-medically necessary EEDs and encouraged discussion between patients, care providers and hospitals. Additionally, voluntary efforts combined with payment reform have been found to further decrease EED rates while increasing gestational age and birth weight for the covered population.*

To improve birth outcomes for our members and further reduce EEDs, effective January 1, 2018, we'll require a Z3A code indicating the gestational age on all professional delivery claims with supporting medical necessity diagnosis codes for EEDs. We'll apply *McKesson InterQual Criteria: Procedures – Cesarean Section, Prior to Onset of Labor*, which defines medically necessary criteria for EEDs.

What is the impact of this change?

All professional delivery claims (i.e., 59400, 59409, 59410, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620 and 59622) with dates of service January 1, 2018, or after, will require a Z3A code indicating the gestational age at the time of delivery. If the code isn't on the claim, we'll deny the claim with the explanation code e02 – *Delivery diagnoses incomplete without report of pregnancy weeks of gestation*. You may resubmit the claim with the appropriate Z3A code.

Professional delivery claims with dates of service date, or after with gestational ages of 37 and 38 weeks will require a supporting medically necessary diagnosis code for the early delivery. If a professional delivery claim is submitted without evidence of medical necessity, we'll deny the claim with the explanation code k34 – *Delivery is not medically indicated*. You may resubmit the claim with the appropriate supporting diagnosis code or submit an appeal with the relevant medical records. For more information on the appeal process, refer to your provider manual at <https://providers.amerigroup.com> > Manuals and QRCs.

What if I need assistance?

If you have questions, received this communication in error or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

Thank you for being a valued partner.

Sincerely,

Mark Levy
Medical Director
Amerigroup Iowa, Inc.