Amerigroup
District of Columbia

Provider update

Facility reimbursement for early elective deliveries

Background: 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 nonmedically 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 October 1, 2019, we will require a Z3A code indicating the gestational age on all facility delivery claims. Claims for EEDs will also require a medical necessity diagnosis that supports coverage of an EED to be eligible for reimbursement. We will apply *McKesson/InterQual® Criteria: Procedures – Cesarean Section or Induction, Prior to Onset of Labor*, which defines medically necessary criteria for EEDs.

What is the impact of this change?
All facility delivery claims (e.g., 10D, 10D0, 10D00Z0, 10D00Z1, 10D00Z2, 10D00Z3, 10D00Z4, 10D00Z5, 10D00Z6, 10D00Z7, 10D00Z8, 10D1, 10D17Z9, 10D17ZZ, 10D18Z9, 10D18ZZ, 10E, 10E0 & 10E0XZZ) with dates of service of October 1, 2019, 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 will 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.

Facility delivery claims with dates of service on or after October 1, 2019, with gestational ages of 37 and 38 weeks will require a supporting medically necessary diagnosis code for the early delivery. If a facility delivery claim is submitted without evidence of medical necessity, it will deny with the explanation code *k34 — Delivery is not medically indicated*. Instances of spontaneous labor early delivery will require the submission of code O60.10x0. 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 the provider manual located on the provider website (https://providers.amerigroup.com/DC).

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.