Amerigroup
An Anthem Company

Provider update

Important reminder – coding requirements for reimbursement for early elective deliveries

Amerigroup Washington, Inc. appreciates the recent improvements seen in early elective delivery (EED) rates across the country. These improvements have been brought about through the collaborative efforts of state Medicaid agencies, the March of Dimes, CMS, the Joint Commission, the American College of Obstetricians and Gynecologists (ACOG), and many others. The implementation of hospital hard stop policies describing the review of clinical indications and scheduling approval for EED has also increased awareness of the harm that can be caused by non-medically necessary EED and encouraged discussion on the topic between patients, their care providers and hospitals. 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.[1]

Early elective delivery is defined as a delivery by induction of labor without medical necessity followed by vaginal or caesarean section delivery or a delivery by caesarean section before 39 weeks gestation without medical necessity. Vaginal or caesarean delivery following non-induced labor is not considered an early elective delivery regardless of gestational weeks.

What does this mean for providers?

To improve birth outcomes for our members and further reduce EED, Amerigroup requires a Z3A code indicating gestational age, the appropriate code to indicate the outcome of delivery and supporting medical necessity diagnosis codes on all professional delivery claims for all EED. Amerigroup will apply *Milliman Care Guidelines*, which defines medically necessary criteria for EED.

All professional delivery claims (59400, 59409, 59410, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622) with dates of service January 1, 2018, or after, will require a Z3A code indicating gestational age at the time of delivery. If the code is not present on the claim, the claim will deny 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 January 1, 2018, or after, with gestational age dates 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 for the early delivery, the claim will deny with code k34: Delivery is not medically indicated. You may resubmit the claim with the appropriate supporting diagnosis code or appeal with medical records.

Should you have questions about this communication, received this communication in error or need assistance with any other item, contact your local provider relations representative or call provider services toll-free at **1-800-454-3730.**

Thank you for being a valued partner. We appreciate your commitment to the health of our members.

[1] Dahlen, Heather M., J. Mac Mccullough, Angela R. Fertig, Bryan E. Dowd, and William J. Riley. *Texas Medicaid Payment Reform: Fewer Early Elective Deliveries and Increased Gestational Age And Birthweight.* Health Affairs 36.3 (2017): 460-67. Print.