

PROVIDER BULLETIN

Volume 37 Number 07

<http://dss.mo.gov/mhd/>

December 3, 2014

Physician and Hospital Bulletin

CONTENTS

- EARLY ELECTIVE DELIVERIES
- SERVICES RELATED TO EARLY ELECTIVE DELIVERY
- NEW REQUIREMENT: GESTATIONAL AGE/DELIVERY INDICATOR
- LAST MENSTRUAL PERIOD
- INPATIENT CLAIMS
- ASSOCIATED CHARGES FOR MOTHER AND BABY
- REVIEW OF DENIED CLAIMS

EARLY ELECTIVE DELIVERIES

Pursuant to **13 CSR 70-3.250 Payment Policy for Early Elective Delivery** effective September 30, 2014, the MO HealthNet Division (MHD) will no longer reimburse for Early Elective Deliveries, or deliveries prior to 39 weeks gestational age that are not medically indicated. Those delivery-related services shall be denied or recouped by MO HealthNet. Non-payment includes services billed by the delivering physicians/provider and the delivering institution.

MHD is still in the process of implementing system changes that will deny claims for Early Elective Deliveries, and anticipates implementation in June 2015. Until that time, retrospective manual reviews will be conducted and recoupment of payment will be made when appropriate.

SERVICES RELATED TO EARLY ELECTIVE DELIVERY

(I) All services provided during the delivery-related stay at the delivering institution for maternal care related to an early elective delivery shall not be reimbursed by MHD. Non-payment or recoupment includes obstetric and institutional or facility charges; and

(II) Non-routine newborn services provided for newborns during the initial delivery-related stay at the delivering institution for conditions resulting from an early elective delivery and that are identified within seventy-two (72) hours of delivery may be subject to review and recoupment. Non-payment or recoupment includes facility or institutional charges.

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.

NEW REQUIREMENT: GESTATIONAL AGE/DELIVERY INDICATOR

For MHD to identify early elective delivery services, an additional field will be required on the CMS 1500 claim form, and its electronic equivalents including the X12 5010 837P and the eMOMED Medical claim transactions for delivery charges. Claims submitted by the delivering physician will be edited to determine if the service is for an early elective delivery. Field 19 of the CMS 1500 paper claim, Loop 2300, or 2400, NTE, 02 of the 837P or equivalent field on the eMOMED Medical claim MUST contain a new “gestational age/delivery” indicator. This field will be required for all claims that report a delivery or global prenatal/delivery procedure code. The new field requires one of the following four (4) digit alphanumeric values. This field will be used to determine the early elective delivery payment policy. If the value entered in the field contains a character that is not indicated below or is not in the format indicated, the value will be considered invalid and the claim will be denied.

- 1st and 2nd digits represent the gestational age, based on the best obstetrical estimate. They must be numeric characters and values from 20 through 42
- 3rd and 4th digits represent the method of delivery. They must be one of following alpha characters:
 - LV – Labor non-induced followed by vaginal delivery
 - LC – Labor non-induced followed by caesarean delivery
 - IV – induced labor followed by vaginal delivery
 - IC – induced labor followed by caesarean delivery
 - CN – caesarean delivery without labor, non-scheduled (i.e. add-ons)
 - CS – caesarean delivery, scheduled

If the gestational age/delivery indicator contains an LV or LC value or contains a gestational age of 39 or greater, the claim will be exempt from this editing and will continue processing through the system.

If the gestational age/delivery indicator contains IV, IC, CN, or CS, and the gestational age is less than 39, the claim will be subject to editing for early elective delivery. If one of the diagnoses on the claim indicates that there is a medical indication for an early delivery, the claim will be exempt from this editing and continue to process. MHD will use the American Congress of Obstetricians and Gynecologists (ACOG) list of conditions that may be indications for early induction of labor and delivery to determine diagnosis codes that are appropriate to justify an early delivery.

Claims that have the IV, IC, CN, or CS indicator with a gestational age less than 39 weeks and do not have a qualifying diagnosis for early induction of labor and delivery will be denied. If an inpatient claim for the participant has been paid for the delivery, the claim will be recouped, unless it contains one of the qualifying diagnosis codes referenced above.

LAST MENSTRUAL PERIOD

In addition to the gestational age/delivery indicator, the last menstrual period (LMP) is still required on all claims for global and/or prenatal/delivery services. There is no change to how this field is completed or used. It will not be used to determine the early elective delivery payment policy. Providers **must** enter the date of the last menstrual period (LMP) on the

professional claim. The date of service is the delivery date. A delivery diagnosis code *must* be used.

Providers may reference Section 13.67, Obstetric Services of the Physician Manual for further information regarding reimbursement of services related to the delivery.

INPATIENT CLAIMS

Inpatient claims that are received for delivery services will be denied if there is a professional claim in the system that has previously been denied for the early elective delivery edit. Inpatient claims that contain one of the ACOG qualifying diagnosis codes will not be denied.

ASSOCIATED CHARGES FOR MOTHER AND BABY

MHD will identify claims that have been denied for early elective delivery for the mother. A manual retrospective review will be done of any professional charges submitted for reimbursement by the delivering physicians/provider for delivery related care following an early elective delivery. These claims will be subject to review and may result in denial or recoupment of MHD payment. Non-payment or recoupment includes obstetric and institutional or facility charges.

Through a report of claims that have been denied for early elective delivery, MHD will identify claims for newborns. MHD will allow the inpatient claim for the established length of stay for a healthy newborn. Any inpatient days resulting from non-routine newborn services provided for newborns during the initial delivery-related stay at the delivering institution for conditions resulting from an early elective delivery and that are identified within seventy-two (72) hours of delivery that exceed the established length of stay will be subject to review and possible denial or recoupment. Non-payment or recoupment includes facility or institutional charges.

If a newborn is transferred to another hospital for a higher level of care, the receiving hospital will **NOT** be subject to the early elective delivery policy.

Other considerations include rural processes for advanced cervical dilatation with a long distance to a delivering institution in certain circumstances and medical judgment; if these deliveries are occurring prior to 39 weeks they will be reviewed and undergo a peer-peer review to evaluate for application of the early elective delivery policy.

REVIEW OF DENIED CLAIMS

If a medical or inpatient claim is denied for early elective delivery, the provider may submit documentation from the medical record to show that the delivery was medically necessary. The request for review must be received within 60 days of the date of the Remittance Advice on which the claim denied. The provider will have 45 days within which to submit the required materials for review and MOHealthNet will complete the review within 45 days and communicate its outcome to the facility and delivering physicians/provider. The information will be reviewed by clinical staff and, if appropriate, can be reconsidered for payment. The information should be sent to:

Medical Director
MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102

The provider will be notified by mail of the outcome of the review.

Provider Bulletins are available on the MO HealthNet Division (MHD) (Formerly the Division of Medical Services) Web site at <http://dss.mo.gov/mhd/providers/pages/bulletins.htm>. Bulletins will remain on the Provider Bulletins page only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletin page.

MO HealthNet News: Providers and other interested parties are urged to go to the MHD Web site at <http://dss.mo.gov/mhd/global/pages/mednewssubscribe.htm> to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official MO HealthNet communications via E-mail.

MO HealthNet Managed Care: The information contained in this bulletin applies to coverage for:

- MO HealthNet Fee-for-Service
- Services not included in MO HealthNet Managed Care

Questions regarding MO HealthNet Managed Care benefits should be directed to the patient's MO HealthNet Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the MO HealthNet card or by calling the Provider Communications Interactive Voice Response (IVR) System at 573-751-2896 and using Option One for the red or white card.

Provider Communications Hotline
573-751-2896