



# Provider Notice

December 21, 2023

## ***Updated Notice December 2023***

### **Change in payment for early elective deliveries effective October 3, 2022- Updated Claims Criteria Effective: August 7, 2023**

CountyCare Health Plan is committed to ensuring that our members who are pregnant get timely access to prenatal care and have positive birth outcomes. In October 2022, CountyCare implemented a new claims payment process for early elective deliveries. After review and implementation of these payment changes, we have re-assessed the claims requirement for payment and are making changes as noted in this document.

As previously noted, the payment process changes were based on the American College of Obstetrics and Gynecology (ACOG) and the Society for Maternal-Fetal Medicine (SMFM) recommendations regarding early elective deliveries. It was noted that any elective delivery performed prior to 39 weeks of gestation has demonstrated increased neonatal risks, such as: respiratory distress syndrome, transient tachypnea of the newborn, ventilator use, pneumonia, respiratory failure or neonatal intensive care unit admission.

The ACOG recommendation will still apply, and a high-risk condition must be indicated on the claims to validate the early elective delivery. These requirements are intended to ensure that maternity deliveries that are elective are based on recommendations from ACOG. The following still apply:

- It is inclusive of elective deliveries: normal vaginal and cesarean section (C-Section) deliveries.
- No prior authorization is required for elective inductions or c-sections.
- No notification is required for non-elective deliveries.
- Review and payment for elective deliveries will be managed through the Claims Adjudication process.
- There is a required set of ICD10 Diagnosis and CPT Codes that need to be used when submitting claims as outlined in this notice.
- There are high risk diagnoses that are exceptions. The high-risk diagnosis codes are listed [here](#). See Elective-Deliveries-GA-High-Risk-Dx-Codes-Effective-11.1.23
- This process applies to both facilities and physician/professional payments.
- If the mother or baby stay longer than 48 hours for a vaginal delivery or 96 hours for a c-section, the UM department must be notified for an authorization for the additional days.

#### **What changes are being made to the previous payment criteria?**

- There is no longer a requirement for the presence of diagnoses codes O80 or O82 to consider payment or denial.
- A gestational age diagnosis MUST be present on the claim (therefore any claims without gestational age diagnosis will deny). A list of gestational age dx codes can be found [here](#). See Elective-Deliveries-GA-High-Risk-Dx-Codes-Effective-11.1.23
- Additionally, if the gestational age is present and indicates less than 39 weeks, payment will deny unless there is the presence of a diagnosis code indicating medical necessity or high-risk indication). The list of diagnosis codes indicated as medical necessity or high-risk has been expanded with these changes. For a full list of these diagnoses, please click [here](#). See Elective-Deliveries-GA-High-Risk-Dx-Codes-Effective-11.1.23

- Click here for the previous list of high risk dx codes [here](#). See GA and HR Diagnosis-and-Procedure-Codes-Effective 10\_6\_22.

In accordance with the changes described above, delivery claims will be denied based on the following criteria:

- The absence of a Gestational Age (GA) Indicator **OR**
- A Gestational Age Indicator with ICD10 <39 weeks gestation **AND** no high-risk/medical necessity diagnosis (based on dx code list) noted on the claim
- The applicable service coding is required

For professional claims, must have the appropriate CPT delivery code:

CPT	CPT Code Description
59409	VAGINAL DELIVERY ONLY (WITH OR WITHOUT EPISIOTOMY AND/OR FORCEPS)
59410	VAGINAL DELIVERY ONLY (WITH OR WITHOUT EPISIOTOMY AND/OR FORCEPS); INCLUDING POSTPARTUM CARE
59612	VAGINAL DELIVERY ONLY, AFTER PREVIOUS CESAREAN DELIVERY (WITH OR WITHOUT EPISIOTOMY AND/OR FORCEPS)
59614	VAGINAL DELIVERY ONLY, AFTER PREVIOUS CESAREAN DELIVERY (WITH OR WITHOUT EPISIOTOMY AND/OR FORCEPS); INCLUDING POSTPARTUM CARE
59514	CESAREAN DELIVERY ONLY
59515	CESAREAN DELIVERY ONLY; INCLUDING POSTPARTUM CARE
59620	CESAREAN DELIVERY ONLY, FOLLOWING ATTEMPTED VAGINAL DELIVERY AFTER PREVIOUS CESAREAN DELIVERY
59622	CESAREAN DELIVERY ONLY, FOLLOWING ATTEMPTED VAGINAL DELIVERY AFTER PREVIOUS CESAREAN DELIVERY; INCLUDING POSTPARTUM CARE

For hospital claims, must have the appropriate APR/DRG:

APR/DRG	Description
540	CESAREAN DELIVERY
541	VAGINAL DELIVERY W STERILIZATION &/OR D&C
542	VAGINAL DELIVERY W COMPLICATING PROCEDURES EXC
560	VAGINAL DELIVERY

**This notice is intended to provide guidance for In-Network facilities and providers. All Out of Network requests are subject to prior authorization along with Medical Director review and may be redirected to an In-Network facility.**



## **CONTACT US**

Over the next few months Provider Relations will be sharing information about these changes and contacting your office to set up education sessions to review this new process and answer any questions you or your staff might have.

Thank you for working with us to ensure that CountyCare members receive quality care at the right time and in the right setting. If you have any questions or would like additional information, please contact your assigned Provider Relations Representative or if you do not know your assigned Representative, please contact [CountyCareProviderServices@cookcountyhhs.org](mailto:CountyCareProviderServices@cookcountyhhs.org).