Provider Notice

September 6, 2022

Update Notice: Change in payment for elective deliveries effective October 3, 2022

CountyCare Health Plan is committed to ensuring that our members who are pregnant get timely access to prenatal care and have positive birth outcomes. After serious consideration and review of the current literature, along with payment processes for elective deliveries, **we are making a change to how we pay for these services. This change will apply to both elective inductions resulting in vaginal deliveries or cesarean sections and planned elective cesarean sections.**

The new payment process is based on American College of Obstetrics and Gynecology (ACOG) and the Society for Maternal-Fetal Medicine (SMFM) recommendations that non-medically indicated elective deliveries performed prior to 39 weeks of gestation can increase neonatal risks, such as respiratory distress syndrome, transient tachypnea of the newborn, ventilator use, pneumonia, respiratory failure or neonatal intensive care unit admission.

For more information regarding ACOG's position and recommendations on elective deliveries, use this link: Avoidance of Nonmedically Indicated Early-Term Deliveries and Associated Neonatal Morbidities | ACOG

The following requirements apply for this change:

- 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 for this payment process. The high-risk diagnosis codes are listed here.
- This process applies to both facilities and physician/professional payments.

The following UM requirements remain in place:

- No authorization is required for non-elective vaginal deliveries or c-sections.
- Payment for newborns will continue to be paid under the mother's ID until the newborn is discharged.
- 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.

Based on these guidelines, CountyCare WILL PAY for delivery claims when they have all the necessary information based on any one of the scenarios below:

Scenario 1 Pay Delivery Claims- Vaginal Delivery or C-Section	
If the claim includes	High-risk diagnosis
and	CPT Code- See Procedure Codes or
Or	APR/DRG See Procedures Codes
Then	Pay
Scenario 2 Pay Delivery Claims for Vaginal Delivery	
If the claim includes	Diagnosis code of O80: Encounter for full-term uncomplicated delivery
and	Gestational age (GA) Indicator or
Or	ICD10 Diagnosis Code Z3A.39- Z3A.49 that indicates greater than or equal to 39 weeks
and	CPT Code- See Procedure Codes
Or	APR/DRG- See Procedure Codes
Then	Pay
Scenario 3 Pay Delivery Claims for C-Section	
If this	Diagnosis code of O82: Encounter for full-term uncomplicated c-section
and	Gestational age (GA) Indicator of greater than or equal to 39 weeks or
and	ICD10 Diagnosis Code Z3A.39- Z3A.49 that indicates greater than or equal to 39 weeks
and	CPT Code- See Procedure Codes
Or	APR/DRG- See Procedure Codes
Then	Pay

CountyCare will no longer pay facility or professional claims for elective deliveries if the following scenarios are received on a maternity claim. The following scenarios outline how a denial would be considered based on the information provided on the claim.

Scenario 1- Deny Vaginal Delivery	
If claim includes:	CPT Code: 59409, 59410, 59612, 59614
Or	APR/DRG: 541, 542, 560
and	ICD10 O80 Encounter for full-term pregnancy- uncomplicated vaginal delivery
and	A gestational age indicator less than 39 weeks gestation
or	ICD10 Z3A Code Less than 39 weeks
or	No high-risk dx code
Then	Deny
Scenario 2-Deny C-Section	
If claim includes:	CPT Code: 59514, 59515,59620,59622
Or	APR/DRG: 540
and	ICD10 O82: ICD10 O82: Encounter for full-term uncomplicated c-section
and	A gestational age indicator less than 39 weeks gestation
or	ICD10 Z3A code less than 39 weeks
or	No high-risk dx code
Then	Deny

Scenario 3-Deny No Gestational Age Indicator- Vaginal Delivery	
If claim includes:	CPT Code: 59409, 59410, 59612, 59614
Or	APR/DRG: 541, 541, 560
and	ICD10 O82 or O80
and	No gestational age indicator or
or	No ICD10 Z3A code less than 39 weeks
or	No high-risk dx code
Then	Deny
Scenario 4 -Deny No Gestational Age Indicator- C-Section	
If claim includes:	CPT Code: 59514, 59515,59620,59622
Or	APR/DRG: 540
and	ICD10 O82 or O80
and	No gestational age indicator or
or	No ICD10 Z3A code less than 39 weeks
or	No high-risk dx code
Then	Deny

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's review, and may be redirected to an In-Network facility.

CONTACT US

Over the next few months Provider Relations will be sharing information 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 CountyCare Provider Services at ProviderServices@countycare.com or your Provider Relations Representative.