APPENDIX V

Early Elective Deliveries (EED) and Elective Inductions Policy

Effective October 1, 2013, the Medicaid Division within the Department of Community Health changed its benefit coverage for non-medically necessary cesarean deliveries prior to 39 weeks gestation. Claims submitted for ANY labor inductions or cesarean sections on or before 39 weeks gestation that are not properly documented as medically necessary will be denied in the Georgia Medicaid Management System (GAMMIS). HP's current MMIS will be updated later for claims processing of this benefit coverage for early elective deliveries (EED) including non-medically necessary cesarean deliveries and early inductions. This policy was approved as a mandate by the 2013 Georgia legislature in Georgia's SFY 2014 budget bill.

Hospital UB 04 Claims

There are no proposed changes to the current billing process of inpatient claims for induction/delivery services when processed through the claims adjudication process for payment. Hospitals are strongly encouraged to collaborate with their physicians privileged to provide obstetric services in order to develop guidelines and protocols (i.e., a scheduling protocol or Hard Stop Policy and/or establish documentation standards) for deliveries prior to 39 weeks gestation. Hospitals are also encouraged to enforce those guidelines and protocols.

Professional 1500 Claims

Practitioners are to continue billing obstetric procedure codes on their professional 1500 claim forms for payment: 59400, 59409, 59410, 59514, 59510, 59515, 59610, 59612, 59614, 59618, 59620, and 59622, along with one of the three (3) modifiers (UB, UC, or UD) appended to the billed delivery procedure code. GAMMIS will be configured with system edit(s) for the delivery claims that do not append one of the required EED modifier and/or that do not meet the approved guidelines of billing certain clinical indications. Delivery claims that are submitted with medical conditions that do not warrant an exception prior to 39 weeks gestation will post the EED edit requiring medical review by our state's peer review organization, Georgia Medical Care Foundation (GMCF). Clinical justification and the proper documentation must be submitted to GMCF for review of the denied obstetric delivery claim. Also, **ALL Medicaid practitioners' claims for elective inductions/C-sections must include EITHER the last menstrual period (LMP) or the estimated date of confinement (EDC) or the estimated delivery date (EDD) in field locator 14 of the CMS 1500 paper/electronic form.**

Delivery Modifiers for Professional 1500 Claims

One of the following modifiers is required when billing obstetric services for payment:

UB—Medically-necessary delivery prior to 39 weeks of gestation

- For deliveries resulting from members presenting in labor, or at risk of labor, and subsequently delivering before 39 weeks, or
- For inductions or cesarean sections that meet the ACOG or approved medically necessary guidelines, the appropriate ACOG Patient Safety Checklist must be completed and maintained for documentation in the GA enrolled member's file, or

- For inductions or cesarean sections that do not meet the ACOG or approved guidelines, the appropriate ACOG Patient Safety Checklist must be completed. Additionally, the enrolled provider must obtain approval from the state's peer review organization, Georgia Medical Care Foundation (GMCF), and maintain this checklist in the enrolled member's file. The practitioner must submit to GMCF the clinical justification and documentation for review along with the Patient Safety Checklist.

UC—Delivery at 39 weeks of gestation or later

- For all deliveries at 39 weeks gestation or more regardless of method (induction, cesarean section or spontaneous labor).

UD—Non-medically necessary delivery prior to 39 weeks of gestation (Elective non-medically necessary deliveries less than 39 weeks gestation)

- For deliveries less than 39 weeks gestation that do not meet ACOG or approved guidelines or are not approved by the Georgia Medical Care Foundation as medically necessary with clinical justification. Examples of unacceptable medical reasons include patient choice, physician going out of town, history of a fast labor, etc.

NOTE: Obstetric delivery claims that are submitted without one of the required modifiers listed above will be denied. To avoid claim denials, the two-digit modifier is required whenever billable obstetrical procedure codes are submitted for payment either for vaginal deliveries or cesarean sections.

Documentation Requirements

Providers should utilize medical standards before performing cesarean sections, labor inductions, or any delivery following labor induction. The documents required for peer review are the member's history and physical, admission notes for the delivery, operative report, if applicable, for cesarean sections, physician progress notes, labor and delivery report, discharge summary, and the ACOG Patient Safety Checklist or an appropriate checklist that meets national guidelines. There are medically necessary conditions that may warrant clinical justification with the proper documentation for an early induction or cesarean section (refer to links in references) for some approved exceptions of medical conditions for deliveries prior to 39 weeks. The list of conditions is not meant to be exclusive.

References

http://www.acog.org/~/media/Patient%20Safety%20Checklists/psc005.pdf?dmc=1&ts=20130911T1426455280 (Scheduling Induction of Labor Checklist)

http://www.acog.org/~/media/Patient%20Safety%20Checklists/psc003.pdf?dmc=1&ts=20130911T1426455290 (Scheduling Planned Cesarean Delivery Checklist)

https://manual.jointcommission.org/releases/TJC2013A/AppendixATJC.html#Table_Number_11_07_Conditions_Po (Joint Commission Conditions)