

**NEW YORK STATE MEDICAID
OBSTETRICAL DELIVERIES PRIOR TO 39 WEEKS GESTATION**

**Medicaid Fee-for-Service
And
Medicaid Managed Care**

This article supersedes the guidance for elective deliveries that was published in the June 2013, June 2014, April 2015, April 2016 and May 2016 Medicaid Update articles regarding elective deliveries (C-sections and inductions of labor) less than 39 weeks gestation without medical indication.

**MEDICAID FEE-FOR-SERVICE (FFS) AND MEDICAID MANAGED CARE (MMC)
REIMBURSEMENT POLICY FOR C-SECTIONS OR INDUCTIONS PRIOR TO 39
WEEKS GESTATION**

NYS Medicaid reimburses 100% for C-sections or inductions performed at less than 39 weeks gestation for medical necessity. NYS Medicaid reimburses 25% for C-sections or inductions performed at less than 39 weeks gestation electively.

New York State Medicaid follows the most recent recommendations of the American College of Obstetricians and Gynecologists (ACOG) to identify medically indicated deliveries prior to 39 weeks. The information contained in ACOG's Committee Opinion should not be construed as dictating an exclusive course of treatment or procedure to be followed.

For information on ACOG Guidelines, please visit the following links:

ACOG Committee Opinion Number 560, April 2013.

<https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Medically-Indicated-Late-Preterm-and-Early-Term-Deliveries>

ACOG Committee Opinion Number 561, April 2013.

<https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Nonmedically-Indicated-Early-Term-Deliveries>

The NYS Department of Health (Department) has identified billing issues related to coding (procedure and diagnosis) for early delivery obstetrical claims. To resolve this issue, both FFS and MMC are enacting claim coding and billing guideline changes detailed in their respective sections below in this document. Of note, both FFS and MMC require that a condition code be reported on institutional claims and a procedure code modifier be reported on practitioner claims to identify elective and medically

necessary early deliveries. The condition code or modifier reported on the claim should reflect the status of the delivery based on ACOG guidelines.

Medicaid FFS and Managed Care Inpatient Facility Claim Coding Guidelines:

All C-Sections and inductions of labor, whether prior to, at, or after 39 weeks gestation, require the use of a condition code (81, 82 or 83). For all spontaneous labor under 39 weeks gestation resulting in a C-Section delivery, please report condition code 81.

- Condition code 81 - C-sections or inductions performed at less than 39 weeks gestation for medical necessity.
Full payment
- Condition code 82 - C-sections or inductions performed at less than 39 weeks gestation electively.
Reduced payment
- Condition code 83 - C-sections or inductions performed at 39 weeks gestation or greater.
Full payment

Please Note:

For those facilities submitting a Graduate Medical Education (GME) claim to fee-for-service Medicaid, please follow the billing instructions stated under fee-for-service inpatient facility billing guidelines.

Table 1: Fee-For-Service ICD-10 Procedure Codes Requiring a Condition Code When a C-Section or Induction of Labor Occurs

*Please Note: Augmentation of labor does not require a condition code.

ICD-10 PROCEDURE CODE	DESCRIPTION
10900ZC	Drainage of amniotic fluid, therapeutic from products of conception, open approach
10903ZC	Drainage of amniotic fluid, therapeutic from products of conception, percutaneous approach
10904ZC	Drainage of amniotic fluid, therapeutic from products of conception, endoscopic approach
10907ZC	Drainage of amniotic fluid, therapeutic, from products of conception, via natural or artificial opening
10908ZC	Drainage of amniotic fluid, therapeutic from products of conception, via natural or artificial opening endoscopic
0U7C7ZZ	Dilation of cervix, via natural or artificial opening
3E030VJ	Introduction of other hormone into peripheral vein, open approach

3E033VJ	Introduction of other hormone into peripheral vein, percutaneous approach (New code 10/01/2017)
3E0P7VZ	Introduction of hormone into female reproductive, via natural or artificial opening
3E0P7GC	Introduction of other therapeutic substance into female reproductive, via natural or artificial opening
10D00Z0	Extraction of products of conception, classical open approach
10D00Z1	Extraction of products of conception, low cervical, open approach
10D00Z2	Extraction of products of conception, extraperitoneal, open approach

Medicaid FFS and Managed Care Practitioner Claim Coding Guidelines:

All obstetrical deliveries, whether prior to, at, or after 39 weeks gestation, require the use of a modifier (U7, U8 or U9). Failure to include a U7, U8, or U9 modifier, as appropriate, on a claim will result in denial of the claim.

- U7 – Delivery less than 39 weeks for medical necessity
Full payment
- U8– Delivery less than 39 weeks electively
Reduced payment
- U9 – Delivery 39 weeks or greater
Full payment

Table 2: Fee-for-Service Procedure Codes Requiring a Modifier:

CPT PROCEDURE CODE	DESCRIPTION
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59409	Vaginal delivery only (with or without episiotomy and/or forceps)
59410	Vaginal delivery (with or without episiotomy and/or forceps); including postpartum care
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59514	Cesarean delivery only
59515	Cesarean delivery; including postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care, after previous cesarean delivery
59612	Vaginal delivery, after previous cesarean delivery (with or without episiotomy and/or forceps)
59614	Vaginal delivery, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery
59622	Cesarean delivery, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

FEE FOR SERVICE BILLING GUIDELINES:

Effective November 1, 2017, FFS is eliminating diagnosis code editing to identify elective and medically necessary early deliveries. FFS will now rely solely on the condition code reported on institutional claims and the procedure code modifier reported on practitioner claims to identify elective and medically necessary early deliveries.

eMedNY system changes are currently in the process of being implemented to reflect the new FFS billing guidelines. **Until the system changes are fully implemented, providers will receive full payment for all deliveries prior to 39 weeks.** Providers will be notified when the system changes are fully implemented.

After the system changes are implemented, FFS will be reprocessing previously paid claims that received full payment on or after November 1, 2017 and will recoup payment if the condition code/procedure code modifier reported by the provider indicates that the early delivery was not medically necessary. It is therefore imperative that all providers continue to report the appropriate condition code and procedure code modifier to ensure proper payment is made for a delivery.

Practitioners and facilities are responsible for ensuring that the codes (and modifiers when applicable) submitted for reimbursement accurately reflect the diagnosis and procedure(s) that were reported. Post payment reviews may be conducted by the Office of the Medicaid Inspector General (OMIG) and/or through a Medicaid-funded utilization management contractor, as appropriate (pursuant to 18 NYCRR 504.8) on adjudicated claims. Recoupment of funds and fraud investigations, when applicable, will be enforced.

Medical records must be maintained by providers for a period of not less than six years from the date of payment.

If you have Medicaid FFS billing questions, please contact eMedNY provider Services at (800) 343-9000. If you identify that your FFS payment for an early elective delivery related claim was inappropriately reduced or denied, please contact the Office of Health Insurance Programs at (518) 473-2160. Policy questions regarding Medicaid FFS may be directed to the Office of Health Insurance Programs (OHIP), Division of Program Development and Management at (518) 473-2160.

MEDICAID MANAGED CARE BILLING GUIDELINES:

In accordance with the NYS's Medicaid reimbursement policy for C-sections or inductions performed prior to 39 weeks gestation (stated above), effective January 8,

2018, the Department of Health requires MMC plans to implement mechanisms to pay providers for C-sections or inductions performed at less than 39 weeks gestation when deemed medically necessary, and reduce payments for C-sections or inductions performed at less than 39 weeks gestation when deemed elective (not medically necessary). Payment is to be negotiated between providers and the managed care plans.

Providers participating in MMC should check with the individual health plans to determine how each MMC plan will apply this policy. Questions regarding MMC reimbursement and/or documentation requirements should be directed to the enrollee's MMC plan.