Early Elective Delivery Non-Payment Guide

Background: The Case for Reducing Early Elective Deliveries

Since 1979, the American College of Obstetricians and Gynecologists has recommended against deliveries before 39 weeks unless there is a medical indication (see Appendix C). Early elective deliveries are associated with an increased risk of maternal and neonatal morbidity (and longer hospital stays) for both mothers and newborns, as compared to deliveries occurring between 39 and 40 weeks gestation.[1] Because they often result in the delivery of newborns who require additional medical interventions, early elective deliveries often generate higher medical costs compared to full-term, spontaneous births**.** The induction of labor is associated with higher medical costs than spontaneous birth; for every 100 women induced, there is an average additional 88 days in the hospital.[2] The American Academy of Family Physicians notes that elective induction more than doubles the cesarean delivery rate, a procedure that carries health risks for infants and mothers and greater medical expenses.[3] Commercial payers paid an extra $1,464 to clinicians and $7,518 to facilities for cesarean versus vaginal births.[4] Despite the overwhelming evidence against early elective deliveries, an estimated 10 to 15 percent of babies in the U.S. continue to be delivered early without medical cause.[5] The Leapfrog Group, a national nonprofit organization committed to advancing hospital safety and quality, has set a standard that no more than five percent of all deliveries should be early on an elective basis.[6]

Based on lessons learned from South Carolina's Birth Outcomes Initiative, Catalyst for Payment Reform strongly recommends a multi-pronged approach to improving birth outcomes, including educating consumers and providers, working collaboratively with the provider community to develop indications for an early elective delivery, and participating in voluntary, quality improvement efforts with hospitals. To ensure the best outcomes, these approaches should be pursued for a significant timeframe before implementing a policy of nonpayment. There are of course other methods of payment reform that can create more mild disincentives for early elective deliveries, such as a single blended payment rate for vaginal and cesarean deliveries (see more examples in CPR's Action Brief on Maternity Care Payment). When an agency or health plan decides to implement a non-payment policy, they should consider the key features and implementation guidelines discussed in this paper.

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[1] Ashton DM. 2010 Elective delivery at less than 39 weeks. Current Opinion in Obstetrics & Gynecology. 22(6):506 510.

[2] University of Rochester Medical Center, "Scheduled Deliveries Raise Risks for Mothers, Do Not Benefit Newborns," last modified February 18,2011, http://www.urmc.rochester.edu/news/story/index.cfm?id=3120

[3] Ehrenthal, D.B., Jiang, X. & Strobino, DM. (2010). Labor induction and the risk of a cesarean delivery of nulliparous women at term. *Obstetrics and Gynecology, 116*, 35-42 doi: 10.1097/AOG.0b013e3181e10c5c

[4] Childbirth Connection, "The Cost of Having a Baby," last modified January 2013, http://transform.childbirthconnection.org/wp-content/uploads/2013/01/Cost-of-Having-a-Baby1.pdf

[5] Health and Human Services, "News Release," last modified February 2012, http://www.hhs.gov/news/press/2012pres/02/20120208a.html

[6] Leapfrog, "Factsheet," last modified February 2013, https://leapfroghospitalsurvey.org/web/wp-content/uploads/FSdeliveries.pdf

Key Features of an Early Elective Delivery Non-Payment Policy

A clearly defined definition of early elective delivery

An early elective delivery is defined as a birth where either an induction or cesarean section has taken place without medical indication between the 37th and the 39th completed week of gestation.

As specified by joint commission standards, the included population is defined by claims with *ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes* for one or more of the following:

- Medical induction of labor defined by ICD9 code 73.01, 73.1, and 73.4.
- Cesarean section as defined in Appendix A, Table 1 while not in *Labor* or experiencing *Spontaneous Rupture of Membranes*

The following exclusions should be taken into consideration when establishing a non-payment policy for early elective deliveries:

- *ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes* for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 2
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of stay > 120 days
- Enrolled in clinical trials
- Prior uterine surgery

Any delivery between 37-39 weeks gestation without one of the above exclusions to justify induction is subject to non-payment.

A clearly defined scope for nonpayment

The extent of services covered in the nonpayment policy must clearly be specified. Typically, nonpayment is limited to the labor and delivery DRG based on the ICD9 codes listed above. However, a policy could be developed to extend beyond just labor and delivery and further limit reimbursement for complications that stem from an elective induction. These complications can extend to complications experienced by the mother due the induction as well as additional newborn care necessary due to the induction. Extending nonpayment to complications from the early elective delivery creates numerous administrative challenges as demonstrating that complications are exclusively due to the early and elective nature of the delivery is extremely difficult.

A clearly defined claims adjudication process

The administration of nonpayment for early elective deliveries can occur in two ways: 1) the non-payment policy can work prospectively through utilization review --prior approval would be required for all elective induction/cesareans between 37 and 39 weeks gestation and, 2) the non-payment policy can be administered retrospectively -- claims would be subject to audit for early elective deliveries and any payment for these deliveries would be reversed and reclaimed or applied as a credit toward future claims. In either method, it is critical that all claims specify the reason for induction. A combination of both methods can also be applied, with physician payments monitored prospectively and facility payments reversed retrospectively. In these cases physician payments withheld for elective deliveries on

the front end and then the corresponding hospital payments are reverse. Regardless of the adjudication process, policies should clearly state that claims not specifying the reason for induction will be subject to nonpayment regardless of elective status.

An outlined course of action when an early elective delivery occurs

If an early elective delivery does occur, expectation of financial liability for the non-payment should be clearly defined. For example, providers not reimbursed for an early elective delivery should not pursue the expected payment from patients. In states where there is limited regulation on balanced billing practices, it is particularly important to safeguard patients from out-of-pocket exposure from deliveries subject to non-payment.

Special consideration for Medicaid

While the principles describe above are applicable to both the private and public sector, there are a few considerations of note for Medicaid agencies looking to institute an early elective delivery nonpayment policy. Medicaid agencies looking to apply the policy to both their fee-for-service and managed care populations will need to work through their contracted plans for the managed care population. Medicaid must also note any state specific regulations/requirements limiting implementation of new payment policies. On a state-by-state basis, some agencies may need to pursue a federal waiver to implement the nonpayment policy. Additionally, Medicaid agencies may want to use legislation to implement the policy. In some cases, depending on the political climate and provider relationships, legislative options may be the best route to establish the nonpayment policy.

Steps to Implement a Non-Payment Policy for Early Elective Deliveries

Collect, analyze, and understand data

Before implementing any nonpayment policy to reduce early elective deliveries, a state, purchaser or employer should have a good sense of current rates of early elective deliveries in their population, and some way to measure progress reducing these rates over time. The Leapfrog Group can provide a starting point, as it shares rates of early electives at specific hospitals, and across states (see Appendix B). States may be able to collect additional data from providers and payers as well. Payment reform champions may wish to take additional steps to make these measures public and to share them with providers to enhance accountability.

Engage providers

Providers should be engaged in developing and understanding the medical indications for an early delivery and should designate champions at hospitals, charged with changing practice patterns to reduce the rate of early elective deliveries. For example, in South Carolina a provider workgroup developed guidelines for medically-indicated early deliveries, based on ACOG guidelines (see Appendix C). Hospitals were asked to designate a champion and sign a pledge letter, committing to reduce early elective deliveries (see Appendix D for pledge letter). In addition, engaging providers in developing the mechanics of the nonpayment policy can help ensure they are well understood and workable. See Appendix E for a sample of how the nonpayment policy works in South Carolina.

Provide ample notice of its implementation

Depending on the state, Medicaid may be able to do this without a waiver or a formal change in policy. Private payers can adopt policy changes as well and provide notice to providers. See Appendix F for an example of a Medicaid and commercial plan notice of nonpayment. If two commercial plans want to

issue a policy in tandem, they may need to approach their state insurance commissioner, to get a safe harbor from any anti-trust concerns.

Educate employees and/or the public

Before and during embarking on all of the steps above, a state, purchaser, or employer should educate consumers about the health reasons to avoid early elective deliveries. Your state March of Dimes Chapter can provide support, and reviewing the March of Dimes "Less than 39 Weeks Toolkit" is a good place to start. It can be found at: http://www.marchofdimes.com/professionals/less-than-39-weeks-toolkit.aspx. March of Dimes can also provide technical assistance to hospitals to help them change policies and practice patterns.

Pay close attention to cesarean delivery rates at 39 weeks, and be prepared to change payment policy for those too

While implementing a nonpayment policy for early elective deliveries can reduce inductions and cesarean deliveries at 37 and 38 weeks, some providers may still be willing to perform elective cesarean deliveries when patients reaches 39 weeks. To eliminate these elective cesarean deliveries occurring at term, a state, employer or other health care purchaser, or health plan may also want to consider implementing a change to payment policy to discourage them. Examples include global payment for maternity care, or decreasing reimbursement rates for elective cesarean deliveries. More information is available in CPR's Action Brief, located at http://www.catalyzepaymentreform.org/images/documents/maternity.

Appendix A: Specified IDC-9 Codes for Defining Elective Deliveries

Table 1: Cesarean Section

Code	Shortened Description
74.0	CLASSCIAL C-SECTION
74.1	LOW CERVICAL C-SECTION
74.2	EXTRAPERITONEAL C-SECTION
74.4	CESAREAN SECTION NEC
74.99	CESAREAN SECTION NOS

Table 2: Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation

Code	Shortened Description
042	HUMAN IMMUNO VIRUS DIS
641.01	PLACENTA PREVIA-DELIVER
641.11	PLACENTA PREV HEM-DELIV
641.21	PREM SEPAR PLACEN-DELIV
641.31	COAG DEF HEMORR-DELIVER
641.81	ANTEPARTUM HEM NEC-DELIV
641.91	ANTEPARTUM HEM NOS-DELIV
642.01	ESSEN HYPERTEN-DELIVERED
642.02	ESSEN HYPERTEN-DEL W P/P
642.11	RENAL HYPERTEN PG-DELIV
642.12	RENAL HYPERTEN-DEL P/P
642.21	OLD HYPERTEN NEC-DELIVER
642.22	OLD HYPERTEN-DELIV W P/P
642.31	TRANS HYPERTEN-DELIVERED
642.32	TRANS HYPERTEN-DEL W P/P
642.41	MILD/NOS PREECLAMP-DELIV
642.42	MILD PREECLAMP-DEL W P/P
642.51	SEVERE PREECLAMP-DELIVER
642.52	SEV PREECLAMP-DEL W P/P
642.61	ECLAMPSIA-DELIVERED
642.62	ECLAMPSIA-DELIV W P/P
642.71	TOX W OLD HYPERTEN-DELIV
642.72	TOX W OLD HYP-DEL W P/P
642.91	HYPERTENS NOS-DELIVERED
642.92	HYPERTENS NOS-DEL W P/P
645.11	POST TERM PREG-DEL
646.21	RENAL DIS NOS-DELIVERED
646.22	RENAL DIS NOS-DEL W P/P
646.71	LIVER/BIL TRCT DISR-DEL
648.01	DIABETES-DELIVERED
648.51	CONGEN CV DIS-DELIVERED
648.52	CONGEN CV DIS-DEL W P/P
648.61	CV DIS NEC PREG-DELIVER

648.62	CV DIS NEC-DELIVER W P/P
648.81	ABN GLUCOSE TOLER-DELIV
648.82	ABN GLUCOSE-DELIV W P/P
649.31	COAGULATION DEF-DELIV
649.32	COAGULATN DEF-DEL W P/P
651.01	TWIN PREGNANCY-DELIVERED
651.11	TRIPLET PREGNANCY-DELIV
651.21	QUADRUPLET PREG-DELIVER
651.31	TWINS W FETAL LOSS-DEL
651.41	TRIPLETS W FET LOSS-DEL
651.51	QUADS W FETAL LOSS-DEL
651.61	MULT GES W FET LOSS-DEL
651.71	MULT GEST-FET REDUCT DEL
651.81	MULTI GESTAT NEC-DELIVER
651.91	MULT GESTATION NOS-DELIV
652.01	UNSTABLE LIE-DELIVERED
652.61	MULT GEST MALPRES-DELIV
655.01	FETAL CNS MALFORM-DELIV
655.11	FETAL CHROMOSO ABN-DELIV
655.31	FET DAMG D/T VIRUS-DELIV
655.41	FET DAMG D/T DIS-DELIVER
655.51	FET DAMAG D/T DRUG-DELIV
655.61	RADIAT FETAL DAMAG-DELIV
655.81	FETAL ABNORM NEC-UNSPEC
656.01	FETAL-MATERNAL HEM-DELIV
656.11	RH ISOIMMUNIZAT-DELIVER
656.21	ABO ISOIMMUNIZAT-DELIVER
656.31	FETAL DISTRESS-DELIVERED
656.41	INTRAUTER DEATH-DELIVER
656.51	POOR FETAL GROWTH-DELIV
657.01	POLYHYDRAMNIOS-DELIVERED
658.01	OLIGOHYDRAMNIOS-DELIVER
658.11	PREM RUPT MEMBRAN-DELIV
658.21	PROLONG RUPT MEMB-DELIV
658.41	AMNIOTIC INFECTION-DELIV
659.71	ABN FTL HRT RATE/RHY-DEL
663.51	VASA PREVIA-DELIVERED
V08	ASYMP HIV INFECTN STATUS
V23.5	PREG W POOR REPRODUCT HX
V27.1	DELIVER-SINGLE STILLBORN

Appendix B: Leapfrog Data on Early Elective Delivery Rates

Leapfrog tracks the rate of early elective deliveries at individual hospitals, and also shares statewide rates. More information is available at: http://www.leapfroggroup.org/cp?form=cp_start. Hospitals who decline to participate in Leapfrog's Hospital Survey should be encouraged to do so--the website provides tools employers and purchasers can use.

Appendix C: ACOG Examples of Medical Indications for Late-Preterm or Early-Term Deliveries

- Preeclampsia, eclampsia, gestational hypertension, or complicated chronic hypertension
- Oligohydramnios
- Prior classical cesarean delivery or prior myomectomy
- Placenta previa or placenta accreta
- Multiple gestations
- Fetal growth restriction
- Pregestational diabetes with vascular disease
- Pregestational or gestational diabetes—poorly controlled
- Placental abruption
- Chorioamnionitis
- Premature rupture of membranes
- Cholestasis of pregnancy
- Alloimmunization of pregnancy with known or suspected fetal effects
- Fetal congenital malformations

Appendix D: Hospital Pledge

South Carolina Department of Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

Dear Chief Executive Officer,

The South Carolina Department of Health and Human Services is partnering with the South Carolina Hospital Association, other state agencies, private providers, payors, consumers and advocacy groups in an effort to reduce the number of low birth weight babies born in South Carolina. Our first step in working towards this goal is the elimination of non-medically necessary elective deliveries prior to 39 weeks gestation.

Nationally, there has been an increased focus on improving the quality and safety of perinatal care. Research has shown that early elective delivery without medical or obstetrical indication is linked to neonatal morbidities with no benefit to the mother or infant. (*March of Dimes "Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age" toolkit.*)

We are asking for your written commitment to actively participate in this initiative starting September 1, 2011. Please identify two physician champions, such as an OBGYN and Neonatologist or Pediatrician, who will be responsible for leading this effort in your hospital. Please fax the completed template by August 26th to the attention of Birth Outcomes Initiative at 803-255-8232. Or, if you prefer, you may email the completed form to martinml@scdhhs.gov.

Thank you in advance,

Ms. Bz Giese
Deputy Director Medical and Managed Care Services, SCDHHS

Dr. Rick Foster
Senior Vice President of Quality and Patient Safety, SCHA

Dr. Scott Sullivan
President, SC Obstetrical and Gynecological Society
Vice-Chair, SC Section of the American Congress of Obstetrics and Gynecology

Ms. Kathy Douglas
State Director, SC Chapter of March of Dimes

P.O. Box 8206 • Columbia, South Carolina 29202-8206

Beginning September 1, 2011 _____ affirms its
(*hospital name*)
commitment to the elimination of all non-medically necessary elective deliveries prior to 39 weeks gestation.

_____
(*Chief Executive Officer*)

This initiative will be championed by: (*Please print name*)

_____
(*OBGYN*)

_____
(*Neonatologist/Pediatrician*)

Appendix E: Mechanics of the Non-Payment Policy in South Carolina

1. If physicians want to schedule an elective delivery, they send the ACOG checklist (or a comparable form) to the hospital, and if the nurse/scheduler/clerk notices there is no medical indication for an early elective delivery, the procedure does not get scheduled (unless the physician returns with a medically indicated reason)—a "hard stop."
2. When a delivery occurs before 39 weeks with a medical indication, the physician completes a billing card with a "CG" modifier. This is then given to the people who handle coding and claims. If the "CG modifier" is included, the provider is paid for delivering the baby. (Modifiers were developed by the provider community based on ACOG guidelines).
3. If there is no modifier, there is no payment for the early elective delivery.
4. Finally, if a patient does not have one of the approved indications, but her provider perceives a valid reason for early delivery, maternal-fetal medicine physicians at the regional tertiary care centers may grant exemptions. South Carolina put this process in place to accommodate exceptions, but has been very rarely required in practice.[7]

[7] Information provided by Amy H. Picklesimer, MD, MSPH, South Carolina Birth Outcomes Initiative Clinical Lead, Division of Maternal-Fetal Medicine, Greenville Health System, via email, October 14, 2013

Appendix F. South Carolina Department of Health and Human Services Notice of Nonpayment

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.scdhhs.gov
December 12, 2012
MB# 12-062

MEDICAID BULLETIN

Phys
Hosp
MC

TO: **Providers Indicated**

SUBJECT: **Non Payment Policy for Deliveries Prior to 39 weeks: Birth Outcomes Initiative**

Effective for dates of service on or after January 1, 2013, the South Carolina Department of Health and Human Services (SCDHHS) will no longer provide reimbursement for elective inductions or non–medically indicated deliveries prior to 39 weeks to hospitals and to physicians. This change is a result of an extensive effort and partnership by SCDHHS, South Carolina Hospital Association, South Carolina Chapter of the American Congress of Obstetricians & Gynecologists, Maternal Fetal Medicine physicians, BlueCross BlueShield of SC and other stakeholders to reduce non-medically necessary deliveries.

In September of 2011, through the Birth Outcomes Initiative (BOI) and South Carolina Hospital Association (SCHA), all 43 birthing hospitals in South Carolina signed a pledge to stop early elective deliveries. In July of this year, physicians were notified that as of August 1, 2012, all claims submitted for deliveries and inductions had to contain a specific modifier (GB or CG). Please visit http://www.scdhhs.gov/press-release/birth-outcomes-initiative-modifiers to view the SCDHSS Medicaid bulletin released in July 2012.

All hospital claims that are associated with physician claims resulting from non-medically necessary deliveries and inductions prior to 39 weeks gestation will be audited and payment will be re-couped in its entirety through a retrospective review process.

Physicians must continue to append the following modifiers to all CPT surgical codes when billing for vaginal deliveries and cesarean sections or their claims will be automatically denied:

GB – 39 weeks gestation and or more

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

Fraud & Abuse Hotline 1-888-364-3224

CG – Less than 39 weeks gestation

- For deliveries resulting from patients presenting in labor, or at risk of labor, and subsequently delivering before 39 weeks, or
- For inductions or cesarean sections that meet the ACOG guidelines, the appropriate ACOG Patient Safety Checklist must be completed and maintained for documentation in the patient's file, or
- For inductions or cesarean sections that do not meet the ACOG guidelines, the appropriate ACOG Patient Safety Checklist must be completed. Additionally, the physician must obtain and document approval from the regional perinatal center's maternal fetal medicine physician in the patients file and in the hospital record

No Modifier – Claims that do not have the GB/CG modifiers indicated will be denied

For elective deliveries less than 39 weeks gestation that do not meet ACOG approved guidelines or are not approved by the designated regional perinatal center's maternal fetal medicine physician

This bulletin applies to all fee-for-service, medical home networks and managed care organization participants. If you have any questions, please contact the Provider Service Center at (888)289-0709. Thank you for your continued support of the SC Medicaid program.

/s/
Anthony E. Keck
Director