



State of New Mexico
Medical Assistance Program Manual
Supplement



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TO: PROVIDERS PARTICIPATING IN THE NEW MEXICO MEDICAID PROGRAM

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SUBJECTS: I. LIMITING PAYMENT FOR INDUCTIONS AND CESAREAN SECTIONS THAT ARE NOT MEDICALLY NECESSARY

II. BILLING WHEN C-SECTIONS OR INDUCTIONS ARE MEDICALLY NECESSARY

III. HYSTERECTOMY CONSENT FORM

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I. LIMITING PAYMENT FOR INDUCTIONS AND CESAREAN SECTIONS THAT ARE NOT MEDICALLY NECESSARY

For decades, organizations like American College of Obstetricians and Gynecologists (ACOG) and the March of Dimes have been promoting the importance of full-term pregnancies, those naturally reaching at least 39 weeks gestation. Yet, early elective deliveries still account for 10 to 15 percent of all deliveries.

Numerous studies show early elective deliveries are associated with increased maternal and neonatal complications for both mothers and newborns compared to deliveries occurring beyond 39 weeks and women who go into labor on their own.

The March of Dimes website contains a number of useful resources and toolkits for professional education on the topic of reducing early and elective deliveries at http://www.marchofdimes.com/professionals/medicalresources_39weeks.html.

The Centers for Medicare and Medicaid Services (CMS) also recently launched the Strong Start Initiative which educates professionals on how they can help in reducing early and elective deliveries. This website can be found at <http://www.innovation.cms.gov/initiatives/Strong-Start/>

A New Mexico workgroup led by the March of Dimes and comprised of representatives from the American College of Obstetricians and Gynecologists (ACOG), the American College of Nurse Midwives (ACNM) and the American Academy of Family Physicians (AAFP) assembled to develop strategies for decreasing early elective deliveries (EED). They have comprised a list of conditions that may be indications for induction or early c-section. They are intended only as a general resource for hospitals and clinicians, and are not intended to reflect or establish a standard of care or to replace individual clinician judgment and medical decision making for specific healthcare environments and patient situations.

They include the following:

- Placental abruption, placenta previa, unspecified antenatal hemorrhage
- Gestational hypertension, preeclampsia, eclampsia, chronic hypertension
- Rupture of membranes prior to labor (term or preterm)
- Diabetes requiring medication (GDM A2 or pre-existing DM)
- Renal disease
- Maternal coagulation defects in pregnancy (includes anti-phospholipid syndrome)
- Liver diseases (including cholestasis of pregnancy)
- Cardiovascular diseases (congenital and other)
- Human Immunodeficiency Virus (HIV) infection
- Intrauterine Growth Restriction, oligohydramnios, polyhydramnios, fetal distress, abnormal fetal heart rate
- Isoimmunization (Rh and other), fetal-maternal hemorrhage
- Fetal malformation, chromosomal abnormality, or suspected fetal injury
- Multiple gestation
- Prior classical cesarean or cesarean with extension into active segment of uterus or three or more prior cesareans
- Unstable lie or transverse presentation after cephalic version
- Active/current pulmonary disease

Currently, the Medical Assistance Division (MAD) pays for cesarean sections (c-sections) that are not medically necessary at the same rate as vaginal deliveries. This provision applies specifically to codes 59510, 59514, or 59515. If the provider bills code 59510, 59514, or 59515, and medical necessity for the c-section is documented in the medical record, the provider bills these codes with the modifier U1, in which case MAD pays the claim at the c-section rate.

However, because of the importance of this issue and its relation to healthy outcomes, MAD will be limiting payment for services that are not medically necessary as follows:

1. **Deliveries Following Inductions Prior to 39 Weeks Gestation:**
Effective November 1, 2013, the New Mexico Medicaid program will no longer pay deliveries when labor was induced prior to 39 weeks unless the induction was medically indicated.

This is consistent with federal requirements that only services that are medically necessary can be paid by the Medicaid program such as those circumstances noted above. This would preclude payment for elective inductions which lack medical

justification. Prenatal and post partum care will be paid, but not the induction or the delivery.

**2. Cesarean Sections Regardless of Gestational Period:
Effective November 1, 2013, the New Mexico Medicaid program will no longer pay for c-sections that are not medically indicated.**

This is consistent with federal requirements that only services that are medically necessary can be paid by the Medicaid program. Performance of a c-section must be dictated by medical necessity. Prenatal and post partum care will be paid, but not the c-section delivery.

Maternal and fetal conditions that provide the medical necessity for a cesarean section could include the following. However, note that this list is also intended only as a general resource for hospitals and clinicians, and is not intended to reflect or establish a standard of care or to replace individual clinician judgment and medical decision making for specific healthcare environments and patient situations:

- Labor arrest disorders (active phase arrest, arrest of descent)
- Prior cesarean
- The mother has a serious medical condition that requires delivery for emergency treatment
- The mother has an infection that may be transmitted to the baby, such as herpes or HIV
- The mother is delivering twins, triplets, or more
- Malpresentation (breech, transverse lie, etc) or unstable lie or transverse presentation after cephalic version
- Non-reassuring fetal status requiring immediate delivery

II. BILLING WHEN C-SECTIONS OR INDUCTIONS ARE MEDICALLY NECESSARY

C-Sections: The provider's claim must include the ICD9 diagnosis code indicating the complication or necessity, i.e. 640.xx to 649.xx or 651.xx to 676.xx, and continue to bill the modifier U1 on the CPT procedure code for the c-section in order to identify the medical necessity on the claim.

By using the modifier U1 with these codes, the provider is indicating the c-section was medically necessary and that the recipient's medical record supports the physician's conclusion for the medical necessity of the services.

If a claim with procedure code 59510, 59514, or 59515 is billed without modifier U1 to indicate the medical necessity of the c-section, the payment will be denied or where prenatal and post partum care is included, be paid for only prenatal and post partum care.

Inductions: It is not possible for a provider to indicate that an induction was performed at a gestational age of less than 39 weeks prior to a delivery because of the lack of distinct codes for this procedure. However, MAD will use retrospective audits to assure that medical necessity requirements are being met.

Appropriate documentation must be contained within the recipient's medical record but should not be submitted. Upon retrospective review, medical records and documentation for any cesarean section or induction must establish the medical necessity of the service. Payments made for cesarean sections or deliveries following labor inductions that fail to meet these criteria or otherwise lack medical justification will be subject to recoupment.

III. HYSTERECTOMY CONSENT FORM

MAD provider rules stipulate that:

1. Hysterectomies require a signed, voluntary informed consent which acknowledges the sterilizing results of the hysterectomy. The form must be signed by recipients prior to the operation.
2. Acknowledgement of the sterilizing results of the hysterectomy is not required from recipients who have been previously sterilized or who are past child-bearing age as defined by the medical community.
3. An acknowledgement can be signed after the fact if the hysterectomy is performed in an emergency.

MAD has now published a form, MAD 320 Hysterectomy Consent Form, which must accompany the professional claim (837P electronic claim or CMS-1500 form) as the acknowledgment of hysterectomy.

IV. INSERTION OF LONG ACTING REVERSIBLE CONTRACEPTIVES AT TIME OF AN INPATIENT DELIVERY STAY

For Medicaid recipients - including those eligible for pregnancy-related services only - family planning related services, drug items, supplies, and devices are all covered benefits. This includes the insertion of a long acting birth control device provided in a hospital setting within the delivery stay. The following codes can be billed in addition to the inpatient hospital stay and will be reimbursed at the lesser of the provider's usual and customary charge or the New Mexico Medicaid fee schedule:

- J7300 – Intrauterine copper contraceptive device (e.g. Paragard)
- J7302 – Levonorgestral-releasing intrauterine contraceptive system, 52mg (e.g. Mirena)
- J7307 – Etonogestrel implant system including implant and supplies (e.g. Implanon)

- Q0090- Levonorgestrel-Releasing Intrauterine Contraceptive System, 13.5 mg (SKYLA, NDC 50419-0422-01)

Physician supplied long acting birth control devices

A physician billing for the device and the insertion of the device must use a professional claim (837P electronic claim or CMS-1500 form). These services may be billed on the same claim form as the delivery procedure indicating the place of service as 21 (Inpatient Hospital). The correct CPT code for the insertion of the device would most likely be 58300 or 11981. If the provider procured the device, the provider may also bill the HCPC code for the device itself including the NDC number.

The exception to billing for the insertion is if the device is placed within the same surgery as a cesarean section, the insertion is considered incidental and the provider may only bill for the device.

Hospital supplied long acting birth control devices

If the hospital supplies the device, the hospital facility must be enrolled in the New Mexico Medicaid program as a medical supplier (provider type 414) in order to be paid for the device for the same date of service covered by the DRG payment. As a medical supply company the facility will be required to submit a professional claim (837P electronic claim or CMS-1500 form) with the appropriate HCPCs procedure code for the device itself including the NDC number, using Place of Service code 21 (Inpatient Hospital). Also, be sure to include the billing taxonomy number for a medical supplier on the claim, which is typically 332B00000X.

It is not necessary for a hospital to have a separate distinct NPI as a medical supply provider if the device is billed as professional claim (837P electronic claim or CMS-1500 form) and the medical supply taxonomy is submitted on the claim.

If you have questions regarding the above information, you may contact the Medicaid Program Policy and Integrity Bureau at (505) 827-3171.

We appreciate your participation in the Medicaid program.

HYSTERECTOMY CONSENT FORM

New Mexico Medicaid

A hysterectomy is the removal of the whole uterus (womb). A hysterectomy cannot be undone, and the hysterectomy will permanently prevent you from having children. A hysterectomy should only be done when there is disease of the uterus or some other medical condition that can only be treated by removing the uterus.

New Mexico Medicaid does not cover hysterectomy procedures when performed only for the sole purpose of rendering a woman sterile.

By signing below, I consent of my own free will to be sterilized by a hysterectomy which will render me permanently incapable of reproducing. My signature, also, acknowledges that I have read and understood the above information.

Patient Name (Please Print)

Date

Patient Signature

Patient Identification Number

In accordance with Federal Regulation, 42 CFR § 441.258, the signature and dates below are required in order for Medicaid reimbursement to be made.

Physician Name (Please Print)

Physician Signature and Date

Person who obtained the patient's consent
For the hysterectomy

Signature and Date

Interpreter Name, if provided (Please Print)

Signature and Date

Note: This Medicaid recipient has been previously sterilized therefore has not signed this form.

Physician Name (Please Print)

Physician Signature and Date