



State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

NEWSLETTER

Volume 30 No. 21

November 2020

TO: Hospitals, Physicians, Advanced Practice Nurses, Midwives,
Independent Clinics – **For Action**
Health Maintenance Plans – **For Action**

SUBJECT: **Non-Medically Indicated Early Elective Deliveries**
****Revised Effective Date****

EFFECTIVE: Claims with service dates on or after **January 1, 2021**

PURPOSE: To clarify that NJ FamilyCare (NJFC) Medicaid will not reimburse providers for non-medically indicated early elective deliveries (EEDs).

BACKGROUND: On May 8, 2019, Public Law 2019, Chapter 87 was signed into law by Governor Murphy prohibiting NJ FamilyCare (NJFC) coverage of any non-medically indicated early elective deliveries. The original effective date was July 1, 2020. On March 9, 2020 Governor Murphy signed Executive Order 159 as part of New Jersey's response to the current COVID-19 crisis. One of the provisions of Executive Order 159 was to extend the effective date of Public Law 2019, Chapter 87 to January 1, 2021.

EEDs are defined as scheduled cesarean sections or medical inductions performed prior to 39 weeks of gestation without medical indication. An EED is not justified solely by maternal request, availability of effective pain management, facility or provider scheduling issues. Studies have demonstrated that non-medically indicated early elective deliveries performed prior to 39 weeks of gestation carry risks for both babies and mothers, including higher incidences of neonatal intensive care unit admissions, pneumonia and longer hospital stays for infants than when the pregnancy is allowed to progress naturally to full term. Unsuccessful inductions may result in a cesarean section, which can lead to infections, bleeding and anesthesia complications for mothers.

ACTION: Public Law 2019, Chapter 87 prohibits NJFC Medicaid reimbursement for professional and hospital, as well as clinic claims, for non-medically indicated early elective deliveries. Obstetricians and midwives are encouraged to share educational materials with their patients to ensure their understanding of the risks associated with early elective deliveries. ACOG and the March of Dimes provide educational information at:

<https://www.acog.org/womens-health>,
<https://www.marchofdimes.org/materials/HBWW-Infographic.pdf>, and
<https://marchofdimes.org/39weeks>.

Obstetricians, midwives, hospitals and clinics requesting NJFC Medicaid reimbursement for a labor and delivery claim are required to report an ICD-10-CM diagnosis code

indicating the week of gestation (ICD-10-CM category code Z3A). Claims submitted without a diagnosis code indicating the week of gestation shall be denied payment.

Any claims with service dates on or after January 1, 2021 reporting a week of gestation ICD-10-CM diagnosis code of less than 39 weeks without one of the diagnosis codes identified by the ICD-10-CM categories: O10; O11; O12; O13; O14; O15; O16; O24; O30; O31; O33; O35; O36; O42; O43; O44; O45; O71; or R03 shall be denied payment by the NJFC Medicaid Program.

Providers denied payment may request that the denial be re-considered for payment based on medical necessity by submitting the attached **DXC Technology, Medicaid Claim Inquiry/Response Form** to the DXC Technology, Correspondence Unit. Please attach a hard-copy claim and supportive medical documentation to justify payment of the claim.

If you have any questions concerning this Newsletter, please contact the DXC Technology, Provider Services Unit at 1-800-776-6334.

RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE



MEDICAID CLAIM INQUIRY/RESPONSE FORM

INSTRUCTIONS:

Attach a copy of your claim form(s) and any applicable documentation, e.g. reports, Remittance Advice. Fill in information at top of form. Write or type your question in the INQUIRY area. Print your name and date the form.

PROVIDER'S NAME & ADDRESS _____

MEDICAID PROVIDER NUMBER

PROVIDER'S GROUP #

PROVIDER'S TELEPHONE #

CLAIM INFORMATION

RECIPIENT'S NAME	HSP (MEDICAID) CASE / PERSON NO.	DATE OF SERVICE	REMITTANCE DATE	INTERNAL CONTROL NUMBER
1.				
2.				
3.				

INQUIRY

REQUESTOR'S NAME _____ DATE _____

PLEASE PRINT

RESPONSE

MAIL TO:
 PROVIDER SERVICES
 DXC TECHNOLOGY
 PO BOX 4801
 TRENTON, NJ 08650

SIGNATURE _____ DATE _____