2023-2024 MPIP Florida Medicaid Cesarean Section Rate Calculation Specifications

Description	The percentage of single liveborn Medicaid births in a practice (pay to provider) that were delivered via cesarean section (C-section).
Initial Measurement Period	January 1, 2022 - December 31, 2022 Plans must use this measurement period to calculate the C-section rate to determine which Identified Providers are qualified to receive the incentive payment as of October 1, 2023.
Re-measurement Period	July 1, 2023 - November 30, 2023 Plans may use this re-measurement period to calculate the C-section rate to determine which Identified Providers are newly qualified to receive the incentive payment as of April 1, 2024. The re-measurement period cannot be used to remove an October 1, 2023, qualified provider from receiving the April 1, 2024 incentive payment.
Numerator	The number of unduplicated Medicaid recipients between the ages of 10 and 60 who meet each of the following criteria is included in the measure numerator: • Recipient's baby was delivered by a Provider who had a delivery date of service during the measurement period (see above for date spans for each period). • Recipient had a single liveborn delivery (use codes in Table 1). • Recipient had a delivery via a cesarean section (use codes in Table 2). • Recipient's baby was delivered by a Provider who had a delivery date of service during the measurement period (see above for date spans for each period). • Recipient had a single liveborn delivery (use codes in Table 1). • Recipient had a delivery via a cesarean section (use codes in Table 2). Plans must exclude births that have a diagnosis code listed in Table 4. The numerator should be calculated at the practice (pay to provider) level, rather than at the rendering/treating provider level.
Denominator	The number of unduplicated Medicaid recipients between the ages of 10-60 who meet each of the following criteria is included in the measure denominator: • Recipient's baby was delivered by a Provider who had a delivery date of service during the measurement period (see above for date spans for each period). • Recipient had a single liveborn delivery (use codes in Table 1). • Recipient had a delivery via a vaginal or cesarean section (use codes in Tables 2 and 3). Plans must exclude births that have a diagnosis code listed in Table 4.

	The denominator should be calculated at the practice (pay to provider) level, rather than at the rendering/treating provider level.
Calculation	$\frac{\text{Numerator}}{\text{Denominator}} * 100$

Codes used to Identify Included Births

Table 1: ICD-10 Diagnosis Codes for identifying Singleton Liveborn

ICD-10	Description
Z370	Single liveborn

Table 2: CPT Procedure Codes for Identifying Cesarean Section Deliveries

CPT Procedure	CPT Procedure Code Description
59510	Global code: routine obstetric care including antepartum care, C-section delivery, and postpartum
59514	C-section delivery only
59515	C-section delivery including postpartum care
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care. Following an attempted vaginal delivery after previous C-section delivery.
59525	C-section delivery with removal of uterus (hysterectomy)
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery
59622	C-section delivery (following attempted vaginal delivery after previous C-section delivery; including postpartum care
540	APR – DRG Inpatient C-Section delivery, liveborn

Table 3: CPT Procedure Codes for Identifying Vaginal Deliveries

CPT Procedure	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)

CPT Procedure	CPT Procedure Code Description
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); 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 Only, after previous cesarean section (with or without episiotomy, and/or forceps).
APR-DRG Codes	**APR-DRG Description**
541	Vaginal delivery with sterilization and/or D&C
542	Vaginal delivery with complicating procedures exc sterilization and/or D&C
560	Vaginal Delivery

Codes Used to Identify Excluded Births

Table 4: ICD-10 Diagnosis Codes for identifying Stillborn and Multiple Gestation Births

ICD-10	Description
Z37.1	Outcome of delivery, single stillborn
Z37.2	Outcome of delivery, twins, both liveborn
Z37.3	Twins, one liveborn and one stillborn
Z37.4	Twins, both stillborn
Z37.50	Multiple births, unspecified, all liveborn
Z37.51	Triplets, all liveborn
Z37.52	Quadruplets, all liveborn
Z37.53	Quintuplets, all liveborn
Z37.54	Sextuplets, all liveborn
Z37.59	Other multiple births, all liveborn
Z37.60	Multiple births, unspecified, some liveborn
Z37.61	Triplets, some liveborn
Z37.62	Quadruplets, some liveborn
Z37.63	Quintuplets, some liveborn
Z37.64	Sextuplets, some liveborn
Z37.69	Other multiple births, some liveborn
Z37.7	Other multiple births, all stillborn
O36.4XXØ	Stillborn or intrauterine death
O3Ø.ØØ9	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, unspecified trimester
O30.109	Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, unspecified trimester

ICD-10	Description
O30.209	Quadruplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, unspecified trimester
O30.899	Other specified multiple gestation, unable to determine number of placenta & number of amniotic sacs, unspecified trimester
O3Ø.91 O3Ø.92 O3Ø.93	Multiple gestations, unspecified first, second, or third trimester