MPIP Year 6 Florida Medicaid Cesarean Section Rate Calculation Specifications

<table>
<tr><td>Description</td><td>The percentage of single liveborn Medicaid births in a practice (pay to provider) that were delivered via cesarean section (C-section).</td></tr>
<tr><td>Initial Measurement Period</td><td>January 1, 2019 – December 31, 2019

Note: Health plans must also identify eligible providers whose calendar year 2020 performance data meets the plan’s benchmark for the Florida Medicaid Cesarean Section measure.

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, 2021.</td></tr>
<tr><td>Re-measurement Period</td><td>July 1, 2020 – November 30, 2020

Note: Health plans must also identify eligible providers whose performance data for the July 1, 2021 – November 30, 2021 measurement period, meets the plan’s benchmark for the Florida Medicaid Cesarean Section measure.

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, 2022. The re-measurement period cannot be used to remove an October 1, 2021 qualified provider from receiving the April 1, 2022 incentive payment.</td></tr>
<tr><td>Numerator</td><td>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.</td></tr>
<tr><td>Denominator</td><td>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).</td></tr>
</table>

	• 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-9 and ICD-10 Diagnosis Codes for identifying Singleton Liveborn

ICD- 9	ICD-10	Description
V27.0	Z370	Single live-born

Table 2: CPT Procedure Codes for Identifying Cesarean Section Deliveries

CPT Procedure Codes	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 Codes	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 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
APR-DRG Codes	APR-DRG Desc
541	VAGINAL DELIVERY W STERILIZATION &/OR D&C
542	VAGINAL DELIVERY W COMPLICATING PROCEDURES EXC STERILIZATION &/OR D&C
560	VAGINAL DELIVERY

Codes Used to Identify Excluded Births

Table 4: ICD-9 and ICD-10 Diagnosis Codes for identifying Stillborn and Multiple Gestation Births

ICD- 9	ICD-10	Description
V27.1	Z37.1	Outcome of delivery, single stillborn
V27.2	Z37.2	Multiple gestations
V27.3	Z37.3	Twins, one live-born and one stillborn
V27.4	Z37.4	Twins, both stillborn
V27.5	Z37.59	Other multiple births, all live-born
V27.6	Z37.69	Other multiple births, some live-born
V27.7	Z37.7	Twins, both live-born
656.40-656.43	O36.4XXØ	Stillborn or intrauterine death
651.00 - 651.93	O3Ø.ØØ9	Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, unspecified trimester
	O3Ø.91 O3Ø.92 O3Ø.93	Multiple gestations, unspecified first, second, or third trimester