ADMINISTRATIVE POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Obstetrical Care-Hospital Inpatient Admissions-GA MCD-AD-1142	03/01/2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

Table of Contents

A. Subject

Obstetrical Care-Hospital Inpatient Admissions

B. Background

Obstetrical care refers to the health care treatment given in relation to pregnancy and delivery of a newborn child. This includes care during the prenatal period, labor, birthing, and the postpartum period. CareSource covers obstetrical services members receive in a hospital or birthing center as well as all associated outpatient services. The services provided must be appropriate to the specific medical needs of the member.

C. Definitions

- **Induction of Labor** – The use of pharmacological and/or mechanical methods to initiate labor.
- **Time of the Onset of Labor** – When regular uterine contractions begin resulting in labor with or without pharmacological and/or mechanical interventions.

D. Policy

I. Prior to the elective induction of labor before 39 weeks or inpatient admission for a pregnancy-related illness:
   A. Medical necessity review is required.
   B. Medical necessity is based on MCG.

II. For active/spontaneous onset of labor:
   A. Hospital admissions do NOT require a medical necessity review.
   B. Medical necessity determination is the responsibility of the provider.

III. For post-delivery hospital stays:
   A. CareSource supports the following federal guidelines:
      1. Two-day stay for mother and newborn after a vaginal delivery
      2. Four-day stay for mother and newborn after a cesarean delivery
   B. If a complication develops with the mother or baby that necessitates additional hospital days, NICU admission, or non-well-baby service, an authorization should be submitted along with clinical information to support the stay.
   C. Medical necessity is based on MCG.

E. Conditions of Coverage

N/A

F. Related Policies/Rules

Newborn and Neonatal Intensive Care (NICU) Level of Care

G. Review/Revision History

	DATES	ACTION
Date Issued	09/01/2021	

The ADMINISTRATIVE Policy Statement detailed above has received due consideration as defined in the ADMINISTRATIVE Policy Statement Policy and is approved.

Date Revised	09/14/2022 11/06/2024 11/05/2025	Annual review completed. References updated. Periodic review. Updated references. Approved at Committee. Annual review. Updated references. Revised D.III.B. Approved at Committee.
Date Effective	03/01/2026	
Date Archived		

H. References

1. *Hospital Based Triage of Obstetric Patients*. Committee Opinion 667 American College of Obstetricians and Gynecologists; 2016. Committee Opinion No. 667. Reaffirmed 2023. Accessed October 27, 2025. www.acog.org
2. Newborns and mothers' health protection act (NMHPA). Centers for Medicare and Medicaid Services. Updated September 10, 2024. Accessed October 27, 2025. www.cms.gov
3. Newborn Baby and Mother Protection Act; Minimum Health Benefit Policy Coverage; Prohibited Actions by Insurance Providers; Required Notice to Mother, Ga Code Ann. § 33-24-58.2 (2024).

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