



## ADMINISTRATIVE POLICY STATEMENT OHIO MEDICAID

| Policy Name                                    | Policy Number         | Date Effective        |
|--|-----------------------|-----------------------|
| Obstetrical Care-Hospital Inpatient Admissions | AD-1143               | 01/01/2022-12/31/2022 |
| Policy Type                                    |                       |                       |
| Medical  | <b>ADMINISTRATIVE</b> | Pharmacy              |
|  |                       | Reimbursement         |

Administrative Policy Statements 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

|                                      |   |
|--------------------------------------|---|
| Administrative Policy Statement..... | 1 |
| A. Subject.....                      | 2 |
| B. Background.....                   | 2 |
| C. Definitions.....                  | 2 |
| D. Policy.....                       | 2 |
| E. Conditions of Coverage.....       | 2 |
| F. Related Policies/Rules.....       | 2 |
| G. Review/Revision History.....      | 3 |
| H. References.....                   | 3 |



## 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

- **Time of the onset of labor:** When regular uterine contractions begin resulting in labor. This can be with or without pharmacological and/or mechanical interventions.
- **Induction of labor:** The use of pharmacological and/or mechanical methods that are utilized to initiate labor.

## D. Policy

- I. A prior authorization is required for elective induction of labor for any member that is less than 39 weeks gestation.
- II. Active/spontaneous onset of labor
  - A. Hospital admissions require a newborn notification.
  - B. Medical necessity is the responsibility of the provider.
- III. Post-delivery hospital stays
  - A. CareSource supports the following federal guidelines:
    1. 2 day stay for mother and newborn after a vaginal delivery.
    2. 4 day stay for mother and newborn after a cesarean delivery.
  - B. A medical necessity review is required if a newborn is admitted to the special care nursery or NICU. Documentation must support medical necessity.
  - C. Medical necessity is based on MCG.

## E. Conditions of Coverage

NA

## F. Related Policies/Rules

NA



G. Review/Revision History

| DATES                 |            | ACTION  |
|-----------------------|------------|---|
| <b>Date Issued</b>    | 09/01/2021 |   |
| <b>Date Revised</b>   |            |   |
| <b>Date Effective</b> | 01/01/2022 |   |
| <b>Date Archived</b>  | 12/31/2022 | This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy. |

H. References

1. American College of Obstetricians and Gynecologists (2014). Retrieved on 07/23/2021 from <https://www.acog.org>
2. Centers for Medicare and Medicaid (n.d.). 33-24-28.2. Newboms and Mothers' Health Protection Act. Retrieved 07/23/2021 from <https://www.cms.gov>

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

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