Hospital, Inpatient

Program Overview

A hospital (other than tuberculosis or psychiatric) is a state licensed, Medicare certified inpatient medical facility primarily engaged in providing, by or under the supervision of a physician or dentist, services for the diagnosis, care and treatment or the rehabilitation of sick, injured or disabled individuals, and is not primarily for the care and treatment of mental disease.

See Medicaid Services Manual (MSM) Chapters 200 and 400 for additional policy and guidelines.

Providers who have difficulty placing an individual in a nursing facility may contact the Division of Health Care Financing and Policy's (DHCFP) Long Term Services and Supports Unit by sending an email to ltss@dhcfp.nv.gov requesting assistance, along with the supporting documentation.

Managed Care vs. Fee For Service (FFS)

When a recipient is enrolled in a Managed Care Organization (MCO), request prior authorization from and submit claims to the MCO.

When a recipient is enrolled in the FFS plan, request prior authorization from and submit claims to the Nevada Medicaid fiscal agent, Gainwell Technologies, which is referred to as Nevada Medicaid throughout this document.

Rates

Rates information is on the DHCFP website at http://dhcfp.nv.gov (select "Rates and Cost Containment" from the "Resources" menu). Rates are available on the Provider Web Portal at www.medicaid.nv.gov through the Search Fee Schedule function, which can be accessed on the Provider Web Portal (PWP Login) webpage under Resources (you do not need to log in). Any provider-specific rates will not be shown in the Search Fee Schedule function.

Authorization

Claims will be denied if proper authorization is not obtained. See MSM Chapter 200, Section 203.1(B) for complete authorization requirements.

Use the Authorization Criteria search function in the Provider Web Portal at www.medicaid.nv.gov to verify which services require authorization. Authorization Criteria can be accessed on the PWP Login webpage under Resources (you do not need to log in).

Authorization is valid only for the date(s) specified. If the corresponding claim includes unauthorized dates of service, services provided on those dates cannot be paid.

Authorization does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

Hospitals are not permitted to submit a claim as an outpatient service after an inpatient service has been authorized. Authorization does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

Requesting Authorization

To request authorization:

- Complete form FA-3 or FA-8 as appropriate and submit through the Provider Web Portal.

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- Complete form FA-12 (request for initial inpatient psychiatric review and detoxification) and submit through the Provider Web Portal. Subsequent requests for concurrent review are to be submitted on FA-14. A hospital must transfer the same PA if a recipient, first admitted as a medical/surgical inpatient, is then transferred to a psychiatric, substance abuse treatment or rehabilitation unit. The facility must submit the FA-29 Data Correction Form with the FA-12 for initial inpatient psychiatric review and use the same PA number as was given to the main hospital (medical/surgical) for purposes of continuity for the same hospitalization by the recipient.

Required Documentation:

Documentation for Authorization Requests:

- Give a synopsis of the medical necessity that you wish to have considered.
- Include only the medical records that support the medical necessity issues identified in the synopsis.
- Voluminous documentation will not be reviewed to determine medical necessity of requested services. It is the provider's responsibility to identify the pertinent information in the synopsis.

Documentation for Authorization Reconsideration:

- Give a synopsis of the medical necessity not presented in the initial authorization request that you wish to have considered.
- Include only the medical records that support the medical necessity issues identified in the synopsis.
- Voluminous documentation will not be reviewed to determine medical necessity of requested services. It is the provider's responsibility to identify the pertinent information in the synopsis.

Documentation for Retrospective Authorization:

- Give a synopsis of the medical necessity of all dates of service being requested. Include the code you are requesting and specify the days for each when you are requesting more than one level of care.
- Include only the medical records that support the medical necessity issues identified in the synopsis.
- Voluminous documentation will not be reviewed to determine medical necessity of requested services. It is the provider's responsibility to identify the pertinent information in the synopsis.

Authorization requests must be received within the time frames listed below.

- Prior authorization must be obtained before non-emergent inpatient admission. Additional inpatient days must be requested within **five business** days of the last day of the current/existing authorization period. See MSM Chapter 200, Section 203.1(B)(6).
- **Five business days** for emergency inpatient admission, emergency transfer to another in-state and/or out-of-state facility or unit, or emergency change in level of care. Additional inpatient days must be requested within **five business days** of the last day of the current/existing authorization period.
- **Ten business days** if the recipient was not Medicaid-eligible upon admission, but obtained retroactive eligibility during their stay. If a recipient has been in the hospital for over 30 days when retroactive eligibility is determined, providers must:
    - Submit clinical information in (at least) 30-day increments **and**
    - Provide a weekly summary of the treatment plan for the date range(s) submitted.
- If an initial authorization request is not received within **the above time frames**, a second authorization period, if clinically appropriate, can begin on the date Nevada Medicaid receives an initial authorization request.
- **Ninety calendar days** from the date of decision if the recipient obtained retroactive eligibility after discharge. These retro eligible notification requirements apply even if a recipient has TPL.

- **Concurrent authorization requests** must be received within **five business days** of the last day of the current/existing authorization period. For example, if the current authorization period is 05/11/15 through 05/15/15, then the concurrent authorization request is due no later than five business days following 5/15/15, which is the last date authorized. If a concurrent authorization request is not received within this time frame, a second authorization period, if clinically appropriate, can begin on the date Nevada Medicaid receives a concurrent authorization request. Nevada Medicaid will not pay for unauthorized days between the end date of the first authorization period and the begin date of a second authorization period.

If Nevada Medicaid **requests additional clinical information** to complete an inpatient authorization request, the additional information must be submitted within five business days of the request or a technical denial will be issued.

After receipt of complete information, **Nevada Medicaid will notify the provider** of a determination within one business day for eligible recipients and within 30 days for discharged, retro-eligible recipients.

Nevada Medicaid's determination is based on clinically appropriate standards and may include approval, denial or level of care adjustment.

Acute Inpatient Admissions

Each request for acute inpatient admission must include specific pertinent medical information that substantiates an acute inpatient admission meets both severity of illness and intensity of service requirements.

Services that require authorization

See MSM Chapter 200, Sections 203.1(B)(6) and 203.1(B)(7) for a complete list of services that require authorization. See MSM Chapter 400, Section 403.9C regarding the authorization process for psychiatric admissions.

Examples of services requiring prior authorization include:

- Any surgery, treatment, or invasive diagnostic testing unrelated to the original reason for admission; or days associated with unauthorized surgery, treatment, or diagnostic testing.
- Non-emergency admissions.
- Pre-planned change in level of care and/or transfer between hospital units.
- Hospital admissions for Induction of Labor (IOL) prior to thirty-nine (39) weeks gestation must be prior authorized as medically necessary to be eligible for reimbursement. Failure to obtain authorization for IOL prior to 39 weeks gestation will result in claim denial. Use Induction of Labor Prior to 39 Weeks form FA-8A.
- Antepartum admission for the purpose of delivery when an additional elective procedure is planned (excluding tubal ligations).
- Hospital admission for Medicare Part A recipients after their Medicare benefits are exhausted. Reference MSM Chapter 200, Section 203.1(B)(6)(n).
- Transplants: Submit outpatient medical/surgical authorization requests as soon as the recipient is placed on a wait list and include PT 12 or PT 20 as the rendering provider and the transplant CPT code. Dates of service requested will be 365 days. This request will be reviewed for medical necessity of the service.

  Once the organ is available and the recipient is admitted to the hospital, an inpatient medical/surgical authorization request must be submitted to cover the inpatient stay.

Examples of services that must be authorized within five business days of admission include:

- Emergency inpatient admission, emergency transfer to another in-state and/or out-of-state facility or unit, or emergency change in level of care. Reference MSM Chapter 400 regarding emergency psychiatric or alcohol/substance use disorder treatment admission requirements.
- Admissions initiated through emergency or observation when a physician writes the inpatient admission order.
- Obstetric or newborn admissions:
  1. that, from the date of admission, exceed two (2) calendar days for vaginal or four (4) calendar days for medically necessary or emergency cesarean delivery. After this scenario has been exceeded, the authorization must be submitted within five (5) business days; or
  2. when delivery occurs immediately prior to hospital admission. (See *Prior Authorization Requirements for Obstetrical Hospital Admissions* on the last page of this billing guide.)
- Any newborn/neonate admission or transfer to a Neonatal Intensive Care Unit (NICU).
- See MSM Chapter 400, Section 403.10 for policy regarding alcohol and substance use disorder treatment and acute detoxification coverage and limitations, provider responsibilities, and authorization requirements. Admissions to a freestanding alcohol/substance use disorder hospital or specialty unit of a general hospital for acute detoxification must be authorized within five (5) business days of admission. However, policy does not require that a recipient is first admitted for detoxification, prior to alcohol or substance use disorder treatment. A recipient can be admitted/transferred to these units/facilities for alcohol or substance use disorder treatment after prior authorization is obtained.

  Recipients can be admitted to an acute hospital without an alcohol/substance use disorder unit only for emergent, acute detoxification. Authorization must be obtained within five business days of admission. If additional treatment for alcohol/substance use disorder is required subsequent to acute detoxification, prior authorization must be obtained and the recipient transferred to a specialty alcohol/substance use disorder unit in an acute hospital or a freestanding alcohol/substance use disorder facility.

Authorization submission time frames related to vaginal and c-section deliveries

- An obstetric admission: The request must be submitted within five (5) business days after the second (2^{nd}) inpatient day related to a vaginal delivery performed at or after 39 weeks gestation, OR within five (5) business days after the fourth (4^{th}) inpatient day related to a medically necessary cesarean delivery.
- A newborn admission: The request must be submitted within five (5) business days after the second (2^{nd}) inpatient day related to a vaginal delivery, OR within five (5) business days after the fourth (4^{th}) inpatient day related to a medically necessary cesarean delivery, for admissions not involving Neonatal Intensive Care Unit days.

Authorization Appeals

Please refer to the Billing Manual Chapter 4 for information regarding the reconsideration and peer-to-peer processes and required documentation.

Peer-to-Peer Review or Reconsideration

A Peer-to-Peer Review or Reconsideration can be requested for prior authorizations that are denied or modified. If you request a Peer-to-Peer and afterward determine a Reconsideration is appropriate, the Reconsideration may be requested if within the timelines identified below. Once a Reconsideration is requested, you no longer have the option of requesting a Peer-to-Peer Review of the prior authorization.

Peer-to-Peer Review

A provider may request a Peer-to-Peer Review by emailing nvpeer_to_peer@gainwelltechnologies.com within 10 calendar days of the adverse determination. A Peer-to-Peer Review does not extend the 30-day deadline for Reconsideration.

Peer-to-Peer Reviews are a physician-to-physician discussion or in some cases between the Nevada Medicaid (Gainwell Technologies) second level clinical review specialist and a licensed clinical professional operating within the scope of their practice. The provider is responsible for having a licensed clinician who is knowledgeable about the case participate in the Peer-to-Peer Review.

Reconsideration

Reconsideration is a written request from the provider asking Nevada Medicaid (Gainwell Technologies) or DHCFP (as appropriate) to re-review a denied or reduced authorization request.

Reconsideration is not available for technical denials.

The provider must request Reconsideration within *30* calendar days from the date of the original determination.

For a Reconsideration request, the provider is also responsible to provide additional medical information (e.g., intensity of service, severity of illness, risk factors) that might not have been submitted with the original/initial request that supports the level of care/services requested.

Nevada Medicaid (Gainwell Technologies) or DHCFP will notify the provider of the outcome of the Reconsideration within 30 calendar days. The 30-day provider deadline for Reconsideration is independent of the 10-day deadline for Peer-to-Peer Review.

If proper medical justification is not provided to Nevada Medicaid in an initial/continued stay request, a Peer-to-Peer Review, and/or a Reconsideration review, this demonstrates failure of the provider to comply with proper documentation requirements. New information will not be considered at a hearing preparation meeting.

If proper documentation is not submitted as described above, the authorization request will not be considered by Nevada Medicaid at any later date.

Hospital presumptive eligibility authorization process

For recipients who are not eligible upon admission but become eligible through the presumptive eligibility process, the authorization requests are processed as retrospective authorizations:

- Once the eligibility is showing in PWP, the provider has 10 business days to submit the request to Nevada Medicaid.
- If the patient is still in house, Nevada Medicaid reviews the request in the same time frame as any other initial or concurrent review (one day).
- If the patient has been discharged on or prior to the date of Nevada Medicaid's receipt of the retrospective authorization request, Nevada Medicaid has 30 days to review the request.

Newborn and/or Neonatal Intensive Care Unit (NICU)

Newborn and/or Neonatal Intensive Care Unit (NICU) admissions using revenue codes 0170, 0171, 0172, 0173 and 0174

- An initial newborn admission using codes 0170, 0171 and 0172 does not need a prior authorization unless the inpatient days go beyond two (2) days for a vaginal delivery or four (4) days for a cesarean delivery (MSM Chapter 200, Section 203.1(B)(7)(c)).
- When a newborn goes directly to NICU (0173 and 0174), an authorization is required within five (5) business days (MSM Chapter 200, Section 203.1(B)(7)(e)).
- When a newborn goes from newborn to NICU, authorization is required based on a change in emergency level of care (MSM Chapter 200, Section 203.1(B)(7)(a)).
- If the newborn does not have a Recipient ID when admitted, but receives one during their stay, prior authorization must be requested **within ten business days of the date of eligibility decision.**
- If the newborn receives a Recipient ID after discharge, a retroactive authorization request must be submitted **no later than 90 calendar days after the newborn is assigned a Recipient ID.**
- Prior authorization must be requested using the newborn's Recipient ID.

Prior Authorization Submission and Billing Instructions for NICU

- The Division of Health Care Financing and Policy (DHCFP) will review NICU prior authorization requests per the table below effective with dates of service on or after January 1, 2015.
- The DHCFP utilizes InterQual[1], MCG[2], and the Uniform Billing (UB) Editor[3] to define levels of care needed for each infant and revenue billing codes[4]. These levels of care and revenue codes indicate the nursing care provided to newborn and premature infants in nursery accommodations. These revenue codes range from a healthy newborn to intensive care.
- Hospitals will submit prior authorization requests in the Provider Web Portal at the most appropriate InterQual or MCG level and related National Uniform Billing revenue code based on the table below.

NURSERY/NICU LEVEL OF CARE

Levels of Care by InterQual[1], MCG[2]	Levels of Care by UB Editor[3]	UB Revenue Codes[4] by UB Editor[3]
Newborn Nursery	Level I	0170 / 0171
InterQual I / MCG Level I / Transitional Care	Level II	0172
InterQual II / MCG Level II	Level III	0173
InterQual III & IV / MCG Level III & IV	Level IV	0174

[1] InterQual is published by Change Healthcare. All rights reserved.
[2] MCG. All rights reserved.
[3] Uniform Billing Editor is published by Optum360[0]. All rights reserved.
[4] Correspond with National Uniform Billing Committee revenue code descriptions and guidelines by the Uniform Billing Editor published by Optum360[0].

InterQual is a proprietary, nationally recognized standard utilized by Nevada Medicaid's QIO-like vendor to perform utilization management, determine medical necessity, and appropriate level of care. Many hospitals in Nevada also use this same selected tool for self-monitoring. However, hospitals may also use MCG to perform the same tasks.

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Billing Instructions for Pediatric Intensive Care Unit (PICU)

The DHCFP utilizes the Uniform Billing Editor for pediatrics who need intensive levels of care. These revenue codes indicate routine service charged for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit. For children 18 years of age or younger, the following revenue code may be used for PICU services.

- 0203 = Intensive Care - Pediatric

Family Planning Admissions

Refer to Section 603.3 in MSM Chapter 600 for requirements.

Non-emergent Transfers

The provider who initiates a recipient's non-emergent transfer from an acute hospital to any other acute hospital (general, medical/surgery, psychiatric, rehabilitation or specialty) is responsible for requesting prior authorization before the transfer.

The receiving hospital is responsible for verifying that the transferring provider obtained authorization for a non-emergent transfer prior to agreeing to accept/admit the recipient and prior to the transfer.

Oral and Maxillofacial Surgery

Two prior authorizations are required: one for the procedure and a second for the admission. One of the authorizations must be for the dental procedure code. The dental procedure(s) must be approved before the facility request for admission can be reviewed.

Special Billing Instructions

An Authorization Number issued by Nevada Medicaid must be entered on the claim. Out-of-state inpatient providers with special rate reimbursement must be sure to bill (split bill, when applicable) only services that meet Nevada Medicaid coverage requirements and that are authorized, when authorization is required. The entire claim will be denied if services are billed on the claim that either do not meet coverage requirements or that occur on a date of service, requiring authorization, that was not authorized.

When a recipient is in a hospital for an extended period of time, providers must submit interim claims, as applicable, to avoid untimely/stale dated billing issues. Each claim can only contain one authorization number. Timely submission of a claim is calculated based on the "through" date on that claim. A claim filed untimely based on the "through" date on that claim will not be reimbursed.

Ordering, Prescribing or Referring (OPR) Provider Requirements

The Patient Protection and Affordable Care Act and the Centers for Medicare & Medicaid Services (CMS) require all ordering, prescribing and referring physicians to be enrolled in the state Medicaid program (§455.410 Enrollment and Screening of Providers). The Affordable Care Act (ACA) requires physicians or other eligible practitioners to enroll in the Medicaid program to order, prescribe and refer items or services for Medicaid recipients, even when they do not submit claims to Medicaid. Physicians or other eligible professionals who are already enrolled in Medicaid as participating providers and who submit claims to Medicaid are not required to enroll separately as OPR providers.

For any services or supplies that are ordered, prescribed or referred, the National Provider Identifier (NPI) of the Nevada Medicaid-enrolled Ordering, Prescribing or Referring (OPR) provider must be included on Nevada

Medicaid/Nevada Check Up claims or those claims will be denied. To prevent claim denials for this reason, please confirm that the OPR provider is enrolled with Nevada Medicaid; this can be done on the Provider Web Portal by using the Search Providers feature:
https://www.medicaid.nv.gov/hcp/provider/Resources/SearchProviders/tabid/220/Default.aspx

Reminders for providers who submit institutional claims:

- If your provider type requires the attending physician to be listed on the Institutional claim, that attending physician must be enrolled with Nevada Medicaid.
- If the service was ordered, prescribed or referred by another provider, the NPI of the OPR provider is required to be listed on the claim form. The OPR provider must be enrolled in Nevada Medicaid.
- If the attending physician is the same as the OPR provider, leave the OPR field blank.
- The attending and OPR NPI must be for an individual provider (not an organization or group).
- For detailed claim completion information, refer to the 837I FFS Companion Guide located at: https://www.medicaid.nv.gov/providers/edi.aspx and the PWP User Manual Chapter 3 located at: https://www.medicaid.nv.gov/providers/evsusermanual.aspx

Emergency Department (ED)

ED services resulting in a direct inpatient admission in the same facility as part of one continuous episode of care are included in (rolled into) the inpatient hospital per diem rate for the date of admission, even if the emergency services are provided on the calendar date preceding the admission date. Do not bill outpatient emergency services in addition to the inpatient per diem rate.

Non-U.S. citizens eligible for emergency medical only coverage

For non-U.S. citizens eligible for emergency medical only coverage, Nevada Medicaid covers services to stabilize the sudden onset of an emergency medical condition — services provided before the emergency or provided after the emergency has been stabilized are not covered. For these persons, Medicaid does not cover:

- Non-emergent or elective services.
- Services for an existing, underlying, chronic condition.
- Services once an emergency medical condition is stabilized or in the absence of an emergency medical condition.

Reference "ICD-10-CM Emergency Diagnosis Codes for Non-U.S. Citizens with Emergency Medical Only Coverage" for a list of diagnosis codes for which emergency medical services are covered (at https://www.medicaid.nv.gov, select "Procedure and Diagnosis Reference Lists" from the "Prior Authorization" menu). This list also includes diagnoses related to the provision of outpatient emergency dialysis through the Federal Emergency Services Program. **Note:** Use ICD-10 codes on claims with dates of service on or after October 1, 2015.

Direct Admissions from Observation

When there is a direct inpatient admission from observation, the inpatient hospital per diem rate includes all observation/ancillary services that occur in the same facility as part of one continuous episode of care beginning on the same calendar date the physician writes the inpatient admission order.

Do not bill observation hours and ancillary service in addition to the inpatient per diem rate on the same calendar date.

Observation and ancillary services rendered on a calendar date preceding the rollover inpatient admission date may be billed as outpatient services up to the 48-hour policy limit.

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Please refer to the Billing Guide for Provider Type 12, Hospital Outpatient.

Denied Inpatient Admissions

Physician-ordered medically necessary services provided prior to the inpatient admission denial must be billed as outpatient services.

Administrative Days

Use revenue codes 0160 and 0169 to bill for administrative days, as applicable. At least one acute inpatient hospital day must immediately precede an administrative level of care day.

Admission from the community, another facility, a physician's office, emergency department (ED), or observation directly to an administrative level of care are not covered.

For requirements on requesting concurrent authorization, please see the "Requesting Authorization" section beginning on page 2 in this document.

Refer to MSM Chapter 200, Section 204 for Administrative Day policy.

Maternity

Submit two claims for maternity services: one for the newborn and a second for the mother. On claims for services provided to newborns, use the newborn's 11-digit Recipient ID. (The newborn must have a Recipient ID before a claim for the newborn can be submitted.)

When billing for maternity services include both an ICD-10 procedure code and an ICD-10 diagnosis code on your claim. **Use ICD-10 codes on claims with dates of service on or after October 1, 2015.**

Tubal Ligation

When a tubal ligation is performed at the time of obstetric delivery, be sure to submit a Sterilization Consent Form with your claim. Use Direct Data Entry (DDE). See PWP User Manual Chapter 3 Claims for billing instructions. Failure to provide this form with a claim, when a copy of the form is not on file with Nevada Medicaid, will result in denial of the inpatient day that the sterilization was performed. For additional requirements, see the Sterilization and Abortion Policy, which is located on the Providers Billing Information webpage at https://www.medicaid.nv.gov/providers/BillingInfo.aspx.

Out-of-state inpatient providers with special rate of reimbursement that bill for a tubal ligation without submitting a sterilization form meeting all federal sterilization consent form requirements with a claim, must only bill (split bill) for services provided on inpatient days during which the sterilization procedure was not performed. The entire claim will be denied if other services provided on the same date of service as the tubal ligation are billed and the required consent form is not submitted with the claim.

Psychiatric/Detoxification

Any acute inpatient days authorized at a psychiatric/detoxification level of care must be billed separately from days authorized at a medical/surgical/ICU level of care. Refer to MSM Chapter 400, Section 403.9 for additional information.

Swing beds (*Medicare Certified* in rural or critical access hospitals only)

Refer to the Billing Guide for provider type 44 (Swing-bed, Acute Hospital) for billing instructions. Refer to MSM Chapter 200, Attachment A, Policy #02-03 for Hospital and Swing Bed policy.

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Discharge Day

The date of discharge is not reimbursed, except when discharge/death occurs on the day of admission.

Leave of Absence

Providers must notify Nevada Medicaid and, when applicable, obtain prior authorization for a leave of absence that exceeds eight hours or involves an overnight stay. Bill the inpatient day(s) related to the leave of absence according to the authorized revenue code.

Admit/Discharge/Death Notice

Submit the Admit/Discharge/Death Notice (form 3058-SM) to the local Division of Welfare and Supportive Services District Office whenever a hospital admission, discharge, or death occurs. Failure to submit this form could result in payment delay or denial.

Take-Home Drugs

Take-home drugs are billed through the Point-of-Sale (POS) system using the hospital's Pharmacy National Provider Identifier (NPI). Do not include take-home drugs on your Direct Data Entry (DDE) or 837I claim. See PWP User Manual Chapter 3 Claims for billing instructions. See MSM Chapter 1200 for Nevada Medicaid coverage and criteria for medications.

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Prior Authorization Requirements for Obstetrical Hospital Admissions

Medically Necessary Vaginal Delivery	Day Prior to Delivery	Day of Delivery	First Post-Partum Day	Second Post Partum Day	Third Post-Partum Day	Fourth Post-Partum Day
Normal	n/a	Covered at maternity level. Prior authorization not required.		n/a	n/a	n/a
With complications that require a stay of more than 2 days	n/a	Request prior authorization through the Provider Web Portal within five business days.				n/a
Induced labor (at 39 weeks or more gestation) with or without complications that require a stay of more than 2 days	n/a	Request prior authorization through the Provider Web Portal within five business days.				n/a
With active labor that meets acute level of care criteria prior to the day of delivery	**Request prior authorization through the Provider Web Portal within five business days of labor** for 1 active labor day and 2 maternity-level days.				n/a	n/a
With active labor that meets acute level of care criteria prior to the day of delivery and medical complications after delivery that require a stay of more than 2 days	**Request prior authorization through the Provider Web Portal within five business days of labor** for 1 active labor day and additional days as maternity or acute days.					n/a
Medically Necessary Cesarean Delivery	**Labor**	**Day of Delivery**	**First Post-Partum Day**	**Second Post Partum Day**	**Third Post-Partum Day**	**Fourth Post-Partum Day**
Normal	n/a	Covered at maternity level. Prior authorization not required.				n/a
With complications that require a stay of more than 4 days	n/a	Request prior authorization through the Provider Web Portal within five business days.				
With complications during labor that met acute level of care criteria	**Request prior authorization through the Provider Web Portal within five business days of labor** for 1 active labor day and up to 4 normal maternity days.					n/a
With active labor that meets acute criteria prior to the day of delivery and medical complications after delivery that require a stay of more than 4 days	**Request prior authorization through the Provider Web Portal within five business days of labor** for 1 active labor day and additional days as maternity or acute days.					

Please note: These requirements do not apply to hospital admissions for early induction of labor prior to 39 weeks gestation. Refer to MSM Chapter 200, Sections 203.1(A)(8), 203.1(B)(6)(c), 203.1(B)(7)(c) for coverage and policy requirements.