256B.756 REIMBURSEMENT RATES FOR BIRTHS.

Subdivision 1. **Provider rate.** (a) Notwithstanding section 256B.76, effective for services provided on or after October 1, 2009, the payment rate for professional services related to labor, delivery, and antepartum and postpartum care when provided for any of the diagnostic categories identified in paragraph (b) shall be calculated using the methodology specified in paragraph (b).

(b) The commissioner shall calculate a single rate for the following diagnosis-related groups, as they fall within the diagnostic categories: (1) 371 cesarean sections without complicating diagnosis; (2) 372 vaginal delivery with complicating diagnosis; and (3) 373 vaginal delivery without complicating diagnosis. The rate shall be consistent with an increase in the proportion of births by vaginal delivery and a reduction in the percentage of births by cesarean section. The calculated single rate must not reflect a shift of greater than five percent in the current proportion of all births delivered vaginally and by cesarean section.

(c) The rates described in this subdivision do not include newborn care.

Subd. 2. [Repealed by amendment, 2009 c 173 art 1 s 31]

Subd. 3. **Health plans.** Payments to managed care and county-based purchasing plans under sections 256B.69, 256B.692, or 256L.12 shall be reduced for services provided on or after October 1, 2009, to reflect the adjustments in subdivision 1.

Subd. 4. **Prior authorization.** Prior authorization shall not be required before reimbursement is paid for a cesarean section delivery.

History: *2009 c 79 art 5 s 50; 2009 c 173 art 1 s 31*