Table of Contents

Overview 11.1
OB/GYN Emergency coverage 11.1
Direct Access OB/GYN℠ for HMO/POS Members 11.1
OB/GYN electronic Referrals 11.2
OB/GYN capitation requirements for HMO Members 11.2
Preapproval requirements 11.3
Women's preventive health services 11.3
Annual gynecological exam 11.3
Copayments for routine and nonroutine services 11.4
Requirements/restrictions by State and product line 11.4
Reimbursement above examination fees 11.5
Breast cancer screening 11.5
Cervical cancer screening 11.6
Osteoporosis screening 11.6
Assisted reproductive technologies coverage 11.6
Maternity care 11.6
Notifications of fetal loss 11.6
Performing antepartum ultrasounds 11.7
OB services paid above the global fee 11.7
Postpartum office visits 11.7
Delivery out of the service area 11.7
Baby FootSteps® maternity program 11.8
Encourage your AmeriHealth patients to self-enroll 11.8
Educational materials 11.8
Risk assessment 11.8
Pregnancy depression screening 11.9
Antenatal/Antepartum care 11.9
Free tobacco cessation program 11.10
Postpartum programs 11.10
Mother's Option® program 11.10

Baby FootSteps postpartum services 11.11
Preapproval for home phototherapy 11.12

Overview

This section provides information on benefits, policies, and procedures specific to obstetrical/ gynecological (OB/GYN) care, women's preventive health services, Baby FootSteps® perinatal case management, and postpartum programs, including the Mother's Option® program. Not all groups have access to all services; therefore, providers should verify Member eligibility and benefits using the NaviNet® web portal or by calling the Provider Automated System at 1-888-YOUR-AH1.

Note: OB/GYN specialists cannot be designated as the HMO/POS Member's Primary Care Physician (PCP).

OB/GYN Emergency coverage

- In emergent situations, Members should proceed directly to a hospital for treatment. HMO/POS Members are instructed to call their PCP (or OB/GYN Provider if pregnant) for instructions in nonemergent situations. The OB/GYN Provider may act as the referring Physician during pregnancy for pregnancy-related conditions.
- Be aware that Member Copayments for emergency room/department (ER) visits (emergent or nonemergent) are generally higher than office visit Copayments.

Direct Access OB/GYN℠ for HMO/POS Members

Direct Access OB/GYN allows HMO/POS Members to receive services from any network OB/GYN specialist or subspecialist without a Referral for Preventive Care visits, routine OB/GYN care, or problem-focused OB/GYN conditions.

Specialties and subspecialties not requiring Referrals include, but are not limited to, the following:

- OB
- GYN (including urogynecologist)
- OB/GYN
- gynecologic oncologist
- reproductive endocrinologist/infertility specialist
- maternal fetal medicine/perinatologist
- midwife
- reproductive health centers
- abortion centers
- mammography centers (screening and diagnostic mammograms and follow-up ultrasounds only)

Although no PCP or OB/GYN Referrals are required when services are provided by network OB/GYN Providers, OB subspecialists, or certified nurse midwives (CNM), plan and specific group restrictions may apply. Check the Member's benefits before providing the following services:

- abortion
- assisted infertility services
- Depo-Provera®
- diaphragm fitting
- intrauterine device (IUD) insertion and removal for contraception

- contraceptive implant insertion and removal
- tubal ligation

OB/GYN electronic Referrals

- OB/GYN Providers, CNMs, and OB/GYN specialists may send HMO/POS Members for additional services.
- Referrals must be sent and retrieved using NaviNet.
- The *OB/GYN Referral Request Form*, available on NaviNet, must be used for the following services:
  - pelvic ultrasounds, abdominal X-rays, intravenous pyelograms (IVP), and DXA scans; see “OB/GYN capitation requirements for HMO Members” below for more information;
  - initial consultations for HMO Members for endocrinology, general surgery, genetics, gastrointestinal, urology, pediatric cardiology, and fetal cardiovascular studies (visits beyond the initial consultation still require a PCP Referral).
- OB/GYN Referrals are valid for 90 days from the date of issue.
- Referrals are valid for eligible HMO Members. Members are responsible for payment if they are not eligible HMO Members on the date services are rendered.

AmeriHealth HMO Plus and POS Plus Members are exempt from all Referral requirements.

OB/GYN capitation requirements for HMO Members

There are no capitated programs for PCPs in certain counties in New Jersey. Check the Member’s ID card or Eligibility Details screen on NaviNet for more information.

If capitation applies to the Member, adhere to the following procedures:

- Laboratory:
  - All routine laboratory work must be sent to the PCP’s capitated laboratory site. The Member’s capitated laboratory is indicated on her Member ID card. Further information is also available on NaviNet.
  - Both a Referral and laboratory requisition form must be issued if your patient chooses to receive services at a participating laboratory site other than her PCP’s capitated site.
- Ultrasounds:
  - If your patient chooses to receive services at a participating radiology site, other than the PCP’s capitated site, a Referral is required. OB/GYN offices and antenatal testing units are not considered part of the HMO radiology network and may not be used for general ultrasound.
  - Nuchal translucency screening ultrasounds (first trimester screening) must be performed by ultrasound units certified for the study. Visit the Nuchal Translucency Quality Review Program website at *www.ntqr.org*. Verify certification before issuing a referral. Participating laboratories provide the accompanying blood tests; therefore, there is no need to send Members out-of-network for these tests.
  - High-risk or follow-up ultrasounds, testing, and consultations for high-risk OB patients may be sent directly to a network HMO maternal fetal medicine Provider without Preapproval.

- Radiology:
  - Diagnostic or screening mammograms and follow-up ultrasounds may be performed at any participating site.
  - Sonohysterograms and hysterosalpingograms are not included in capitation and may be scheduled at any participating radiology facility.
  - If your patient chooses to receive services you have authorized from a Participating Provider or facility other than the PCP's capitated site, a Referral is required.

Preapproval requirements

Prenotification of maternity care and Preapproval of the hospital length of stay is not required.

All requests for services from a nonparticipating Provider must be Preapproved for HMO Members. Referrals to a nonparticipating facility or Provider are not accepted electronically.

- If you determine that a nonparticipating Provider is needed for your patient, submit the request through NaviNet or call Customer Service.
- POS and PPO Members have the option to receive care from an out-of-network Provider but will incur a higher out-of-pocket cost.
- To request an exception for services to be covered at the Member's in-network level, Preapproval is required.

Certain services may require Preapproval, depending on benefits coverage. Go to *www.amerihealth.com/preapproval* for a list of services that require Preapproval.

Please note the following:

- Hospital admissions, other than maternity/surgical procedures require Preapproval. Also note the following:
  - Except for deliveries, the admitting Physician is responsible for obtaining Preapproval at least five days prior to the scheduled admission and notifying the facility of the Preapproval number.
  - A separate Referral to a participating hospital is not required for hospital admissions for participating OB/GYN Providers. The hospital must contact us prior to the admission to verify Member eligibility and the Preapproval number.
- Pre-admission testing and hospital-based Physician services (e.g., anesthesia) are covered under the hospital Preapproval.

Women's preventive health services

Annual gynecological exam

The following services are components of a routine, preventive OB/GYN visit:

- breast examination;
- limited screening history and examination;
- physical exam (breast, abdomen, pelvic, and rectal);
- counseling regarding contraception, human sexuality and dysfunction, menopause, and sexually transmitted diseases;
- Pap test;
- pelvic examination;

- specimen collection and wet mount.

Copayments for routine and nonroutine services

When a Member visits your office for GYN services, you should collect the appropriate Copayment. To verify the correct Copayment, refer to the Member's ID card and NaviNet.

As required by the Patient Protection and Affordable Care Act of 2010 (Health Care Reform), there is no Member cost-sharing (i.e., $0 Copayment) for certain preventive services provided to Members. Claim Payment Policy #00.06.02: Preventive Care Services, which includes the list of applicable preventive codes, is available on NaviNet or at *www.amerihealth.com/medpolicy*.

Therefore, in most circumstances for routine annual GYN visits, Copayment should not be collected. However, in cases where *both* a routine annual screening *and* specific problem-focused Evaluation and Management (E&M) services are delivered during the same visit, both routine and nonroutine Copayments may apply. Bill separately for the problem-focused E&M visit only if the services you rendered beyond the preventive visit separately meet Current Procedural Terminology (CPT®) criteria for the E&M code.

Note: Documentation in the medical record must support the services billed.

Contraceptive services

Under Health Care Reform, AmeriHealth is required to pay the cost of certain contraceptive services for eligible Members within non-profit religious organizations. These Members will receive a separate ID card that indicates "Contraceptive Coverage." Using this ID card, contraceptive methods approved by the U.S. Food and Drug Administration will be covered at an in-network level with no cost-sharing under the medical benefit and covered with no cost-sharing for generic products and for those brand products for which we do not have a generic equivalent under the pharmacy benefit at retail and mail order pharmacies. Please note these contraceptive services are covered under the pharmacy benefit only if the Member has an AmeriHealth prescription drug plan.

Requirements/restrictions by State and product line

HMO and POS Members (Split and Plus)

- For covered routine and nonroutine gynecological exams, female Members have the option of coordinating care through their PCP or by self-referral to a Participating OB/GYN Provider, reproductive health center, or CNM.
- All initial Referrals for services related to GYN care may be ordered by the specialist through NaviNet without a Referral from the PCP.
- AmeriHealth POS Plus and HMO Plus Members are exempt from all Referral requirements.

PPO Members

- The highest benefits level is available when network radiology and laboratory sites are used.
- Members may visit any participating specialist without a Referral.
- Members are eligible for one preventive GYN exam and one routine screening Pap test every calendar year.

Medicare Advantage HMO Members

Members have coverage for one routine GYN exam and Pap test annually.

Reimbursement above examination fees

The following procedures are eligible for separate reimbursement (if they are a covered benefit for the Member) when performed during a routine GYN exam:

- administration of Depo-Provera®
- endometrial biopsy
- office ultrasound ONLY with diagnosis of "rule out ectopic pregnancy" (for HMO Members only)
- contraceptive implant insertion and removal*
- diaphragm fitting*
- IUD insertion and removal*

For more information on ultrasounds for New Jersey Members, refer to the *Billing* section of this manual.

**This is not a standard PPO benefit. In addition, some HMO groups do not cover these procedures. However, all contraceptives are covered for Members whose groups are subject to the New Jersey contraceptive mandate. Verify eligibility through NaviNet or the Provider Automated System.*

Breast cancer screening

Mammography screening reminder program

An annual reminder to schedule a yearly mammogram is sent to female managed care Members who are turning 40 as well as females ages 42 through 69 who haven't had a mammography in the last 18 months.

Mammography Referral requirements

Referrals are not required for screening and/or diagnostic mammography from an accredited in-network radiology Provider. Breast ultrasounds also do not require a Referral and may be performed by a participating radiology site or outpatient department of a hospital. Note the following:

- Certain radiology facilities may require a physician's written prescription. You may need to communicate this to your HMO Members asking about mammography. Be sure to provide a prescription for the mammography study if this is a requirement of the radiology site.
- Proper certification, credentialing, and accreditation are required for in-network Providers to render mammography services to our Members.
- In northern New Jersey*, HMO Members may have follow-up X-ray studies, ultrasounds, and MRIs at any participating radiology site. Refer to the *Specialty Programs* section for guidelines on radiology.
- In southern New Jersey†, HMO Members may have follow-up X-ray studies at any participating radiology site. Follow-up ultrasounds and MRIs may also be done at any participating radiology site. A valid Referral is required if these procedures are performed at a site other than the capitated site.
- All MRIs require precertification through AIM Specialty Health® (AIM). Refer to the *Specialty Programs* section for additional information about AIM.

**Counties that comprise northern New Jersey are: Bergen, Essex, Hudson, Hunterdon, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex, Union, and Warren.*

†Counties that comprise southern New Jersey are: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Salem, and Ocean.

Breast Cancer Risk Assessment Tool

Based on the Gail Model, the Breast Cancer Risk Assessment Tool is a computer program developed by the National Cancer Institute that estimates a woman's five-year and lifetime risk of developing breast cancer. The tool is available on *www.amerihealth.com/providers* by selecting *Resources for Patient Management* from the Providers drop-down menu, then *Internet Resources*. Women are advised to discuss their individual risk factors and options for prevention and treatment with their health care Providers. Women who are identified as high-risk may be offered chemoprophylaxis against breast cancer.

Cervical cancer screening

We provide coverage for standard Pap test and liquid-based Pap test technologies, such as ThinPrep® and SurePath®, and for other appropriate studies and procedures, including human papillomavirus (HPV) viral typing. The Member may be responsible for office visit Copayments, and the Member's health plan benefits may be based on specific time frames. For coverage questions, Members should contact Customer Service at the telephone number on their ID card.

We also mail educational materials about the importance of Pap tests to our female managed care Members, ages 21 and older, for whom we have no record of a Pap test within a specified time frame.

Osteoporosis screening

Bone mineral density testing is covered according to Medical Policy #09.00.04: Bone Mineral Density (BMD) Testing, but no more frequently than every two years, except for specific situations. Visit *www.amerihealth.com/medpolicy* to view this medical policy.

To learn about FRAX® (World Health Organization Fracture Risk Assessment Tool), go to *www.shef.ac.uk/FRAX*.

Assisted reproductive technologies coverage

- Verify a Member's benefits coverage through NaviNet or the Provider Automated System. Not all groups are included in the State infertility mandate.
- No Referral is necessary for assisted reproductive technologies (ART) services. Members may be sent by either their PCP or OB/GYN Provider, or they may schedule a visit with the specialist.

Maternity care

First trimester prenatal care correlates well with good maternity outcomes. We urge you to schedule first visits with your pregnant AmeriHealth Members within the first trimester so that folic acid and appropriate counseling can be provided. In addition, we ask you to encourage your pregnant AmeriHealth members to self-enroll in our Baby FootSteps® maternity program by calling 1-800-313-8628, prompt 3.

Notifications of fetal loss

AmeriHealth does not require prenotification of maternity care. However, in the event of an interrupted pregnancy (miscarriage or termination), for a member who is enrolled in Baby FootSteps, please notify us as soon as possible by calling 1-800-313-8628, prompt 3, so we can discontinue maternity-related calls and educational mailings.

Performing antepartum ultrasounds

HMO Members

- Maternal fetal medicine specialists may perform ultrasounds in the office for patients with high-risk pregnancies.
- OB/GYN Providers may perform limited abdominal and transvaginal ultrasounds to rule out ectopic pregnancies. No Preapproval is required if the ultrasound is billed with the appropriate diagnosis code. See the *Billing* section for more information.

PPO Members

- OB and maternal fetal medicine specialists may perform ultrasounds in their offices as medically appropriate.
- Preapproval is not required.

OB services paid above the global fee

OB Providers may perform the following OB services in their offices and be paid above the global fee (or refer to in-network Providers with OB/GYN Referrals):

- glucose tolerance test
- non-stress test
- amniocentesis
- RhoGAM®
- tubal ligation
- 17-alpha hydroxyprogesterone caproate with Preapproval through *www.amerihealth.com/directship*
- external cephalic version
- CNMs*

Note: The home birth global fee includes postpartum home visits.

**CNMs performing home births are eligible for a site-of-service differential.*

Postpartum office visits

Postpartum visits should be scheduled 21 to 56 days after delivery. Adhering to this time frame provides the best opportunity to assess the physical healing of new mothers and to safely prescribe contraception, if necessary. It also meets National Committee for Quality Assurance guidelines for postpartum care. Visits should be clearly labeled "postpartum care." Members should schedule postpartum visits prior to discharge from the hospital.

Delivery out of the service area

- **HMO Members.** If Members do not deliver in the service area, they must call the Customer Service number on their ID card. Some services may not be fully covered if performed out-of-network.
- **POS Members.** Members have the option to deliver out-of-network and/or out of the service area, but they will be subject to Deductibles and Coinsurance.
- **PPO Members.** Members may access care outside of the service area from out-of-network Providers. Out-of-network services are subject to out-of-network cost-sharing (i.e., Deductible/Coinsurance).

Baby FootSteps® maternity program

Our maternity program is designed to educate all pregnant AmeriHealth Members about pregnancy and preparing for parenthood. The program also helps to identify expectant mothers who may be at risk for complications during their pregnancy and to assist in improving the quality of care to pregnant women and newborns. If any risk factors are detected, our OB nurse case managers provide telephone support to our Members and their Physician or midwife to help coordinate their benefits and provide information they need for the healthiest delivery possible.

Note: Some value-added services covered under this program are enhancements to the standard Member benefits and are therefore subject to change at any time upon notice.

Encourage your AmeriHealth patients to self-enroll

Ensuring that maternity Members are enrolled in our Baby FootSteps high-risk perinatal program is imperative for early outreach. We ask that you inform AmeriHealth Members about the Baby FootSteps program and encourage them to call our toll-free number 1-800-313-8628, prompt 3, and leave a message requesting enrollment. During the return call, a case manager will explain the program to the Member and ask her a series of questions to complete the enrollment process.

Our case managers use the information as a means for identifying, tracking, and risk-stratifying all pregnant Members for care management and coordination.

If in subsequent prenatal visits you discover that a maternity Member has not yet self-enrolled in Baby FootSteps, or you feel that she may benefit from case management due to a high-risk pregnancy, you can refer the Member to the program by completing an online physician referral form at *www.amerihealth.com/providerforms*. When you submit this form, we will make certain that Members who need additional support are encouraged to enroll in case management. You can also call 1-800-313-8628 to refer a high-risk maternity Member for case management.

Educational materials

Baby FootSteps materials focus on education. Once enrolled, mothers-to-be will receive a packet detailing information about good self-care during pregnancy and its impact on mother and baby and about potential problems during pregnancy. Benefits information is also provided.

The packet also includes offers for reimbursements for:

- parenting classes (e.g., childbirth preparation, lactation, sibling, exercise), up to $50;*
- lactation consultation, $100 per pregnancy for one visit with any International Board Certified Lactation Consultant (IBCLC).*

Additionally, Members can receive exclusive discounts on the *Saving Baby's Cord Blood*® storage program from CorCell®.

Members may also participate in the following:

- Quit&Fit® tobacco cessation program (see *Free tobacco cessation program*);
- Mother's Option® program (see *Postpartum programs*).

Risk assessment

Members are screened for risk by our case managers during the enrollment process for Baby FootSteps and then are screened again at 28 weeks into their pregnancy by telephone if they are enrolled in case

management. An OB nurse case manager is available to talk to Members, answer questions, and assist with their care throughout their pregnancy.

If complications are detected, Members can expect:

- personalized OB nurse case management;
- individualized education on how to reduce risk factors;
- periodic assessments throughout their pregnancy;
- coordination of home care services as Medically Necessary and ordered by doctor or midwife.

Pregnancy depression screening

A targeted program screens pregnant women enrolled in case management around their 28th week for risk factors associated with depression. Your office may receive calls regarding those Members who screen positive on the 28th week questionnaire or who are judged to be at risk during any other intervention. Case managers will assist you with triage and Referrals to the Member's behavioral health Provider or to Emergency services as required.

Antenatal/Antepartum care

Antenatal case management programs are available for, but not limited to, the following:

- hyperemesis gravidarum
- gestational diabetes
- pregnancy-induced hypertension
- preterm labor

In addition, the following antepartum services are available:

- skilled nursing visits, which may include:
  - 17-alpha hydroxyprogesterone caproate injections for women who are at complete bed rest and have a history of preterm delivery;
  - self-injection techniques for insulin, heparin, and others;
  - home blood glucose, blood pressure, and urine monitoring;
  - betamethasone injections (initial set only, repeat injections require Medical Director approval);
- nutritional consults/evaluations;
- social service evaluations;
- DME.

Preapproval review of antepartum home care services

Call the appropriate perinatal home health agency for them to obtain Preapproval review of all antepartum home care programs/services, such as, but not limited to:

- hyperemesis gravidarum
- gestational diabetes
- pregnancy-induced hypertension
- preterm labor

The perinatal agency will then obtain orders for all care to be rendered from the attending Physician/CNM.

Case managers are available to provide support during regular business hours, 8 a.m. to 5 p.m., Monday through Friday by calling 1-800-313-8628.

Free tobacco cessation program

We have teamed up with American Specialty Health to provide a free, comprehensive tobacco cessation program called Healthyroads Quit&Fit®. This program is designed to provide maximum counselor intervention and support and to enhance office-based intervention.

Features of the program include:

- tobacco cessation manual and stress-tobacco connection CD;
- information for mothers-to-be describing the benefits of quitting smoking;
- up to four telephone sessions per month for 12 months, including kick-off, pre-quit, and general assessment sessions;
- a toll-free phone number for calls any time for counselor support;
- lifetime access to *www.quitandfit.com*, which includes online self-guided coaching modules, tools, and trackers for monitoring progress in meeting goals related to tobacco cessation; articles and video classes on a variety of tobacco cessation topics; and an electronic message center to ask questions, receive electronic guides, and receive support from a tobacco cessation coach.

Quit&Fit programs, conducted by experienced, specially trained counselors, are periodically reviewed and evaluated by an editorial board comprised of qualified health professionals.

Pregnant Members can contact a case manager for more information or self-enroll by calling Healthyroads Quit&Fit at 1-877-330-2746.

Quit&Fit is a federally registered trademark of American Specialty Health Incorporated.

Postpartum programs

Mother's Option® program

Through this program, all Members who have an uncomplicated pregnancy and delivery have the option of choosing a shorter stay in the hospital. In order to support a smooth and safe transition home, home care visits are available according to the following guidelines:

Shortened length of stay (managed care Members)

Uncomplicated vaginal delivery

- **If discharged within the first 24 hours following delivery.** Two home health visits are available if desired by the Member. These visits *do not require preapproval*, but they should be arranged by a hospital discharge planner with one of the Mother's Option home care Providers. The first visit should occur within 48 hours of discharge. The second visit should occur within five days of discharge.
- **If discharged within the first 48 hours following delivery.** One home health visit is available if desired by the Member. This visit *does not require Preapproval*, but it should be arranged by a hospital discharge planner with one of the Mother's Option home care Providers. This visit should occur within 48 hours of discharge.

Uncomplicated cesarean delivery

- **If discharged within the first 96 hours following delivery.** One home health visit is available if desired by the Member. This visit *does not require preapproval,* but should be arranged by a hospital

discharge planner with one of the Mother's Option home care Providers and should occur within 48 hours of discharge.

Standard length of stay (managed care Members)

When the standard length of stay is 48 hours (vaginal) or 96 hours (cesarean), one home health visit is available if desired by the Member/Provider. This visit *does not require preapproval*, but it should be arranged by a hospital discharge planner with one of the Mother's Option home care Providers. These visits must occur within five days of discharge.

If additional home health visits are Medically Necessary beyond the described Mother's Option visits, these must be preapproved by calling 1-800-313-8628.

CMM Members. Members who opt for less than 48-hour discharge for vaginal delivery and less than 96 hours for cesarean section are eligible for one home care visit. Prenotification for this visit must be done by calling the maternity department as previously noted.

Individual Health Coverage Basic Plan Members. Members do not have a benefit for home care. Therefore, no postpartum home visits are available.

Baby FootSteps postpartum services

Postpartum care

Postpartum home skilled nursing visits beyond those provided through Mother's Option are approved when Medically Necessary. These visits must be preapproved and include:

- wound/incision checks and wound care as needed
- bilirubin checks and home phototherapy
- infant assessments
- blood pressure checks
- IV antibiotics
- home physical therapy

Lactation support programs and breast pump reimbursement through AmeriHealth Healthy Lifestyles℠

- Lactation support services include information about valuable community resources, educational websites, or certified lactation consultants.
- Members may self-refer to any IBCLC and receive a $100 reimbursement through AmeriHealth Healthy Lifestyles℠. Members may submit a receipt listing the date of the visit and the consultant's IBCLC Certification number within 90 days after delivery.
- Case managers are available for initial breast feeding support by telephone. Additionally, they will be able to evaluate the need for further assistance (e.g., community resources, lactation consultant, or OB Provider).
- Managed care Members who obtain a manual/mini-electric breast pump at pharmacies or baby supply stores may submit their receipt to AmeriHealth Healthy Lifestyles for reimbursement up to $50 within 90 days after delivery.
- Hospital-grade pumps are covered under the following circumstances and when supplied by an in-network Provider:
  - detained premature newborn;

- infants with feeding problems that interfere with breast feeding (e.g., cleft palate/cleft lip).

Breast pump coverage under Health Care Reform

As required by the Patient Protection and Affordable Care Act (ACA), Members can purchase one portable manual or electric breast pump, plus supplies, per pregnancy from a participating, in-network DME Provider with no Member cost-sharing.

Note: The rental of hospital-grade breast pumps requires approval for Medical Necessity. Rentals are available at no cost-sharing only for those Members who require the use of a hospital-grade pump. If approval is obtained for Medical Necessity, Member cost-sharing will not be applied when the Member rents the breast pump from an in-network DME Provider.

Lactation support and counseling under Health Care Reform

Lactation support and counseling, by a trained provider during pregnancy, and/or in the postpartum periods, is currently covered during an inpatient maternity stay as part of an inpatient admission, the postpartum Mother's Option visit, and through the OB postpartum visit and/or pediatrician well-baby visit.

Preapproval for home phototherapy

Preapproval is required when ordering home phototherapy to treat jaundiced newborns. Skilled nursing visits must also be Preapproved.