

## Table of contents

---

Overview .....	12.2
OB/GYN Emergency coverage .....	12.2
Direct Access OB/GYN <sup>SM</sup> for HMO/POS Members .....	12.2
OB/GYN electronic Referrals .....	12.3
OB/GYN capitation requirements for HMO Members .....	12.3
Preapproval/Precertification requirements .....	12.4
Women's preventive health services .....	12.5
Annual gynecological exam .....	12.5
Copayments for routine and nonroutine services .....	12.5
Contraceptive services .....	12.5
Requirements/restrictions by product line .....	12.6
Reimbursement above examination fees .....	12.6
Breast cancer screening .....	12.6
Cervical cancer screening .....	12.7
Osteoporosis screening .....	12.8
Assisted reproductive technologies coverage .....	12.8
Maternity care .....	12.8
Notifications .....	12.8
Performing antepartum ultrasounds .....	12.8
OB services paid above the global fee .....	12.9
Postpartum office visits .....	12.9
Delivery out of the service area .....	12.9
Baby FootSteps <sup>®</sup> maternity program .....	12.9
Encourage your AmeriHealth patients to self-enroll .....	12.9
Educational materials .....	12.10
Risk assessment .....	12.10
Pregnancy depression screening .....	12.10
Antenatal/Antepartum care .....	12.11
Postpartum programs .....	12.12
Mother's Option <sup>®</sup> program .....	12.12
Baby FootSteps postpartum services .....	12.12
Preapproval/Precertification for home phototherapy .....	12.13

## 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 Practice Management (PM) on the Provider Engagement, Analytics & Reporting (PEAR) portal.

OB/GYN specialists can be designated as the HMO/POS Member's Primary Care Physician (PCP) during a Member's pregnancy.

*Note:* Benefits may vary by employer group. Individual benefits must be verified.

## 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<sup>SM</sup> for HMO/POS Members

---

Direct Access OB/GYN allows HMO/POS Members to receive obstetrical/gynecological 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. PCPs certified in family planning can also provide direct access to these services.

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

- Obstetrics
- Gynecology (including urogynecology)
- OB/GYN
- gynecologic oncology
- Reproductive endocrinology / Infertility
- Maternal fetal medicine/ Perinatology
- midwifery
- 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 PEAR PM.
- Use the Referral Submission transaction in PEAR PM 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, POS Plus, EPO, and PPO Members are exempt from all Referral requirements. In addition, Members in a Medicare Advantage HMO/POS plan of one of our Affiliates are excluded from 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 use the Eligibility & Benefits transaction on PEAR PM 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 PEAR PM.
  - 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, 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](http://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/Precertification.

## Preapproval/Precertification requirements

---

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

All requests for services from a nonparticipating Provider must be Preapproved/Precertified for HMO and EPO Members. For HMO Members, Referrals to a nonparticipating facility or Provider are not accepted electronically.

- If you determine that a nonparticipating Provider is needed to treat your patient, submit the request through PEAR PM or call Customer Service.
- POS, POS Plus, 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/Precertification is required for HMO, POS, and PPO Members.

Certain services may require Preapproval/Precertification, depending on benefits coverage. For a list of services that require Preapproval/Precertification, go to [www.amerhealthnj.com/html/providers/policies.html](http://www.amerhealthnj.com/html/providers/policies.html).

Please note the following:

- Hospital admissions, other than maternity, require Preapproval/Precertification. Also note the following:
  - Except for deliveries, the admitting Physician is responsible for obtaining Preapproval/Precertification at least five days prior to the scheduled admission and notifying the facility of the Preapproval/Precertification 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/Precertification number.
- Pre-admission testing and hospital-based Physician services (e.g., anesthesia) are covered under the hospital Preapproval/Precertification.

## 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 and human papillomavirus (HPV) testing as appropriate per guidelines;
- pelvic examination;
- specimen collection and wet mount (including those for sexually transmitted infection [STI] testing).

### Copayments for routine and nonroutine services

When a Member visits your office for GYN services, you should collect the appropriate Copayment except as noted below. To verify the correct Copayment, refer to the Member's ID card and PEAR PM.

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.

Review the preventive care services policy, which includes the list of applicable preventive codes, at [www.amerithealth.com/medpolicy](http://www.amerithealth.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 and closely held corporations. 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 alternative or 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 product line

### **HMO and POS Members**

- 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 PEAR PM without a Referral from the PCP.
- AmeriHealth POS Plus and HMO Plus Members are exempt from all Referral requirements.

### **EPO and 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.

### **Members in a Medicare Advantage plan of one of our Affiliates**

- Members have coverage for one routine GYN exam and Pap test annually.
- Members do not require Referrals.

## 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 PEAR PM.*

## Breast cancer screening

### **Mammography screening reminder program**

We provide annual reminders to schedule a yearly mammogram for female managed care Members ages 42 – 64 with a gap in care (i.e., no record of having a mammography screening during a certain time frame). Outreach strategies include direct mailings, telephone calls, emails, text message reminders, or any combination thereof.

### **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 written 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 Preapproval/Precertification through Carelon Medical Benefits Management (Carelon). Refer to the *Specialty Programs* section for additional information about Carelon.

\*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. 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 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.

### **Cervical cancer screening reminder program**

We provide annual reminders to encourage female Members to discuss revised recommendations for cervical cancer screening, as well as their individual risk factors, with their health care Providers, as appropriate.

Female Members ages 21 – 29 with a gap in care (i.e., no plan evidence of a Pap test during a certain time frame) are encouraged to schedule and receive regular Pap tests.

Female Members ages 30 – 64 with a gap in care (i.e., no plan evidence of a Pap test with an HPV co-test during a certain time frame) are encouraged to schedule and receive regular Pap tests with an HPV co-test.

Outreach strategies include direct mailings, telephone calls, emails, text message reminders, or any combination thereof.

### Osteoporosis screening

According to our medical policy, bone mineral density testing is covered, but no more frequently than every two years, except for specific situations. Visit [www.amerhealth.com/medpolicy](http://www.amerhealth.com/medpolicy) to view this medical policy in its entirety.

To learn about FRAX<sup>®</sup> (World Health Organization Fracture Risk Assessment Tool), go to [www.shef.ac.uk/FRAX](http://www.shef.ac.uk/FRAX).

## Assisted reproductive technologies coverage

---

- Verify a Member's benefits coverage through PEAR PM. 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<sup>®</sup> maternity program by calling 1-800-598-BABY.

### Notifications

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 1-800-598-BABY so we can discontinue maternity-related calls.

### 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/Precertification is required if the ultrasound is billed with the appropriate diagnosis code. See the *Billing* section for more information.

#### **EPO and PPO Members**

- OB and maternal fetal medicine specialists may perform ultrasounds in their offices as medically appropriate.
- Preapproval/Precertification 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®
- 17-alpha hydroxyprogesterone caproate with Preapproval/Precertification through [www.amerihealthnj.com/html/providers/pharmacy/injectables.html](http://www.amerihealthnj.com/html/providers/pharmacy/injectables.html)
- CNMs\*

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

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

### Postpartum office visits

Postpartum visits should be scheduled 7 to 84 days after delivery. Adhering to this time frame provides the best opportunity to assess the physical healing of new mothers and to answer questions around family planning, if necessary. It also meets HEDIS® (Healthcare Effectiveness Data and Information Set) 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/EPO Members.** If Members do not deliver in the service area, they must call the Customer Service number on their Member ID card. Some services may not be fully covered if performed out-of-network.
- **PPO/POS/POS Plus 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 throughout each trimester. 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, **1-800-598-BABY**,

to self-enroll. All pregnant Members have access to and may self-enroll in our perinatal support program, Baby FootSteps. Enrolled Members receive digital messaging with educational information about each month of pregnancy. Based on Baby FootSteps enrollment, expectant mothers are assessed for risk and may be enrolled in our condition management program for high-risk pregnancy. This program is telephone, with Health Coaches working with Providers to cooperatively support and educate the members throughout the pregnancy continuum. Starting in 2020, members in some groups also have access to Ovia Health, an app-based fertility, pregnancy, and parenting support program, with triage to Baby FootSteps Maternity Program for high-risk Members. Upon calling, a Health Coach will explain to the Member how they became eligible to participate, how to use the program services, and how to opt-in or out of the program. They will also ask her a series of questions to complete the enrollment process.

Our Health Coaches 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.amerhealth.com/providerforms](http://www.amerhealth.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 or 1-800-598-BABY 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 welcome letter and information on how to access educational materials on our secure Member website, [amerhealthexpress.com](http://amerhealthexpress.com). Once on the site, Members can find 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.

Members may also participate in the Mother's Option<sup>®</sup> program (see *Postpartum programs*).

### Risk assessment

Members are screened for risk by our Health Coaches when they call to enroll into 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 Health Coach 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 Physician or midwife.

### Pregnancy depression screening

Targeted questions screen pregnant women at enrollment and, if 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. OB nurse Health Coaches 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;
- durable medical equipment (DME).

### ***Preapproval/Precertification review of antepartum home care services***

Call the appropriate perinatal home health agency for them to obtain Preapproval/Precertification 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.

Members can obtain additional support from Health Coaches by calling **1-888-YOUR-AH1** and requesting a health coach when prompted.

## 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/Precertification*, 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/Precertification*, 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/Precertification*, but it 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/Precertification*, 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/Precertified by submitting an authorization request through PEAR PM.

### 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/Precertified 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 coverage**

- Lactation support services include information about valuable community resources, educational websites, or certified lactation consultants.
- Health Coaches 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).

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.

### **Breast pump coverage**

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).

Under Health Care Reform, 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.

We cover:

- **Single-user breast pump.** Purchase of one manual or double electric breast pump. The unit will be repaired or replaced if necessary and will not require a prescription, letter of medical necessity, or prior authorization.
- **Multi-user breast pump.** Rental of a multi-user (hospital-grade) breast pump on the recommendation of a licensed health care provider. A doctor's order is required.
- **Breast pump kits.** Purchase of two breast pump kits, appropriate size breast pump flanges or other lactation accessories recommended by a health care provider per birth event.

DME providers must supply members with breast pumps and related equipment within these time frames:

- Single-user breast pumps after the child's birth: within 48 hours of request
- Single-user breast pumps before the child's birth: the later of two weeks before the expected due date or 72 hours after requested
- Multi-user breast pumps: within 12 hours of request

*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 eligible Members rent the breast pump from an in-network DME Provider.

### **Preapproval/Precertification for home phototherapy**

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