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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 1-800-275-2583.

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/GYNSM 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 or the Provider Automated System.
- 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.

Pennsylvania and Delaware Members

OB/GYN Providers can use the OB/GYN Referral for Members being referred for OB/GYN-related radiology studies to any participating radiology facility.

Direct POS Pennsylvania Members should be referred to their PCP’s capitated site for laboratory and radiology services.

Note: PPO Members do not need Referrals; however, you should verify their benefits through NaviNet or the Provider Automated System before rendering care. Only certain procedures require Preapproval. Refer to www.amerhealth.com/preapproval for a list of services that require Preapproval.

OB/GYN capitation requirements for HMO Members

There are no capitated programs for PCPs in certain counties in Delaware. 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.
 - Direct POS Pennsylvania Members should be referred to their PCP’s capitated site for laboratory and radiology services. Referrals are required.
 - For HMO and POS referred benefits, Referrals are required.
- Ultrasounds:
 - In areas where radiology capitation applies, general ultrasound for normal pregnancy and gynecology must be referred to the Member’s capitated site; otherwise, the Member may go to any participating radiology site with a Referral.

- 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.
 - All other radiologic procedures, including DXA scans, must be performed at the PCP's capitated site in areas where capitation applies; otherwise, a participating radiology site must be used with a Referral.

Preapproval requirements

Prenotification of all maternity care must be made through our Baby FootSteps *Initial Maternity Patient Questionnaire*. Go to www.amerihealth.com/providerforms for information on obtaining this form. 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. The following are some examples:

- Procedures (office-based, outpatient, ambulatory surgical center, short procedure unit, and hospital inpatient) require preapproval, except for termination of pregnancies performed in a participating freestanding facility (surgical center, reproductive health center, office, or abortion center).
- 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.
- Administration of Lupron® for medical indications requires preapproval.*
- Insertion of a Mirena® IUD for medical (noncontraceptive) indications requires preapproval.*

**Preapproval is not required for these services for PPO Members.*

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 or NaviNet.

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.

As required by the Patient Protection and Affordable Care Act of 2010, 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.amerithealth.com/medpolicy.

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

Requirements/restrictions

HMO and POS Members (Non-Flex)

- PCP capitated sites must be used for those Members in areas where capitation applies, except for Emergencies and for mammograms.
- Members have coverage for all required routine and nonroutine visits.
- All initial services related to GYN care can be ordered directly by the OB/GYN Provider without a Referral from the PCP.

HMO and POS Members (Flex)

- PCP capitated sites must be used for those Members in areas where capitation applies, except for Emergencies and for mammograms.
- Members have coverage for an annual routine GYN exam with Pap test.
- Nonroutine GYN visits are covered.

PPO Members (Flex and Non-Flex)

- Members may visit any specialist in the PPO network without a Referral.
- The highest benefits level is available when network radiology and laboratory sites are used.
- Members have coverage for an annual routine GYN exam with Pap test. Some groups' coverage runs on a calendar-year basis and some on a contract-year basis. Contact Customer Service for further information on your patient's specific group.
- Nonroutine GYN visits are covered.

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 Pennsylvania 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.*

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

All commercial and Medicare Advantage HMO Members may obtain screening and/or diagnostic mammography from an accredited in-network radiology Provider without obtaining a Referral. 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 Delaware, HMO Members may have follow-up X-ray studies, ultrasounds, and MRIs at any participating radiology site. Refer to the *Specialty Programs and Laboratory Services* section for guidelines on radiology.
- All MRIs require precertification through AIM Specialty HealthSM (AIM). Refer to the *Specialty Programs and Laboratory Services* section for additional information about AIM.

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. Be aware that a 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

HMO/POS Members

- Most HMO/POS Member benefits contracts exclude in vitro fertilization (IVF) and related services.
- Verify coverage of specific procedures and pharmacy benefits through NaviNet or the Provider Automated System.
- All facility-based infertility procedures require Preapproval, regardless of whether they are provided by a reproductive endocrinologist or general gynecologist.
- No Referral is necessary for ART services. Members may be sent by either their PCP or OB/GYN Provider, or they may schedule a visit with the specialist themselves.

PPO Members

All Member benefits contracts exclude coverage for assisted reproductive technologies.

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.

Prenotification of maternity care

AmeriHealth requires early prenotification of all maternity care, regardless of the planned delivery site — hospital or birth center. Home birth requests should be submitted by the provider using the *Initial Maternity Patient Questionnaire* indicating the back-up hospital. Go to www.amerhealth.com/providerforms for information on obtaining this form.

You can verify a Member's maternity prenotification reference number and get the inpatient routine maternity services status through NaviNet or the Provider Automated System.

Notification of fetal loss

In the event of an interrupted pregnancy (miscarriage or termination), notify Baby FootSteps as soon as possible so we can discontinue maternity-related educational mailings and information.

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.amerhealth.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. Since the maternity prenotification process includes confirmation of intended delivery for an in-network Provider, 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 award-winning 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.

For more information about Baby FootSteps or to refer a Member, call **1-800-598-BABY**. Case managers are available Monday through Friday from 8 a.m. to 5 p.m. Nurse case managers are also available after hours to assist you with urgent home care or durable medical equipment (DME) needs.

Register your AmeriHealth patients

Registering maternity Members into our Baby FootSteps high-risk perinatal program is imperative for early outreach. *Note: The Baby FootSteps maternity program is offered only to AmeriHealth Members. Therefore, remind your staff to verify eligibility prior to giving a patient the questionnaire to complete.*

The *Initial Maternity Patient Questionnaire* should be completed by the OB Provider and the Member at the first prenatal visit and mailed immediately after to ensure timely registration into this program. These forms should not be batched and held. OB providers should mail the form to the Baby FootSteps department immediately, using the postage-paid envelope supplied by the program. This registers the Member in the Baby FootSteps program and triggers educational mailings. Our case managers use the information as a means for identifying, tracking, and risk stratifying all pregnant Members for care management and coordination.

If you need to request additional forms, call the Provider Supply Line at **1-800-858-4728**.

Educational materials

Baby FootSteps materials focus on education. 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;*
- breast pump purchase, up to \$50;*
- lactation consultation, \$100 per pregnancy for one visit with any International Board Certified Lactation Consultant (IBCLC).*

**Some of these programs are available to managed care Members only.*

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” on [page 11.11](#));
- Mother's Option[®] program (see “Postpartum programs” on [page 11.12](#)).

Risk assessment

Members are screened for risk at the time of enrollment into Baby FootSteps using the completed enrollment forms and then are screened again at 28 weeks into their pregnancy by telephone when 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

Baby FootSteps has a targeted program that screens pregnant women enrolled in case management in their 28th week for risk factors associated with depression (using the Whooley Questionnaire, a two-question depression screening tool). 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.

Baby FootSteps case managers are available to provide support during regular business hours, 8 a.m. to 5 p.m., Monday through Friday. Call **1-800-598-BABY**.

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 Baby FootSteps 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 the Perinatal Case Management department at **1-800-598-BABY**.

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 Perinatal Case Management department as previously noted.

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 through Baby FootSteps 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

- 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 LifestylesSM. Members may submit a receipt listing the date of the visit and the consultant's IBCLC Certification number within 90 days after delivery.
- Baby FootSteps 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).

Breast pumps

- **Breast pump reimbursement.** Managed care Members who participate in Baby FootSteps and 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.
- **Electric breast pump rentals.** Hospital-grade pumps must be Preapproved for Medical Necessity. These 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).

Preapproval for home phototherapy

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