Chapter 16: Women and Children Services

Health Choice Insurance Co. (Health Choice) wants to keep members healthy. Many health problems begin during childhood. The good news is that most of these problems can be prevented through early exams and treatment.

Health Choice provides preventive health services listed on the USPSTP lists A and B without cost share to the member (deductible, copayment and coinsurance do not apply) when provided by an in-network provider.

Health Choice provides all services including well-child, shots and exams for children and routine health screenings for adults, family planning and birth control when provide by a network provider.

Covered Benefits for Maternity Services Including Medical, Surgical and Hospital Care

(1) During the time of pregnancy
(2) Upon delivery and during the postpartum period for normal delivery
(3) Cesarean section
(4) Spontaneous abortion (miscarriage)
(5) Complications of pregnancy
(6) Maternal risk

Coverage for a Mother and Her Newly Born Child

1. A minimum of forty-eight (48) hours of inpatient care following a vaginal delivery
2. A minimum of ninety-six (96) hours of inpatient care following a cesarean section

Any decision to shorten the period of inpatient care for the mother of the newborn must be made by attending Physician consultation with the mother.

Under Federal law, benefits may not be restricted for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending contracted network provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, under Federal law, Covered physicians are not required to obtain prior authorization from the Prior Authorization Department for prescribing a length of stay not in excess of 48 hours (or 96 hours).

OB Ultrasound Authorization

OB ultrasounds as part of the Total OB (TOB) authorization

- Authorization for two (2) routine OB ultrasounds is included in the TOB authorization

TOB Package Authorization and billing process

- Provider offices notifies Health Choice by completing the Maternal Risk Assessment form and fazing it to the Maternal Health Department

- Health Choice Maternal Health Department issues a TOB authorization
- Ultrasounds with CPT codes 76801 through 76810 and 76813 through 76817
  1. If a 76817 is done on the same date of service as another OBUS, it is not considered to be an additional US under the TOB authorization
- Providers will use the TOB authorization number for the two (2) routine ultrasounds when sending their claim to Health Choice
- All other OB ultrasounds will require prior authorization by Health Choice. A prior authorization request must be faxed to 1-855-432-2494 or 480-800-6703

OB Ultrasounds that are medically necessary

- Providers are required to request a prior authorization request for clinical review of OB ultrasounds that are medically indicated or those done in excess of the 2 TOB ultrasounds
- Providers will submit these claims to Health Choice using the authorization number provided by the Prior Authorization Department
- If an urgent or emergent medically indicated ultrasound is needed, providers can proceed with the procedure and then, call within 3 business days for an authorization

Note:

- When requesting an US prior authorization, providing a diagnosis code is not sufficient, include as much pertinent medical information about the patient as possible
- Maternal Fetal Medicine Specialists (MFM) who do not bill under the TOB must request a prior authorization for all OB ultrasounds
- OB ultrasounds are paid FFS – outside of the TOB contracted package

Additional Covered Services

Coverage will be provided for physician and other health professional services. Such services include:

1. Diagnostic and treatment services
2. Office visits
3. Periodic health assessments
4. Well-baby and well child care and routine immunizations provided in accordance with accepted medical practices
5. Hospital care
6. Consultation
7. Surgical procedures

Other health professional services include those services provided by an individual other than a physician, and who is licensed or otherwise authorized under the applicable state law to deliver medical services and who is an in-network provider.

Family Planning Services

Covered benefits are provided for family planning services including:

1. Medical history
2. Physical examination
3. Related laboratory tests
4. Medical supervision in accordance with generally accepted medical practice
5. Information and counseling on contraception
6. Implanted/injected contraceptives
7. Tubal ligation after appropriate counseling and consent
8. Vasectomy after appropriate counseling and consent

Prescription birth control products that are payable under the Prescription Drug Benefit can be found and will be paid under the Prescription Drug Benefit only. Elective abortions are not a covered benefit.

Infertility Services

Covered benefits are provided for diagnostic services rendered for infertility evaluation. Any medical treatment and/or prescription related to infertility once diagnosed are excluded by this Policy.