MATERNITY AND NEWBORN CARE

Policy Number: BIP094.F
Effective Date: December 1, 2018

Covered benefits are listed in three (3) Sections - A, B and C. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations and exclusions as stated in the member’s Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member’s EOC/SOB, the member’s EOC/SOB provision will govern.

Essential Health Benefits for Individual and Small Group
For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits (“EHBs”). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member’s specific plan document to determine benefit coverage.

For information related to those items covered on or after 08/01/12 under the Expanded Women’s Preventive Health Mandate, please refer to the Medical Management Guideline: Preventive Care Services.

A. FEDERAL/STATE MANDATED REGULATIONS

Newborns’ and Mothers’ Health Protection Act (NMHPA) of 1996, Title VI: Minimum Hospital Stay-UnitedHealthcare and its contracted providers may not restrict the benefits for any hospital length of stay for a mother and her newborn to less than 48 hours following a vaginal delivery and 96 hours following a Cesarean Section (C-Section). Protections for health plans include
allowance of discharge before 48-96 hours if the attending physician, in consultation with the mother, makes the decision.

Title VII of the Civil Rights Act, as amended by the Pregnancy Discrimination Act: 42 U.S. Code § 2000e
(k) The terms “because of sex” or “on the basis of sex” include, but are not limited to, because of or on the basis of pregnancy, childbirth, or related medical conditions; and women affected by pregnancy, childbirth, or related medical conditions shall be treated the same for all employment-related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected but similar in their ability or inability to work, and nothing in section 2000e–2 (h) of this title shall be interpreted to permit otherwise. This subsection shall not require an employer to pay for health insurance benefits for abortion, except where the life of the mother would be endangered if the fetus were carried to term, or except where medical complications have arisen from an abortion: Provided, That nothing herein shall preclude an employer from providing abortion benefits or otherwise affect bargaining agreements in regard to abortion.

Note: The Pregnancy Discrimination Act (PDA) amended the Title VII of the Civil Rights Act to prohibit employment discrimination based on pregnancy, childbirth, or related medical conditions. In summary, the PDA generally applies to all private and governmental (state and local) employers with 15 or more employees for each working day in at least 20 calendar weeks in the current or preceding calendar year. Any health insurance provided by such employers must cover expenses for pregnancy-related conditions on the same basis as costs for other medical conditions. Health insurance for expenses arising from abortion is not required, except where the life of the mother is endangered. Pregnancy-related expenses should be reimbursed exactly as those incurred for other medical conditions, whether payment is on a fixed basis or a percentage of reasonable-and-customary-charge basis. The amounts payable by the insurance provider can be limited only to the same extent as amounts payable for other conditions (i.e., no additional, increased, or larger deductible can be imposed).

(2) Any fringe benefit program implemented after October 31, 1978, must comply with the provisions of § 1604.10(b) upon implementation.

RCW 48.43.115
Maternity services-Intent-Definitions-Patient preference-Clinical sovereignty of provider-Notice to policyholders-Application.
(1) The legislature recognizes the role of health care providers as the appropriate authority to determine and establish the delivery of quality health care services to maternity patients and their newly born children. It is the intent of the legislature to recognize patient preference and the clinical sovereignty of providers as they make determinations regarding services provided and the length of time individual patients may need to remain in a health care facility after giving birth. It is not the intent of the legislature to diminish a carrier's ability to utilize managed care strategies but to ensure the clinical judgment of the provider is not undermined by restrictive carrier contracts or utilization review criteria that fail to recognize individual postpartum needs.

(2) Unless otherwise specifically provided, the following definitions apply throughout this section:
(a) “Attending provider” means a provider who: Has clinical hospital privileges consistent with RCW 70.43.020; is included in a provider network of the carrier that is providing coverage; and is a physician licensed under chapter 18.57 or 18.71 RCW, a certified nurse midwife licensed under chapter 18.79 RCW, a midwife licensed under chapter 18.50 RCW, a physician's assistant licensed under chapter 18.57A or 18.71A RCW, or an advanced registered nurse practitioner licensed under chapter 18.79 RCW.
(b) “Health carrier” or “carrier” means disability insurers regulated under chapter 48.20 or 48.21 RCW, health care services contractors regulated under chapter 48.44 RCW, health maintenance organizations regulated under chapter 48.46 RCW, plans operating under the health care authority under chapter 41.05 RCW, the state health insurance pool operating under chapter 48.41 RCW, and insuring entities regulated under this chapter.
(3) (a) Every health carrier that provides coverage for maternity services must permit the attending provider, in consultation with the mother, to make decisions on the length of inpatient stay, rather than making such decisions through contracts or agreements between providers, hospitals, and insurers. These decisions must be based on accepted medical practice.

(b) Covered eligible services may not be denied for inpatient, postdelivery care to a mother and her newly born child after a vaginal delivery or a cesarean section delivery for such care as ordered by the attending provider in consultation with the mother.

(c) At the time of discharge, determination of the type and location of follow-up care must be made by the attending provider in consultation with the mother rather than by contract or agreement between the hospital and the insurer. These decisions must be based on accepted medical practice.

(d) Covered eligible services may not be denied for follow-up care, including in-person care, as ordered by the attending provider in consultation with the mother. Coverage for providers of follow-up services must include, but need not be limited to, attending providers as defined in this section, home health agencies licensed under chapter 70.127 RCW, and registered nurses licensed under chapter 18.79 RCW.

(e) This section does not require attending providers to authorize care they believe to be medically unnecessary.

(f) Coverage for the newly born child must be no less than the coverage of the child's mother for no less than three weeks, even if there are separate hospital admissions.

(4) A carrier that provides coverage for maternity services may not deselect, terminate the services of, require additional documentation from, require additional utilization review of, reduce payments to, or otherwise provide financial disincentives to any attending provider or health care facility solely as a result of the attending provider or health care facility ordering care consistent with this section. This section does not prevent any insurer from reimbursing an attending provider or health care facility on a capitated, case rate, or other financial incentive basis.

(5) Every carrier that provides coverage for maternity services must provide notice to policyholders regarding the coverage required under this section. The notice must be in writing and must be transmitted at the earliest of the next mailing to the policyholder, the yearly summary of benefits sent to the policyholder, or January 1 of the year following June 6, 1996.

(6) This section does not establish a standard of medical care.

(7) This section applies to coverage for maternity services under a contract issued or renewed by a health carrier after June 6, 1996, and applies to plans operating under the health care authority under chapter 41.05 RCW beginning January 1, 1998.

RCW 48.42.100(2) and (3)-Women’s Health Care Services-Duties of Health Care Carriers:

(2) For purposes of this section and consistent with their lawful scopes of practice, types of health care practitioners that provide women's health care services shall include, but need not be limited by a health care carrier to, the following: Any generally recognized medical specialty of practitioners licensed under chapter 18.57 or 18.71 RCW who provides women's health care services; practitioners licensed under chapters 18.57A and 18.71A RCW when providing women's health care services; midwives licensed under chapter 18.50 RCW; and advanced registered nurse practitioner specialists in women's health and midwifery under chapter 18.79 RCW.

(3) For purposes of this section, women's health care services shall include, but need not be limited by a health carrier to, the following: Maternity care; reproductive health services; gynecological care; general examination; and preventive care as medically appropriate and medically appropriate follow-up visits for the services listed in this subsection.
WAC 284-170-350 (1)(a) and (b)- Issuer Standards for Women's Right To Directly Access Certain Health Care Practitioners For Women's Health Care Services:

(1) (a) "Women's health care services" means organized services to provide health care to women, inclusive of the women's preventive services required by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. The services include, but are not limited to, maternity care, reproductive health services, gynecological care, general examination, and preventative care as medically appropriate, and medically appropriate follow-up visits for these services. Women's health care services also include any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a women's health care service, which is within the practitioner's scope of practice. For purposes of determining a women's right to directly access health services covered by the plan, maternity care, reproductive health and preventative services include, contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast-feeding, and complications of pregnancy.

(b) An insurer may not exclude or limit access to covered women's health care services offered by a particular type of women's health care provider, practitioner, or facility in a manner that would unreasonably restrict access to that type of provider, practitioner, or facility or covered service. For example, a carrier may not impose a limitation on maternity services that would require all child birth to occur in a hospital attended by a physician thus, preventing a woman from choosing and using the birthing services of an advanced registered nurse practitioner, a certified midwife or a licensed midwife.

Notes:
- Licensed midwife and licensed nurse midwife services, including home deliveries, are covered by participating providers within their scope of practice.
- If facility services are needed, women may also self-refer to any UnitedHealthcare contracted facility (inpatient care, outpatient surgery, birthing center, home health or hospice) affiliated with their chosen women's health care provider.

RCW 48.44.344, Prenatal Diagnosis of Congenital Disorders: On or after January 1, 1990, every group health care services contract entered into or renewed that covers hospital, medical, or surgical expenses on a group basis, and which provides benefits for pregnancy, childbirth, or related medical conditions to enrollees of such groups, shall offer benefits for prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures during pregnancy to such enrollees when those services are determined to be medically necessary by the health care service contractor in accord with standards set in rule by the board of health. Every group health care services contractor shall communicate the availability of such coverage to all group health care service contract holders and to all groups with whom they are negotiating.

RCW 48.42.090 Prenatal testing - Limitation on changes to coverage. The carrier or provider of any group disability contract, health care services contract or health maintenance agreement shall not cancel, reduce, limit or otherwise alter or change the coverage provided solely on the basis of the result of any prenatal test.

WAC 246-680-020 Board of health standards for screening and diagnostic tests during pregnancy (1) For the purpose of RCW 48.21.244, 48.44.344, and 48.46.375 the following are standards of medical necessity for insurers, health care service contractors, and health maintenance organizations to use when authorizing requests or claims for prenatal screening and/or diagnosis without the requirement of a case-by-case determination and including preprocedure and post procedure genetic counseling:
- a) Maternal serum marker screening for all pregnant women beginning prenatal care before the twentieth completed week of gestation.
- b) Maternal hepatitis B surface antigen (HBsAg) screening for all pregnant women during the first trimester of pregnancy and the last trimester of pregnancy if the woman is at high risk for hepatitis B infection.
c) Information about Group B strep should be provided to all pregnant women, including the risk to the newborn, if the woman is identified through screening as potentially colonized with Group B strep. Screening is done through prenatal vaginorectal cultures, although specific clinical indicators may preclude screening. Pregnant women who are currently colonized with Group B strep, or who have unknown Group B strep status should receive intrapartum treatment in accordance with the current standard of practice in order to reduce risk to the newborn.

d) Prenatal ultrasonography if specific criteria are met:
   i. A woman undergoing amniocentesis, chorionic villus sampling, or percutaneous umbilical cord blood sampling or fetal tissue biopsy;
   ii. The results of a maternal serum marker screening test indicate an increased risk to the fetus or pregnancy;
   iii. A woman or the biological father of the fetus has a personal or family history of a congenital abnormality detectable by prenatal ultrasound;
   iv. An increased risk of a congenital abnormality is present due to an environmental exposure including maternal exposure to alcohol; or
   v. A medical evaluation indicates the possibility of polyhydramnios or oligohydramnios.

e) Amniocentesis if specific criteria are met:
   i. A woman is thirty-five years of age or older at the time of delivery;
   ii. A woman or the biologic father of the fetus has a previous child or fetus with a chromosomal abnormality or other prenatally diagnosable disorder;
   iii. A woman or the biologic father of the fetus has a family history that includes birth defects or developmental delays;
   iv. A woman or the biologic father of the fetus is a carrier of a chromosomal rearrangement;
   v. A woman and/or the biologic father of the fetus are carriers of, or affected with, a prenatally diagnosable inherited disorder;
   vi. The results of a maternal serum marker screening test indicate an increased risk to the pregnancy or fetus;
   vii. A woman has a documented history of three or more miscarriages of unknown cause when circumstances prevent parental chromosomal testing;
   viii. There is an ultrasound diagnosis of fetal anomaly;
   ix. A medical evaluation indicates an increased risk of fetal infection;
   x. Fetal blood studies are indicated for isoimmunization studies or therapy

f) Chorionic villus sampling with preprocedure and post procedure genetic counseling if one or more of the following criteria are met:
   i. A woman is thirty-five years of age or older at the time of delivery;
   ii. A woman or the biologic father of the fetus has a previous child or fetus with a chromosomal abnormality or other prenatally diagnosable inherited disorder;
   iii. A woman or the biologic father of the fetus is a carrier of a chromosomal rearrangement;
   iv. A woman or the biologic father of the fetus is a carrier of, or affected with, a prenatally diagnosable inherited disorder;
   v. A woman has a documented history of three or more miscarriages of unknown cause when circumstances prevent parental chromosomal testing; or
   vi. Fetal genotyping is indicated to determine risks for isoimmunization

g) Fluorescent in-situ hybridization (FISH) if a medical evaluation indicates a rapid or specific submicroscopic chromosomal diagnosis is required to predict the prognosis for the fetus.

RCW 48.44.440 Phenylketonuria.

(1) The legislature finds that:
   (a) Phenylketonuria is a rare inherited genetic disorder.
   (b) Children with phenylketonuria are unable to metabolize an essential amino acid, phenylalanine, which is found in the proteins of most food.
   (c) To remain healthy, children with phenylketonuria must maintain a strict diet and ingest a mineral and vitamin-enriched formula.
   (d) Children who do not maintain their diets with the formula acquire severe mental and physical difficulties.
   (e) Originally, the formulas were listed as prescription drugs but were reclassified as medical foods to increase their availability.
(2) Subject to requirements and exceptions which may be established by rules adopted by the commissioner, any contract for health care services delivered or issued for delivery or renewed in this state on or after September 1, 1988, shall provide coverage for the formulas necessary for the treatment of phenylketonuria.

B. STATE MARKET PLAN ENHANCEMENTS

None

C. COVERED BENEFITS

IMPORTANT NOTE: Covered benefits are listed in Sections A, B and C. Always refer to Sections A and B for additional covered benefits not listed in this Section.

Note: Depending on the member’s benefit plan, some members may have coverage for dependents, including grandchildren for medical coverage which includes maternity care. Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefit (SOB) to determine coverage eligibility.

Note: UnitedHealthcare may seek recovery of actual costs incurred by UnitedHealthcare from a member who is receiving reimbursement for medical expenses for maternity services while acting as a surrogate.

Note: Certain prenatal services are covered as preventive care. Please refer to the Medical Management Guideline titled Preventive Care Services.

1. Prenatal and Postnatal care must be provided by a Plan Provider, including a participating Certified Nurse-Midwife only if working under the direction of a participating plan provider and within the contracting network.
   a. Examples include, but are not limited to:
      1) Prenatal office visits
      2) Postnatal (after delivery) office visits up to 6 weeks post-delivery
      3) Outpatient (office visit) physician services
      4) Screening and diagnostic laboratory and radiological procedures, including but not limited to:
         a) Alpha fetoprotein blood testing (Please see above section A for more information regarding Prenatal screening)
         b) Fetal fibronectin enzyme immunoassay for women symptomatic for pre-term birth
            i. Symptomatic pregnancy between 24 and 34 weeks, especially when tocolytic therapy is initiated
            ii. Minimal cervical dilation (< 3 cm)
      5) Related genetic testing and counseling for Prenatal diagnosis of congenital disorders of the unborn child
      6) Educational materials for individual needs provided in physician's office

2. Complete inpatient maternity care, including but not limited to:
   a. Complete inpatient hospital care
   b. Labor and delivery room care, treatment and services
   c. Contracted birthing center/alternate birthing centers including a home birth when available through the contracting provider.
   d. Delivery by either normal/vaginal or Cesarean-section (C-Section)
   e. Treatment of a miscarriage and complications of pregnancy or childbirth
   f. Physician services (visits) related to all medically necessary inpatient maternity care, treatment and services
   g. All medically necessary ancillary services related to inpatient maternity care, treatment and services, including but not limited to:
      1) Diagnostic laboratory and/or radiologic procedures
      2) Services of a Certified Nurse/Midwife only if working under the direction of a participating Plan Provider and within the contracting network.
h. Circumcision
   1) For male newborns performed at the hospital prior to hospital discharge
   2) For male newborns performed after hospital discharge when:
      a) Circumcision was delayed by the participating provider during initial hospitalization. Unless the delay is for medical reasons, the circumcision is covered after discharge only through the twenty-eight (28) day neonatal period.
      b) Circumcision was determined medically inappropriate during initial hospitalization due to medical reasons (for example, prematurity, congenital deformity, etc.) The circumcision is covered when the participating provider determines it is medically safe and the circumcision is performed within 90 days of that determination.

Note: All other requests for circumcision must be reviewed for medical necessity by a UnitedHealthcare Medical Director or designee.

D. NOT COVERED

1. Non-medically indicated diagnostic testing such as:
   a. Any procedure intended solely for sex determination (e.g., ultrasound)
   b. Blood testing to determine paternity

2. Take home medications and/or supplies, unless member has a supplemental pharmacy benefit

3. Childbirth classes (e.g., Lamaze)

4. Maternity services for non-UnitedHealthcare member acting as surrogate to UnitedHealthcare member

5. Educational courses on child care and lactation

E. DEFINITIONS

Certified Nurse-Midwife: A registered nurse (RN) who has successfully completed a program of study and clinical experience in nurse-midwifery, meeting prescribed guidelines or who has been certified by a recognized organization such as the American College of Nurse-Midwives.

Newborns’ and Mothers’ Health Protection Act (NMHPA) of 1996: This act established new requirements for plans and insurers with respect to hospital length of stay for childbirth. The NMHPA applies to all group health plans, including self-insured plans, and health insurance coverage. Plans and issuers that do not provide maternity benefits are not required to offer them, and thus are not subject to the provisions of the Act. The Act does not apply to Medicaid or the handful of births covered each year under Medicare. The NMHPA states that the Act is applicable when a beneficiary is receiving the coverage through a group health plan. Group health plan is defined as an employee welfare benefit plan to the extent that the plan provides medical care to employees or their dependents directly or through insurance. The NMHPA does not apply to individuals who are Medicare independent of a group health plan. The Act is not applicable to Medicaid beneficiaries.

Postnatal: The period of time occurring or being after birth, generally considered to be 6 weeks.

Prenatal: Occurring, existing, or performed before birth.

F. REFERENCES

Newborns’ and Mothers’ Health Protection Act (NMHPA) of 1996, Title VI

### G. POLICY HISTORY/REVISION INFORMATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
</thead>
</table>
| 12/01/2018 | - Updated list of related policies; added reference link to the Benefit Interpretation Policy titled:  
  - Fetal Aneuploidy Testing using Cell-Free Fetal Nucleic Acids in Maternal Blood  
  - Intrauterine Fetal Surgery  
  - Federal/State Mandated Regulations  
  - Revised language pertaining to  
    - WAC 284-170-350 (1)(a) and (b) Issuer Standards for Women's Right to Directly Access Certain Health Care Practitioners for Women's Health Care Services  
    - WAC 246-680-020 Board of Health Standards for Screening and Diagnostic Tests During Pregnancy  
  - Updated code title for WAC 284-170-35 (1)(a) and (b) Issuer Standards for Women's Right to Directly Access Certain Health Care Practitioners for Women's Health Care Services; previously titled WAC 284-170-35 (1)(a) and (b) Health Carrier Standards for Women's Right to Directly Access Certain Health Care Practitioners for Women's Health Care Services  
  - Covered Benefits  
    - Added notation to indicate:  
      - UnitedHealthcare may seek recovery of actual costs incurred by UnitedHealthcare from a member who is receiving reimbursement for medical expenses for maternity services while acting as a surrogate  
      - Certain prenatal services are covered as preventive care; refer to the Medical Management Guideline titled Preventive Care Services  
    - Added language to clarify Prenatal and Postnatal care must be provided by a Plan Provider, including a participating Certified Nurse-Midwife only if working under the direction of a participating plan provider and within the contracting network  
    - Revised list of examples of Prenatal and Postnatal care services; removed "Utero Treatment for the Fetus"  
    - Replaced references to "Certified Registered Nurse-Midwife" with "Certified Nurse-Midwife"  
    - Revised language pertaining to circumcision for male newborns performed after hospital discharge; replaced language indicating coverage is provided when:  
      - "Circumcision is delayed by the physician at the time of hospitalization; unless the delay is for a medical reason, the circumcision will be covered after discharge only through the twenty-eight (28) day neonatal period" with "circumcision was delayed by the contracting physician during first hospitalization; unless the delay was for medical reasons, the circumcision is covered after discharge only through the twenty-eight (28) day neonatal period"  
      - "It is medically inappropriate to circumcise at birth due to medical reasons (e.g., prematurity, congenital deformity, etc.); the circumcision must be postponed and offered to the parent(s) when the infant's physician determines it is medically safe and the circumcision is performed within 90 days of that determination" with "circumcision was determined to be medically inappropriate during first hospitalization due to medical reasons (for example, prematurity, congenital deformity, etc.); the circumcision is covered when the contracting physician determines it is medically safe and the
| 12/01/2018 | circumcision is performed within 90 days from that determination |

**Definitions**
- Updated definition of “Certified Nurse-Midwife”

**References**
- Updated references
- Archived previous policy version BIP094.E