Maternity and Newborn Care

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Instructions for Use

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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.
https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html

Title VII of the Civil Rights Act, as amended by the Pregnancy Discrimination Act: 42 U.S. Code § 2000e

https://www.eeoc.gov/statutes/pregnancy-discrimination-act-1978

(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.

https://www.eeoc.gov/eeoc/publications/fs-preg.cfm
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).

Oklahoma

OAC 310:550-3-1. Testing of newborns

Section 310:550-3-1. Testing of newborns, Subchapter 3. Testing of Newborns, Chapter 550. Newborn Screening Program, Title 310. Oklahoma State Department of Health, Oklahoma Administrative Code (elaws.us)

(a) All newborns in Oklahoma shall be tested by a Certified Newborn Screening Laboratory for phenylketonuria, congenital hypothyroidism, galactosemia, sickle cell diseases, cystic fibrosis, congenital adrenal hyperplasia, medium-chain acyl coenzyme A dehydrogenase deficiency (MCAD), biotinidase deficiency, amino acid disorders, fatty acid oxidation disorders, organic acid disorders, and Severe Combined Immunodeficiency (SCID) spinal muscular atrophy (SMA), x-linked adrenoleukodystrophy (X-ALD), mucopolysaccharidosis type I (MPS I) and Pompe disease upon completion of laboratory validation studies, establishment of short-term follow-up services, and approval by the Commissioner of Health; a parent or guardian may refuse screening of their newborn on the grounds that such examination conflicts with their religious tenets and/or practices.

(b) All newborns in Oklahoma shall be tested for CCHD by a pulse oximetry screening after twenty-four (24) hours of age or prior to discharge from the birthing facility.

(c) A parent or guardian who refuses the newborn screening blood test or pulse oximetry screening of their newborn on the grounds that such examination conflicts with their religious tenets and practices shall also indicate in writing this refusal utilizing the Newborn Screening Program Parent Refusal Form provided by the program.

(d) The refusal form shall include the infant's name, date of birth, gender, demographic information, location of birth, name of the attending physician or provider, medical record number, indication of which screen is being refused (newborn blood test, newborn hearing screening, pulse oximetry screening), parent/guardian's printed name and signature as well as a witness' printed name and signature, and date signed. This signed refusal form shall be placed in the newborn's medical record with a copy sent to the Newborn Screening Program Coordinator.

OAC 317:30-5-1157 Newborn Screening

http://okrules.elaws.us/oac/317:30-5-1157/

(a) The newborn hearing screening is for the purpose of testing all newborns for hearing impairments to alleviate the adverse effects of hearing loss or speech and language development. The screening is a test or battery of tests administered to determine the need for an in-depth hearing diagnostic evaluation. Payment for the initial screening is included in the inpatient facility payment. Follow-up screening is covered if the child has not been seen by his/her PCP/CM.

(b) The newborn metabolic screening is for the purpose of testing all newborns born in Oklahoma for disorders as determined by the OSDH Board of Health. Short-term and long-term follow-up services are provided in conjunction with the laboratory testing.

OAC 310:550-1-2 Definitions

http://okrules.elaws.us/oac/310:550-1-2

The following words or terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

- **"Amino Acid Disorders"** refers to a group of inherited metabolic conditions in which the body is unable to metabolize or process amino acids properly due to a defective enzyme function. This causes an amino acid or protein build up in the body. If not treated early in life these defects can cause disability, developmental disability or death. Each amino acid disorder is associated with a specific enzyme deficiency. Treatment depends on the specific amino acid disorder.
- **"Biotinidase Deficiency"** means an inherited disease caused by the lack of an enzyme that recycles the B vitamin biotin, which if not treated may cause serious complications, including coma and death.
- "**Birth Defects Registry**" means a registry established by the Commissioner of Health to monitor and track birth defects for all infants born in Oklahoma.
- "**Birthing Facility**" means a facility that provides care during labor and delivery, and their newborn infants. This includes a unit of a hospital that is licensed and accredited to provide birthing services, or a freestanding birthing center.
- **"Certified Laboratory"** refers to the Oklahoma State Public Health Laboratory and/or a laboratory approved by the Oklahoma State Department of Health to conduct newborn screening.

- **CCHD Screening**" means the screening test for the detection of critical congenital heart disease that are recommended by the United States Department of Health and Human Services.
- **"CLIA '88"** means the Clinical Laboratory Improvement Amendments of 1988, public law 100-578. This amendment applies to the Federal Law that governs laboratories who examine human specimens for the diagnosis, prevention, or treatment of any disease or impairment, or the assessment of the health of human beings.
- **"Confirmatory Testing"** means definitive laboratory testing needed to confirm a diagnosis.
- **"Congenital Adrenal Hyperplasia" or "CAH"** refers to the most common form of CAH, 21-hydroxylase deficiency. This genetic disorder is caused by the lack of an enzyme that the adrenal gland uses to process hormones. Serious loss of body salt and water can result in death. In girls the genitalia may appear as a male's, and can result in incorrect sex assignment. Hormone treatment is required for life.
- **"Congenital Hypothyroidism"** means a disease caused by a deficiency of thyroid hormone (thyroxine) production, which if not treated leads to developmental and physical disability.
- **“Critical Congenital Heart Disease"** means a congenital heart defect that places an infant at significant risk for disability or death if not diagnosed soon after birth.
- **"Cystic Fibrosis"** means a multisystem genetic disorder in which defective chloride transport across membranes causes dehydration of secretions. The result is a production of a thick, viscous mucus that clogs the lungs. This leads to chronic lung infections, fatal lung disease, and also interferes with digestion. Early detection and treatment can prevent malnutrition, and enhance surveillance and treatment of lung infections.
- **"Days of Age"** means the age of a newborn in 24-hour periods so that a newborn is one day of age 24 hours following the hour of birth for both blood spot screening and pulse oximetry screening.
- **"Department"** refers to the Oklahoma State Department of Health.
- **"Discharge"** means release of the newborn from care and custody of a perinatal licensed health facility to the parents or into the community.
- **"Disorder"** means any condition detectable by newborn screening that allows opportunities, not available without screening, for early treatment and management to prevent developmental disability and/or reduce infant morbidity and mortality.
- **“Echocardiogram**" means a test that uses ultrasound to provide an image of the heart.
- **"Fatty Acid Oxidation Disorders"** refers to a group of inherited metabolic conditions in which the body is unable to oxidize (breakdown) fatty acids for energy due to a defective enzyme function. If not treated early in life this defect may cause developmental disability or death.
- **"Galactosemia"** means an inherited disease caused by the body's failure to break down galactose due to a defective enzyme function, which if not treated early in life may cause developmental disability or death.
- **“Hemoglobin"** means a protein in the red blood cell that carries oxygen.
- **"Hemoglobinopathy"** means an inherited hemoglobin disorder.
- **"Infant"** means a child 6 months of age and under.
- **Infant’s Physician** means the licensed medical or osteopathic physician listed by the submitter or individual responsible for the medical care of the newborn.
- **“Initial Specimen"** means the first blood specimen collected subsequent to birth, pursuant to these procedures.
- **"Long-term Follow-up"** means follow-up services that begin with diagnosis and treatment and continues throughout the lifespan, including parent education, networking, referral, and case coordination.
- **Medical Home** means a Planned Health Care Provider
- **"Medium-chain acyl coenzyme A dehydrogenase deficiency** or **"MCAD"** means a genetic disorder of fatty acid metabolism. This disorder can cause metabolic crisis when an infant/child fasts. This crisis can lead to seizures, failure to breathe, cardiac arrest and death. Treatment is effective by preventing fasting.
- **"Mucopolysaccharidosis Type I" or "MPS I**" means a condition in which individuals are missing an enzyme to break down large sugar molecules. This disorder can impact many different organs and tissue leading to developmental delays if not identified and treated early.
- **"Newborn"** means an infant 30 days of age and under.
- **"Newborn Screening" or "newborn screening tests"** means screening infants for the disorders of phenylketonuria, congenital hypothyroidism, galactosemia, sickle cell diseases, cystic fibrosis, congenital adrenal hyperplasia, medium-chain acyl coenzyme A dehydrogenase deficiency (MCAD), biotinidase deficiency, amino acid disorders, fatty acid oxidation disorders, organic acid disorders. Severe Combined Immunodeficiency (SCID) spinal muscular atrophy (SMA), x-linked adrenoleukodystrophy (X-ALD), mucopolysaccharidosis type I (MPS I) and Pompe disease upon completion of laboratory validation studies, establishment of short-term follow-up services, and approval by the Commissioner of Health.

Also includes critical congenital heart disease (CCHD) via pulse oximetry screening conducted by birthing facilities on all newborns born in the state of Oklahoma.

- **"Newborn Screening Laboratory"** means a laboratory operated by the Department or a laboratory certified by the Department to conduct the tests and carry out the follow-up required by these procedures.
- **Newborn Screening Form Kit or Form Kit** means an approved by the Department for collection of the newborn screening specimen.
- **"Newborn Screening Program" or "The Program"** refers to the Public Health Laboratory and Family Health Services Short-term Follow-up Program at the Oklahoma State Department.
- **"Newborn Screening Program Coordinator"** refers to the coordinator of the Short-term Follow-up Program at the Department.
- **"Organic Acid Disorders"** refers to a group of inherited metabolic conditions in which the body is unable to metabolize or process organic acids properly. Each organic acid disorder is associated with a specific enzyme deficiency that causes the accumulation of organic acids in blood and urine. The accumulated compounds or their metabolites are toxic, resulting in the clinical features of these disorders including developmental disability and death.
- **"Pediatric Sub-Specialist"** means a physician licensed in Oklahoma, board certified in pediatrics and board certified in a pediatric sub-specialty of pediatric endocrinology, pediatric pulmonology, or pediatric hematology; or a physician licensed in Oklahoma, board certified in pediatrics whose primary area of practice is pediatric endocrinology, pediatric hematology, pediatric pulmonology, or metabolic specialist.
- **"Phenylketonuria"** or **"PKU"** means an inherited disease caused by the body's failure to convert the amino acid phenylalanine to tyrosine due to defective enzyme function, which if not treated early in life, causes developmental disability.
- **"Planned Health Care Provider" or "Medical Home"** means the health care provider who will be providing health care for the infant after discharge from the hospital.
- **Pompe or "Pompe Disease"** means a condition in which individuals are missing an enzyme to break down complex sugar molecules. The disorder can lead to muscle weakness, poor muscle tone and heart defects if not identified and treated early.
- **"Premature Infant"** means an infant weighing less than 2500 grams or any live birth before the thirty-seventh week of gestation.
- **"Pulse Oximetry Screening**" means a test using a device placed on an extremity to measure the percentage of oxygen in the blood.
- **"Repeat Specimen"** means an additional newborn screening specimen to be collected after the initial specimen.
- **"Satisfactory Specimen"** means a specimen collected using a single form kit which is suitable in both blood quantity and quality to perform screening for phenylketonuria, congenital hypothyroidism, galactosemia, sickle cell disease, cystic fibrosis, congenital adrenal hyperplasia, medium-chain acyl coenzyme A dehydrogenase deficiency (MCAD), biotinidase deficiency, amino acid disorders, fatty acid oxidation disorders, organic acid disorders. Severe Combined Immunodeficiency (SCID) spinal muscular atrophy (SMA), x-linked adrenoleukodystrophy (X-ALD), mucopolysaccharidosis type I (MPS I) and Pompe disease upon completion of laboratory validation studies, establishment of short-term follow-up services, and approval by the Commissioner of Health. All requested demographic information on the form kit must be completed. Federal CLIA '88 regulations require that the form kit's data that must include patient's name, date of birth, sex, date of collection, test(s) to be performed, and complete name and address of person requesting the test.
- **"Screened"** means a specimen that has been collected and tested on an infant less than 6 months of age.
- **"Screening"** means a test to sort out apparently well persons who probably have a disease from those who probably do not. A screening test is not intended to be diagnostic.
- **"Severe Combined Immunodeficiency**" means a group of potentially fatal inherited disorders related to the immune system, which if not treated can lead to potentially deadly infections.
- **"Short-term Follow-up"** includes services provided by the Department and the health care provider that begins when the laboratory reports an abnormal or unsatisfactory screen result and ends with a diagnosis of normal, lost (repeat testing not achieved), or affected with appropriate treatment and referral has been initiated.
- **"Sick Infant"** means an infant with any condition or episode marked by pronounced deviation from the normal healthy state; illness.
- **"Sickle Cell Disease**" means an inherited disease caused by abnormal hemoglobin(s) which if not treated early in life may result in severe illness, developmental disability or death (one variation is commonly referred to as sickle cell anemia).
- **"Specimen"** means blood collected on the filter paper Newborn Screening Form Kit.
- **"Submitter"** means a hospital, other facility, or physician submitting a Newborn Screening specimen.

- "**The Program** means The Newborn Screening Program
- **"Transfer"** means release of the newborn from care and custody from one licensed health facility to another.
- **"Unsatisfactory Specimen"** means a specimen which is not collected on a form kit and/or is not suitable in blood quantity and quality to perform screening for phenylketonuria, congenital hypothyroidism, galactosemia, sickle cell disease, cystic fibrosis, congenital adrenal hyperplasia, and medium-chain acyl coenzyme A dehydrogenase deficiency (MCAD), biotinidase deficiency, amino acid disorders, fatty acid oxidation disorders, organic acid disorders and Severe Combined Immunodeficiency (SCID) spinal muscular atrophy (SMA), x-linked adrenoleukodystrophy (X-ALD), mucopolysaccharidosis type I (MPS I) and Pompe disease upon completion of laboratory validation studies, establishment of short-term follow-up services, and approval by the Commissioner of Health and/or Federal CLIA '88 regulations are not followed and the form kit's laboratory requisition does not include patient's name, date of birth, sex, date of collection, test(s) to be performed, and complete name and address of person requesting test.
- **X Linked Adrenoleukodystrophy"** or **"X-ALD"** means condition in which the nervous system and adrenal glands are affected. Impact to the nervous system reduces the ability of the nerves to relay information to the brain. Impact to the adrenal glands may cause weakness, weight loss, skin changes, vomiting, and coma.

36 OK Statute Section 36-6060.3 Maternity Coverage Postpartum Care

Oklahoma Statutes §36-6060.3 (2020) - Maternity benefits - Postpartum care. :: 2020 Oklahoma Statutes :: US Codes and Statutes :: US Law :: Justia

A. Every health benefit plan issued, amended, renewed or delivered in this state on or after July 1, 1996, that provides maternity benefits shall provide for coverage of:
   1. A minimum of forty-eight (48) hours of inpatient care at a hospital, or a birthing center licensed as a hospital, following a vaginal delivery, for the mother and newborn infant after childbirth, except as otherwise provided in this section;
   2. A minimum of ninety-six (96) hours of inpatient care at a hospital following a delivery by caesarean section for the mother and newborn infant after childbirth, except as otherwise provided in this section; and
   3. a. Postpartum home care following a vaginal delivery if childbirth occurs at home or in a birthing center licensed as a birthing center. The coverage shall provide for one home visit within forty-eight (48) hours of childbirth by a licensed health care provider whose scope of practice includes providing postpartum care. Visits shall include, at a minimum:
      (1) Physical assessment of the mother and the newborn infant,
      (2) Parent education, to include, but not be limited to:
         (a) The recommended childhood immunization schedule,
         (b) The importance of childhood immunizations, and
         (c) Resources for obtaining childhood immunizations,
      (3) Training or assistance with breast or bottle feeding, and
      (4) The performance of any medically necessary and appropriate clinical tests.
   b. At the discretion of the mother, visits may occur at the facility of the plan or the provider.

B. Inpatient care shall include, at a minimum:
   1. Physical assessment of the mother and the newborn infant;
   2. Parent education, to include, but not be limited to:
      a. The recommended childhood immunization schedule,
      b. The importance of childhood immunizations, and
      c. Resources for obtaining childhood immunizations;
   3. Training or assistance with breast or bottle feeding; and
   4. The performance of any medically necessary and appropriate clinical tests.

C. A plan may limit coverage to a shorter length of hospital inpatient stay for services related to maternity and newborn infant care provided that:
   1. In the sole medical discretion or judgment of the attending physician licensed by the Oklahoma State Board of Medical Licensure and Supervision or the State Board of Osteopathic Examiners or the certified nurse midwife licensed by the Oklahoma Board of Nursing providing care to the mother and to the newborn infant, it is determined prior to discharge that an earlier discharge of the mother and newborn infant is appropriate and meets medical criteria contained in the most current treatment standards of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon:
      a. Evaluation of the antepartum, intrapartum and postpartum course of the mother and newborn infant,
      b. The gestational age, birth weight and clinical condition of the newborn infant,

c. The demonstrated ability of the mother to care for the newborn infant post-discharge, and
d. The availability of post-discharge follow-up to verify the condition of the newborn infant in the first forty-eight (48) hours after delivery.

A plan shall adopt these guidelines by July 1, 1996; and

2. The plan covers one home visit, within forty-eight (48) hours of discharge, by a licensed health care provider whose scope of practice includes providing postpartum care. The visits shall include, at a minimum:
   a. Physical assessment of the mother and the newborn infant,
   b. Parent education, to include, but not be limited to:
      1) The recommended childhood immunization schedule,
      2) The importance of childhood immunizations, and
      3) Resources for obtaining childhood immunizations,
   c. Training or assistance with breast or bottle feeding, and
   d. The performance of any medically necessary and clinical tests.

At the mother's discretion, visits may occur at the facility of the plan or the provider.

D. The plan shall include, but is not limited to, notice of the coverage required by this section in the evidence of coverage of the plan, and shall provide additional written notice of the coverage to the insured or an enrollee during the course of the prenatal care of the insured or enrollee.
E. In the event the coverage required by this section is provided under a contract that is subject to a capitated or global rate, the plan shall be required to provide supplementary reimbursement to providers for any additional services required by that coverage if it is not included in the capitation or global rate.
F. No health benefit plan subject to the provisions of this section shall terminate the services of, reduce capitation payments for, refuse payment for services, or otherwise discipline a licensed health care provider who orders care consistent with the provisions of this section.
G. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title.
H. The Insurance Commissioner shall promulgate any rules necessary to implement the provisions of this section.

Oregon

ORS 743B.222 Designation of Women's Health Care Provider As Primary Care Provider; Direct Access to Women's Health Care Provider

https://www.oregonlaws.org/ors/743B.222

(1) As used in this section, "women's health care provider" means an obstetrician or gynecologist, physician assistant specializing in women's health, advanced registered nurse practitioner specialist in women's health or certified nurse midwife, practicing within the applicable lawful scope of practice.
(2) Every health insurance policy that covers hospital, medical or surgical expenses and requires an enrollee to designate a participating primary care provider shall permit a female enrollee to designate a women's health care provider as the enrollee's primary care provider if:
   (a) The women's health care provider meets the standards established by the insurer in collaboration with interested parties, including but not limited to the Oregon section of the American College of Obstetricians and Gynecologists; and
   (b) The women's health care provider requests that the insurer make the provider available for designation as a primary care provider.
(3) If a female enrollee has designated a primary care provider who is not a women's health care provider, an insurance policy as described in subsection (2) of this section shall permit the enrollee to have direct access to a women's health care provider, without a referral or prior authorization, for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology.
(4) The standards established by the insurer under subsection (2) of this section shall not prohibit an insurer from establishing the maximum number of participating primary care providers and participating women's health care providers necessary to serve a defined population or geographic service area.

ORS 743A.090

https://www.oregonlaws.org/ors/743A.090

(1) All individual and group health benefit plans, as defined in ORS 743B.005 (Definitions), that include coverage for a family member of the insured shall also provide that the health insurance benefits applicable for children in the family shall be payable with respect to:
   (a) A child of the insured from the moment of birth; and
   (b) An adopted child effective upon placement for adoption

(2) The coverage of natural and adopted children required by subsection (1) of this section shall consist of coverage of preventive health services and treatment of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(3) If payment of an additional premium is required to provide coverage for a child, the policy may require that notification of the birth of the child or of the placement for adoption of the child and payment of the premium be furnished to the insurer within 31 days after the date of birth or date of placement in order to effectuate the coverage required by this section and to have the coverage extended beyond the 31-day period.

(4) In any case in which a policy provides coverage for dependent children of participants or beneficiaries, the policy shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply to the natural, dependent children of the participants and beneficiaries, regardless of whether the adoption has become final.

(5) As used in this section:
   (a) "Child" means an individual who is under 26 years of age.
   (b) "Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of such legal obligations.

(6) The provisions of ORS 743A.001 (Automatic repeal of certain statutes on individual and group health insurance) do not apply to this section. [Formerly 743.707; 2011 c.500 §40; 2013 c.681 §33]

ORS 743A.080 Pregnancy and Childbirth Expense

https://www.oregonlaws.org/ors/743A.080

(1) As used in this section, "pregnancy care" means the care necessary to support a healthy pregnancy and care related to labor and delivery.

(2) All health benefit plans as defined in ORS 743B.005 (Definitions) must provide payment or reimbursement for expenses associated with pregnancy care and childbirth. Benefits provided under this section shall be extended to all members, enrolled spouses and enrolled dependents.

ORS 743B.225 Continuity of Care

https://www.oregonlaws.org/ors/743B.225

(8) An enrollee who is undergoing care for a pregnancy and who becomes entitled to continuity of care after commencement of the second trimester of the pregnancy shall receive the care until the later of the following dates:
   (A) The 45th date after the birth; or
   (B) As long as the enrollee continues under an active course of treatment, but not later than the 120th day after the date of notification by the insurer to the enrollee of the termination of the contractual relationship with the individual provider.

ORS 743A.082 Diabetes Management for Pregnant Women

https://www.oregonlaws.org/ors/743A.082

(1) Except as provided in subsections (2) and (3) of this section, a health benefit plan, as defined in ORS 743B.005, may not require a copayment or impose a coinsurance requirement or a deductible on the covered health services, medications and supplies that are medically necessary for a woman to manage her diabetes during the period of each pregnancy, beginning with conception and ending six weeks postpartum.

(2) Subsection (1) of this section does not apply to a high deductible health plan described in 26 U.S.C. 223.

(3) The coverage required by subsection (1) of this section may be limited by network and formulary restrictions that apply to other benefits under the plan. Subsection (1) of this section does not apply to services, medications, test strips and syringes that are not covered due to the network or formulary restrictions.
(4) An insurer may require an enrollee or the enrollee's health care provider to notify the insurer orally, in a timely manner, that the enrollee is diabetic and is pregnant or has given birth and is within six weeks postpartum.

ORS 743A.078 Newborn Nurse Home Visiting Services

https://www.oregonlaws.org/ors/743A.078
(1) As used in this section, "carrier," "enrollee" and "health benefit plan" have the meanings given those terms in ORS 743B.005 (Definitions).
(2) A health benefit plan offered in this state must reimburse the cost of universal newborn nurse home visiting services as prescribed by the Oregon Health Authority by rule under ORS 433.301 (Newborn nurse home visiting services program) (7).
(3) The coverage must be provided without any cost-sharing, coinsurance or deductible applicable to the services.
(4) Carriers must offer the services in their health benefit plans but enrollees are not required to receive the services as a condition of coverage and may not be penalized or in any way discouraged from declining the services.
(5) A carrier must notify an enrollee about the services whenever an enrollee adds a newborn to coverage.
(6) A carrier may use in-network providers or may contract with local public health authorities to provide the services.
(7) This section does not require a carrier to reimburse the cost of the services in any specific manner. The services may be reimbursed using:
  (a) A value-based payment methodology;
  (b) A claim invoicing process;
  (c) Capitated payments;
  (d) A payment methodology that takes into account the need for a community-based entity providing the services to expand its capacity to provide the services and address health disparities; or
  (e) Any other methodology agreed to by the carrier and the provider of the services.
(8) Carriers shall report to the authority, in the form and manner prescribed by the authority, data regarding claims submitted for services covered under this section to monitor the provision of the services. [2019 c.552 §3]

Texas

Texas Health and Safety Code Section 81.090. During Pregnancy and After Birth

https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=HS%2fHS.81&Phrases=81.090&HighlightType=1&ExactPhrase=False&QueryText=81.090
(a) A physician or other person permitted by law to attend a pregnant woman during gestation or at delivery of an infant shall:
  (1) Take or cause to be taken a sample of the woman's blood or other appropriate specimen at the first examination and visit;
  (2) Submit the sample to an appropriately certified laboratory for diagnostic testing approved by the United States Food and Drug Administration for:
    (A) Syphilis;
    (B) HIV infection; and
    (C) Hepatitis B infection; and
  (3) Retain a report of each case for nine months and deliver the report to any successor in the case.
(a-1) A physician or other person permitted by law to attend a pregnant woman during gestation or at delivery of an infant shall:
  (1) Take or cause to be taken a sample of the woman's blood or other appropriate specimen at an examination in the third trimester of the pregnancy, but not earlier than the 28th week of the pregnancy;
  (2) Submit the sample to an appropriately certified laboratory for a diagnostic test approved by the United States Food and Drug Administration for syphilis and HIV infection; and
  (3) Retain a report of each case for nine months and deliver the report to any successor in the case.
(b) A successor is presumed to have complied with this section if the successor in good faith obtains a record that indicates compliance with Subsections (a) and (a-1), if applicable.
(c) A physician or other person in attendance at a delivery shall:
  (1) Take or cause to be taken a sample of blood or other appropriate specimen from the mother on admission for delivery; and
  (2) Submit the sample to an appropriately certified laboratory for diagnostic testing approved by the United States Food and Drug Administration for hepatitis B infection and syphilis.

(c-1) If the physician or other person in attendance at the delivery does not find in the woman's medical records results from the diagnostic test for syphilis and HIV infection performed under Subsection (a-1), the physician or person shall:
  (1) Take or cause to be taken a sample of blood or other appropriate specimen from the mother;
  (2) Submit the sample to an appropriately certified laboratory for diagnostic testing approved by the United States Food and Drug Administration for syphilis and HIV infection; and
  (3) Instruct the laboratory to expedite the processing of the HIV test so that the results are received less than six hours after the time the sample is submitted.

(c-2) If the physician or other person responsible for the newborn child does not find in the woman's medical records results from a diagnostic test for syphilis and HIV infection performed under Subsection (a-1), and the diagnostic test for syphilis and HIV infection was not performed before delivery under Subsection (c-1), the physician or other person responsible for the newborn child shall:
  (1) Take or cause to be taken a sample of blood or other appropriate specimen from the newborn child less than two hours after the time of birth;
  (2) Submit the sample to an appropriately certified laboratory for a diagnostic test approved by the United States Food and Drug Administration for syphilis and HIV infection; and
  (3) Instruct the laboratory to expedite the processing of the HIV test so that the results are received less than six hours after the time the sample is submitted.

(d) Repealed by Acts 2009, 81st Leg., R.S., Ch. 1124, Sec. 7, eff. September 1, 2009.

(e) Repealed by Acts 2009, 81st Leg., R.S., Ch. 1124, Sec. 7, eff. September 1, 2009.

(f) Repealed by Acts 2009, 81st Leg., R.S., Ch. 1124, Sec. 7, eff. September 1, 2009.

(g) Repealed by Acts 1993, 73rd Leg., ch. 30, Sec. 3, eff. Sept. 1, 1993.

(h) Repealed by Acts 2009, 81st Leg., R.S., Ch. 1124, Sec. 7, eff. September 1, 2009.

(i) Before conducting or causing to be conducted a diagnostic test for HIV infection under this section, the physician or other person shall advise the woman that the result of a test taken under this section is confidential as provided by Subchapter F, but that the test is not anonymous. The physician or other person shall explain the difference between a confidential and an anonymous test to the woman and that an anonymous test may be available from another entity. The physician or other person shall make the information available in another language, if needed, and if resources permit. The information shall be provided by the physician or another person, as needed, in a manner and in terms understandable to a person who may be illiterate if resources permit.

(j) The result of a test for HIV infection under Subsection (a)(2)(B), (a-1), (c-1), or (c-2) is a test result for purposes of Subchapter F.

(k) Before the sample is taken, the health care provider shall distribute to the patient printed materials about AIDS, HIV, hepatitis B, and syphilis. A health care provider shall verbally notify the patient that an HIV test shall be performed if the patient does not object. If the patient objects, the patient shall be referred to an anonymous testing facility or instructed about anonymous testing methods. The health care provider shall note on the medical records that the distribution of printed materials was made and that verbal notification was given. The materials shall be provided to the health care provider by the department and shall be prepared and designed to inform the patients about:
  (1) The incidence and mode of transmission of AIDS, HIV, hepatitis B, and syphilis;
  (2) How being infected with HIV, AIDS, hepatitis B, or syphilis could affect the health of their child;
  (3) The available cure for syphilis;
  (4) The available treatment to prevent maternal-infant HIV transmission; and
  (5) Methods to prevent the transmission of the HIV virus, hepatitis B, and syphilis.

(l) A physician or other person may not conduct a diagnostic test for HIV infection under Subsection (a)(2)(B), (a-1), or (c-1) if the woman objects. A physician or other person may not conduct a diagnostic test for HIV infection under Subsection (c-2) if a parent, managing conservator, or guardian objects.

(m) If a screening test and a confirmatory test conducted under this section show that the woman is or may be infected with HIV, hepatitis B, or syphilis, the physician or other person who submitted the sample for the test shall provide or make available to the woman disease-specific information on the disease diagnosed, including:
  (1) Information relating to treatment of HIV infection, acquired immune deficiency syndrome, hepatitis B, or syphilis, which must be in another language, if needed, and must be presented, as necessary, in a manner and in terms understandable to a person who may be illiterate if resources permit; and
  (2) Counseling under Section 81.109, if HIV infection or AIDS is diagnosed.

(n) A physician or other person may comply with the requirements of Subsection (m)(1) by referring the woman to an entity that provides treatment for individuals infected with the disease diagnosed.

(o) In this section, "HIV" has the meaning assigned by Section 81.101.
(p) Not later than January 1 of each odd-numbered year, the department shall report to the legislature the number of cases of early congenital syphilis and of late congenital syphilis that were diagnosed in this state in the preceding biennium.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1993, 73rd Leg., ch. 30, Sec. 3, eff. Sept. 1, 1993; Acts 1993, 73rd Leg., ch. 420, Sec. 1, eff. June 6, 1993; Acts 1995, 74th Leg., ch. 805, Sec. 1, eff. Sept. 1, 1995; Acts 1999, 76th Leg., ch. 573, Sec. 1, eff. Sept. 1, 1999.
Amended by:

- Acts 2009, 81st Leg., R.S., Ch. 1124 (H.B. 1795), Sec. 5, eff. September 1, 2009.
- Acts 2009, 81st Leg., R.S., Ch. 1124 (H.B. 1795), Sec. 6, eff. September 1, 2009.
- Acts 2009, 81st Leg., R.S., Ch. 1124 (H.B. 1795), Sec. 7, eff. September 1, 2009.
- Acts 2015, 84th Leg., R.S., Ch. 206 (S.B. 1128), Sec. 1, eff. September 1, 2015.
- Acts 2019, 86th Leg., R.S., Ch. 973 (S.B. 748), Sec. 5, eff. September 1, 2019.

Texas Insurance Code Section 1366.055 Coverage for Inpatient Care Required

https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1366&Phrases=1366.055&HighlightType=1&ExactPhrase=False&QueryText=1366.055

(a) Except as provided by Subsection (b), a health benefit plan that provides maternity benefits, including benefits for childbirth, must provide to a woman who has given birth to a child and the newborn child coverage for inpatient care in a health care facility for not less than:
  (1) 48 hours after an uncomplicated vaginal delivery; and
  (2) 96 hours after an uncomplicated delivery by cesarean section.
(b) A health benefit plan that provides to a woman who has given birth to a child and the newborn child coverage for in-home postdelivery care is not required to provide the coverage required under Subsection (a) unless:
  (1) The attending physician determines that inpatient care is medically necessary; or
  (2) The woman requests inpatient care.
(c) For purposes of Subsection (a), the attending physician shall determine whether a delivery is complicated.
(d) This section does not require a woman who is eligible for coverage under a health benefit plan to:
  (1) Give birth to a child in a hospital or other health care facility; or
  (2) Remain under inpatient care in a hospital or other health care facility for any fixed term following the birth of a child.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Section 1366.056 Coverage for Postdelivery Care Required

https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1366&Phrases=1366.055&HighlightType=1&ExactPhrase=False&QueryText=1366.055

(a) If a decision is made to discharge a woman who has given birth to a child or the newborn child from inpatient care before the expiration of the minimum hours of coverage required under Section 1366.055(a), a health benefit plan must provide to the woman and child coverage for timely postdelivery care.
(b) The timeliness of the postdelivery care shall be determined in accordance with recognized medical standards for that care.
(c) The postdelivery care may be provided by a physician, registered nurse, or other appropriate licensed health care provider.
(d) Subject to Subsection (e), the postdelivery care may be provided at:
  (1) The woman's home;
  (2) A health care provider's office;
  (3) A health care facility; or
  (4) Another location determined to be appropriate under rules adopted by the commissioner.
(e) The coverage required under this section must give the woman the option to have the care provided in the woman's home.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Section 1366.057 Prohibited Conduct

https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1366&Phrases=1366.057&HighlightType=1&ExactPhrase=False&QueryText=1366.057

An issuer of a health benefit plan may not:

(1) Modify the terms and conditions of coverage based on a request by an enrollee for less than the minimum coverage required under Section 1366.055(a);
(2) Offer to a woman who has given birth to a child a financial incentive or other compensation the receipt of which is contingent on the waiver by the woman of the minimum coverage required under Section 1366.055(a);
(3) Refuse to accept a physician's recommendation for inpatient care made in consultation with the woman who has given birth to a child if the period of inpatient care recommended by the physician does not exceed the minimum periods recommended in guidelines for perinatal care developed by:
    (A) The American College of Obstetricians and Gynecologists;
    (B) The American Academy of Pediatrics; or
    (C) Another nationally recognized professional association of obstetricians and gynecologists or of pediatricians;
(4) Reduce payments or other forms of reimbursement for inpatient care below the usual and customary rate of reimbursement for that care; or
(5) Penalize a physician for recommending inpatient care for a woman or the woman's newborn child by:
    (A) Refusing to permit the physician to participate as a provider in the health benefit plan;
    (B) Reducing payments made to the physician;
    (C) Requiring the physician to:
        (i) Provide additional documentation; or
        (ii) Undergo additional utilization review; or
    (D) Imposing other analogous sanctions or disincentives.

Section 1367.103 Coverage Required

https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1367&Phrases=1367.103&HighlightType=1&ExactPhrase=False&QueryText=1367.103

(a) A health benefit plan that provides coverage for a family member of an insured or enrollee shall provide to each covered child coverage for:
    (1) A screening test for hearing loss from birth through the date the child is 30 days of age, as provided by Chapter 47, Health and Safety Code; and
    (2) Necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months of age.
(b) For purposes of Subsection (a), a covered child is a child who, as a result of the child's relationship to an insured or enrollee in a health benefit plan, would be entitled to coverage under an accident and health insurance policy under Section 1201.061, 1201.062, 1201.063, or 1201.064.
(c) This section does not require a health benefit plan to provide the coverage described by this section to a child of an individual residing in this state if the individual is:
    (1) Employed outside this state; and
    (2) Covered under a health benefit plan maintained for the individual by the individual's employer as an employment benefit.

Washington

RCW 48.43.115 Maternity Services-Intent-Definitions-Patient Preference-Clinical Sovereignty of Provider-Notice to Policyholders-Application

https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.115

(Effective until July 1, 2022)

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

https://app.leg.wa.gov/rcw/default.aspx?cite=48.42.100

Effective until July 1, 2022

(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.

(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 chapter 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 care 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

https://apps.leg.wa.gov/wac/default.aspx?cite=284-170-350

(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 issuer must 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, an issuer must 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, Benefits for Prenatal Diagnosis of Congenital Disorders- Contracts Entered Into or Renewed On or After January 1, 1990

https://app.leg.wa.gov/rcw/default.aspx?cite=48.44.344

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

https://app.leg.wa.gov/rcw/default.aspx?cite=48.42.090

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

https://apps.leg.wa.gov/wac/default.aspx?cite=246-680-020

Effective until July 1, 2022

(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 one or more of the following 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 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 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 postprocedure 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.

(2) The board recommends the following additional procedures for use by insurers, health service contractors, and health maintenance organizations in determining medical necessity on a case-by-case basis:

(a) Percutaneous umbilical cord blood sampling with preprocedure and postprocedure genetic counseling if one or more of the following criteria are met:

(i) A medical evaluation indicates rapid or specific submicroscopic chromosomal diagnosis or DNA diagnosis is required to predict prognosis for the fetus;

(ii) A medical evaluation indicates the possibility of a prenatally diagnosable fetal infection;

(iii) Fetal blood studies are medically indicated for isoimmunization studies or therapy;

(iv) Fetal blood is the only means to provide biochemical genetic diagnosis;

(v) Prenatal diagnosis of a hematological disorder is medically indicated.

(b) Prenatal tissue biopsy if the nature of the disorder in question indicates that fetal liver, skin, or other tissue biopsy is the only means to provide biochemical genetic diagnosis to protect the health of the mother or predict the prognosis of the fetus.

Effective July 1, 2022

(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 or diagnosis without the requirement of a case-by-case determination:

(a) Hepatitis B surface antigen (HBsAg) screening for all pregnant persons during the first trimester of pregnancy and the last trimester of pregnancy if the person is at high risk for hepatitis B infection.

(b) Group B strep screening through prenatal vaginorectal cultures at thirty-five to thirty-seven weeks of gestation. Pregnant persons 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.

(2) 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 or diagnosis without the requirement of a case-by-case determination and including preprocedure and postprocedure genetic counseling:

(a) Maternal serum marker screening for all pregnant persons at the beginning of prenatal care if initiated before the twenty-second completed week of gestation.

(b) Prenatal ultrasonography:

(i) During the first trimester to establish viability, gestational age, and determine if singleton or multiple births; and

(ii) During second trimester for fetal morphology.

(c) Additional prenatal ultrasonography can be done at any time during a pregnancy if one or more of the following criteria are met:

(i) A person is undergoing amniocentesis, chorionic villus sampling, percutaneous umbilical blood sampling, or fetal tissue biopsy;

(ii) The results of a maternal serum marker screening or prenatal cell free DNA test indicate an increased risk to the fetus or pregnancy;

(iii) There is an increased risk of a congenital abnormality due to:

(A) An environmental exposure;

(B) A medical evaluation indicating the possibility of polyhydramnios, oligohydramnios, or poor or accelerated fetal growth; or

(C) A personal or family history of a congenital abnormality that is potentially detectable by prenatal ultrasound.

(d) Amniocentesis after fourteen weeks of gestation.

(e) Chorionic villus sampling between ten and fourteen weeks of gestation.

(f) Fetal diagnostic testing including:

(i) Cytogenetic studies on fetal cells including chromosome analysis, targeted cytogenomic microarray analysis (CMA), and fluorescent in-situ hybridization (FISH) for any person undergoing amniocentesis or chorionic villus sampling; and

(ii) DNA testing, biochemical testing, or testing for infectious diseases if medically indicated because of an abnormal ultrasound finding, intrauterine fetal demise, or known family history; and

(iii) Cytogenomic microarray analysis in the case of recurrent intrauterine fetal demise.

(g) Prenatal cell free DNA testing performed after nine weeks of gestation for the detection of aneuploidy including trisomy 21, 18, 13, or the sex chromosomes if the following criteria are met:
  (i) There is documentation of preprocedure genetic counseling;
  (ii) There is documentation of how postprocedure genetic counseling will be provided; and
  (iii) Testing the sex chromosomes is not solely for the purposes of determining the sex of the fetus.

(h) Carrier screening at any time during the pregnancy for:
  (i) Recessive or X-linked conditions if indicated by a positive family history; and
  (ii) Any of the following conditions irrespective of family history:
    (A) Alpha-thalassemia (HBA1/HBA2);
    (B) Beta-thalassemia;
    (C) Bloom syndrome;
    (D) Canavan disease;
    (E) Cystic fibrosis;
    (F) Familial dysautonomia (IKBKAP);
    (G) Fanconi anemia type C (FANCC);
    (H) Gaucher disease (GBA);
    (I) Mucolipidosis IV (MCOLN1); or
    (J) Niemann-Pick disease (SMPD1);
    (K) Sickle cell disease;
    (L) Spinal muscular atrophy (SMN1);
    (M) Tay-Sachs disease (HEXA);
    (N) Fragile-X Syndrome.
  (iii) Carrier screening under (h)(i) and (ii) of this subsection may be limited to once per lifetime.

(i) Molecular genetic or cytogenetic testing of parents to allow for definitive fetal testing, or parental testing to better inform results that are suggestive of, but do not identify a unifying diagnosis and when the results of the parental testing will be used to guide treatment, reproductive decisions, or care planning that would not otherwise be made.

(3) The following procedures are for use by insurers, health service contractors, and health maintenance organizations in determining medical necessity on a case-by-case basis to use when authorizing requests for claims for prenatal screening and diagnosis:

(a) Percutaneous umbilical cord blood sampling after fifteen weeks of gestation if one or more of the following criteria are met:
  (i) A medical evaluation indicates rapid or specific submicroscopic chromosomal diagnosis or DNA diagnosis is required to predict prognosis for the fetus;
  (ii) A medical evaluation indicates the possibility of a prenatally diagnosable fetal infection;
  (iii) Fetal blood studies are medically indicated for isoimmunization studies or therapy;
  (iv) Fetal blood is the only means to provide biochemical genetic diagnosis;
  (v) Prenatal diagnosis of a hematological disorder is medically indicated.

(b) Prenatal tissue biopsy if the nature of the disorder in question indicates that fetal liver, skin, or other tissue biopsy is the only means to provide biochemical genetic diagnosis to protect the health of the pregnant person or predict the prognosis of the fetus.

(c) Cytogenomic microarray analysis (CMA) if medically indicated because of an abnormal ultrasound finding or known family history.

RCW 48.44.440 Phenylketonuria

https://app.leg.wa.gov/rcw/default.aspx?cite=48.44.440

(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.

State Market Plan Enhancements

None

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Notes:

- 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.
- 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.

Prenatal and Postnatal Care

Prenatal and Postnatal care: must be provided by a plan provider

- Examples include, but are not limited to:
  - Prenatal office visits
  - Postnatal (after delivery) office visits up to 6 weeks post-delivery
    Note: Refer to *Federal/State Mandated Regulations* section for newborn screening
  - Outpatient (office visit) physician services
  - Screening and diagnostic laboratory and radiological procedures.
    (Refer to the *Federal/State Mandated Regulations* section)
  - Genetic testing and counseling for Prenatal diagnosis of congenital disorders of the unborn child as part of an amniocentesis or chorionic villus sampling procedure when authorized by the member's contracting primary care physician, contracting medical group or UnitedHealthcare
  - Educational course materials on childcare and/or prepared childbirth classes for individual needs provided in physician's office may or may not be covered. Refer to the member's EOC/SOB to determine coverage.
  - Licensed Midwife and licensed nurse midwife services. Refer to the member's EOC/SOB to determine coverage.

Inpatient Maternity Care

Inpatient maternity care, including but not limited to:

- Inpatient hospital care. A minimum 48-hour inpatient stay for normal vaginal delivery and a minimum 96-hour inpatient stay following delivery by caesarian section are covered. Coverage for inpatient hospital care may be for a time period less than the minimum hours if the decision for an earlier discharge of the mother and newborn is made by the treating physician in consultation with the mother. In addition, if the mother and newborn are discharged prior to the 48- or 96-hour minimum time periods, a post-discharge follow-up visit for the mother and newborn will be provided within 48 hours of discharge, when prescribed by the treating physician.
- Labor, delivery room, and recovery care, treatment and services
- Alternative/birthing center services when provided or arranged by a network hospital affiliated with the members network medical group. Refer to the member's EOC/SOB to determine coverage.
- Delivery by either normal/vaginal or cesarean-section (c-section)
- Elective home deliveries. Refer to the member's EOC/SOB to determine coverage
- Treatment of a miscarriage and complications of pregnancy or childbirth

- Physician services (visits) related to all medically necessary inpatient maternity care, treatment and services
- All medically necessary ancillary services related to inpatient maternity care, treatment and services, including but not limited to diagnostic laboratory and/or radiologic procedures
- Circumcision
  - For male newborns performed at the hospital prior to hospital discharge
  - For male newborns performed after hospital discharge when:
    - 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, or
    - 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 circumcision is performed within 90 days from that determination.
    - All other requests for circumcision must be reviewed for medical necessity by a UnitedHealthcare medical director or designee

Newborn Care

Postnatal hospital services from birth through 31 days, including special care nursery.

Not Covered

- Non-medically indicated diagnostic testing such as:
  - Any procedure intended solely for sex determination (e.g., ultrasound)
  - Blood testing to determine paternity
- Take home medications and/or supplies, unless member has a supplemental pharmacy benefit
- Childbirth classes (e.g., Lamaze)
- Elective home deliveries or home births unless covered under the *Federal/State Mandated Regulations* section and/or refer to the member's EOC/SOB to determine coverage for elective home deliveries
- Maternity services for non-UnitedHealthcare member acting as surrogate to UnitedHealthcare member
- Licensed midwife and licensed nurse midwife services unless covered under the *Federal/State Mandated Regulations* section and/or refer to the member's EOC/SOB to determine coverage
- Educational courses on childcare. Refer to the member's EOC/SOB to determine coverage.

Definitions

Certified Registered Nurse-Midwife: **(CNM) or Certified Midwife (CM)**: CNMs and CMs are educated in graduate-level midwifery programs accredited by the Accreditation Commission for Midwifery Education (ACME). CNMs and CMs pass a national certification exam administered by the American Midwifery Certification Board (AMCB) to receive the professional designation of CNM or CM. CNMs and CMs provide care during pregnancy, childbirth, and the postpartum period; sexual and reproductive health; gynecologic health; and family planning services, including preconception care. Midwives also provide primary care for individuals from adolescence throughout the lifespan as well as care for the healthy newborn during the first 28 days of life.

Newborns' and Mothers' Health Protection Act (NMHPA) of 1996: The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) is a federal law that affects the length of time a mother and newborn child are covered for a hospital stay in connection with childbirth. The NMHPA applies to all group health plans, including self-insured plans, and health insurance coverage, subject to any state specific regulations. 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. In general, group health plans and health insurance issuers that are subject to NMHPA may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

Postnatal: Begins immediately after the birth of the baby and extends up to six weeks (42 days) after birth.

Prenatal: The time a female is pregnant, before birth occurs.

References

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NCI Dictionary of Cancer Terms. (n.d.). National Cancer Institute. https://www.cancer.gov/publications/dictionaries/cancer-terms/def/prenatal. Accessed February 22, 2024.

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World Health Organization. (2010). WHO technical consultation on postpartum care. WHO Technical Consultation on Postpartum and Postnatal Care - NCBI Bookshelf. https://www.ncbi.nlm.nih.gov/books/NBK310595/. Accessed February 22, 2024.

Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
05/01/2024	All	**Covered Benefits** ***Inpatient Maternity Care*** • Revised list of covered services; replaced "labor and delivery room care, treatment, and services" with "labor, delivery, *and recovery* room care, treatment, and services" **Definitions** • Updated definition of: ○ Certified Nurse-Midwife (CNM) or certified Midwife (CM) ○ Newborns' and Mothers' Health Protection Act (NMHPA) of 1996 ○ Postnatal ○ Prenatal **Supporting Information** • Updated *References* section to reflect the most current information • Archived previous policy version BIP092.K

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. 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.