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Overview

This section provides information on benefits, policies, and procedures specific to obstetrical/gynecological (OB/GYN) care, women's preventive health services, Baby BluePrints® perinatal case management, and postpartum programs, including the Mother's Option® program. Not all groups have access to all services; therefore, Providers should verify Member eligibility and benefits using Practice Management (PM) on the Provider Engagement, Analytics & Reporting (PEAR) portal.

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

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

OB/GYN Emergency coverage

- In emergent situations, Members should proceed directly to a hospital for treatment. HMO/POS Members are instructed to call their PCP (or OB/GYN Provider if pregnant) for instructions in nonemergent situations. The OB/GYN Provider may act as the referring Physician during pregnancy for pregnancy-related conditions.
- Be aware that Member Copayments for emergency room/department (ER) visits (emergent or nonemergent) are generally higher than office visit Copayments.

Direct Access OB/GYN℠ for HMO/POS Members

Direct Access OB/GYN allows HMO/POS Members to receive obstetrical/gynecological services from any network OB/GYN specialist or subspecialist without a Referral for care visits, routine OB/GYN care, or problem-focused OB/GYN conditions. PCPs certified in family planning can also provide direct access to these services.

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

- Obstetrics
- Gynecology (including urogynecology)
- OB/GYN
- gynecologic oncology
- Reproductive endocrinology / Infertility
- Maternal fetal medicine/ Perinatology
- midwifery
- reproductive health centers
- abortion centers
- mammography centers (screening and diagnostic mammograms and follow-up ultrasounds only)

Although no PCP or OB/GYN Referrals are required when services are provided by network OB/GYN Providers, OB subspecialists, or certified nurse midwives (CNM), Plan and specific group restrictions may apply. Check the Member's benefits before providing the following services:

- abortion
- assisted infertility services
- Depo-Provera®
- diaphragm fitting
- intrauterine device (IUD) insertion and removal for contraception
- contraceptive implant insertion and removal
- tubal ligation

OB/GYN electronic Referrals

HMO/POS Members

- OB/GYN Providers, CNMs, and OB/GYN specialists may send HMO/POS Members for additional services.
- Referrals must be sent and retrieved using PEAR PM.
- Use the Referral Submission transaction in PEAR PM for the following services:
  - pelvic ultrasounds, abdominal X-rays, intravenous pyelograms (IVP), and DXA scans (these tests must be performed at the Member's capitated radiology site); see "OB/GYN capitation requirements for HMO/POS Members" below for more information;
  - initial consultations for HMO Members for endocrinology, general surgery, genetics, gastrointestinal, urology, pediatric cardiology, and fetal cardiovascular studies (visits beyond the initial consultation still require a PCP Referral).
- OB/GYN Referrals are valid for 90 days from the date of issue.
- Referrals are valid for eligible HMO Members. Members are responsible for payment if they are not eligible HMO Members on the date services are rendered.
- Medicare Advantage HMO/POS Members do not require Referrals.

Direct POS Members

Direct POS Members never need a Referral to receive care from participating specialists. Preapproval/Precertification requirements can be found at *www.ibx.com/preapproval*. *Note:* Direct POS Members should be referred to their PCP's capitated site for laboratory and radiology services.

PPO Members

- PPO Members do not need Referrals. However, their benefits can be different from those of HMO Members. Benefits should be verified through PEAR PM before rendering care. Preapproval/Precertification requirements can be found at *www.ibx.com/preapproval*.

OB/GYN capitation requirements for HMO/POS Members

- Laboratory:
  - All routine laboratory work must be sent to the PCP's capitated laboratory site. The Member's capitated laboratory site is indicated on her Member ID card. Further information is also available on PEAR PM. Note: Direct POS Members should be referred to their PCP's capitated site for laboratory and radiology services for in-network benefits.
  - For Commercial HMO and POS referred benefits, Referrals are required.
- Ultrasounds:
  - General ultrasounds for normal pregnancy and gynecology must be referred to the PCP's capitated radiology site. Nuchal translucency screening ultrasounds (first trimester screening) must be performed by ultrasound units certified for the study. Verify certification before issuing a Referral. Visit the Nuchal Translucency Quality Review Program website at *www.ntqr.org*.

    Participating laboratories provide the accompanying blood tests; therefore, there is no need to send Members to an out-of-network Provider for these tests.
  - For high-risk or follow-up ultrasounds, testing, and consultations for high-risk OB patients, Members can be sent directly to a network HMO maternal fetal medicine Provider without Preapproval/Precertification.
- Radiology:
  - Diagnostic or screening mammograms and follow-up ultrasounds may be performed at any participating site.
  - Sonohysterograms and hysterosalpingograms are not included in capitation and may be scheduled at any participating radiology facility.
  - All other radiologic procedures, including DXA scans, must be performed at the PCP's capitated site.
  - Medicare Advantage HMO/POS Members do not require a Referral by a PCP to a capitated radiology site.

Preapproval/Precertification requirements

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

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

- If you determine that a nonparticipating Provider is needed to treat your patient, submit the request through PEAR PM or call Customer Service.
- POS and PPO Members have the option to receive care from an out-of-network Provider but will incur a higher out-of-pocket cost.
- To request an exception for services to be covered at the Member's in-network level, Preapproval/Precertification is required for HMO, POS, and PPO Members.

Certain services may require Preapproval/Precertification, depending on benefits coverage. For a list of services that require Preapproval/Precertification, go to *www.ibx.com/preapproval*. CMS prohibits preapproval/precertification for out-of-network services on PPO products.

Please note the following:

- Hospital admissions, other than maternity, require Preapproval/Precertification. Also note the following:
  - Except for deliveries, the admitting Physician is responsible for obtaining Preapproval/Precertification at least five days prior to the scheduled admission and notifying the facility of the Preapproval/Precertification number.
  - A separate Referral to a participating hospital is not required for hospital admissions for participating OB/GYN Providers. The hospital must contact us prior to the admission to verify Member eligibility and the Preapproval/Precertification number.
- Pre-admission testing and hospital-based Physician services (e.g., anesthesia) are covered under the hospital Preapproval/Precertification.

Women's preventive health services

Annual gynecological exam

The following services are components of a routine, preventive OB/GYN visit:

- breast examination;
- limited screening history and examination;
- physical exam (breast, abdomen, pelvic, and rectal);
- counseling regarding contraception, human sexuality and dysfunction, menopause, and sexually transmitted diseases;
- Pap and human papillomavirus (HPV) testing as appropriate per guidelines;
- pelvic examination;
- specimen collection and wet mount (including those for sexually transmitted infection [STI] testing).

Copayments for routine and nonroutine services

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

As required by the Patient Protection and Affordable Care Act of 2010 (Health Care Reform), there is no Member cost-sharing (i.e., $0 Copayment) for certain preventive services provided to Members. Review the preventive care services policy, which includes the list of applicable preventive codes, at *www.ibx.com/medpolicy*.

Therefore, in most circumstances for routine annual GYN visits, a Copayment should not be collected. However, in cases where both a routine annual screening and specific problem-focused Evaluation and Management (E&M) services are delivered during the same visit, both routine and nonroutine Copayments may apply. Bill separately for the problem-focused E&M visit only if the services you rendered beyond the preventive visit separately meet Current Procedural Terminology (CPT®) criteria for the E&M code.

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

Routine mammogram is a preventive service for Medicare Advantage: An annual screening mammogram is covered as a preventive service once every 12 months for females 40 years of age and older. If a screening mammogram turns into a diagnostic mammogram the diagnostic mammogram is covered as a preventive service.

Contraceptive services

Under Health Care Reform, Independence is required to pay the cost of certain contraceptive services for eligible Members within non-profit religious organizations and closely held corporations. These Members will receive a separate ID card that indicates “Contraceptive Coverage.” Using this ID card, contraceptive methods approved by the U.S. Food and Drug Administration will be covered at an in-network level with no cost-sharing under the medical benefit and covered with no cost-sharing for generic products and for those brand products for which we do not have a generic alternative or generic equivalent under the pharmacy benefit at retail and mail-order pharmacies. Please note these contraceptive services are covered under the pharmacy benefit only if the Member has an Independence prescription drug plan.

Requirements/restrictions by product line

HMO and POS Members (Non-Flex)

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

HMO and POS Members (Flex Series)

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

PPO Personal Choice® Members (Flex and Non-Flex)

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

Medicare Advantage HMO/POS and PPO Members

- Members have coverage for one routine GYN exam and Pap test annually.
- Members do not require a Referral by a PCP to a capitated radiology site.
- Members do not require Referrals.

Reimbursement above examination fees

The following procedures are eligible for separate reimbursement (if they are a covered benefit for the Member) when performed during a routine GYN exam:

- administration of Depo Provera®
- endometrial biopsy
- office ultrasound ONLY with diagnosis of "rule out ectopic pregnancy" (for HMO Members only)
- contraceptive implant insertion and removal*
- diaphragm fitting*
- IUD insertion and removal*

For more information on ultrasounds, refer to the *Billing* section of this manual.

**This is not a standard PPO benefit. In addition, some HMO groups do not cover these procedures. Verify eligibility through PEAR PM.*

Breast cancer screening

Mammography screening reminder program

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

Mammography Referral requirements

Referrals are not required for screening and/or diagnostic mammography from an accredited radiology Provider.

Commercial HMO Members must go to an in-network capitated radiology site, but they are not restricted to their capitated site for diagnostic or screening mammograms or for ultrasound follow-up if needed. However, follow-up MRI and other radiologic imaging must be done at their capitated site, unless an out-of-capitation exception is requested and approved by Independence.

Medicare Advantage HMO/POS Members do not require a Referral by a PCP to a capitated radiology site.

Breast ultrasounds also do not require a Referral and may be performed at an in-network radiology site or outpatient department of a hospital.

Note the following:

- Certain radiology facilities may require a Physician's written prescription. You may need to communicate this to your HMO Members asking about mammography. Be sure to provide a written prescription for the mammography study if this is a requirement of the radiology site.
- Proper certification, credentialing, and accreditation are required for in-network Providers to render mammography services to our Members.
- All MRIs require Preapproval/Precertification through Carelon Medical Benefits Management (Carelon). Refer to the *Specialty Programs* section of this manual for additional information about Carelon.

Breast Cancer Risk Assessment Tool

Based on the Gail Model, the Breast Cancer Risk Assessment Tool is a computer program developed by the National Cancer Institute that estimates a woman's five-year and lifetime risk of developing breast cancer. The tool is available on *www.ibx.com/providers* by selecting *Learn more* from the Patient Management tile, then *Internet Resources*. Women are advised to discuss their individual risk factors and options for prevention and treatment with their health care Providers. Women who are identified as high-risk may be offered chemoprophylaxis against breast cancer.

Cervical cancer screening

We provide coverage for standard Pap test and liquid-based Pap test technologies, such as ThinPrep® and SurePath®, and for other appropriate studies and procedures, including HPV viral typing. The Member may be responsible for office visit Copayments, and the Member's health plan benefits may be based on specific time frames. For coverage questions, Members should contact Customer Service at the telephone number on their ID card.

Cervical cancer screening reminder program

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

- Female Members ages 21 – 29 with a gap in care (i.e., no plan evidence of a Pap test during a certain time frame) are encouraged to schedule and receive regular Pap tests.
- Female Members ages 30 – 64 with a gap in care (i.e., no plan evidence of a Pap test with an HPV co-test during a certain time frame) are encouraged to schedule and receive regular Pap tests with an HPV co-test.

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

Osteoporosis screening

According to our medical policy, bone mineral density testing is covered, but no more frequently than every two years, except for specific situations. Visit *www.ibx.com/medpolicy* to view this medical policy in its entirety.

To learn about FRAX® (World Health Organization Fracture Risk Assessment Tool), go to *www.shef.ac.uk/FRAX*.

Assisted reproductive technologies coverage

HMO/POS Members

- No Referral is necessary for assisted reproductive technologies (ART) services. Members may be sent by either their PCP or OB/GYN Provider, or they may schedule a visit with the specialist themselves.
- Most HMO/POS Member benefits contracts exclude in vitro fertilization (IVF) and related services.
- Verify coverage of specific procedures and pharmacy benefits through PEAR PM.

PPO Members

- Not all Member benefits contracts include coverage for ART services. Verify coverage of specific procedures and of pharmacy benefits through PEAR PM.
- Infertility drug coverage:
  - Office injectables are covered under PPO medical benefits when group coverage includes an ART coverage rider.
  - If a rider exists, Preapproval/Precertification may be required.
  - Providers should call Customer Service for specific information about benefits coverage for infertility treatments.

Maternity care

First trimester prenatal care correlates well with good maternity outcomes. We urge you to schedule first visits with your pregnant Independence Members within the first trimester so that folic acid and appropriate counseling can be provided. In addition, we ask you to encourage your pregnant Independence Members to self-enroll in our Baby BluePrints® maternity program by calling 1-800-598-BABY.

Notifications

Independence does not require prenotification of maternity care. In the event of an interrupted pregnancy (miscarriage or termination) for a Member who is enrolled in Baby BluePrints, please notify us as soon as possible by calling 1-800-598-BABY so we can discontinue maternity-related calls.

Performing antepartum ultrasounds

HMO Members

- Maternal fetal medicine specialists may perform ultrasounds in the office for patients with high-risk pregnancies.
- OB/GYN Providers may perform limited abdominal and transvaginal ultrasounds to rule out ectopic pregnancies. No Preapproval/Precertification is required if the ultrasound is billed with the appropriate diagnosis code. For more information see the *Billing* section of this manual.
- All other ultrasounds should be performed at the capitated site of the Member's PCP.

PPO Members

- OB and maternal fetal medicine specialists may perform ultrasounds in their offices as medically appropriate.
- Preapproval/Precertification is not required.

OB services paid above the global fee

OB Providers may perform the following OB services in their offices and be paid above the global fee (or refer to in-network Providers with OB/GYN Referrals):

- glucose tolerance test
- non-stress test
- amniocentesis

- RhoGAM®
- 17-alpha hydroxyprogesterone caproate with Preapproval/Precertification through *www.ibx.com/directship*
- CNMs*

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

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

Postpartum office visits

Postpartum visits should be scheduled 7 to 84 days after delivery. Adhering to this time frame provides the best opportunity to assess the physical healing of new mothers and to answer questions around family planning, if necessary. It also meets HEDIS® (Healthcare Effectiveness Data and Information Set) guidelines for postpartum care. Visits should be clearly labeled "postpartum care." Members should schedule postpartum visits prior to discharge from the hospital.

Delivery out of the service area

- **HMO Members.** If Members do not deliver in the service area, they must call the Customer Service number on their Member ID card. Some services may not be fully covered if performed out-of-network.
- **POS Members.** Members have the option to deliver out-of-network and/or out of the service area, but they will be subject to Deductibles and Coinsurance.
- **PPO Members.** Members may access care outside of the service area from Providers who participate in the BlueCard® PPO Program. Out-of-network services are subject to out-of-network cost-sharing (i.e., Deductible/Coinsurance).

Baby BluePrints® maternity program

Our maternity program is designed to educate all pregnant Independence Members about pregnancy and preparing for parenthood throughout each trimester. The program also helps to identify expectant mothers who may be at risk for complications during their pregnancy and to assist in improving the quality of care to pregnant women and newborns. If any risk factors are detected, our OB nurse Health Coaches provide telephone support to our Members and their Physician or midwife to help coordinate their benefits and provide information they need for the healthiest delivery possible.

Encourage your Independence patients to self-enroll

Ensuring that maternity Members are enrolled in our Baby BluePrints high-risk perinatal program is imperative for early outreach. We ask that you inform Independence Members about the Baby BluePrints program and encourage them to call our toll-free number, 1-800-598-BABY, to self-enroll. All pregnant Members have access to and may self-enroll in our perinatal support program, Baby BluePrints. Enrolled Members receive digital messaging with educational information about each month of pregnancy. Based on Baby BluePrints enrollment, expectant mothers are assessed for risk and may be enrolled in our condition management program for high-risk pregnancy. This program is telephone, with Health Coaches working with Providers to cooperatively support and educate the members throughout the pregnancy continuum. Starting in 2020, members in some groups also have access to Ovia Health, an app-based fertility, pregnancy, and parenting support program, with triage to Baby BluePrints Maternity Program for high-risk Members. Upon calling, a Health Coach will explain to the Member how they became

eligible to participate, how to use the program services, and how to opt-in or out of the program. They will also ask her a series of questions to complete the enrollment process.

Our Health Coaches use the information as a means for identifying, tracking, and risk-stratifying all pregnant Members for care management and coordination.

If in subsequent prenatal visits you discover that a maternity Member has not yet self-enrolled in Baby BluePrints, or you feel that she may benefit from case management due to a high-risk pregnancy, you can refer the Member to the program by completing an online *Case and Condition Management Physician Referral Form* at *www.ibx.com/providerforms*. When you submit this form, we will make certain that Members who need additional support are encouraged to enroll in case management. You can also call 1-800-313-8628 or 1-800-598-BABY to refer a high-risk maternity Member for case management.

Educational materials

Baby BluePrints materials focus on education. Once registered, mothers-to-be will receive a welcome letter and information on how to access educational materials through *www.ibx.com*. Once on the site, Members can find information about good self-care during pregnancy and its impact on mother and baby and about potential problems during pregnancy. Benefits information is also provided.

Enrolled Baby BluePrints Members who are eligible for condition management and provide their email or enroll in our text messaging program will also receive monthly email or IBX Wire® communications to each stage of their pregnancy.*

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

**Standard message and data rates may apply. Text STOP to stop and HELP for help. Terms and Conditions are available at myhelpsite.net/ibx. Notification messages within IBX Wire are sent via automated SMS. Enrollment in IBX Wire is not a requirement to purchase goods and services from IBX.*

Risk assessment

Members are screened for risk by our Health Coaches when they call to enroll into Baby BluePrints and then are screened again at 28 weeks into their pregnancy by telephone if they are enrolled in case management. An OB nurse Health Coach is available to talk to Members, answer questions, and assist with their care throughout their pregnancy.

If complications are detected, Members can expect:

- personalized OB nurse case management;
- individualized education on how to reduce risk factors;
- periodic assessments throughout their pregnancy;
- coordination of home care services as Medically Necessary and ordered by a Physician or midwife.

Pregnancy depression screening

Targeted questions screen pregnant women at enrollment and, if enrolled in case management, around their 28th week for risk factors associated with depression. Your office may receive calls regarding those Members who screen positive on the 28th week questionnaire or who are judged to be at risk during any other intervention. OB nurse Health Coaches will assist you with triage and Referrals to the Member's behavioral health Provider or to Emergency services as required.

Antenatal/antepartum care

Antenatal case management programs are available for, but not limited to, the following:

- chronic or gestational hypertension
- hyperemesis gravidarum
- gestational diabetes
- preterm labor

In addition, the following antepartum services are available:

- skilled nursing visits, which may include:
  - 17-alpha hydroxyprogesterone caproate injections for women who are at complete bed rest and have a history of preterm delivery;
  - self-injection techniques for insulin, heparin, and others;
  - home blood glucose, blood pressure, and urine monitoring;
  - betamethasone injections (initial set only, repeat injections require Medical Director approval);
- nutrition consults/evaluations;
- social service evaluations;
- durable medical equipment (DME).

Preapproval/Precertification of antepartum home care services

Call the appropriate perinatal home health agency for them to obtain Preapproval/ Precertification review of all antepartum home care programs/services, such as, but not limited to:

- chronic or gestational hypertension
- hyperemesis gravidarum
- gestational diabetes
- preterm labor

The perinatal agency will then obtain orders for all care to be rendered from the attending Physician/CNM.

Members can obtain additional support from Health Coaches by calling 1-800-ASK-BLUE and requesting a health coach when prompted.

Postpartum programs

Mother's Option® program

Through this program, all Members who have an uncomplicated pregnancy and delivery have the option of choosing a shorter stay in the hospital. In order to support a smooth and safe transition home, home care visits are available according to the following guidelines:

Shortened length of stay (managed care Members)

Uncomplicated vaginal delivery

- **If discharged within the first 24 hours following delivery.** Two home health visits are available if desired by the Member. These visits *do not require Preapproval/Precertification*, but they should be arranged by a hospital discharge planner with one of the Mother's Option home care Providers. The first visit should occur within 48 hours of discharge. The second visit should occur within five days of discharge.
- **If discharged within the first 48 hours following delivery.** One home health visit is available if desired by the Member. This visit *does not require Preapproval/Precertification*, but it should be arranged by a hospital discharge planner with one of the Mother's Option home care Providers. This visit should occur within 48 hours of discharge.

Uncomplicated cesarean delivery

- **If discharged within the first 96 hours following delivery.** One home health visit is available if desired by the Member. This visit *does not require Preapproval/Precertification*, but it should be arranged by a hospital discharge planner with one of the Mother's Option home care Providers and should occur within 48 hours of discharge.

Standard length of stay (managed care Members)

When the standard length of stay is 48 hours (vaginal) or 96 hours (cesarean), one home health visit is available if desired by the Member/Provider. This visit *does not require Preapproval/Precertification*, but it should be arranged by a hospital discharge planner with one of the Mother's Option home care Providers. These visits must occur within five days of discharge.

If additional home health visits are Medically Necessary beyond the described Mother's Option visits, these must be Preapproved/Precertified by submitting an authorization request through PEAR PM.

Baby BluePrints postpartum services

Postpartum care

Postpartum home skilled nursing visits beyond those provided through Mother's Option are approved when Medically Necessary. These visits must be Preapproved/Precertified and include:

- wound/incision checks and wound care as needed
- bilirubin checks and home phototherapy
- infant assessments
- blood pressure checks
- IV antibiotics
- home physical therapy

Lactation support coverage

- Lactation support services include information about valuable community resources, educational websites, or certified lactation consultants.
- Health Coaches are available for initial breast-feeding support by telephone. Additionally, they will be able to evaluate the need for further assistance (e.g., community resources, lactation consultant, or OB Provider).

Under Health Care Reform, lactation support and counseling, by a trained Provider during pregnancy and/or in the postpartum periods, is currently covered during an inpatient maternity stay as part of an inpatient admission, the postpartum Mother's Option visit, and through the OB postpartum visit and/or pediatrician well-baby visit.

Breast pump coverage

Hospital-grade pumps are covered under the following circumstances and when supplied by an in-network Provider:

- detained premature newborn;
- infants with feeding problems that interfere with breast feeding (e.g., cleft palate/cleft lip).

Under Health Care Reform, Members can purchase one portable manual or electric breast pump, plus supplies, per pregnancy from a participating, in-network DME Provider with no Member cost-sharing.

Note: The rental of hospital-grade breast pumps requires approval for Medical Necessity. Rentals are available at no cost-sharing only for those Members who require the use of a hospital-grade pump. If approval is obtained for Medical Necessity, Member cost-sharing will not be applied when eligible Members rent the breast pump from an in-network DME Provider.

Preapproval/Precertification for home phototherapy

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