Revised: January 2006
Approval: [signature]

Perinatal Services

Benefit Coverage

Health care services for pregnant patients are available, without prior authorization, through any credentialed obstetrical provider in the same IPA as the patients' PCP. Services include prenatal care, diagnostic testing, labor and delivery services and postpartum examinations.

Nurse midwife services are covered when provided by a Certified Nurse Midwife contracted by the IPA. Services are limited to the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth and the immediate postpartum period.

Inpatient services in contracted hospitals are covered for a minimum of 48 hours following a normal vaginal delivery, and a minimum of 96 hours following a delivery by Cesarean section without prior authorization. A mother and newborn may be discharged before the 48 or 96 hour time period if the decision to do so is made by the treating physician in consultation with the mother. A post-discharge follow-up visit may be prescribed for the mother and newborn within 48 hours of discharge if the mother and newborn are released in less than 48 or 96 hours.

Hospitalization beyond two days for vaginal deliveries, or four days for Cesarean sections require authorization from the IPA. Authorization should be obtained by the treating physician on or before the second day for vaginal deliveries, or the third day for Cesarean sections.

Early discharge from a postpartum hospitalization allows for follow up visits within 48 hours post discharge per PCP's discretion. Visits shall include parent education, assistance and training in breast or bottle-feeding and any necessary maternal or neonatal physical assessments.

Perinatal Services (continued)

Benefit Exclusion

Diagnostic testing for convenience is not covered.

Examples of Covered Benefits

1. Routine pregnancy testing.
2. Routine and high risk prenatal care, including inpatient and outpatient medically necessary services.
3. Postpartum services including, at minimum, an examination at 4-8 weeks.
4. Routine alpha-fetoprotein screening for neural tube defects (spina bifida and anencephaly).
5. Ultrasound examinations as medically indicated.
6. Genetic counseling and Amniocentesis, as medically indicated.

Examples of Non-Covered Benefits

1. Non-medically indicated diagnostic testing (e.g., ultrasound to determine gender of fetus).
2. Perinatal education or interventions not medically necessary.

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Approval: [signature]

Periodic Health Exams

Benefit Coverage

Initial and periodic health examinations and medically necessary diagnostic preventive procedures are covered when performed by the patient's PCP. These examinations include well child visits, breast and pelvic examinations, pap smears and blood pressure checks.

Benefit Exclusion

Physical examinations for employment, insurance, licensing or any non-preventive purpose, such as pre-adoption, are not a covered benefit.

Examples of Covered Benefits

1. Periodic health examinations, including all diagnostic testing and laboratory services appropriate for such examinations consistent with the most current recommendations for Preventative Pediatric Health Care, as adopted by the American Academy of Pediatrics.

Examples of Non-Covered Benefits

1. Pre-employment physicals.
2. Insurance physicals.
3. Physicals for adoption purposes.
4. Increased frequency of such examinations, which are unrelated to the medical needs of the Member.

Revised: March 2002
Approval: [signature]

Phenylketonuria

Definitions (Health & Saf. Code, § 1374.56)

Phenylketonuria, commonly referred to as "PKU", is a rare, inherited metabolic disease that inhibits an individual's ability to metabolize certain proteins. PKU can result in mental retardation and other neurological problems when treatment is not started within the first few weeks of life. A diet comprised of special medical formula and specialty manufactured foods is necessary to avoid irreversible brain damage.

Benefit Coverage

1. Testing and treatment of PKU, including formula and special food products that are medically necessary for treatment, and prescribed, as specified.
2. Formula and special food products are covered if the cost exceeds the cost of a normal diet.
3. Members diagnosed with PKU have access as medically necessary to a physician who specializes in the treatment of metabolic diseases.

Examples of Covered Benefits

1. For PKU screening:
   a. Enzyme Assay to detect carrier state
   b. Chorionic Villus Sample to detect fetal PKU
   c. PKU Screening (a heel-stick blood sample from the infant)
2. For treatment of PKU:
   a. Formula, such as Lofenalac, an enteral product, for use at home, when prescribed by a physician or nurse practitioner, or ordered by a registered dietitian upon referral by a healthcare provider authorized to prescribe dieting treatments.
   b. Special food products that are prescribed by a physician or nurse practitioner and are consistent with the recommendations and best practices of qualified health professionals experienced in the treatment of PKU. Special food products may include a food product that is specifically formulated to have less than one gram of protein per serving. Special food products may be used in place of normal food products, such as grocery store foods, used by the general population.

Phenylketonuria (continued)

Examples of Non-Covered Benefits

1. Special food products may not include a food that is naturally low in protein, such as fruits and vegetables.
2. Special food products when the extent of the cost of such items does not exceed the cost of a normal diet.

See: Nutritional Supplements and Special Formulas

Physical, Occupational, and Speech Therapy (POST)

Benefit Coverage

Physical, Occupational and Speech Therapy services shall include evaluation, treatment planning, treatment, instruction, consultative services, and application of topical medication. Services are limited to treatment necessary to prevent or to reduce anticipated hospitalization or to continue a plan of treatment after discharge from the hospital.

Provision of the services is with the expectation that the patient will improve significantly in a reasonable and generally predictable period of time or to establish an effective maintenance program in connection with a specific disease state and that the service is reasonable and medically necessary for the treatment of the patient's condition.

All physical therapy, occupational therapy and speech therapy can be subject to prior authorization.

Benefit Exclusion

Services, which do not require the skills of a physical therapist, occupational therapist, or speech therapist, shall not be covered or authorized.

Examples of Covered Benefits

1. Physical, Occupational and/or Speech Therapy in inpatient, outpatient, skilled nursing facility or home setting.
2. Additional non-home based therapy beyond the 60 days shall be covered if medically necessary and the condition is expected to improve significantly.
3. Speech therapy for the following:
   a. Stroke.
   b. Surgery or injury to the mouth or throat.
4. Initial gait evaluation and training.

Physical, Occupational, and Speech Therapy (POST) (continued)

Examples of Non-Covered Benefits

1. Therapy for chronic, long-term problems where slow, minimal progress or maintenance is anticipated rather than significant improvement such as:
   a. Chronic strains.
   b. Chronic low back pain.
   c. Maintenance therapy of spinal cord injuries.
2. Speech therapy for lisping or stuttering.
3. Repetitious exercises to improve gait, maintain strength and endurance and assist in walking which can be provided by non-skilled persons.
4. Conditions where no measurable improvement may be expected.

Prescription Drugs

Benefit Coverage

Pharmaceutical services and prescribed drugs will be provided through the services of contracted pharmacies and pharmacists. Drugs on the IEHP Formulary are covered, subject to limitations specified in the Formulary, when medically necessary and when prescribed by a licensed practitioner.

Drugs administered while a Member is a patient or resident in a rest home, nursing home, convalescent hospital or similar facility when prescribed by a plan physician in connection with a covered service and obtained through a plan designated pharmacy.

IEHP will provide coverage for one cycle or course of treatment of tobacco cessation drugs in each twelve (12) consecutive month period. IEHP requires the Member to attend tobacco use cessation classes or programs in conjunction with tobacco cessation drugs.

Benefit Exclusions

Experimental or investigational drugs, medicines available over the counter or non-formulary drugs not authorized by IEHP, via a PER.

Examples of Covered Benefits

1. Injectable medication (including insulin).
2. Needles and syringes necessary for the administration of the covered injectable medication.
3. Blood glucose testing strips in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent and gestational diabetes.
4. Ketone urine testing strips for type I diabetes, and lancets.
5. Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins, which require a prescription.
6. Contraceptive drugs and devices: all FDA approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered including internally implanted time release contraceptives such as Norplant.

Prescription Drugs (continued)

Examples of Non-Covered Benefits

1. Drugs or medications for cosmetic purposes.
2. Patent or over-the-counter medicines, including non-prescription contraceptive jellies, ointments, foams, condoms.
3. Medicines not requiring a written prescription order (except insulin).
4. Dietary supplements, appetite suppressants or any other diet drugs.
5. Non-formulary drugs without prior authorization.

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Preventive Health Services

Benefit Coverage

The following Preventive Health Services are provided by IEHP with no co-payment:

1. Periodic health exams (see: Periodic Health Examinations)
2. Voluntary family planning (see: Family Planning)
3. Prenatal care (see: Perinatal Services)
4. Vision and hearing testing (see: Vision Aids and/or Hearing Aids and Services)
5. Sexually transmitted disease testing
6. Cytology exams (see: Diagnostic Services)
7. Selected health education services (see: Health Education)

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Professional Services

Benefit Coverage

Professional services are those services performed or provided by physicians, including, but not limited to, office visits, surgery, anesthesiology, radiology, chemotherapy, dialysis, consultations, home and institutional calls.

Outpatient physician services, as defined above, are covered if they are medically necessary.

Physician services provided to hospital, skilled nursing facility or intermediate care facility in-patients are covered only during authorized periods of confinement.

PCP services rendered by non-physician medical practitioners are covered as professional services to the extent permitted by applicable professional licensing statutes and regulations.

Benefit Exclusion

Services prescribed or ordered by a provider who is not a participating provider are not covered, except in emergencies or when authorized by the contracted IPA or Hospital.

Examples of Covered Benefits

1. PCP visits in an outpatient setting.
2. Specialist and/or consultants requested by Emergency Room personnel during emergency room treatment.
3. Licensed specialist services (e.g., Neurologists, Cardiologist, and Surgeons).
4. Licensed Physician's Assistants (PAs) who are under the supervision of a physician.
5. Nurse Practitioners (NPs) working within Standard Procedures.

Examples of Non-Covered Benefits

1. Non-emergent, non-authorized care by out-of-plan providers.