

Perinatal Services

Benefit Coverage

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

Nurse midwife services (Cal. Code Regs., tit. 22, § 51345) 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 contracting hospitals are covered for a minimum of forty-eight (48) hours following a normal vaginal delivery, and a minimum of ninety-six (96) hours following a delivery by Cesarean section without prior authorization. A mother and newborn may be discharged before the forty-eight (48) or ninety-six (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 forty-eight (48) hours of discharge if the mother and newborn are released in less than forty-eight (48) or ninety-six (96) hours.

Hospitalization beyond two days for vaginal deliveries, or four days for Cesarean sections may require authorization per contracted IPA. Authorization should be obtained by the hospital on or before the second day for vaginal deliveries, or the third day for Cesarean sections.

Benefit Exclusion

Diagnostic testing for convenience is not covered.

Perinatal Services (continued)

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 indicated by risk.

Perinatal Support Services

Benefit Coverage

All pregnant Members will receive perinatal support services from an IEHP Obstetrician or qualified prenatal care provider. These services include prenatal care, nutrition, psychosocial and obstetrical risk assessments and follow-up interventions, diagnostic testing, labor and delivery services, postpartum examinations and must be obtained from a perinatal provider in the same IPA as the Member's PCP, or an IEHP approved hospital-based perinatal service program.

All pregnant Members must undergo a risk assessment, using the mandated IEHP forms, at the time of initiation of prenatal care, and re-assessments in each subsequent trimester, and a post partum assessment. The assessment must include nutritional, education, and psychosocial as well as obstetrical risk factors. Any identified risk factors must be addressed with appropriate interventions. All patients must have an individualized care plan developed, outlining risk factors, proposed interventions, method(s) of intervention (e.g., referral, counseling by a specified staff person, etc.), and anticipated outcome of intervention. The care plan and interventions must be in adherence to the standardized protocols developed by IEHP, and consistent with the requirements of the California Code of Regulations, Title 22, Sections 51348 and 51348.1.

During the course of pregnancy, the prenatal care provider will assess for risk factors and the need for appropriate services. Basic interventions for low-risk conditions, including basic counseling in the areas of diet, family planning, and postpartum care, will be provided by the prenatal provider or office staff. Interventions for high risk conditions, such as advanced nutritional assessment and counseling, programs such as Sweet Success, or counseling for smoking cessation, will generally be provided through referral by the IPA as medically indicated by risk assessment.

Nutrition, health education, and psychosocial reassessments shall be offered to each Member at least once every trimester, and postpartum. The individualized care plan will be revised and implemented accordingly.

Benefit Exclusion

Any perinatal education or intervention, whether in office or by referral, that is not indicated by risk assessment, or is not medically necessary, is not covered.

Perinatal Support Services (continued)

Examples of Covered Benefits

1. One-on-one counseling with a dietitian for high-risk nutrition issues such as Anemia, inappropriate weight gain, and Pica.
2. Infant care, parenting, and childbirth education for Members at risk.
3. Counseling with a psychosocial professional for domestic violence during pregnancy.
4. Counseling and interventions for a Member with Gestational Diabetes, including referral to Sweet Success or a similar program.
5. Prenatal vitamin supplements.
6. Group or individual counseling for smoking cessation.

The following are considered a part of basic prenatal care, and should not require intervention outside of the perinatal providers' office:

1. Counseling and education on secondhand smoke exposure.
2. Counseling and education on common discomforts of pregnancy.
3. Orientation to office procedures, and hospital information.
4. Counseling and methods for family planning.

Examples of Non-Covered Benefits

1. Consultation with a Mental Health professional for significant mental health issues, are covered in the FFS Mental Health program.
2. Any services provided without specific evidence of risk based on risk assessment.

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. Food products prescribed by a physician or nurse practitioner that are naturally low in protein, such as fruits and vegetables.
2. Special food products that do not exceed the cost of a normal diet.

See: Nutritional Supplements and Special Formulas

Physical Examination

Benefit Coverage

Initial and periodic health examinations and medically necessary diagnostic preventive procedures are covered when performed by the patient's PCP. These examinations can include 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

Periodic health assessments and preventive services for patients under age 21 are covered when performed by the patient's PCP according to the IEHP Well Child Service Schedule and American Academy of Pediatrics (AAP) guidelines.

The following are a core set of preventive services that shall be provided to all asymptomatic and healthy adult patients age 21 or older. (This is not an inclusive list of all appropriate preventive services. The presence of risk factors in individual patients will affect the type and quantity of preventive services that may be appropriate. A given patient may need additional services or core services at more frequent intervals.)

1. Initial history and physical examination within 120-days of enrollment.
2. Targeted history and physical examinations focusing on the needs and risk factors of each Member to be done every one to three years for adults age 21 to 64 years, and annually for individuals age 65 and older.
3. Blood Pressure - persons who are normotensive should have blood pressure measurements as part of each exam.
4. Cholesterol - total cholesterol to be measured routinely for men ages 35-65 and women age 45-65.
5. Clinical breast examination - all women over age 40 should have annual clinical breast examinations.
6. Mammogram - all women over age 40 should have a screening mammogram every year, concluding at age 75, unless pathology has been previously demonstrated.
7. Pap smears - beginning with first sexual activity, pap smears to be performed every one to three years, depending on risk status.

Physical Examination (continued)

Examples of Covered Benefits (continued)

8. Tuberculosis (TB) screening - all high risk children and adults should be screened for TB risk factors. Mantoux skin tests are indicated whenever a Member is determined to be at risk of TB, and at periodic intervals for children.
9. Counseling for smoking, alcohol and drug use, exercise, nutrition, sexually transmitted diseases, injury prevention, dental health and unintended pregnancy.
10. Sexually Transmitted Disease (STD) screening.
11. Stool examination for occult blood performed with the physical examination for Members age 50 and older.
12. Sigmoidoscopy to be performed according to the presence or absence of risk factors, routinely every 5 years for adults age 50 to 65, and annually for adults over age 65.
13. Digital rectal exam every year for all men 40 and over.
14. Health Education Behavioral Assessment (HEBA) – The HEBA should be administered at the Member's initial physical examination, and reviewed annually thereafter. Appropriate interventions must be provided as required.

Examples of Non-Covered Benefits

1. Pre-employment physicals.
2. Insurance physicals.
3. Physicals for adoption purposes.

Physician Services

Definition (Medi-Cal Regulations – Cal. Code Regs., tit. 22, § 51055)

Physician services mean professional services performed or provided by physicians, including, but not limited to, office calls, surgery, anesthesiology, radiology, consultations, home and institutional calls.

Benefit Coverage (Medi-Cal Regulations – Cal. Code Regs., tit. 22, § 51305)

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.

Primary Care Physician (PCP) services rendered by non-physician medical practitioners are covered as physician services to the extent permitted by applicable professional licensing statutes and regulations, and as set forth in the California Code of Regulations, Title 22, Section 51240.

Benefit Exclusion

Services prescribed or ordered by a provider suspended, for any reason, from participating in the Medi-Cal program shall not be covered by the program while the suspension is in effect. Services prescribed or ordered by a provider who is not a participating Medi-Cal Managed Care 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. Specialists and/or consultants requested by Emergency Room personnel during emergency room treatment.
3. Licensed specialist services (e.g., Neurologists, Cardiologist, Surgeons).
4. Licensed Physician's Assistants (P.A.s) under the supervision of a physician.

Examples of Non-Covered Benefits

1. Providers suspended from participation in the Medi-Cal program.
2. Non-emergent, non-authorized care by out-of-plan providers.

Podiatry Services

NOTE: The State of California eliminated this benefit for adults age 21 and over effective July 1, 2009. IEHP adult Medi-Cal Members will continue to receive medically necessary podiatry services to prevent hospitalization and/or serious medical complications. See Appendix C, for IEHP Memorandum on Optional Benefit Changes.

Benefit Coverage (Members up to age 21)

Podiatry services are provided by podiatrists licensed in the State of California acting within the scope of their practice as authorized by California law. Podiatric office visits described by procedure codes 99201-99203 and 99211-99213 in the current CPT are covered as medically necessary. All outpatient podiatry services can be subject to prior authorization by contracted IPA and are limited to medical and surgical services necessary to treat disorders of the feet, ankles, or tendons that insert into the foot, secondary to or complicating chronic medical diseases, or which significantly impair the ability to walk.

Podiatry services rendered on an emergency basis are exempt from prior authorization.

Podiatry services rendered to hospital, skilled nursing or intermediate care facilities are covered only when ordered and signed by the admitting physician, specifying the care to be given. The services in skilled nursing or intermediate care facilities are further subject to prior authorization.

Podiatry services can be limited to a maximum of two services in any one calendar month .

Benefit Exclusion

Routine or non-medically necessary foot care is not a covered benefit.

Examples of Covered Benefits (Members up to age 21)

1. Treatment of infections of the foot (e.g., gangrene, athlete's foot).
2. Medically necessary surgical correction.
3. Medically necessary foot care (e.g., cutting or removal of corns, plantar warts, calluses or nails) for Members with documented severe circulatory problems in the legs or feet or with diabetes.

Podiatry Services (continued)

Examples of Covered Benefits (Members up to age 21) (continued)

4. Medically necessary podiatry services provided by a licensed podiatrist are subject to prior authorization when applicable.

Examples of Non-Covered Benefits

1. Routine nail trimming.
2. Routine cutting or removal of corns, calluses, plantar warts or toenails with no medical necessity.
3. All other routine foot care.

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Prayer and Spiritual Healing

Benefit Coverage

Prayer and Spiritual Healing is not a covered benefit through the Medi-Cal Managed Care Program. These services are covered by the Medi-Cal Fee-For-Service (FFS) program.

Prosthetic/Orthotic Devices

Benefit Coverage (Medi-Cal Regulations – Cal. Code Regs., tit. 22, § 51315)

All prosthetic and orthotic appliances necessary for the restoration of function or replacement of body parts are covered when provided by a prosthetist, orthotist, or the licensed practitioner and when prior authorization is obtained from the contracted IPA or hospital, if applicable.

Benefit Exclusion

Prosthetic and orthotic appliances that have not been prescribed by a physician and that have not obtained prior authorization are not covered.

Examples of Covered Benefits

1. External breast prosthesis, including support brassieres following medically necessary mastectomy. (See: Reconstructive Surgery, Cosmetic Surgery.)
2. Breast implants after medically necessary mastectomy.
3. Standard prosthetic artificial limbs (e.g., arm, hand, leg, foot).
4. Prosthetic shoe when all or a substantial portion of the front part of the foot is missing.
5. Orthopedic shoes when a leg length discrepancy exists due to injury or illness or when they are an integral part of a leg brace.
6. Eye Prosthesis.
7. Orthotics that will alleviate pain, or mitigate a injury or condition.

Examples of Non-Covered Benefits

1. Breast prosthesis not following a medically necessary mastectomy (e.g., cosmetic implants).
2. Prosthesis to correct a cosmetic deformity (e.g., testicular implants).
3. Prosthetics/braces for use in sports (light weight materials).

See: Appendix A

DME, Corrective Appliances, Medical Supplies and Surgical Implantables Grid

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Psychiatric Hold (5150)

See: Behavioral Health
(Crisis Intervention)

Mental Health