PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="4">Guideline/Procedure Number: MCUG3118 (previously MCQG1017 & QG100117)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Guideline/Procedure Title: Prenatal & Perinatal Care</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/22/1994 (Policy HS-1)</td><td colspan="4">Next Review Date: 09/11/2025
Last Review Date: 09/11/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 09/11/2024</td></tr>
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I. RELATED POLICIES:

A. MCUP3141 – Delegation of Inpatient Utilization Management
B. MPQP1022 – Site Review Requirements and Guidelines
C. MCUP3028 – Mental Health Services
D. MPCP2017 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines
E. MCND9006 – Doula Services
F. MPCR15 – Doula Credentialing
G. MCUP3124 – Referral to a Specialist
H. MCUP3052 – Medical Nutrition Services
I. MCCP2020 – Lactation Policy and Guidelines
J. MCUP3113 – Telehealth Services
K. MCQG1015 – Pediatric Preventive Health Guidelines

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Comprehensive perinatal services are defined as obstetrical, psychosocial, nutritional, and health education services and related case coordination provided by or under the personal supervision of a physician during the perinatal period.
B. The Comprehensive Perinatal Services Program (CPSP) has divided authority between the California Department of Health Services (DHCS) and the California Department of Public Health (CDPH). It is an enhanced program of perinatal services to be offered through the Medi-Cal program and reimbursed (by DHCS) at higher rates than traditional obstetrical services. The CPSP provider certification process is administered and approved by the CDPH. *Note:* Partnership HealthPlan of California (Partnership) encourages, but does not require, providers to be CPSP certified in order to provide obstetrical and perinatal services, however, obstetrics providers need to provide CPSP-like services or refer to another CPSP provider for non-obstetric CPSP or CPSP-like services. (*see also the Partnership HealthPlan Perinatal Services (PHPS) definition below*)
C. Certified Nurse Midwife is licensed as a Registered Nurse and certified as a Nurse Midwife by the California Board of Registered Nursing. (*see related definition for Licensed Midwife below)*
D. Doula: A trained birth worker credentialed by Partnership who provides health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and

after childbirth, including support before, during, and after miscarriage, stillbirth, and abortion. Doulas are not licensed and they do not require clinical supervision.

E. Licensed Midwife is licensed as a Midwife by the Medical Board of California.

F. Partnership HealthPlan Perinatal Services (PHPS): CPSP-like services that are equivalent to, or substantially similar to, the services defined by the CDPH-defined CPSP program. *(see also the Comprehensive Perinatal Services Program (CPSP) definition above)*

G. Perinatal Case Manager: Provides services of health education and case management in a perinatal program using CPSP or other protocols and under the supervision of the Clinical Director.
   1. A Perinatal Case Manager is equivalent to a Comprehensive Perinatal Health Worker (CPHW) in a CPSP program

H. Perinatal services are defined as pregnancy related services given before and during delivery and for a period of 12 months following delivery

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IV. ATTACHMENTS:

A. Partnership HealthPlan Perinatal Services (PHPS) Application and Update Form
B. Partnership Perinatal Case Management TAR Thresholds
C. Applying for the CDPH CPSP program

V. PURPOSE:

To describe, define and provide guidelines for the perinatal services to be provided to Members of Partnership HealthPlan of California (Partnership).

VI. GUIDELINE / PROCEDURE:

A. Goals of the Partnership HealthPlan Perinatal Services (PHPS) Program
   1. To make comprehensive perinatal services accessible to all pregnant Partnership Members.
   2. To assure all Members initiate prenatal care within the first twelve (12) weeks of pregnancy and pregnant Members who are new to the HealthPlan obtain prenatal care on the enrollment start date or within forty-two (42) calendar days after enrollment in the Plan.
   3. To support and expand the range of comprehensive perinatal services provided to Partnership Members.
   4. To strongly encourage obstetrical (OB) providers to become CPSP certified providers or to have an agreement with a CPSP provider to provide comprehensive perinatal services.
   5. To inform all Partnership Members about the availability of comprehensive perinatal services and the added benefits of these programs.
   6. To assist Members with engaging in perinatal services .
   7. To assess each Member during each trimester and postpartum, utilizing an assessment tool and to develop an individualized care plan that addresses deficiencies for:
      a. Psychosocial Needs/ Risks/ Concerns (prenatal tool / postpartum tool)
      b. Health Education Learning Needs/ Risks/ Concerns (prenatal tool / postpartum tool)
      c. Nutrition (prenatal tool / postpartum tool)
   8. To increase provider awareness of comprehensive perinatal services and the potential benefits for pregnant Members.

B. Partnership HealthPlan Perinatal Services (PHPS)
   1. All pregnant Members are eligible to receive perinatal case management services.
      a. Partnership encourages universal participation in the CPSP and CPSP-like programs, collectively called Partnership HealthPlan Perinatal Services (PHPS). Members are eligible for PHPS services from the time they believe they may be pregnant through 12 months post-partum.
      b. PHC offers a perinatal program called the Growing Together Program, open to all pregnant and post-partum individuals.

   c. For patients with additional needs and risks, Partnership shall refer Members to Partnership Care Coordination and local resources for programs (e.g. Enhanced Care Management (ECM), home visiting programs, Black infant health, targeted case management, etc.).
2. Program materials for PHPS are subject to audit and review during the Site Review process at least every three years for prenatal care providers and Perinatal Case Managers.
   a. A PHPS program may submit claims for services using Z-codes for any affiliated practice site.
   b. PHPS services may be performed in the home, office or via telemedicine, using the appropriate modifiers and place of service codes.
   c. Partnership allows all practices sites of a provider organization that has a CDPH-approved CPSP program to submit claims for perinatal services using applicable CPSP billing codes for the services provided.
3. Modular Approach: All organizations with a CDPH-certified CPSP program are expected to follow the statutory standards. To meet Member needs, PHPS providers may provide and bill for a subset of perinatal support services. If a CPSP program is unable to provide comprehensive services, they are expected to partner with other providers to ensure all Member needs and program requirements are fulfilled. In the event that CDPH-certified programs experience a temporary challenge with providing a subset of CPSP/PHPS services due to staffing or capacity challenges, they are also expected to solicit partner organization(s) to fill any gaps. To accomplish this, perinatal providers may submit claims for any CPSP service, whether or not they are providing case management services. For example, "CPSP-like Program A" may provide case management for a member but needs to use a Registered Dietician (RD) at "CPSP-like Program B" to provide nutrition education services. Each program will bill for the services that they provide and ensure that any services and assessments are centralized in the care plan of the program providing primary case management responsibilities (in the example, "CPSP-like Program A").
4. Partnership Tracking of Perinatal Services Providers: To ensure Partnership oversight of Perinatal Case Management Services, all PHPS providers (including both CPSP programs and providers offering CPSP-like services) need to complete an application (see Attachment A).
   a. All components of the PHPS program relying on outside providers (including delivering providers) require a written letter of agreement from the outside provider.
   b. Providers that may have a PHPS program include: physicians specializing in OB/GYN, Pediatrics, Family Physician; a physician group; a health center, including Federally Qualified Health Centers, Rural Health Centers and Tribal Health Centers; an alternative birthing center; a county run health clinic; a hospital outpatient clinic; a Certified Nurse Midwife run practice; a Licensed Midwife practice.
   c. Quality Monitoring of PHPS providers will be completed as follows:
      1) At the time of the Site Review of all PHPS and perinatal providers which occurs at least every three years
      2) Monitoring of grievances
      3) Reviewing administrative data to evaluate quality outcomes and utilization. Specific measures to be evaluated include:
         a) The percentage of all deliveries in which a patient has at least one PHPS service
         b) The percentage of pregnant members with at least one PHPS service who complete at least:
            i. three antenatal and one postpartum PHPS case management visit
            ii. one mental health service (either PHPS service or other)
            iii. four nutrition services (either PHPS or other)
            iv. one doula visit
5. In areas with a hospital capitation agreement, perinatal services including antenatal care, labor and delivery services, should be provided by perinatal providers who deliver at or collaborate with

delivery teams at the contracted hospital nearest the Member or a hospital associated with capitation agreements that pertain as related to Member's primary care or other capitation factors. Exceptions to this include emergency deliveries and out-of-area hospital admissions authorized according to policy MCUP3141 Delegation of Inpatient Utilization Management, Members determined to be high risk who require the services of a perinatologist, and pregnant Members who are not assigned to a primary care provider because they are in a Direct Member category.

6. Obstetrics providers and Perinatal Services Providers are encouraged to refer Partnership Members who are pregnant to Partnership's Growing Together Program for support and to assist Members with connections to community resources when and where appropriate.
7. Obstetrics providers are encouraged to refer Partnership Members who are pregnant that may have clinical, behavioral and/or psycho-social risk, or those who have intensive case management and/or care coordination needs to Partnership's Care Coordination department for support.
8. All providers of perinatal services must deliver services in conformance with the following:
   a. Current ACOG Standards for Obstetric-Gynecologic Services, (available at this website): https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx
   b. Perinatal care should generally follow the CPSP Program guidelines which can be found in the CPSP Provider Handbook. Updates to these guidelines may be made, but these should be standardized and memorialized in written clinical policies, procedures and protocols. Specific recommendations for addition are:
      1) Screening for Adverse Childhood Events (ACES). See Partnership policy MCQG1015 Pediatric Preventive Health Guidelines
      2) Universal Substance Use Screening using the 4Ps Plus or other evidenced based standardized screening tool to screen for substance use
      3) Screening for Anxiety with the GAD 2, with reflex follow up and referrals for positive result to the GAD7
   c. Claims for PHPS services should be submitted using the codes defined by DHCS for CPSP services. These Z-codes should be used by all PHPS programs, both CDPH-recognized CPSP programs and by CPSP-like programs.
   d. Newborn Screening Regulations as set forth in Title 17, California Code of Regulations, Section 6500 et seq.
   e. Hemolytic disease of the Newborn Requirements as set forth in Title 17, California Code of Regulations, Section 6510 et seq.
   f. Title 22 regulations; Title 17 regulations and all applicable sections of the Health and Safety Code.
   g. The California Prenatal Screening Program.
   h. Pregnant and post-partum patients must be screened for perinatal mood disorders using a standardized tool.
      1) Patients who meet diagnostic criteria or have risk factors for perinatal mood disorders should be referred to a behavioral health specialist for further treatment (see policy MCUP3028 Mental Health Services and/or policy MPCP2017 Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines).
9. Perinatal service providers include all of the following practitioners for the purpose of providing perinatal services:
   a. Physicians who are general practitioners, family medicine physicians, pediatricians, or obstetrician-gynecologists
   b. Certified Nurse Midwives
   c. Licensed Midwives
   d. Nurse Practitioners
   e. Physician Assistants

f. Registered Nurses, Licensed Vocational Nurses, Social Workers, Health Educators, Childbirth Educators, Registered Dietitians, Comprehensive Perinatal Health Workers or Perinatal Case Managers

10. Doulas can provide non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion.

C. PHPS Standards of Perinatal Case Management

1. All obstetrical practitioners are required to provide a comprehensive initial risk assessment that includes medical nutrition, health education, mental health and psychosocial risks, on all pregnant Members at the initiation of pregnancy related services.
2. Formal re-assessments must be offered in each subsequent trimester and in the postpartum period. All identified risk conditions must be followed up by interventions designed to eliminate or remedy the condition or problem in a prioritized manner.
3. Individualized care plans must be developed to include obstetrical, nutritional, health education and psychosocial interventions when indicated by identified risk factors.
4. Every PHPS program should have a designated Clinical Director who may be an OB/GYN, a Family Physician, a Certified Nurse Midwife or Licensed Midwife, Physician Assistant-c, or Nurse Practitioner. The Clinical Director approves all clinical policies, procedures, and protocols; oversees quality oversight of the program; and keeps the staff updated on major advances related to perinatal standards of care.
   a. All Clinical Directors will function within the scope of their license.
5. Perinatal Provider may use group visits for prenatal nutrition, behavioral health and health education issue to address concerns that are identified (using the appropriate group visit CPSP codes)
6. Postpartum health education group visits (using code Z6412) can include topics related to parenting.
7. All services/resources provided must be clearly documented on the Care Plan in the Member's medical record.
8. A non-CPSP provider may choose to use a trained staff person to administer the comprehensive risk assessments and to make referrals to a PHPS or CPSP program or other appropriate program for interventions and completion of care plans.
9. Initial visits with the perinatal case manager are highly recommended to be conducted in-person.
10. Obstetrics office visits may occur via telemedicine when a clinical exam is not medically needed.
11. Group prenatal obstetrical visits using the centering pregnancy model should include (with appropriate chart documentation) a brief individualized visit with the clinician, which would then qualify as a prenatal care visit.
12. Providers for PHPS
    a. Case management services may be provided by a Perinatal Case Manager/CPHW meeting the qualifications specified by the CPSP program.
    b. Nutrition education services:
       1) Perinatal Case managers are expected to provide core educational messages related to nutrition and nutritional risk assessment. These services would be included in their case management services and not billed separately. Targeted nutrition education services may be billed with the nutrition-specific Z-codes, when provided by one of the following:
          a) Nutritionist or Nutrition Coach: General information on healthy diet in pregnancy, which may include motivational interviewing techniques, may be provided by a health educator, a community health worker, or other staff person who has completed at least 6 months of training in nutrition and health coaching. Complex dietary needs or issues would be referred to a Registered Dietician
          b) Certified Registered Dietician: May perform general nutrition education, but also has the expertise to handle more complex issues, such as diet modifications for obesity, gestational diabetes, celiac disease, hyperemesis, food allergies, restrictive diets (such

as those with no dairy products or no meat), etc. In addition, many registered dieticians are certified diabetes educators, and the usual nutritional Z-codes can be used when billing for these services by a Registered Dietician.

c) Pregnant individuals can be more motivated to make changes, and obesity is usually very difficult to treat with little nutrition services available to non-pregnant individuals; we highly recommend that all individuals with a pre-pregnancy BMI greater than 25 have at least one visit with a Nutritionist or Nutrition coach, with additional visits if the patient needs them to reinforce changed behavior.

c. Mental Health Services

1) Perinatal Case Managers are expected to screen for depression and anxiety as part of their initial, ongoing and post-partum assessments and to recommend and arrange for referrals for birthing individuals who screen positive. Additionally, Perinatal Case Managers / CPHWs are expected to offer support and encouragement and to encourage social activities to build mental health resilience. These services would be included as part of their case management services, but they are encouraged to bill separately for depression screening so such screening can be captured using claims data, using one of the following codes:
   a) Preferred:
      i. HCPCS: G8431 for a positive screen with a plan
      ii. HCPCS: G8510 for a negative screen
   b) Other option:
      i. CPT: 96127 used for each screening tool used (can bill two units if G codes above not used and both the PHQ2 $\geq$ 9 (for depression) and the GAD 2 $\geq$ 7 (for anxiety) are used). If the depression screening is reported using the G-codes above, if a GAD is also done, it can be reported using one unit of 96127.
      ii. ICD10: use Z13.31 if screening is done on patient without symptoms concerning for depression or anxiety; use a more specific code if a screening is done in response to signs or symptoms.
2) Mental Health Counselors (including counseling for substance use disorders):
   The United State Preventive Services Task Force (USPSTF) recommends that ALL low-income pregnant individuals receive preventive counseling on building resilience and detecting early signs of depression and anxiety that would require evaluation. Such preventive counseling, and counseling for mild dysphoria, can be provided by a community health worker (CHW) or health educator with special training on such preventive mental health counseling, under the supervision of a licensed mental health clinician. The mental health Z-codes may be used.
3) Licensed mental health and substance use professionals:
   Any licensed mental health or substance use professional may provide mental health and substance use services to pregnant patients using the mental health Z-codes. This includes psychiatrists, clinical psychologists, licensed clinical social workers, licensed marriage and family therapists, licensed professional clinical counselors, certified alcohol and drug abuse counselors etc. The CPSP or CPSP-like program hiring these mental health/behavioral health specialists is responsible for ensuring that the clinical problems addressed by the individual professionals match their training and experience.

d. Perinatal Health Education services may be provided by staff with the qualifications outlined in the CPSP program or by educators or health workers with specific training competencies related to one or more aspects of wellness for birthing individuals. Education conducted in the course of routine prenatal/post-partum/peripartum care provided by clinicians or doulas is not separately reimbursable; it is considered a part of their professional services. Separate and stand-alone educational services, whether individual or in a group setting, may be billed by a

CPSP program or a CPSP-like program using the education Z-codes. CHW provided education may be billed as a CHW service or a perinatal education service, but not both.

D. CPSP/Perinatal Services Case Management Responsibilities
   1. The Perinatal Case Manager/CPHW is expected to plan and ensure the provision of comprehensive perinatal services, including nutrition, health education, and psychosocial assessments and reassessments, individualized care plan development, coordination of services, and referrals. At a minimum, for low-risk individuals, four case management visits are recommended: one in each trimester and one in the post-partum period.
   2. The Perinatal Services case manager must assure that the following has been provided to the Member and documented in the medical record:
      a. An orientation about the purpose of the Perinatal program and the guidelines about the services which have been offered
      b. Identify the location/ provider of medical prenatal care, with planned location of delivery.
      c. Review the warning signs and symptoms that warrant urgent attention and office procedures for the perinatal services.
      d. Information about the available adjunctive referral services available to the Member.
      e. Advise the Member about their rights and responsibilities in accepting or refusing the services offered.
      f. Notification regarding Partnership appeal and grievance policies.
      g. An offering of the initial nutrition, health education and psychosocial assessments, and individualized care plan development, including both individual and group interventions for each service as recommended in the individualized care plans.
      h. Documentation of referrals to services which are not specifically included in the definition of comprehensive perinatal services, but which are appropriate for the medical and/or psychosocial health of the Member, should be noted in the record by the Perinatal case manager.
   3. The Perinatal Services case manager must use orientation, assessments, re-assessments, individual and group process interventions and family support participation as methods for the provision of comprehensive perinatal services.
      a. Standardized assessment and reassessment tools, and the individualized care plan must be revised as necessary at least each trimester and at the post-partum visit
         1) The CDPH standardized tool or a modification of this tool may be used, but it should be standardized and documented in the provider's organizational policies and procedures and, where feasible, integrated into the shared medical record.
      b. Each component of the individualized care plan should identify risk conditions; prioritize the Member's needs, referrals, and proposed interventions including methods, time frames and outcome objectives for psychosocial, health education, and nutrition services.
      c. The perinatal provider must document the assessment of the member's obstetrical status at each visit.
   4. A Member has the right to decline to participate in any part of the Comprehensive Perinatal Services Program. This should be documented clearly in the medical record.
      a. Members who initially declined should be offered the services throughout pregnancy and postpartum period
   5. Within 3 business days of completion of an initial problem list and care plan, and upon update of this care plan each trimester, a copy must be transmitted to the prenatal care provider in a manner agreed upon by the PHPS provider and the prenatal care provider. Any urgent changes or developments should be additionally communicated via phone, secure text, a centralized health information exchange, or secure email (as requested by the prenatal care provider).
      Providers of PHPS must submit a TAR to Partnership for the provision of services in excess of the Partnership maximum frequency allowance for nutrition, psychosocial and health education services.

6. Perinatal Services providers must maintain an updated list of staff working in their program, with their job titles and training/licensure. These will be reviewed at Site Reviews of the perinatal provider at least every 3 years.

E. Perinatal Services Health Education Roles
   1. Provide education based on the Assessment and Reassessment in the following areas with supervision of licensed clinical staff and referral to Behavioral Health/Nutritionist/Licensed clinical staff per agency protocols:
      a. Pregnancy related nutrition
      b. Behavioral Health self-management, goal setting and motivational interviewing
      c. Lactation support education and lactation counseling

F. Diabetes Care in Pregnancy (formerly known as "Sweet Success" programs)
   1. Birthing people with diabetes are at risk of a variety of serious complications for both the birthing person and their baby. A large body of research shows that intensive education, case management and obstetrical support reduces the incidence of complications and improves outcomes (summarized by the American Diabetes Association in the references).
   2. To optimize outcomes for pregnant persons with diabetes, the PHPS program allows for the following services:
      a. Diabetes education (including the use of continuous glucose monitoring) may be provided by any Certified Diabetes Educator (CDE), whether through a PHPS provider or through any other Partnership contracted CDE. When a Registered Dietitian (RD) performs CDE services in a PHPS program, the nutrition Z-codes may be used. When a contracted RD performs CDE services outside of a PHPS program, the codes listed in policy MCUP3052 Medical Nutrition Services may be used. If a nurse within a PHPS program conducts CDE services, the education Z-codes may be used.
      b. Extra perinatal case management services are required for optimal outcomes in patients with pregnancy and diabetes. Any TARS for increased visit frequencies for diabetes in pregnancy will be evaluated with this in mind.
      c. Diabetes education for pregnant individuals may be done either in-person or through video telemedicine visits.
      d. While any licensed prescriber may adjust medications for diabetes in pregnancy, expertise and experience in this area is associated with tighter control and improved outcomes. Ideally there is a hierarchy of expertise in such prescribing, with all levels thoroughly educated on and in alignment of the goal of excellent blood sugar control in a pregnant individual. The details of the hierarchy can vary, but may include a CDE-RN adjusting medication via a written protocol under supervision of a physician with expertise in more complex cases. Such medication titration by an RN is typically associated with additional diabetes education and thus can be billed through PHPS using the education Z-codes.
      e. The decision as to who will provide CDE services and who will manage medication must account for the geographic location of the patient, their preferences for telemedicine, regional access to technology that supports telemedicine, visits, the availability of staff with expertise in this area, and the language and cultural concordance of different provider options. Requiring all patients to travel long distances on a frequent basis for care that could safely be provided locally or via telemedicine results in inequitable care as patients choose to forgo the care altogether.
         1) Where cellular and internet service are unreliable, PHPS programs can consider "hosting" telemedicine visits at their practice sites with non-local consultants to ease access and avoid long distance travel

G. Lactation Counseling and Education
   1. Basic lactation education, more formal lactation counseling or lactation consultation may be included as part of PHPS case management services, nutrition service or health education services,

depending on the credentials of the person providing the services, using the corresponding Z-codes. Non-PHPS providers may also provide lactation counseling or consultation services as outlined in MCCP2020 Lactation Policy and Guidelines.

H. Referral Procedures
   1. Specialist care with an obstetrics provider (e.g. Maternal Fetal Medicine or High Risk Obstetrics) does not require an approved Referral Authorization Form (RAF). However, some specialists and practices require a referral and medical records prior to scheduling a consultation.
      a. Consultation during pregnancy with a non-Obstetrics specialist (Cardiology, Endocrine) requires that a Referral Authorization Form (RAF) be submitted by the Primary Care Provider.
   2. It is the responsibility of the perinatal provider to confirm the Member's eligibility and PCP information with Partnership at each visit.

VII. REFERENCES:

A. Guidelines for Perinatal Care –8th Edition by the American College Obstetricians & Gynecologists (ACOG) and the American Academy of Pediatrics (AAP), September 2017.
B. Title 22 regulations; Title 17 regulations and all applicable sections of the Health and Safety Code
C. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-022 Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services (12/19/2018)
D. DHCS APL 22-024 Population Health Management Policy Guide (11/28/2022)
E. DHCS APL 23-024 *Revised* Doula Services (11/03/2023)
F. California Department of Public Health CPSP Program https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx
G. American Diabetes Association Professional Practice Committee; 15. Management of Diabetes in Pregnancy: Standards of Care in Diabetes—2024. Diabetes Care 1 January 2024; 47 (Supplement_1): S282–S294. https://doi.org/10.2337/dc24-S015

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. OB/GYN practice sites
C. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, Health Services

X. REVISION DATES:

(HS-1 - 12/10/96; 10/10/97 [name change only]; 02/17/99; 06/21/00, 10/17/01; 06/19/02; 10/20/04; 04/20/05; 05/18/05; 05/17/06; 08/15/07; 08/20/08; 06/17/09; 01/16/13; 03/19/14; 09/17/14; 02/18/2015; 01/20/16; 01/18/17; *06/13/18; 06/12/19; 06/10/20; 02/10/21; 03/09/22; 03/08/2023; 11/08/23; 09/11/24

*Through 2017, dates reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.