MIDWEST CENTER FOR WOMEN'S HEALTHCARE

Exceptional care one patient at a time.

www.mcwhc.com

Communication with our Staff

During Normal Business Hours

You can reach our physician's support team member or leave a voice mail at the extensions below by entering the extension as soon as our voice mail commences:

Dr. Carol Ellman	x3312
Dr. Elizabeth Forbes	x3314
Dr. Stephanie Heraty	x3311
Dr. Karyn Grimm Herndon	x3316
Dr. Amy Henriott	x3317
Dr. Jill Hoprasart	x3315
Dr. Jeremy Miller	x3318
Dr. Ronald Miller	x3313
Dr. Miriah Plawer Volmerding	x3319
Dr. Melissa Keene	x3335

If you believe you are in labor or have an urgent medical matter, you may also dial "1" instead, as soon as our voice mail commences.

After Hours Contact

(Outside of normal business hours 8:15 a.m. to 5:00 p.m. Monday-Friday)

Answering Service: 1-773-250-6285

Revised January 2019

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Navigating the world of health care benefits and insurance can be very difficult. Although Midwest Center for Women's Healthcare accepts most benefit plans, coverage and reimbursement levels vary widely. Our website (www.mcwhc.com) contains the most current information regarding the plans in which we participate 'in network' as we do not fully participate in all networks.

For most insurance plans, we are able to verify that your coverage is current. However, we cannot always access current eligibility information from every plan, and we cannot always access information regarding the specific features of your individual plan such as your deductible, co-payments, or out of pocket maximums (also called stop losses). **As the insured, you are responsible for obtaining this information and knowing the features of your plan.**

Key Resources:

- Your benefit summary or your summary plan description contains the details of your plan and the appeal process for any denials.
- If you are employed, your Human Resources Department can assist with your questions and concerns. Benefits representatives can be your advocate with the insurance company, if needed.
- Our website, www.mcwhc.com, provides detailed information regarding our participation in your plan.
- Pre-treatment estimates—particularly for a procedure or the delivery of a new baby. We are able to provide you with an estimate of our fees that you can submit to your insurance company so that there will be few surprises regarding your costs.

Here are some important questions to ask:

- Is my physician in-network or out-of-network? Your coverage and the charges for which you are personally responsible may differ based on the provider network status.
- If I were to be hospitalized or intend to deliver my baby at NorthShore University Health System, is the hospital in-network with my insurance plan? **There are plans in which MCWCH physicians participate as in network providers but the local hospital does not.** We encourage you to check directly with your plan and the hospital to determine the hospital's in network status. If the hospital is out of network, we may be able to assist you with a transfer within Midwest Center for Women's Healthcare.
- What is my deductible---what I will be responsible to pay before my insurance pays any benefit?
- What is my co-payment? This is the percentage you will pay and the percentage that the plan will pay up.
- What is my maximum out-of-pocket amount before the plan pays 100%?
- Does my plan require prior approvals for procedures, medications and/or notification of my pregnancy?

While we provide as much assistance as possible, the reality of health care benefits today is that there are hundreds of thousands of benefit plans. Therefore, we cannot be responsible for knowing the specifics of each and urge you to take the time to learn as much as possible about your health benefits.

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Central Business Office

Precertification/Notification for Maternity Benefits or Surgical Procedures.

Insurance companies are increasingly requiring pre-certification and/or notification after confirmation of pregnancy or need for a surgical procedure . Failure to do so may jeopardize insurance coverage for your fees. While we, at Midwest Center for Women's Healthcare, want to help you as much as possible, as the covered member, you are responsible to ensure that you obtain approvals and are very familiar with the benefits provided to you under your specific plan.

The form below provides you with a place to record that you have taken the necessary steps to verify your coverage and have obtained any required approvals. We recommend that you complete this now and keep a copy of this in your records. We are happy to scan it into your electronic record as well.

The information you need to have is:

Insurance Company: _____
Policy/Plan/Group Numbers: _____
Effective date of Coverage: _____
Estimated due date: _____

Preapproval Information:

Company Representative Name/No: _____
Date of Contact: _____
Date of approval, pre-certification or notification: _____
Approval Number or Authorization Code: _____
Other Pre-approvals Required: _____
_____

Payment Information:

Of the estimated delivery fee[1], what is my:
Deductible: _____
Co-payment or co-insurance after deductible: _____
Co-payment or co-insurance for lab work or ultrasound: _____
Stop loss or Maximum out of Pocket: _____

Important Note about Hospital Fees: Midwest Center for Women's Healthcare is an organization independent from any Hospital Corporation. While you may be in-network for our fees, you will need to verify whether the hospital is in-network and if there are further requirements under your insurance plan for pre-approval, authorization or notification. We recommend that you contact the Hospital now to ensure you have all of the necessary approvals and coverage information regarding their billed services.

[1] We are happy to provide you with an estimate of your delivery fees and costs.

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Prenatal Screening and Diagnostic Testing Options

During your pregnancy, you will be given the option to have any one of several prenatal genetic tests. These tests are optional and you may elect to have no prenatal testing at all.

SCREENING TESTS

- **First Trimester Screening (BUN)**
- **Non-invasive prenatal screening (NIPS)**
- **Quad Screen**
- **Neural Tube Defect Screening**
- **Level II Ultrasound**

First Trimester Screening (BUN)

This screening is designed for women interested in determining whether their baby is at increased risk for Down syndrome and Trisomy 18 which are chromosome abnormalities that result from the presence of an extra chromosome in every cell of the body. The screening is done between 11-14 weeks and involves an ultrasound and a blood test. Results are reported as a risk likelihood based on age alone and then a revised risk after testing. Using this test the detection rate for Down syndrome is 85% and the false positive rate is 5%. A false positive test occurs when an initial screening test is positive but subsequent testing proves reassuring.

Non-invasive prenatal screening (NIPS)

This screening blood test is done after 10 weeks and looks at fetal DNA fragments in a mother's blood to determine a baby's risk for Down syndrome, Trisomy 18 and Trisomy 13, Turner syndrome and triploidy. These are chromosomal abnormalities which are usually sporadic (no family history) and can occur in any pregnancy. Down syndrome, Trisomy 13 and Trisomy 18 result from the presence of an extra chromosome and cause mental disability, birth defects and other health problems. Turner syndrome results from a missing chromosome. Triploidy results from a complete extra set of chromosomes and usually results in miscarriage.

Results for each of the five conditions are reported in one of two categories; "high risk" or "low risk'. The detection rates range from 96-99.5% and the false positive rate is below 0.1%.

A "high risk" result does not mean your baby will have one of these conditions. A further diagnostic test is needed to discover whether the fetus actually has the condition. Similarly, a "low risk" does not guarantee your baby will be free of these abnormalities.

Quad Screen

This is a maternal blood test done between 15-18 weeks that measures the amount of several proteins to predict the risk for Down syndrome and Trisomy 18 (60-70% detection rate) and open neural tube defects (e.g. spina bifida) with a detection rate up to 90%.

Spina Bifida Screen

This is a maternal blood test done between 15-19 weeks that measures alpha-fetoprotein which can be elevated in babies that have neural tube defects such as spina bifida.

Level II Ultrasound

A comprehensive or level II ultrasound, usually performed between 18 and 22 weeks of pregnancy, is a thorough evaluation of the fetal anatomy targeted to identify anatomic or structural birth defects. Anatomic birth defects are present in 2-3% of live born infants. Fetal growth, amniotic fluid volume, and placental anatomy are evaluated during both routine as well as a comprehensive ultrasound. Chromosome abnormalities cannot be diagnosed or ruled-out by ultrasound. However, fetal anatomic abnormalities are observed in 50-70% of fetuses with Down syndrome and over 90% of fetuses with Trisomy 18 or 13. Therefore, a normal comprehensive ultrasound may be associated with a reduced risk for chromosomal abnormalities. In contrast, identification of fetal anatomic abnormalities on ultrasound may be associated with higher risk of chromosome disorders.

NONE of these tests are able to make a certain diagnosis. For those with an abnormal result, we offer subsequent diagnostic tests for confirmation (see below).

DIAGNOSTIC TESTS

In pregnancies at increased risk for a chromosome abnormality or other genetic disorder, diagnostic testing can provide confirmation of the suspected issue. Women who are considered to be at increased risk to have a baby with a chromosomal abnormality include women 35 years old or older at the time of delivery, women who have had an abnormal screening test and/or those with abnormalities identified on ultrasound.

Chorionic Villus Sampling (CVS)

Chorionic villus sampling (CVS) refers to a procedure in which a small sample of the placenta is obtained under ultrasound guidance for prenatal genetic diagnosis, generally in the first trimester between 10-14 weeks of gestation. The cells from the placenta are then studied to analyze the fetal chromosomes. Results are available within 1-2 weeks. There is a small increased risk of miscarriage associated with CVS of approximately 1 to 2 out of 200 (or 0.5 -1.0%). Abnormalities in chromosome number or structure can be determined by CVS. Fetal gender can also be determined. Screening for open neural tube defects cannot be achieved through CVS. Women who opt for CVS are offered the spina bifida screen (as described above).

Amniocentesis

Amniocentesis is a technique for withdrawing amniotic fluid from around the baby and is usually performed between 15-18 weeks of pregnancy. During the procedure, a small sample of amniotic fluid is removed with a needle under ultrasound guidance. The sample contains fetal cells floating in the amniotic fluid, which can be studied to analyze the fetal chromosomes. Results are available approximately within 2-3 weeks. There is a small increased risk of miscarriage associated with amniocentesis, which is thought to be 1 in 200 (or 0.5%). Abnormalities in chromosome number or structure can be determined by amniocentesis. Fetal gender can also be determined. Additionally, the amniotic fluid can be tested to measure the amount of alpha-fetoprotein, which can detect the presence of open neural tube defects.

Although diagnostic tests can provide a yes-or-no answer about chromosome abnormalities, normal results do not guarantee a healthy baby.

Costs for These Tests

Your insurance plan may or may not cover the costs of these tests, some of which can be significant. We would advise you to contact your insurance company regarding your plan and its benefits prior to obtaining the testing.

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Genetic Testing/Carrier Screening

Genetic/carrier screening involves blood tests that determine if a couple is at increased risk of having a baby with a specific genetic disorder. Genetic disorders are caused by changes within genes called mutations. Every individual has two copies of each gene, one from each parent. A carrier is a person who has one normal copy of a gene and one copy with a mutation. Carriers generally have no symptoms and rarely have a family history of the specific condition. If both parents are carriers of the same mutation, there is a 25% chance with each pregnancy of having an affected child. Testing during pregnancy is available to determine whether or not a fetus is affected.

The risk to be a carrier for each of these conditions varies by ethnicity. Similarly, the detection rates for each screen, meaning the chances the screen will find the mutation if you are indeed a carrier, also depends on an individual's ethnicity. It is important to know that although screening is highly accurate, even with a normal screen result, there is still a small chance of being a carrier. There are both basic and comprehensive genetic panels which are explained below.

Basic genetic panels

Ashkenazi Jewish Genetic Panel (AJGP)

The Ashkenazi Jewish Genetic Panel includes conditions specific to individuals with Ashkenazi Jewish ancestry. This tests for several disorders for which carrier testing is available including: Tay-Sachs disease, Canavan disease, familial dysautonomia, Gaucher disease, Niemann-Pick disease, Bloom syndrome and others.

Cystic Fibrosis(CF)

Cystic fibrosis is a disease in which thick mucus accumulates in the respiratory and digestive tract, leading to a variety of illnesses. Intelligence is normal. With modern medical care affected individuals may live into their late thirties, although more severe cases may die in childhood. Cystic fibrosis is most common in Caucasians but can be found in other ethnicities. Approximately 1 in every 25 people of Caucasian descent is a carrier of CF.

Spinal Muscular Atrophy (SMA)

SMA is a severe neurological disease that destroys the nerves responsible for muscle control of breathing, swallowing, head and neck control, walking and crawling. There is no treatment and death usually occurs in early childhood. Approximately 1 in every 40 people is a carrier of SMA.

Hemoglobinopathies (e.g. alpha-thalassemia, beta-thalassemia, sickle cell disease)

Alpha-thalassemia: *most frequent in individuals of Southern Asian ancestry*.

Alpha-thalassemia is a blood disorder that reduces the production of hemoglobin. Hemoglobin is the protein in red blood cells that carries oxygen throughout the body. The most severe form of alpha-thalassemia results in fetal or infant death.

Beta-thalassemia: *most frequent in individuals of Mediterranean, Middle Eastern, Asian and African ancestry*.

Beta-thalassemia is a disorder that causes a deficiency of red blood cells leading to anemia. The most severe form of beta thalassemia can cause organ enlargement, poor growth and changes in the bones. Heart failure and infections are the leading causes of death among children with the most severe form of thalassemia.

Sickle cell disease (SCD): *most frequent in individuals of African ancestry.*

SCD affects red blood cells and can cause pain episodes, anemia, organ damage, and an increased risk for infections, lung problems, leg ulcers and strokes.

Comprehensive genetic panel

Individuals have the option to screen for additional conditions beyond those routinely offered. This panel may include up to 142 conditions that have a wide range of carrier frequencies and detection rates depending on ethnicity. Most of the conditions on this panel are *not* recommended by the American College of Obstetrics and Gynecology or the American College of Medical Genetics.

DECIDING ON CARRIER SCREENING

After learning about carrier screening, some people choose to have screening while others decide against it. Your provider can review the details of any of these screening tests or refer you to a genetic counselor for additional information.

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Online Maternity Pre- Registration

Maternity patients now can complete Maternity Pre-Registration Forms online using a personal computer. The NorthShore University Health System Admitting Offices Created this new service to minimize problems with forms that are lost or delayed in the mail, and to help assure that patients are pre-registered prior to their delivery.

When to Pre-Register

Whether you pre-register online or using paper forms (available from your OB/GYN's office), please complete your pre-registration three months prior to your expected due date.

How to Pre-Register Online

From any computer that has internet access:

1. Go to www.northshore.org/maternityservices
2. Click on "Pre-Register for Delivery"
3. Enter the requested information and click "submit"

Insurance Information

The Admitting Office will need photocopies of your insurance ID card(s) in addition to the information you submit online. Please send or fax the photocopies to the Admitting Office at the appropriate hospital prior to delivery.

Evanston Hospital:

Admitting Office
2650 Ridge Ave. #1222
Evanston, Il 60201
Phone: (847)570-2130
Fax: (847)733-5364

If you have any questions about the pre-registration process, please call the phone number listed above.

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Over the Counter Medication List for Pregnancy or Breastfeeding

CONSTIPATION
Increase fluids and fiber
Senna
Psyllium/Metamucil
Methylcellulose/Citrucel
Magnesium hydroxide/Milk of Magnesia
Bisacodyl/ Dulcolax
Docusate sodium/Colace

ALLERGY
Loratadine/Claritin, Alavert
Cetirizine/ Zyrtec

YEAST
Miconazole/Monistat

COLD SYMPTOMS
Nasal Lavage/Neti pot
Pseudoephedrine/Sudafed
Diphenhydramine/Benadryl
Phenylephrine/Sudafed PE
Guaifenesin/Mucinex
Dextromethorphan/Robitussin
Acetaminophen/ Tylenol
Saline nasal spray
Throat lozenges
Phenol/Chloraseptic

UPSET STOMACHE/INDIGESTION
Aluminum hydroxide, magnesium hydroxide/ Mylanta
Simethicone/Gas-X, Mylicon
Bismuth/Pepto Bismol (not in 3rd trimester)
Calcium carbonate/ Tums
Ranitidine/Zantac
Famotidine/Pepcid

HEADACHE/BACK PAIN
Acetaminophen/ Tylenol

HIVES/RASHES
Diphenhydramine/Benadryl (oral or topical
Loratadine/ Claritin, Alavert
Cetirizine/Zyrtec
Pramoxine/ Caladryl

DIARRHEA
Loperamide/ Imodium
Attpulgite/ Kaopectate

HEMORROIDS
Preparation H (ointment, cream or wipes
Pramoxine/ Anusol
Tucks pads

NAUSEA
Accupressure bracelet/Sea Bands
Emetrol
Vitamin B6
Ginger
Unisom (1/2 tablet per day)

VITAMINS, CALCIUM, IRON
As directed by your provider

General Guidelines

- **When using these medications, remember moderation is best. Use medications according to the manufacturer's direction. If symptoms persist, please discuss with your provider.**
- **Do not take medications or herbal supplements unless you have discussed it with your provider or our herbalist.**
- **No aspirin (Excedrin), ibuprofen (Advil or Motrin), or Naproxen (Aleve) unless prescribed by your provider.**

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Vitamin K and Your Baby

All parents and patients should be informed about the risks and benefits of standard preventive health measures, including Vitamin K supplementation to newborns. The American Academy of Pediatrics recommends that all newborns be given a single dose of intramuscular (shot) Vitamin K_1 at birth. As your care providers, we hope this information sheet will provide you with all the information you need to make the best choice for your baby.

What is Vitamin K?

- Vitamin K_1 (Phylloquinone or Phytonadione) is found in green leafy vegetables, legumes, and vegetable oils.
- The human body needs vitamin K. It is an essential ingredient in helping the liver make many clotting factors.
- It is absorbed in the intestines from food. Very little vitamin K is transported across the placenta to babies, and very little is available in breast milk. Newborn infants do not have vitamin K stores in the liver until they are 2-3 months old.
- The body can recycle vitamin k. The amount given to newborns is enough to last until the baby gets vitamin K from their diet.

What is Vitamin K Deficiency Bleeding (VKDB)?

- Previously called Hemorrhagic Disease of the Newborn, VKDB is unexpected bleeding in otherwise healthy newborns due to low vitamin K. Bleeding can occur without trauma, accidents, and as a result of normal everyday activities.
- Classically, VKDB occurs from 1-7 days of life as bleeding from the belly button, intestines, skin, nose, circumcision site, or rarely in the brain. The incidence of this type of bleeding is 0.25-1.7 per 100 births (not uncommon).
- Late-onset VKDB can happen after 2 weeks of life and as late as 6 months of life. Sudden and severe bleeding in the brain happens in more than half of cases and can be catastrophic. The incidence of this type of bleeding 4.4 to 7.2 per 100,000 births.
- Babies born to mothers taking medicines for seizures, blood thinning, or tuberculosis are at increased risk for very early and severe bleeding.
- Oral vitamin K is available and given in some countries to newborns instead or in addition to a shot. A single dose of oral vitamin K is not enough to prevent the risk of late-onset VKDB in exclusively breast fed infants. Some studies suggest giving weekly doses or even daily doses until the baby is several months old may be as effective as the shot. This has not been completely studied, and so is not recommended as standard care by the American Academy of Pediatrics at this time.

Is Vitamin K safe?

- The giving of vitamin K as a shot to newborns has been the standard of care recommended by the American Academy of Pediatrics since 1961.
- The current preparation of vitamin K is the same type found in food and includes very few ingredients, all of which are considered very safe: vitamin K dissolved in a sugar and fatty acid suspension.
- The most common adverse effects are pain, redness and bruising at the site of injection. Vitamin K has been reported to cause jaundice when given at doses higher than the typical dose. Children and adults can have a serious allergic reaction to vitamin K, but generally not newborns.
- Early on there were questions about whether vitamin K could be related to the development of childhood cancers such as leukemia. Many studies have been done to study this question and have failed to show a relationship between vitamin k and childhood cancer. Furthermore, many studies have been done on babies' blood before they are born demonstrating a genetic link to the development of childhood cancer.

Sources:
1. American Academy of Pediatrics Committee on Fetus and Newborn. Controversies concerning vitamin K and the newborn. Pediatrics. 2003;112(1):191-192.
2. Manco-Johnson MJ. Bleeding disorders in the neonate. NeoReviews. 2008;9(10):e162-e169. DOI: 10.1542/neo.1-10-e196.
3. Nimavat D. Hemorrhagic disease of the newborn. Medscape Reference. 2012. Avail at: http://emedicine.medscape.com/article/974489-overview
4. Puckett RM, Offringa M. Prophylactic vitamin K for vitamin K deficiency bleeding in neonates. Cochrane Database Syst Rev. 2000;4:CD002776. DOI: 10.1002/14651858.CD002776.
5. American Academy of Pediatrics Section on Infectious Disease. Documenting parental refusal to have their children vaccinated: http://www2.aap.org/immunization/pediatricians/pdf/refusaltovaccinate.pdf
6. Vitamin K_1 Drug Label Information as filed by the NIH: http://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=e8808230-2c44-44c6-8cab-8f29b6b34051&type=display
7. Lauer B, Spector N. Vitamins. Pediatrics in Review 2012; 33:339-352; doi:10.1542/pir.33-8-339

Bridget Wild, MD

Vitamin K Refusal

I have been provided with and given the opportunity to read information about Vitamin K supplementation for newborns and the disease(s) is prevents. I have had the opportunity to discuss this information, including risks and benefits, the recommendation and my refusal with my child's physician, who has answered all of my questions about Vitamin K.

I understand:

- That the consequence of not receiving intramuscular vitamin K can be serious bleeding for my newborn up to 6 months of life.
- That my child's doctor and the American Academy of Pediatrics strongly recommend all newborns receive one dose of intramuscular vitamin K at birth.

Nevertheless, I have decided at this time to decline vitamin K for my child. I know that failure to follow the recommendations about vitamin K supplementation may endanger the health or life of my child. I acknowledge that I have read this document in its entirety and fully understand it.

Child's Name: _____ Date of Birth: _____

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

Witness Signature: _____Date:_____

Vitamin K Refusal

1. Nursing identifies family plans for newborn care at admission.
    a. If intending to receive vitamin K, end process.
    b. If unsure, questioning or planning to decline vitamin k, notify pediatrician on call.
2. Pediatrician provides vitamin K handout to family before delivery and enters it as a letter in the infant's chart upon delivery.
    a. Review in person at minimum:
        i. Very little vitamin K is transported across the placenta to babies, and very little is available in breast milk. Newborn infants do not have vitamin K stores in the liver until they are 2-3 months old.
        ii. VKDB is unexpected bleeding in otherwise healthy newborns due to low vitamin K. Bleeding can occur without trauma, accidents, and as a result of normal everyday activities
        iii. Early VKDB occurs from 1-7 days of life as bleeding from the belly button, intestines, skin, nose, circumcision site, or rarely in the brain. Late-onset VKDB can happen after 2 weeks of life and as late as 6 months of life. Sudden and severe bleeding in the brain happens in in most cases and can be catastrophic.
        iv. This has been an AAP recommendation provided to infants born in the United States since 1961.
        v. Parents wishing to refuse vitamin K are asked to sign a waiver stating they have all the information they need to make an informed decision to refuse.
    b. Answer questions.
    c. Offer to return later with refusal form after they have had a chance to look over the form.
    d. Ideally return prior to delivery or shortly after.
        i. If still intending to refuse, provide waiver.
        ii. Waiver should be signed and scanned into infant's chart prior to discharge.
3. Any family requesting information about vitamin K is welcome to receive the hand out and to request discussion with pediatrician.

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Signs and Symptoms of Labor

You should be aware of the signs and symptoms of labor as you progress through your pregnancy. If you experience any of these symptoms before you are 36 weeks pregnancy, please contact our office immediately.

CONTRACTIONS: The contractions associated with labor (those that will cause your cervix to dilate) will come at **regular** intervals and will increase in frequency, duration and intensity as time goes on. These contractions typically begin in the back and radiate around the front causing a "tightening" of the abdomen.

- If your contraction frequency does not decrease despite lying down on your side and keeping well hydrated, this is probably labor.

- If you are having your first baby, we would like the contractions to come every 3 to 5 minutes.
- If you have had children before, particularly if your labors were fast, we would like the contractions to come every 5 to 7 minutes.

RUPTURE OF MEMBRANES: "Breaking the waters" may be a sudden gush of fluid or a constant leak of fluid from the vagina. The fluid may be clear or brown-tinged. When this happens, please call the office or answering service (as above). Even if you are not contracting, it is advised to call our office.

VAGINAL BLEEDING: Sometimes the softening or dilation of your cervix is associated with "bloody show" or blood-tinged mucus discharge. If this is associated with contractions at a regular interval, this is probably labor. However, if you have vaginal bleeding which is excessive: i.e. the amount of a menstrual period or greater, call our office and you will be directed to go to the Evanston Hospital Labor and Delivery Unit **immediately**. Do not go to the Emergency Room.

BABY'S MOVEMENT: If the amount of baby's movement seems to markedly decrease or you do not feel baby move over your typical period of time, we suggest that you eat/drink and rest. If there is no movement by 30-60 minutes, please call our office.

Prior to going to Labor & Delivery, always call our office (847-869-3300) or outside our business ours, call the answering service at (773)250-6285.

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