Medicaid Managed Care

CLEAR HEALTH ALLIANCE

A message for providers

Taking Care of Baby and Me Provider Booklet

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We are committed to healthy outcomes for our members and their babies. That is why we encourage all of our pregnant Members to take part in our Taking Care of Baby and Me® program.

Taking Care of Baby and Me is a proactive care management program for all perinatal Members and their newborns that offers:

- Individualized one-on-one case management support for Members at the highest risk.
- Care coordination for those who just need a little extra support.
- Educational materials and information on community resources.
- Incentives to keep up with checkups.

How it works

Once we identify a Member as pregnant (through notification from your office, enrollment files, claims data, etc.), they are advised of the program and encouraged to complete a risk assessment to determine the level of care management support that will be needed throughout the pregnancy. Many program Members benefit from perinatal and general health and wellness education. They can also benefit through referrals to local service agencies. Others who have experienced prior preterm births or have chronic health conditions such as diabetes or high blood pressure may need extra help.

Maternal Child Health offerings

Pregnancy education:

- Members have access to resources and education on pregnancy, labor, and delivery, postpartum, and well-child care, as well as a host of other topics via the Clear Health Alliance (CHA) Member website. Members may also contact Member Services at the number on their ID card to request printed materials.

Digital Maternity Program:

- As part of the Taking Care of Baby and Me program, perinatal Members of all risk levels have access to a digital maternity program. The digital program provides pregnant and postpartum Members with proactive, culturally appropriate education via a smartphone app on a schedule that works for them.
- Eligible Members are encouraged to access this program by downloading a smartphone app. After the app is installed and the Member registers, they are asked to complete a pregnancy screener. The answers provided in the screener allow CHA to assess their pregnancy risk.

Digital Maternity Program (cont.)

- After the risk assessment is complete, gestational-age-appropriate education is provided directly to the Member. The digital program does not replace the high-touch, individual case management approach for our highest risk pregnant Members; however, it does serve as a supplementary tool to extend our health education outreach. The goal of the expanded outreach is to ensure maternity education is available to all perinatal Members and also help CHA identify Members who experience a change in risk acuity throughout the perinatal period.

We encourage healthcare providers to share information about the digital tools offered at CHA with their Members. Members may access information about the products that are available by visiting the CHA website:

- Each digital educational outreach provides the Member with specific healthcare education in a warm, easy-to-understand, and fun to use fashion.
- What we want to achieve with this program:
  - Provide Members with the information they need to participate in the management of their health.
  - Provide CHA with a practical tool to identify Members' conditions and concerns.
  - Encourage Members to communicate more effectively with their healthcare providers.
- Do not be surprised if your patients mention this digital program. Take it as a sign that it is doing its job! Encourage your patients to participate in the digital program and help us nurture a well-educated and more communicative patient population. If a Member is not enrolled, they can call the number on their ID card and request to speak to an obstetrics case manager.
- For more information on the digital maternity program, reach out to your OB Practice Consultant or Provider Services.

Healthy Rewards®:

- We supply our pregnant Members with information to promote the best outcomes. We even offer incentives to Members who keep their prenatal and postpartum appointments. Parents can also receive incentives for well-child visits.

- You can help to ensure your patients are receiving these incentives by:
  - Scheduling an initial obstetrics visit within the first trimester or 42 days of enrollment with CHA and encouraging the member to enroll with Healthy Rewards.
  - Completing the patient's postpartum checkup 7 to 84 days after delivery.
  - Reminding your patient that once their baby is born, the baby needs to see their provider for regular checkups and immunizations to stay healthy. For the first 15 months of life, the baby should see a provider at 3 to 5 days old, 1 month old, 2 months old, 4 months old, 6 months old, 9 months old, 12 months old, and 15 months old.

Members may call Healthy Rewards for assistance at **888-990-8681**.

Healthcare Effectiveness Data and Information Set (HEDIS) for prenatal and postpartum care

To keep us accountable to you and our Members, we compare our health plan performance against the HEDIS® benchmarks developed by the National Committee for Quality Assurance. This assessment lets us know if our Members are getting the preventive, acute, and chronic healthcare services they need.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Timeliness of Prenatal Care

The Timeliness of Prenatal Care HEDIS measure looks at the percentage of Members who had a live birth or delivery and received a prenatal care visit from an obstetrical (OB) practitioner, midwife, family practitioner, or other primary care provider. The visit must be:

- Documented, indicating when prenatal care was initiated.
- In the first trimester, on or before the enrollment start date or within 42 days of enrollment with CHA. Evidence of at least one of the following needs to be documented:
  - A basic physical obstetrical exam (auscultation for fetal heart tone or pelvic exam with obstetric observations or measurement of fundus height)
  - Prenatal care visits with screening test/obstetric panel or TORCH antibody panel alone or a rubella antibody test/titer with an Rh incompatibility blood typing or a positive pregnancy test or ultrasound/echography of a pregnant uterus
  - Last menstrual period or estimated due date or gravidity and parity or a prenatal risk assessment with counseling/education or a complete obstetrical history
- Pregnancy-related CPT® code:
  - Use the following codes to document services and visits for initial, routine, and subsequent prenatal care.

CPT codes	CPT Category II codes
59400, 59425, 59426, 59510, 59610, 59618, 99201-99205, 99211-99215, 99241-99245, 99500	• 0500F — initial prenatal visit • 0501F — routine prenatal visit • 0502F — subsequent prenatal visit

Postpartum Care

The Postpartum Care HEDIS measure captures the percentage of deliveries that had a postpartum visit on or between 7 to 84 days after delivery (a day early or a day late does not count). Call patients to schedule the postpartum visits and remind them of their appointment dates and times. Be sure to follow up with patients who miss appointments to reschedule.

Documentation must indicate visit date and evidence of one of the following:

- Pelvic exam.
- Evaluation of weight, blood pressure, breasts, and abdomen.
- Notation of postpartum care (for example, six-week check, postpartum care, PP care, PP check).
- Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders.
- Glucose screening for women with gestational diabetes.
- Documentation of any of the following topics:
  - Infant care
  - Resumption of intercourse, birth spacing, or family planning
  - Sleep/fatigue
  - Resumption of physical activity and attainment of healthy weight
- Make sure the postpartum date is on the claim.

Coding at a glance:

Postpartum visit	Postpartum bundled services
CPT: 57170, 58300, 59430, 99501, 0503F	**CPT:** 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622
ICD-10-CM: Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2	
HCPCS: G0101	

Group Prenatal Care

We support efforts to promote adopting a group prenatal care model of care. With this type of model:

- Participants experience their prenatal care visits in a group setting with others who are of a similar gestational age.
- Participants are encouraged to educate, motivate, and support each other as they experience similar changes to their bodies and their lifestyles in general.
- Participants experience positive results and outcomes.[1]

Centering Healthcare Institute is an independent organization that offers health information that Members may find helpful.

1. Centering Healthcare Institute. https://centeringhealthcare.org/what-we-do/centering-pregnancy. (Accessed July 2024).

Preeclampsia and prenatal aspirin

Increasing provider awareness in recognizing those at risk for developing preeclampsia and taking proactive measures can improve pregnancy outcomes, including decreasing the incidence of premature births, and both maternal and infant mortality.

CHA recognizes the opportunity to collaborate with our obstetrical care providers to improve maternal health and pregnancy outcomes by:

- Recommending daily 81 mg aspirin for women at elevated risk of developing preeclampsia starting at 12 to 28 weeks of pregnancy.[2]
- Close surveillance of blood pressure in pregnancy through in-office and routine monitoring.
- Decreasing stress.

The United States Preventive Services Task Force[3] recommends aspirin for those who are pregnant and have one or more of the following high-risk conditions:

- Prior pregnancy with preeclampsia
- Multifetal gestation
- Diabetes
- Hypertension
- Renal disease
- Autoimmune disease (for example, lupus and antiphospholipid syndrome)

The United States Preventive Services Task Force is an independent organization that offers health information that CHA Members may find helpful.

2. "Low-Dose Aspirin Use During Pregnancy." ACOG Committee Opinion No. 743. American College of Obstetricians and Gynecologists. Obstet Gynecol, 2018;132:e44–52. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/07/low-dose-aspirin-use-during-pregnancy. (Accessed July 29, 2024).
3. "Final Update Summary: Low-Dose Aspirin Use for the Prevention of Morbidity and Mortality from Preeclampsia: Preventive Medication." U.S. Preventive Services Task Force. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/low-dose-aspirin-use-for-the-prevention-of-morbidity-and-mortality-from-preeclampsia-preventive-medication. (Accessed July 29, 2024).

Substance use and screening in pregnancy:

- As our nation struggles to deal with the serious health risks posed by the opioid epidemic, CHA recognizes your role at the front lines of defense and supports you. Pregnancy offers an opportunity to break patterns of unhealthy behaviors. As an OB provider, you have a unique opportunity to help break the pattern of opioid misuse and, thus, avoid negative health consequences for both mother and baby.
- Screening, brief intervention, and referral to treatment (SBIRT) is recommended as part of the prenatal interview. A short screening done as part of the patient history intake has been shown to accurately identify substance use and at-risk patients. Those who screen positive should be immediately engaged in a brief conversation that may or may not identify a need for treatment, and a referral should be made as appropriate. Contact the health plan to make a referral for OB case management:
  - Evidence-based screening tools can be found on the Substance Abuse and Mental Health Services Administration (SAMHSA) website at **samhsa.gov/sbirt**.
- SBIRT is a covered benefit for CHA Members.
- The key to success in helping patients break the pattern of opioid misuse is the availability of and access to treatment. While OB providers can — with appropriate training and certification — prescribe treatment for opioid dependence, CHA understands you may not be comfortable providing this type of specialized care. To find treatment in your area, use the SAMHSA treatment locator tool at **findtreatment.samhsa.gov** or call the SAMHSA National Helpline at **800-662-HELP (4357)/TDD: 800-487-4889**.
- Collaboration with community resources, behavioral health providers, addiction treatment centers, and obstetrics providers is imperative to designing programs that engage families at risk for substance use disorders. Parenting education should start as early as possible on pregnancy so that parents-to-be can be prepared to understand and care for their babies who might experience symptoms of Neonatal Abstinence Syndrome (NAS) and who often require prolonged hospitalizations after birth. As these infants may remain symptomatic for several months after hospital discharge, they are at higher risk for abuse and maltreatment. Therefore, close follow-up with ongoing support is imperative.
- SAMHSA's *Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants* comprehensive guide is available at no cost online at **https://store.samhsa.gov/sites/default/files/sma18-5054.pdf**.

Caring for babies born with Neonatal Abstinence Syndrome/Neonatal Opioid Withdrawal Syndrome (NAS/NOWS):

- While traditional care for infants experiencing withdrawal involves tapering doses of opioids, this should not be the first option. Preliminary studies on preterm infants treated with morphine for pain and studies exposing laboratory animals to morphine, heroin, methadone, and buprenorphine reveals structural brain changes and changes in neurotransmitters. While few follow-up studies exist, those available are worrisome for long-term deficits in cognitive function, memory, and behavior. Reduction in any exposure to opioids should be the goal for the fetus and newborn.
- Approaches to reducing the incidence and severity of NAS/NOWS include:
  - The use of nonpharmacologic techniques to calm and ameliorate symptoms.
  - The adoption of and strict adherence to protocols to assess and treat with pharmacologic medication(s) if nonpharmacologic care is not sufficient.
  - Inter-rater reliability testing when using standard assessment tools (such as the modified Finnegan tool).
- Strict rooming-in protocols, rather than placement in neonatal intensive care units, combined with extensive parent education programs improves family involvement and is shown to reduce lengths of stay and the need for pharmaceutical treatment of infants with NAS/NOWS.

Perinatal and postpartum mood disorders:

Perinatal and postpartum mood disorders often go undiagnosed because changes in appetite, sleep patterns, fatigue, and libido may be related to normal pregnancy and postpartum changes. The American College of Obstetricians and Gynecologists (ACOG) has outlined depression screening instruments to use during the pregnancy and postpartum periods, including:

- The Edinburgh Postnatal Depression Scale.
- Patient Health Questionnaire-9.

The American College of Obstetricians and Gynecologists is an independent organization that offers health information that you may find helpful.

Successful best practices:

- Screen pregnant patients at least once for depression and anxiety symptoms and complete a full assessment of mood and emotional wellbeing during the comprehensive postpartum visit.
- If a patient screens positive for depression and anxiety during pregnancy, additional screening should occur during the comprehensive postpartum visit.
- Women with depression or anxiety, a history of perinatal mood disorders, risk factors for perinatal mood disorders (such as life stress, lower income, lower education, or poor social support), or suicidal thoughts warrant close monitoring, evaluation, and assessment.
- Refer patients to mental health healthcare providers, if needed, to offer the maximum support.
- Reference and use appropriate community behavioral health resources (for example, Women, Infants, and Children; Healthy Families America; etc.).
- Ensure a process is in place for follow-up, diagnosis, and treatment.

Women, Infants, and Children, and Healthy Families America are independent organizations that offer health information that Members may find helpful.

Family planning and long-acting reversible contraception (LARC):

- ACOG recommends having a conversation with your patient regarding immediate postpartum placement of LARC as an effective option for postpartum contraception. There are few contraindications to postpartum intrauterine devices and implants.[4]

LARC FAQ:

Q. When should providers insert an intrauterine device (IUD) or Nexplanon® postpartum?

A. Providers can insert IUDs in the postpartum period:

- Within 10 minutes after delivery of the placenta.
- Up to 48 hours after delivery.
- At the time of cesarean delivery.

Q. When should patients avoid postpartum IUD placement?

A. Immediate post-placenta insertion should be avoided in patients with a fever. Additionally, patients with a rupture of membranes greater than 36 hours before delivery, a postpartum hemorrhage or extensive genital lacerations should be referred for interval insertion.

Q. What are the CPT codes associated with IUD and Nexplanon insertion in the hospital setting?

A. The CPT and associated ICD-10-CM codes are unchanged for the hospital setting:

- 11981 — insertion, nonbiodegradable drug delivery implant
- 58300 — insertion of an IUD

4. "Long-Acting Reversible Contraception Implants and Intrauterine Devices. American College of Obstetricians and Gynecologists. https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2017/11/long-acting-reversible-contraception-implants-and-intrauterine-devices. (Accessed July 29, 2024).

Family planning and LARC (cont.)

Q. Does placement of an IUD in the postpartum period increase the chance of infertility in the future?

A. No, there is no data to suggest that there is any adverse effect on future fertility. Baseline fecundity has been shown to return rapidly after IUD removal.

Q. Is there a greater rate of IUD expulsion with postpartum placement of an IUD?

A. According to an ACOG opinion, "expulsion rates for immediate postpartum IUD insertions are higher than for interval or postabortion insertions, vary by study, and may be as high as 10 to 27 percent. Research is underway to determine whether levonorgestrel IUDs have different expulsion rates than copper devices in the immediate postpartum setting. Women should be counseled about the increased expulsion risk, as well as the signs and symptoms of expulsion. Replacement cost may vary by insurance plan, and a woman who experiences or suspects expulsion should contact her obstetrician-gynecologist or other obstetric care provider and use a back-up contraceptive method."[5]

Q. When should patients be seen for follow-up?

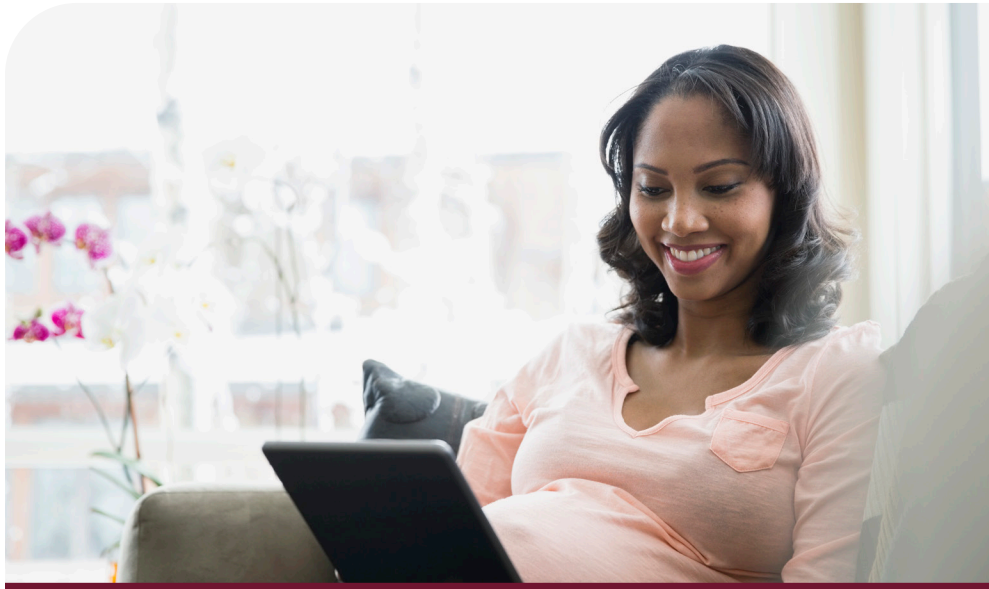
A. Patients should be seen between 7 to 84 days after delivery if not sooner for a complicated pregnancy or birth. Many patients resume intercourse before their postpartum checkup. To prevent unintended pregnancies, it is important to confirm that the device is still in place.

5. "ACOG Committee Opinion: Immediate Postpartum Long-Acting Reversible Contraception Number 670," The American College of Obstetricians and Gynecologist. August 2017. https://pcainitiative.acog.org/wp-content/uploads/IPP-LARC_Clinical-1.pdf. (Accessed February 23, 2024).

Racial and ethnic disparities in maternal mortality

Racial and ethnic disparities have a significant impact on pregnancy-related mortality, and this disparity increases with age according to CDC reports:

- Black women are three times and American Indian and Alaska Native women are two times more likely to die from pregnancy-related causes than white women.[6, 7]
- Cardiomyopathy, thrombotic pulmonary embolism, and hypertensive disorders of pregnancy contributed more to pregnancy related deaths among Black women than among White women.
- Hemorrhage and hypertensive disorders of pregnancy contributed more to pregnancy-related deaths among American Indian and Alaska Native women than White women.



For any questions about the various programs or if you would like more information on Maternal Child Health offerings, please contact your OB Practice Consultant, Provider Services, or your Provider Relations representative.

6. "Working Together to Reduce Black Maternal Mortality." Centers for Disease Control and Prevention. https://www.cdc.gov/womens-health/features/maternal-mortality.html#:~:text=Black%20women%20are%20three%20times,structural%20racism%2C%20and%20implicit%20bias. (Accessed July 29, 2024).
7. "Disparities and Resilience Among American Indian and Alaska Native People who are Pregnant or Postpartum." Centers for Disease Control and Prevention. https://www.cdc.gov/hearher/aian/disparities.html. (Accessed July 29, 2024).

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All Member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of Members. Your state/provider contract(s), Medicaid, Member benefits, and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for a high volume of medical record review requests and provider audits. It also helps us review your performance regarding the quality of care that is provided to our Members and meet the HEDIS measure for quality reporting based on the care you provide our Members.

Note: The information provided is based on HEDIS MY 2024 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS), and state recommendations. Please refer to the appropriate agency for additional guidance

provider.clearhealthalliance.com

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