Amerigroup
District of Columbia

A message for providers

Taking Care of Baby and Me® Provider Booklet

When it comes to our pregnant enrollees, we are committed to keeping both mom and baby healthy.

That's why we encourage all of our moms-to-be to take part in our Taking Care of Baby and Me® program.

The Taking Care of Baby and Me program is a proactive case management and care coordination program for all expectant mothers and their newborns, offering:

- Individualized one-on-one case management support for women at the highest risk.
- Care coordination for moms who may need a little extra support.
- Educational materials and information on community resources.
- Rewards to keep up with prenatal and postpartum checkups.

Amerigroup, District of Columbia, Inc. partners with providers and mothers to ensure all medical and resource needs are met while aiming for the best possible outcomes for moms and babies.

How it works

Once we identify an enrollee as pregnant (through notification from your office, Amerigroup DC enrollment files, Availity,* claims data, etc.), we enroll her in the program and complete a risk assessment to determine the level of case management support she will need throughout her pregnancy. Many programenrollees benefit from tips on eating the right foods and exercising regularly. They can also benefit through referrals to local service agencies. Others who experienced prior preterm births or have chronic health conditions such as diabetes or high blood pressure may need extra help.

Maternal Child Services programs

Pregnancy education packets

- Identified pregnant women will receive packets providing education and resources on pregnancy, labor and delivery, postpartum care and well child care.
- If your patient did not receive a packet, they can call Member Services at the number on their ID card to request a guide.

My Advocate®*

- As part of the Taking Care of Baby and Me program, enrollees are offered the My Advocate program. This program provides pregnant and postpartum women proactive, culturally appropriate outreach and education through Interactive Voice Response or website. This program does not replace the high touch case management approach for high-risk pregnant women. However, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk, to facilitate connections between them and our case managers, and improve enrollee and baby outcomes. Eligible enrollees receive regular calls with tailored content from a voice personality (Mary Beth).

- Each automated My Advocate communication gives the enrollee specific health care education in a warm, easy-to-understand fashion. Eligible enrollees receive twice-weekly messages with tailored content from a voice personality, Mary Beth, in English or Spanish. The topics include:
  - Obstetric high-risk screening.
  - Maternal and child health:
    - Prenatal care
    - Postpartum care
    - Well-baby care

- What we want to achieve with this program:
  - Give enrollees the information they need to participate in the management of their health.
  - Provide Amerigroup DC with a practical tool to identify enrollees' conditions and concerns.
  - Encourage enrollees to communicate more effectively with their care providers — such as health concerns that may otherwise go unreported or uncontrolled.
- Don't be surprised if your patients tell you Mary Beth reminded them to make their appointment! Take it as a sign that the My Advocate program is doing its job. Encourage your patients to participate in the My Advocate program and help us nurture a well-educated and more communicative patient population. If an enrollee is not enrolled, they can call Member Services at the number on their ID card and request to speak to an obstetrics case manager.

For more information on My Advocate,
visit **www.myadvocatehelps.com**.

Healthy Rewards®

- We supply our pregnant moms with information to promote the best outcomes. We even offer reward dollars to moms who keep their prenatal, postpartum and well-baby appointments. She may receive up to $50 and her baby may receive up to $60 worth of rewards through Healthy Rewards for use at a variety of retailers.

How you can ensure your patients are receiving these rewards:

- Schedule an initial obstetrics visit within the first trimester or 42 days of enrollment with Amerigroup DC, and encourage the enrollee to enroll with Healthy Rewards.
- Complete the patient's postpartum checkup 7 to 84 days after delivery.
- Remind your patient that once their baby is born, the baby needs to see their provider for regular checkups and immunizations to keep their baby healthy.

  For the first 15 months of life, the baby should see their 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.
  - 15 months old.

For more information on Healthy Rewards,
visit **https://www.myamerigroup.com/dc**.

Enrollees may call Healthy Rewards for assistance at **1-888-990-8681**.

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

To keep us accountable to you and our enrollees, 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 enrollees are getting the preventive, acute and chronic health care services they need.

Timeliness of Prenatal Care

The *Timeliness of Prenatal Care* HEDIS measure looks at the percentage of enrollees 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 or within 42 days of enrollment with Amerigroup DC.

Make sure your medical record reflects evidence of the following:

- Documentation of when the prenatal care was initiated or the date of the enrollee's first prenatal visit
- Last menstrual period and/or expected date of delivery
- Complete OB history
- Prenatal risk assessments and counseling/education
- Prenatal care procedure that was performed at each visit:
  - Basic physical examination that includes auscultation for fetal heart tone, pelvic exam with OB observation or measurement of fundus
  - Screening test in the form of an obstetric panel
  - Torch antibody panel
  - Rubella antibody/titer with RH incompatibility (ABO/RH blood typing)
  - Ultrasound (echocardiography) of pregnant uterus
- 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

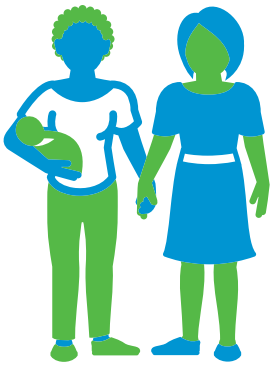
The Postpartum Care HEDIS measure captures the percentage of deliveries that had a postpartum visit on or between 7 to 84 days after delivery (a day early or a day late does not count). Call patients to schedule the postpartum visits as well as remind them of their appointment dates and times. Be sure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

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

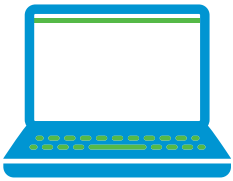
- Pelvic exam
- Evaluation of weight, blood pressure, breasts and abdomen (Notation of breastfeeding is acceptable for the evaluation of breasts component.)
- Notation of postpartum care (for example, six-week check, postpartum care, PP care, PP check)
- Make sure the postpartum date is on the claim

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	



Availity's *Maternity Application*



We've partnered with Availity, the vendor supporting the benefit look-up tool you may currently use in your OB office, to send us information about newly identified pregnant women. This process, including the *Maternity Application* form, helps connect patients with additional benefits as soon as possible. The reporting process includes a few simple steps.

Use the Availity platform to let us know you've identified a pregnant Amerigroup DC enrollee.

Just follow these simple steps:

- Perform an eligibility and benefits request on an Amerigroup DC enrollee and choose one of the following benefit service types: maternity, obstetrical, gynecological, obstetrical/gynecological.
- Before you see the benefit results screen, you will be asked if the enrollee is pregnant and given a *Yes* or *No* option. If you indicate Yes, you will be asked what the estimated due date is. Fill in that date if you have an estimate or leave it blank if you do not.
- After you submit your answer, you will be taken to the benefits page. In the background, a *Maternity Application* form will be generated for this patient in the maternity application in Payer Spaces for Amerigroup DC.

Centering pregnancy

We work directly with the Centering Healthcare Institute to promote and encourage providers to adopt the Centering Pregnancy model of care:

- Participants experience their prenatal care visits in a group setting with other pregnant women of a similar gestational age.
- Women 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 — including increased birth weight.

Nurse-Family Partnership® (NFP) and Healthy Families America (HFA)

To give extra care to our enrollees having their first babies, we also partner with the NFP and HFA programs where available. In these programs, a nurse visits the enrollee throughout her pregnancy and birth until the baby is 2 or 3 years old; the nurse provides education, community assistance and support.

Prior preterm pregnancy program

If we identify an enrollee who is at risk for having a subsequent premature infant, our case managers will notify you and provide information on 17 alpha-hydroxyprogesterone caproate (17P) therapy.[1] For more information on the benefits of 17P and how to obtain it, contact Provider Services or your Provider Relations representative.

1 *Prediction and prevention of preterm birth. Practice Bulletin No. 130*. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012;120:964-73. Reaffirmed 2018.

Diabetes in Pregnancy

In an effort to help your patients maintain healthy blood sugar levels throughout pregnancy, reduce the probability that babies will be born weighing greater than 4,500 grams and, thereby, reduce the potential for cesarean section, Amerigroup DC offers the Diabetes in Pregnancy program to support you and your patients. In addition to having an OB case manager, your enrollee will have access to a registered dietitian nutritionist/certified diabetic educator who will serve as a resource and subject matter expert for the OB case manager and will co-manage pregnant enrollees with diabetes. The program includes providing meal planning assistance, physical activity interventions, weight gain interventions and monitoring blood sugar patterns.

Preeclampsia and prenatal aspirin

Increasing provider awareness in recognizing women 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.

Amerigroup DC recognizes the opportunity to collaborate with our obstetrical care providers to improve women's health and pregnancy outcomes by:

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

The United States Preventive Services Task Force[3] recommends aspirin for women with one or more of the following high-risk conditions:

- Prior pregnancy with preeclampsia
- Multifetal gestation
- Diabetes
- Hypertension
- Renal disease
- Autoimmune disease (e.g., lupus and antiphospholipid syndrome)

2 *Low-dose aspirin use during pregnancy. ACOG Committee Opinion No. 743*. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;132:e44–52.

3 F*inal Update Summary: Low-Dose Aspirin Use for the Prevention of Morbidity and Mortality From Preeclampsia: Preventive Medication*. U.S. Preventive Services Task Force. September 2016

Substance use and screening in pregnancy

- As our nation struggles to deal with the serious health risks posed by the opioid epidemic, Amerigroup DC recognizes your role at the front lines of defense and supports you. Pregnancy offers women 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. Women who screen positive should be immediately engaged in a brief conversation that may or may not identify a need for treatment, and a referral 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 **https://www.samhsa.gov/sbirt**.
- SBIRT is a covered benefit for Amerigroup DC enrollees.

  For more information on SBIRT reimbursement or coding, visit **www.medicaid.gov** > Medicaid > Program Integrity > National Correct Coding Initiative.
- 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, Amerigroup DC 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 **https://findtreatment.samhsa.gov** or call the SAMHSA National Helpline at **1-800-662-HELP (4357)/TDD: 1-800-487-4889**.

- 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. Pregnant women benefit from parenting education as early as possible in their pregnancies so they 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/product/SMA18-5054**.

Caring for babies born with neonatal abstinence syndrome/neonatal opioid withdrawal syndrome (NAS/NOWS)

- While traditional care for infants in 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 reveal some concerning structural brain changes and changes in neurotransmitters. While few follow-up studies exist, those that are 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 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 medications if nonpharmacologic care is not sufficient.
  - Inter-rater reliability testing when using standard assessment tools (such as modified Finnegan).

Strict rooming-in protocols, rather than placement in neonatal intensive care units, combined with extensive parent education programs improve family involvement and have been shown to reduce lengths of stay and the need for treatment of infants with NAS. When mothers are in stable treatment programs or are stable on safely prescribed medications, breastfeeding has also been shown to reduce the symptoms of NAS.

Perinatal and postpartum depression

- Perinatal and postpartum depression 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 be used during the pregnancy and postpartum periods, including:
  - The Edinburgh Postnatal Depression Scale.
  - Patient Health Questionnaire-9.
  - A complete list of screening instruments can be found at **https://tinyurl.com/ACOG-list**.
- 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 care providers, if needed, to offer the maximum support.
  - Reference and use appropriate community behavioral health resources (e.g., Women, Infants, and Children; Healthy Families America; etc.).
  - Ensure a process is in place for follow-up, diagnosis and treatment.

Breastfeeding support and breast pumps

- ACOG recommends exclusive breastfeeding for the first six months of life. As reproductive health experts and women's health advocates who work with a variety of obstetric and pediatric health care providers, OB/GYNs are uniquely positioned to enable women to achieve their infant feeding goals.
- ACOG has created a Breastfeeding Toolkit designed to help OB/GYNs and other women's health care providers do just that. You can access this resource online at **https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/publications/breastfeeding-toolkit-2016.pdf**. Be sure to start discussing breastfeeding early in prenatal care and include the mother's support person in breastfeeding education.

  Amerigroup DC may cover the cost of a standard, non-hospital-grade electric breast pump. Authorization is required for hospital-grade breast pumps.

Family planning and long-acting reversible contraception (LARC)

- ACOG recommends having a conversation with your patient in their third trimester regarding immediate postpartum placement of LARC as an effective option for postpartum contraception; there are few contraindications to postpartum intrauterine devices and implants.[4]
- Please follow the American Academy of Pediatrics guidance and provide additional counseling and support to your teenage and young patients (ages 13 to 19), as this group is at the greatest risk for early discontinuation of these methods.[5] Additional information about postpartum placement of LARC can be found at **www.acog.org**.

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 rupture of membranes greater than 36 hours before delivery, a postpartum hemorrhage or extensive genital lacerations should be referred for interval insertion.

4 *Immediate Postpartum Long-Acting Reversible Contraception. Committee Opinion No. 670.* American College of Obstetricians and Gynecologists. Obstet Gynecol 2016; 128:e32–7.

5 *Contraception for Adolescents. Committee On Adolescence*. Pediatrics Oct 2014, 134 (4) e1244-e1256; DOI: 10.1542/peds.2014-2299

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

Q. Does placement of an IUD in the postpartum period increase a woman's 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. "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%. 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 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."[6]

Q. When should patients be seen in 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.

6 *The American College of Obstetricians and Gynecologist Committee Opinion. Immediate Postpartum Long-Acting Reversible Contraception Number 670*, August 2017. **https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2016/08/immediate-postpartum-long-acting-reversible-contraception**

Zika virus

- Zika virus was declared a worldwide health emergency in February 2016. It is a mosquito-borne virus that poses a risk in pregnant women of serious birth defects, including microcephaly and other brain abnormalities. The virus can be sexually transmitted. Guillain-Barré syndrome has also been reported in patients following suspected Zika virus infection.
- The CDC has established a Zika Registry for pregnant women exposed to the virus. There is no treatment or vaccine for Zika virus infections. Medical care is directed at alleviating symptoms.

  The focus is on prevention of exposure by avoiding travel to areas with active Zika transmission and by protecting against mosquito bites.
- Recommendations on counseling, diagnosis and testing of persons exposed, including pregnant women and women considering pregnancy, can be found at **http://www.cdc.gov/zika/hc-providers/index.html**.

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, American Indian, and Alaska Native women are 2 to 3 times more likely to die from pregnancy-related causes than white women.[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.
- We encourage you to adopt standardized protocols for quality improvement as one possible way to reduce race and ethnicity's impact in your patients' outcomes.

7 **https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html**

You and Your Baby in the NICU

You and Your Baby in the NICU program

- For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the **You and Your Baby in the NICU program**.
- Parents receive education and support on important topics, including visiting the NICU, being involved in the care of their babies, interacting with hospital care providers and preparing for discharge.
- Parents are provided with an educational resource that outlines successful strategies they may use to collaborate with the care team.

NICU Post Traumatic Stress Disorder (NICU PTSD) program

- Another component of You and Your Baby in the NICU is the **NICU Post Traumatic Stress Disorder (NICU PTSD) program**.
- The NICU PTSD program seeks to improve outcomes for families of babies who are in the NICU by screening and facilitating referral to treatment for PTSD in parents.
- This program supports mothers and families at risk for PTSD due to the stressful experience of having a baby in the NICU.
- Case managers will reach out by phone to parents of babies who have been in the NICU for 30 days or more. They will screen and facilitate referral for treatment of PTSD.

For any questions about the various programs or if you would like more information on OB/NICU case management programs, please call Provider Services or your Provider Relations representative.

* Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup, District of Columbia, Inc. Change Healthcare is an independent company managing the My Advocate program on behalf of Amerigroup, District of Columbia, Inc.

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All enrollee 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 enrollees. Your state/provider contract(s), Medicaid, enrollee benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our enrollees and meet the HEDIS measure for quality reporting based on the care you provide our enrollees. Please note: The information provided is based on HEDIS 2018 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.

https://providers.amerigroup.com/DC

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