

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 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.
- Incentives to keep up with prenatal and postpartum checkups and well child visits after the baby is born.

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 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 program enrollees 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

- Identified pregnant women have access to education and resources on pregnancy, labor and delivery, postpartum care and well-child care via the Amerigroup enrollee website. Enrollees may also contact Enrollee Services at the number on their ID card to request a guide.



## My Advocate<sup>®\*</sup>

- As part of the Taking Care of Baby and Me program, enrollees are offered the My Advocate program, managed by Change Healthcare.\* This program provides pregnant and postpartum enrollees proactive, culturally appropriate outreach, and education through interactive voice response. Eligible enrollees receive regular calls with tailored content from a voice personality — Mary Beth — in English or Spanish, or they may choose to access the program via smartphone application 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 enrollees who have become high-risk, to facilitate connections between them and our case managers, and to improve enrollees and baby outcomes.



- Each automated My Advocate communication gives the enrollees specific health care education in a warm, easy-to-understand fashion. Eligible enrollees receive twice-weekly messages with tailored content from Mary Beth. 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 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 the Enrollee 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](http://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.



### 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, 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 stay healthy.

For the first 15 months of life, the baby should see a provider at:

- |                    |                 |                  |
|--------------------|-----------------|------------------|
| ■ 3 to 5 days old. | ■ 4 months old. | ■ 12 months old. |
| ■ 1 month old.     | ■ 6 months old. | ■ 15 months old. |
| ■ 2 months old.    | ■ 9 months old. |                  |

For more information on Healthy Rewards, visit <https://provider.amerigroup.com/DC>.

Enrollees 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 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.

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

**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, 99202-99205, 99211-99215, 99241-99245, 99500	<ul style="list-style-type: none"> <li>■ 0500F — initial prenatal visit</li> <li>■ 0501F — routine prenatal visit</li> <li>■ 0502F — subsequent prenatal visit</li> </ul>



## 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
<b>CPT:</b> 57170, 58300, 59430, 99501, 0503F	<b>CPT:</b> 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622
<b>ICD-10-CM:</b> Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2	
<b>HCPCS:</b> G0101	





## Availity's Maternity Form

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 Form*, helps connect patients with additional benefits as soon as possible. The reporting process includes a few simple steps.



We encourage you to use the Availity platform to let us know you've identified a pregnant Amerigroup enrollee.

### Just follow these simple steps:

- Perform an Eligibility and Benefits (E&B) request on the desired enrollee.
- Choose one of the following benefit service types: maternity, obstetrical, gynecological, or obstetrical/gynecological.
- Before the benefit results screen, you will be asked if the enrollee is pregnant. Choose Yes, if applicable. If you indicate Yes, you will be asked when is the estimated due date. Fill in that date if you know it or have an estimate. You may leave this field blank if the due date is unknown. However, please provide this information by accessing the *Maternity Form* once you know the due date.
- After submitting your answer, the E&B will display. If the enrollee was identified as pregnant, a *Maternity Form* will now be available. You may access the form by navigating to the *Applications* tab and selecting the **Maternity** link.

## CenteringPregnancy

We support the Centering Healthcare Institute's goal to promote and encourage providers to adopt the CenteringPregnancy model of care. Centering Healthcare Institute is an independent organization that offers health information that Amerigroup enrollees may find helpful:

- 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. Nurse-Family Partnership and Healthy Families America are independent organizations that offer health information Amerigroup enrollees may find helpful. 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.<sup>1</sup> 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 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 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.<sup>2</sup>
- Close surveillance of blood pressure in pregnancy through in-office and at-home monitoring.
- Decreasing stress.

The United States Preventive Services Task Force<sup>3</sup> 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)

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

<sup>3</sup> *Final 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 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>.\* The Substance Abuse and Mental Health Services Administration is an independent organization that offers health information that Amerigroup enrollees may find helpful.
- SBIRT is a covered benefit for Amerigroup enrollees.

**For more information on SBIRT reimbursement or coding,** visit [www.medicaid.gov](http://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 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 **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. 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 mood disorders

- 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 may cover the cost of a standard, non-hospital-grade electric breast pump.

## 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.<sup>4</sup>
- Amerigroup reimbursement is the same for immediate postpartum placement and outpatient placement of LARC. 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.<sup>5</sup> Additional information about postpartum placement of LARC can be found at [www.acog.org](http://www.acog.org).\*

## How this benefit works

During an inpatient facility admission, you have the ability to implant the covered device of your patient's choice and receive the same reimbursement from Amerigroup as if the device was implanted in an outpatient setting. The inpatient facility will provide the device. Please work closely with your OB unit to understand the logistics of obtaining devices.

### 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.

#### 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 *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. 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. 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 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.”<sup>6</sup>

**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>







# 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.<sup>7</sup>
- 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.



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

## Newborn intensive care unit (NICU) case management:

- For parents with infants admitted to the neonatal intensive care unit (NICU), we offer the **NICU Case Management program**.
- This program provides education and support designed to help parents cope with the day-to-day stress of having a baby in the NICU, encourages parent/caregiver involvement, and helps them to prepare themselves and their homes for discharge.
- Highly skilled and specialized NICU case managers provide education and resources that outline successful strategies parents may use to collaborate with their baby's NICU care team while inpatient and manage their baby's health after discharge.
- Once discharged, NICU case managers continue to provide education and support to foster improved outcomes, prevent unnecessary hospital readmissions, and ensure efficient community resource consumption.



## NICU Post Traumatic Stress Disorder (NICU PTSD):

- The stress of having an infant in the NICU may result in post-traumatic stress disorder (PTSD) symptoms for parents and loved ones. To reduce the impact of PTSD among our enrollees, we assist by:
  - Guiding parent(s) into hospital-based support programs.
  - Screening parent(s) for PTSD approximately one month after their baby's date of birth.
  - Referring parent(s) to behavioral health program resources, if indicated.
  - Reconnecting with a one-month follow-up call to assess if the parent(s) received benefit from initial contact and PTSD awareness.

**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 Experience associate.**

\* 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.

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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://provider.amerigroup.com/DC>

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