Washington | Medicaid

Wellpoint

A message for providers **Taking Care of Baby and Me Provider Booklet**

We are committed to healthy outcomes for our members and their babies. That is why we encourage 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 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 (such as through notification from your office, enrollment files, and claims data), 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, delivery, postpartum, and well-child care, as well as a host of other topics via the Wellpoint 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 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 us to assess their pregnancy risk.

Digital Maternity Program (cont.)

- After 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, the program serves 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 Wellpoint to identify members who experience a change in risk acuity throughout the perinatal period.

We encourage healthcare providers to share information about the digital tools available to members. Members may access information about the products that are available by visiting our website:

- Each digital educational outreach provides the member 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 us 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, contact your OB practice consultant, Provider Services, or your provider relations representative.

Healthy Rewards®:

- We supply our pregnant members with information to promote the best health outcomes. We even offer incentives to members who keep their prenatal and postpartum appointments.
- 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 Wellpoint and encouraging the member to enroll with Healthy Rewards.
  - Completing the patient's postpartum checkup 7 to 84 days after delivery.

Members may call Member Services if they have questions about Healthy Rewards.

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.

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 OB practitioner, midwife, family practitioner, or other primary care provider. The visit must be:

- In the first trimester, on or before the enrollment start date or within 42 days of enrollment with Wellpoint.
- Documented with the prenatal care visit including one of the following:
  - Diagnosis of pregnancy
  - A physical examination that includes one of the following:
    - Auscultation for fetal heart tone
    - Pelvic exam with obstetric observations
    - Measurement of fundus height
  - Evidence that a prenatal care procedure was performed that may include one of the following:
    - Obstetric panel including hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing)
    - TORCH antibody panel alone
    - A rubella antibody test/titer with an RH incompatibility (ABO/Rh) blood typing
    - Ultrasound of a pregnant uterus
  - Documentation of LMP, EDD, or gestation age in conjunction with either of the following:
    - Prenatal risk assessment and counseling/education
    - Complete obstetrical history
- Prenatal-related billing codes:
  - Use the following codes to document services and visits for initial, routine, and subsequent prenatal care.

Timeliness of Prenatal Care (cont.)

Prenatal visit	Prenatal bundled services
CPT®: 99202-99205, 99211-99215, 99241-99245, 99483, 99500, 0500F-0502F	**CPT**: 59400, 59425, 59426, 59510, 59610, 59618
ICD-10-CM: O00-O9A, Z03.71-Z03.79, Z32.01, Z33.1-Z33.3, Z34.00-Z34.03, Z34.80-Z34.83, Z34.90-Z34.93, Z36.1-Z36.5, Z36.81-Z36.89, 36.9, Z3A.xx	
HCPCS: G0071, G0463, G2010, G2012, G2250-G2252, H1000-H1004, T1015	**HCPCS**: H1005

Postpartum Care

The Postpartum Care HEDIS measure captures the percentage of deliveries that had a postpartum visit on or between 7 and 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 the 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).
- Perineal or cesarean incision/wound check
- Screening for depression, anxiety, tobacco use, substance use disorder or preexisting mental health disorders.
- Glucose screening for those with gestational diabetes.
- Documentation of any of the following topics:
  - Infant care or breastfeeding
  - Resumption of intercourse, birth spacing, or family planning
  - Sleep/fatigue
  - Resumption of physical activity and attainment of healthy weight
- Postpartum-related billing codes:
  - Use the following codes to document services and visits for postpartum care.

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	

Washington Maternity Quality HEDIS tips:

- Virtual or in-person initial prenatal or postpartum appointments with **an RN** meet requirements as long as a credentialed provider cosigns the note, and it meets the criteria detailed above.
- Virtual or in-person initial prenatal or postpartum appointments with **any credentialed provider** meet requirements per the criteria detailed above.

Centering pregnancy:

We support the Centering Healthcare Institute's goal to promote and encourage providers to adopt the Pregnancy Centering model of care:

- Participants experience their prenatal care visits in a group setting with other pregnant women 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]

1 https://centeringhealthcare.org/what-we-do/centering-pregnancy (accessed July 2024)

Preeclampsia and prenatal aspirin

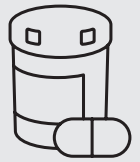
Increasing provider awareness in recognizing those at risk for developing preeclampsia and taking proactive measures can improve pregnancy outcomes, including decreasing the incidence of premature births, and both maternal and infant mortality.

We recognize 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)



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 2029, 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, we recognize your role at the front lines of defense and support 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 Wellpoint 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, we understand 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**.

Substance use and screening in pregnancy (cont.)

- 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 in the 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 improve family involvement and is shown to reduce lengths of stay and the need for pharmaceutical treatment of infants with NAS/NOWS. When mothers are in stable treatment programs and are stable on safely prescribed medications, breastfeeding has also been shown to reduce symptoms of 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.

Successful best practices:

- Screen pregnant patients at least once for depression and anxiety symptoms and complete a full assessment of mood and emotional well-being 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.
- Patients 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 (for example, Women, Infants, and Children; Healthy Families America).
- 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 healthcare providers do just that. You can access this resource online at **breastfeedingtoolkit2020 (acog.org)**. Be sure to start discussing breastfeeding early in prenatal care and include the patient's support person in breastfeeding education.

Wellpoint may cover the cost of a standard, non-hospital-grade electric breast pump. Members should contact Member Services to learn about their benefits.

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 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

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.

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).

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 backup 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.

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).

Newborn intensive care unit (NICU) case management

NICU Case Management Program

For parents with infants who are admitted to the NICU, we offer the NICU Case Management program:

- Parents receive education and support designed to help them cope with the day-to-day stress of having a baby in the NICU and 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 members, 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 Maternal Child Health offerings, please contact your OB practice consultant, Provider Services, or your provider relations representative.

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.

Learn more about Wellpoint programs
https://provider.wellpoint.com/wa

Coverage provided by Wellpoint Washington, Inc. Wellpoint Washington, Inc. profoundly acknowledges and respects the inherent sovereignty of the federally recognized tribes in Washington state. In our efforts to promote high-quality healthcare, we honor the tribal right of self-governance, holding in deep esteem the government-to-government relationship existing between the state and the tribes, a bond reiterated by the *Centennial Accord* and established by *RCW 43.376*. We heartily commit to enhancing our coordination, collaboration, and communication with tribal health programs and providers. Our activities are driven by an intent of respect, understanding, and recognition of the deeply rooted traditions and values of the tribal communities.

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