Anthem Blue Cross and Blue Shield |
MyCare Ohio

A message for providers
New Baby, New Life Provider Booklet

We are committed to keeping members and their babies healthy. That's why we encourage all of our pregnant members to take part in our New Baby, New Life℠ program.

The New Baby, New Life is a proactive care management program for all perinatal members and their newborns, which 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.

How it works

Once we identify a member as pregnant (through notification such as Anthem enrollment files, Availity Essentials, or claims data from your office), 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 Anthem member website. Members may also contact Member Services via the number on the back of their member ID card to request printed materials.

Digital care management

- As part of the New Baby, New Life 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 Anthem to assess their pregnancy risk.

Digital care management (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, 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 Anthem 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 offered at Anthem with their members. Members may access information about the products that are available by visiting the Anthem website.

- Each digital educational outreach offers members targeted healthcare education in a friendly, clear, and engaging way.
- What we want to achieve with this program:
  - Provide members with the information they need to participate in the management of their health.
  - Provide Anthem with a practical tool to identify members' conditions and concerns.
  - Encourage members to communicate more effectively with their healthcare providers.

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 contact Member Services via the number on the back of their member ID card to request to speak to an obstetrics case manager.

For more information on the digital care management program, please contact your provider relationship management representative.

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 measure looks at the percentage of members who had a live birth or delivery and received a prenatal care visit from an obstetrical 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 Anthem.
- 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, 59610, 99202-99205, 99211-99215, 99241-99245	• 0500F — initial prenatal visit • 0501F — routine prenatal visit • 0502F — subsequent prenatal visit

Postpartum Care

The Postpartum Care measure captures the percentage of deliveries that had a postpartum visit on or between seven 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 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 the breasts component)
- Notation of postpartum care (for example, six-week check, postpartum care, or postpartum 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 or breastfeeding
  - Resumption of intercourse, birth spacing, or family planning
  - Sleep/fatigue or resumption of physical activity and attainment of a healthier weight
- Make sure the postpartum date is on the claim

Group Prenatal Care

We support efforts to promote the adoption of 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 lifestyles.
- Participants experience positive results and outcomes.[1]

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	

Preeclampsia and prenatal aspirin

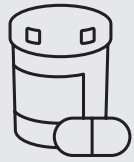
Increasing care provider awareness in recognizing those at risk for developing preeclampsia and taking proactive measures can improve pregnancy outcomes, including decreasing the incidence of premature births and both maternal and infant mortality.

Anthem 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.[1]
- Close surveillance of blood pressure in pregnancy through in-office and routine monitoring.
- Decreasing stress.

The United States Preventive Services Task Force[2] 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 Anthem members may find helpful.

Substance use and screening in pregnancy

- As our nation grapples with the serious health risks of the opioid epidemic, Anthem recognizes your vital role at the front lines and offers support. Pregnancy provides women an opportunity to break patterns of unhealthy behaviors. As an OB provider, you have a unique chance to help disrupt the cycle of opioid misuse and, in doing so, prevent negative health outcomes for both mother and baby.

- Screening, brief intervention, and referral to treatment (SBIRT) are recommended as part of the prenatal interview. A short screening conducted during 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 arrange 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 Anthem 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, Anthem 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://www.findtreatment.samhsa.gov** or call the SAMHSA National Helpline at **800-662-HELP (4357)/TDD: 800-487-4889**.

* The Substance Abuse and Mental Health Services Administration is an independent organization that offers health information that Anthem members may find helpful.

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 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 concerning 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 are 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.

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

Perinatal and postpartum mood disorders (cont.)

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.
- 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 a history of living with suicidal thoughts warrant close monitoring, evaluation, and assessment.
- Refer patients to mental health service care providers, if needed, to offer the maximum support.
- Reference and use appropriate community behavioral health resources (for example, Women, Infants, and Children or Healthy Families America). Women, Infants, and Children and Healthy Families America are independent organizations that offer health information that Anthem members may find helpful.
- 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.

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 healthcare 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** (**https://www.acog.org**). Be sure to start discussing breastfeeding early in prenatal care and include the mother's support person in breastfeeding education.

Anthem 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 the third trimester regarding immediate postpartum placement of LARC as an effective option for postpartum contraception. There are a few contraindications to postpartum intrauterine devices and implants.[3]

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

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%. 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 OB-GYN or other obstetric care provider and use a back-up contraceptive method."[4]

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

A. Patients should be seen between seven 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.

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 more likely, and American Indian and Alaska Native women are two times more likely, to die from pregnancy-related causes than white women.
- 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.

Learn more about Anthem programs

providers.anthem.com/oh

1 Centering Healthcare Institute. https://centeringhealthcare.org/what-we-do/centering-pregnancy.
2 Centering Healthcare Institute. https://centeringhealthcare.org/what-we-do/centering-pregnancy.
3 Low-dose aspirin use during pregnancy. ACOG Committee Opinion No. 743. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;132:e44–52.
4 Immediate Postpartum Long-Acting Reversible Contraception. Committee Opinion No. 670. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016;128:e32–7.
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.
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.
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.

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