ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	UM-025
Policy Name	Guidelines for Obstetrical Services
Department Name	Health Care Services
Department Chief	Chief Medical Officer
Policy Owner	Utilization Management Director
Lines of Business	All
Effective Date	12/4/2006
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

General Guidelines

A. The Alliance covers and ensures the provision of all medically necessary services for members who are pregnant and postpartum. All providers of obstetrical (OB) services to Members are required to follow the most current editions of:

1. Standards for Obstetric Services and Guidelines and Oral Health Care during Pregnancy and Through the Lifespan from the American College of Obstetricians and Gynecologists (ACOG).
2. Guidelines for Perinatal Care, The American Academy of Pediatrics
3. Guide to Clinical Preventive Services, Report of the U.S. Preventive Services Task Force.
4. Newborn Screening regulations as set forth in Title 17, California Code of Regulations, Section 6500 et seq.
5. Comprehensive Perinatal Services Program (CPSP) regulations as set forth in Title 22.
6. Maternity Care Clinical Recommendations & Guidelines, AAFP

B. In addition to medical OB services, all Members receive perinatal support services, including an initial comprehensive risk assessment, reassessments, interventions as determined by risk, and an Individualized Care Plan (ICP).

C. All Members may initiate perinatal services without prior authorization with any Alliance OB practitioner. Perinatal services include basic and low risk nutrition, health education, and psychosocial support services. Referrals for high-risk OB, dental anesthesia, nutrition, health education, and psychosocial services are processed through the regular authorization process.

Obstetrical Care by Certified Nurse Midwives and Certified Nurse Practitioners

A. Pregnant Members may receive perinatal care services from a Certified Nurse Midwife (CNM) and Certified Nurse Practitioners (CNP).

B. CNMs and CNPs must contract with the Alliance to care for Alliance Members.

C. Prenatal care initiation does not require prior authorization from a PCP.

D. Members have the right to obtain out-of-network CNM/CNP services if a CNM/CNP is not available in the Alliance network within the time and distance requirements.

PCP Role in Care of Pregnant Members

A. PCPs are responsible for assessing Member's health status, including potential pregnancy.

B. PCPs may provide prenatal care to pregnant Members within their scope of practice.

C. PCPs are responsible for referring pregnant Members for prenatal care to an obstetrical (OB) practitioner within the Alliance or referring Members for voluntary termination of the pregnancy if desired by the Member.

D. PCPs are responsible for coordination of care with the OB practitioner, if necessary.

E. Members may also self-refer for prenatal care and voluntary termination within the Alliance. Basic prenatal care or preventive services do not require pre-authorization.

F. Members of childbearing age are informed of the availability of comprehensive perinatal services and how to access such services as soon as pregnancy is determined.

G. Alliance provider credentialing standards are applied to all prenatal care providers.

Multi-Disciplinary Perinatal Services

A. All Members receive perinatal support services in addition to medical Obstetrical (OB) care. Support services are in the areas of nutrition, health education, dental and psychosocial issues, and are provided by a variety of multi-disciplinary staff as appropriate, including doula services.

B. The Alliance maintains a Memorandum of Understanding (MOU) with the Alameda County Public Health Department for Maternal and Child Health.

PROCEDURE

General Procedures

A. **Accessing Perinatal Services**:

1. Once the PCP, Case Management or any other practitioner has established that the Member is pregnant, the Member may initiate prenatal care from an Alliance OB Members may receive assistance from the PCP or Alliance Member Services in scheduling an appointment.
2. The initial prenatal visit must be made within one week of the request. Urgent prenatal visits must be scheduled the same day. Prenatal care should be initiated within the first trimester whenever possible. The initial prenatal visit may not be delayed for authorization.
3. Members may access basic support services without prior authorization. Basic services include the initiation of prenatal care visits, initial comprehensive risk assessment, all subsequent risk assessments each trimester, and low risk interventions conducted in the OB practitioner's office. Referrals for high-risk OB conditions, health education, nutrition, dental anesthesia, or psychosocial services are processed through the standard authorization process.

B. Initial Comprehensive Assessment (ICA). The ICA must be completed and documented at the initial prenatal visit, ideally within 4 weeks of entry to prenatal care. Providers must use a comprehensive risk assessment tool for all pregnant Members that is comparable to the ACOG standard and CPSP standards per 22 CCR section 51348. They must maintain the results of this assessment as part of the member's obstetrical record, which includes the following:

1. Physical examination to evaluate the Member's current condition, including height, weight, blood pressure, breast exam, abdominal and pelvic exams, and external and internal genitalia evaluation, as appropriate.
2. Comprehensive health and obstetrical history with information on past and current pregnancies, Estimated Delivery Date (EDD), menstrual history, family planning methods used, detailed history of past pregnancies and outcomes, medication sensitivities and allergies, family health and social history.
3. Nutritional assessment, to include dietary evaluation and prenatal vitamin/mineral supplementation.
4. Psychosocial assessment, to include past and present social and mental health history, substance use/abuse, support systems/resources.
5. Health Education assessment of language and education needs; and
6. Laboratory tests to include:
    a. Hemoglobin/hematocrit
    b. Urinalysis and microscopic examination or culture
    c. Urine testing to detect asymptomatic bacteriuria
    d. Blood group and Rh type determination
    e. Rubella antibody titer measurement
    f. Gonorrhea culture, VDRL/RPR and chlamydia
    g. Antibody screen
    h. Cervical cytology (Pap Smear)

i. Hepatitis B testing
j. TB screen as indicated by risk status
k. Toxicology screen as indicated by risk status

7. Assessment of diabetic risk factors necessitating glucose screening, and any risk factors that may affect treatment (e.g., other medical conditions, significant past medical history, etc.).
8. HIV testing and counseling.

C. Individualized Care Plan (ICP). The initial prenatal evaluation must also include the development of an ICP, and interventions as appropriate. Each identified risk must be followed up with appropriate interventions consistent with ACOG standards and CPSP standards that are documented in the medical record. The interventions must be designed to ameliorate or remedy the specified risk condition and for Medi-Cal members, must be consistent with the requirements of Title 22, CCR, Sections 51348 and 51348.1. Each Member's ICP must document the Member's risk condition(s) and include the following elements:

a. Identification of proposed interventions
b. Identification of method(s) of intervention (e.g., referral, counseling by a specifiedstaff person)
c. Anticipated outcome of intervention
d. Identification of staff person responsible
e. Members should receive care through a multi-disciplinary team approach, with interventions by various staff types as needed.

D. The risk assessment may be completed virtually through a telehealth visit with the member's consent. Whether the assessment is performed in person, telephonically, or by telehealth, it will be conducted in a manner that promotes full sharing of information in an engaging environment of trust and in a culturally and linguistically appropriate manner.

Subsequent Comprehensive Prenatal trimester re-assessments: Comprehensive prenatal re-assessments for risk factors must be completed once each trimester after the initial prenatal visit and at the postpartum visit, using a comprehensive risk assessment tool that is comparable to the ACOG standard and CPSP standards per 22 CCR section 51348, and include documentation of obstetric/medical, nutrition, psychosocial and health education re-assessments.

E. The OB practitioner assesses risk factors and the need to access appropriate specialists to assist in the provision of care, including perinatologists, Freestanding Birthing Centers, Certified Nurse Midwives, Licensed Midwives, Certified Nurse Practitioners, Doulas, and genetic screening. Alliance OB practitioners are responsible for the provision of counseling for nutrition, health education and psychosocial needs, or appropriate referrals to specialists and other services, as required.

F. If administration of the risk assessment tool is missed at the appropriate timeframes, the provider and the Alliance must ensure case management and care coordination are working directly with the member to accomplish the assessment.

G. Each Member's ICP must be reviewed in the second and third trimesters, and in the postpartum period. The ICP should be reviewed more often as the Member's risk status is required and updated accordingly.

H. All Members must receive a prescription for prenatal vitamins as a standard of care.

I. Ante partum Care

1. Visits for an uncomplicated pregnancy include an exam every four weeks for the first 28 weeks of pregnancy, every two to three weeks until 36 weeks of gestation, and weekly thereafter. Women with active medical or OB problems should be seen more frequently at intervals determined by the nature and severity of the problems.
2. Each ante partum visit must include the following:
   a. Measurement of blood pressure
   b. Weight
   c. Measured fundal height
   d. Fetal heart rate
   e. Urinalysis for albumin and glucose
3. The Alliance offers tests and screens recommended by ACOG at the appropriate times during the pregnancy, or as required.

J. Realizing that the pregnant Member has a variety of needs, Alliance allows perinatal services to be provided to Members by a variety of staff, within their scope of practice, as appropriate. Physicians, non-physician practitioners, nurses, medical assistants, social workers, dieticians, health educators, doulas or others may provide interventions as suitable.

K. Antenatal screening must be done when indicated to identify risks prior to pregnancy. Couples who have increased risks for producing abnormal offspring are offered the opportunity to undergo prenatal diagnostic studies after appropriate counseling.

L. OB practitioners are responsible for all education and specialized diagnostic referrals for their members. OB practitioners are responsible for the care and monitoring of pregnancy for Members, and coordination of all referrals and communication between specialists and PCPs.

1. Genetic Screening:
   a. Each pregnant Member receives screening and assessment for genetic risk factors. Members assessed as at risk for genetic disorders receive counseling and referrals, as appropriate.
   b. The initial prenatal evaluation must include a risk assessment and screening for genetic risk factors. Included in the assessment is a maternal serum alpha- fetoprotein (MSAFP) screen between 16-18 weeks of gestation.
   c. Factors which place Members at risk include:
      - Advanced maternal age (mother 35 years or older at expected time of

delivery)

- Previous offspring with a chromosomal aberration
- Chromosomal abnormality in either parent
- Family history of a sex-linked condition
- Ancestry indicating risk for Tay-Sachs, sickle cell anemia, or other hemoglobinopathies

d. Newborns must also be screened and referred for genetic disorder evaluation as appropriate.

M.

N. As the primary practitioner of care during pregnancy, the OB practitioner is responsible for identifying the newborn's Physician on the ante partum record. In addition, the OB practitioner, with the hospital, coordinates referral of the newborn to an Alliance PCP for inpatient newborn care and continuing outpatient care.

O. The OB practitioner is responsible for coordinating the care of the Member back to the PCP after the postpartum evaluation is completed.

P. Dental screening is included as a part of routine prenatal care and is also available through the PCP. The PCP is responsible for screening Members for dental and oral health and making referral for treatment as appropriate. Referral for dental care does not require prior authorization by the Alliance, and Members may self refers to Medi-Cal dental practitioners. Healthy Families and Healthy Kids Members may access dental care through their contracted Dental Plan. See Policy UM-024 "Coordination of Care – Dental Services".

Q. Pregnant Members may receive perinatal care services from a Certified Nurse Midwife (CNM) and Certified Nurse Practitioner, (CNP). CNMs/CNPs must meet Alliance's credentialing standards and be contracted with the Alliance. Services are limited to the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period. CNMs/CNPs must have physician back-up with an Alliance obstetrical practitioner who is contracted and credentialed by the Alliance and must be credentialed to perform obstetrical care in the same delivering facility in which the CNM has privileges.

R. High Risk Obstetrical Care:

1. High risk OB Members must be referred for evaluation and care if beyond the scope of practice of the initial prenatal practitioner. High risk indicators (or markers) include:

   a. Evidence or history of asthma, gestational diabetes, pre-eclampsia, or eclampsia
   b. Indication of multiple fetuses
   c. Prior C-sections
   d. History of complicated deliveries such as placenta previa or abruption placenta
   e. History of pregnancy difficulties such as incompetent cervix
   f. Prior premature labor and/or delivery
   g. History of substance use/abuse

h. Homelessness

i. Under 18 or over 35 years of age.

2. The Alliance ensures that appropriate hospitals are available within the network to provide high-risk pregnancy services.

S. Intra-partum Care

1. As a part of their prenatal care and counseling, all Members must be informed of the hospital where they are going to deliver.

T. Postpartum Care must include the following services:

1. A comprehensive postpartum review and examination is required between three and eight weeks after delivery. The postpartum assessment must include the following 4 components:

   a. Obstetric/medical exam: an interval history and physical examination to evaluate the Member's current condition that includes weight, blood pressure, breast exam, abdominal exam, external and internal genitalia evaluation, and laboratory tests, as necessary;

   b. Nutritional assessment: dietary intake of mom and infant feeding status, that includes evaluation of problems/needs of the breastfeeding mother;

   c. Psychosocial assessment: evaluation of Member's emotional status, resources, and available support system; and

   d. Educational needs assessment.

2. The development of an ICP and interventions as appropriate.

3. Family Planning Evaluation: This evaluation includes education on family planning and counseling, referral, and provision of services.

4. Referral to a pediatric practitioner for follow-up, as indicated.

5. Referral to the WIC program for State Program Members or Members that meet WIC's financial eligibility requirements (see Section 12E, "Referrals to the Supplemental Food Program for Women, Infants, and Children (WIC)").

6. Immunization information, including rubella, if appropriate.

7. Evaluation for special problems and return-to-work status, as indicated.

8. Referral to a Dentist for preventative care (exam/ cleaning) or therapeutic (extractions, fillings, abscess drainage, root canal), and to promote oral health for infants.

   a. <u>Medi-Cal Postpartum Care Extension (PCE) under the Provisions of American Rescue Plan Act (ARPA)"</u>

      - i. "Effective 4/1/2022, the Medi-Cal postpartum coverage period was extended from 60 days to 12 months for all Medi-Cal eligible pregnant individuals under the providers of the ARPA. The 12 month postpartum coverage period for Medi-Cal eligible pregnant individuals begins on the last day of pregnancy and will end on the last day of the month in which the 365th day occurs. ARPA PCE is an automatic postpartum extension"

- ii. "Minor Consent beneficiaries do not qualify for ARPA PCE, as eligibility is month-to-month and cannot be applied automatically."
- iii. The only allowable reasons that an individual can be discontinued from the ARPA PCE protections during their pregnancy and/or the 365-day postpartum period are as follows:
    - Death
    - Loss of California residency
    - Beneficiaries request for discontinuance
    - Receipt of Supplemental Security Income
    - Aid on another Case

Certified Nurse Midwives/Certified Nurse Practitioners

A. Once pregnancy has been established by the PCP, Members may either request initiation of prenatal care from an Alliance Obstetrician, CNM/NPor other qualified prenatal care practitioner, or receive assistance from the PCP or the Alliance in scheduling an appointment.

B. Members may receive services from any gynecological or obstetrical specialist provider (OB/GYN), certified nurse midwife, certified nurse practitioner, or within the Alliance Network. Alliance providers are listed in the Provider Directory.

C. The law states Medi-Cal Members may get family planning services from any family planning agency, clinic, or provider who is willing to accept Medi-Cal rates.

D. CNMs must have physician back up with an Alliance network obstetrical practitioner credentialed by the Alliance for consultation, high-risk referral, and delivery services, as needed.

1. The supervising and back-up physician or surgeon for the CNM must be credentialed to perform obstetrical care in the same delivery facility in which the CNM has delivery privileges.
2. The designated supervising physician or surgeon may not exceed the established ratio of 1:3 (full-time equivalent) CNMs.
3. The designated supervising or back-up physician is available in person or by electronic communication when the CNM is caring for patients.

E. The CNM must operate under written Standardized Procedures that are collaboratively developed and approved by the supervising physician, the CNM, and the administration within the Delegated Provider in which standardized procedures are used.

1. Standardized Procedures for the CNM define the scope of services provided by the CNM, and must identify the furnishing of drugs or devices, extent of physician or surgeon supervision, method of periodic review of competence, including peer review, and review of provisions in the Standardized Procedures.
2. Standardized Procedures and Supervisory Guidelines must undergo periodic review, and are revised, updated, and signed by the supervising physician and CNM at each change in scope of services.

3. A current copy of the Standardized Procedures must be available at each facility where services are rendered for members.

Each CNM that prescribes controlled substances must have a valid DEA Registration Number.

PCPs

A. PCPs are responsible for assessing whether a member is pregnant, including providing pregnancy testing as appropriate.

B. Once a member is determined to be pregnant, PCPs are responsible for determining whether the Member plans to carry the pregnancy to delivery or wishes to pursue a voluntary termination.

C. If the Member plans to continue the pregnancy, the PCP is responsible for referring the Member to an OB, or giving the Member a choice of OB practitioners, within the Alliance network.

D. For Members wishing to pursue voluntary termination of the pregnancy, PCPs are responsible for assisting with the referral to an Alliance provider.

E. For pregnant Members in prenatal care, PCPs are responsible for coordinating care with the OB practitioner as necessary, including but not limited to:

   1. Informing the OB by phone or in writing of any significant medical conditions that may impact, or be impacted, by the pregnancy.

   2. Coordinating referrals with the OB for any necessary specialty care needed for the Member.

F. Providing updates to the OB during the pregnancy of changes in the Member's medical status as needed.

Multi-Disciplinary Perinatal Services

A. Members must have an Individualized Care Plan (ICP) developed that outlines a plan for addressing specific risks. These services are to be offered in the medical, health education, nutrition, and psychosocial areas. Participation in support services is voluntary, and Members have the right to refuse any or all the services offered.

B. Members may access basic perinatal support services from an obstetrical provider within the Alliance Provider Network, without prior authorization from the Alliance. Examples of basic perinatal support services include:

   1. Basic nutritional counseling for women at low nutritional risk due to minor dietary deficiencies.

   2. Basic health education interventions include counseling regarding exposure to secondhand smoke, counseling regarding alcohol use during pregnancy, etc.

   3. A basic psychosocial intervention for women with low-risk conditions such as counseling women regarding sibling rivalry, and expectations for the pregnancy.

C. Basic perinatal support services are generally provided by one of the multi-disciplinary staff members in the perinatal practitioner's office. Examples of staff that can provide basic services include:
   1. MD or DO
   2. Nurse Practitioner
   3. Certified Nurse Midwife
   4. RN
   5. LVN
   6. Medical Assistant
   7. Social Worker
   8. Health Educator
   9. Health Care Worker

D. The Alliance ensures that pregnant and postpartum members are referred to Doulas as required under W&I Code section 14132.24.

E. Multi-disciplinary staff members in a perinatal practitioner's office only provideservices within their scope of licensure and appropriate training.

F. Members needing perinatal support services for high-risk conditions identified through the risk assessment tool are referred for appropriate intervention utilizing the Providers referral authorization process. Examples of high-risk conditions are outlined in Policy 12D1, "Guidelines for Obstetric Services."

G. . Perinatal support services for Members with high-risk conditions are generally provided outside the perinatal practitioner's office by licensed professionals including:
   1. Registered Dietitian
   2. Health Educator with master's level degree
   3. MFCC or LCSW

Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS

None.

AFFECTED DEPARTMENTS/PARTIES

All Alliance Departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

CMP-015 Minor Consent to Medical Care
HED-010 Doula Services
UM-024 Coordination of Care – Dental Services

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACMENTS

None

REVISION HISTORY

1/1/2008, 10/28/2009, 9/6/2012, 4/14/2014, 01/10/2016, 12/15/2016, 04/16/2019, 5/21/2020, 5/20/2021, 6/28/2022, 6/20/2023, 04/24/2024

REFERENCES

1. DHCS Contract Exhibit A, Attachment 10. Provision 7
2. Title 22, CCR, Sections 51240, 51241, 51348, 51348.1
3. California Business and Professional Code 2725
4. W&I Code section 14132.24
5. Title 17, California Code of Regulations, Section 6500 et seq.
6. DHCS MMCD Policy Letter 12-003, Obstetrical Care-Perinatal Services
7. American Rescue Plan Act of the 117th Congress 2021-2022 (ARPA) (Pub. Law 117-2)

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Healthcare Quality Committee annually.