

New York State Medicaid Prenatal Care Standards

November, 2009

Prenatal care standards in New York State (10 NYCRR, Part 85.40) were developed in early 1990 in response to the creation of the Prenatal Care Assistance Program (PCAP), a prenatal care program developed to provide for comprehensive perinatal care to low income, high risk pregnant women. The most recent revision of these standards occurred in 2000. Changes in the clinical standards of prenatal care since that time necessitate a review of Part 85.40 standards to compare them to current professional standards of practice which address new challenges and concepts in prenatal care. In order to accomplish this task, the Department partnered with the Island Peer Review Organization (IPRO) to review the existing PCAP standards and compare them to current American College of Obstetricians and Gynecologists (ACOG) guidelines¹, new recommendations in prenatal care, as well as other national guidelines of obstetric practice to determine the need to modify the prenatal standards as they become applied to all Medicaid prenatal providers.

The Office of Health Insurance Programs, in collaboration with the Division of Family Health, IPRO and a statewide advisory workgroup made up of key stakeholders in the field of prenatal care were charged with the responsibility for developing this revised set of Medicaid Prenatal Care Standards for New York State. Steps in the process included:

- Literature review and comparison of Part 85.40 with current ACOG guidelines and other evidence-based literature;
- Stakeholder meetings to discuss current standards of practice;
- Summary proposal with recommendations for revised standards;
- Revisions to Article 25, New York State Public Health Law; and
- Draft Medicaid Prenatal Care Standards for review and subsequent adoption.

The Department would like to express its appreciation to all the external stakeholders who gave of their time and shared their expertise in the field of prenatal care to assist us in the development of prenatal care standards for the NYS Medicaid Program.

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A. REQUIREMENTS

1. General requirements:

- a) Prenatal care providers shall create and maintain records and reports that are complete, legible, retrievable and available for review by representatives of the Commissioner of Health upon request. Such records and reports shall include the following:
 - i) a comprehensive prenatal care record for each pregnant woman which documents the provision of care and services received and which is maintained in a manner consistent with medical confidentiality requirements;
 - ii) special reports and data submissions as necessary for the Commissioner of Health;
 - iii) records of internal quality assurance;
 - iv) all written policies and procedures required by this section; and
 - v) data submissions in electronic form as requested by the Commissioner of Health in compliance with the most current Department of Health policies for health information exchange in New York State.
- b) Prenatal care providers shall comply with all federal, state and local laws and regulations regarding the disclosure of protected medical information when sharing or transferring medical information with other healthcare providers or facilities. Providers shall therefore obtain written informed consent from patients prior to transfer of medical records or information where required by law.
- c) Prenatal care providers shall comply with the requirements to obtain informed consent for all services described herein, in accordance with all applicable laws and regulations.
- d) Any subcontracts between the prenatal care providers and other agents or agencies providing care and services shall:
 - i) be available for review and inspection by the Department of Health; and
 - ii) require that subcontractors provide contracted care and services that meet the minimum standards established in this section and are provided in accordance with generally accepted standards of practice and patient care services.
- e) Prenatal care providers shall participate in quality improvement initiatives as requested by the Commissioner of Health.

2. Provider/Staff requirements:

- a) Prenatal care services, including prenatal diagnostic and treatment services, provided to pregnant women and postpartum women shall meet generally accepted standards of care as described by the most current American Academy of Pediatrics (AAP) and ACOG guidelines for perinatal care and shall be provided by a qualified provider practicing as:
 - i) a licensed physician practicing in accordance with Article 131 of the New York State Education Law and must be either an obstetrical care physician (MD/DO), Board

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- Certified or Board Eligible in their area of specialty, or have completed an accredited residency program in Family Practice or Obstetrics/Gynecology;
- ii) a nurse practitioner practicing in accordance with Article 139 of the New York State Education Law and certified in the specialty of obstetrics/gynecology;
 - iii) a licensed Midwife practicing in accordance with Article 140 of the New York State Education Law; or
 - iv) a registered physician's assistant practicing in accordance with Part 94 of this Title, Article 37 of the NYS PHL and article 131 of the NYS Education Law.
- b) Prenatal care providers shall promote the delivery of prenatal care services in a culturally sensitive/competent manner to all pregnant women including those with limited English proficiency and diverse cultural and ethnic backgrounds. Interpretation services must be offered to patients whose primary language is not English, in person when practical, or via telephone if a translator is not immediately available.
- c) Prenatal care providers must either have admitting privileges at one or more hospitals or shall develop agreements with planned delivery sites including a system for sharing patient information for continuity and follow-up care.
3. Provider/Specialist/Consultation Requirements:
Prenatal care providers shall provide pregnant women timely access and referral to appropriate levels of prenatal care, (basic, specialty, and subspecialty), based on her assessed risk status in order to prevent, recognize and treat conditions associated with maternal and infant mortality and morbidity.²
- a) Management of pre-existing medical conditions - Providers shall provide or arrange for the provision of care for the specific needs of a pregnant woman with a pre-existing medical condition, according to current standards of practice.
 - b) Transfer of care - Practices shall develop criteria requiring transfer of primary responsibility for patient care from a family medicine practice physician, physician's assistant, licensed midwife or nurse practitioner to an obstetrician and/or maternal-fetal medicine specialist (high risk obstetrician or perinatologist).
 - c) Specialty physician consultation/referral – Prenatal care providers shall develop criteria for consultation and referral for care to a maternal-fetal medicine specialist, perinatologist, high risk obstetrician, specialty physician, behavioral health specialist, including licensed social worker or other health care specialist as necessary based on the identification of specific risk factors or medical conditions requiring additional specialty monitoring and management. Prenatal care providers should follow AAP/ACOG's early and on-going pregnancy risk specific recommendations for consultation.³ Referrals for specialty provider consultations should include:
 - i) a description of the indication for the consult,
 - ii) the role of the consultant during the initial consult

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- iii) the role of the consultant during the follow-up care throughout the stages of pregnancy, and
- iv) the sharing of patient/clinical information between the primary care obstetrical provider and the special care consultant. ⁴

B. ACCESS TO CARE

1. Any pregnant woman who presents for prenatal care should begin receiving care as quickly as possible, preferably the same day. All prenatal care service providers must provide prenatal care services to recipients determined to be presumptively eligible for medical assistance but are not yet enrolled in Medicaid.
2. Prenatal care providers shall assist or refer women for assistance with application for medical assistance and managed care plan selection in accordance with procedures established by the Commissioner.
3. Prenatal care practices must provide or arrange for the provision of 24 hour/7 day week coverage (after hours and weekend/vacation number to call that leads to a person or message that can be returned by a health care professional within one hour). Pregnant women shall have access to unscheduled or emergency visits on a 24 hour basis.⁵
4. Prenatal care providers must develop systems, or arrange for reminder/call backs to patients needing continued or follow-up services, and for visits requiring follow-up for abnormal test results. Prenatal care providers shall outreach to patients to reschedule missed appointments in a manner that maintains patient confidentiality.
5. Prenatal care providers shall schedule prenatal care visits for an uncomplicated pregnancy consistent with AAP/ACOG recommendations. Pregnant women with medical, obstetrical and/or psychosocial problems may require more frequent visits. The need for increased surveillance is best determined by the prenatal care provider based on the individual needs of the woman, and the nature and severity of her problems.

C. PRENATAL RISK ASSESSMENT, SCREENING AND REFERRAL FOR CARE

Prenatal care (PNC) providers shall conduct a comprehensive prenatal care risk assessment for both maternal and fetal risks, at the earliest prenatal care visit, on all pregnant women.

1. The risk assessment shall include but not be limited to an analysis of individual characteristics affecting pregnancy, such as genetic, nutritional, environmental, behavioral health, psychosocial and history of previous and current obstetrical/fetal and medical/surgical risk factors. Prenatal care providers are encouraged to use a standardized written risk

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assessment tool, such as the ACOG, Hollister or POPRAS form. Using established criteria for determining high risk pregnancies, the prenatal care provider shall determine the woman's risk status based on generally accepted standards of practice.

The risk assessment shall be:

- a) reviewed at each visit;
 - b) repeated formally early in the third trimester;
 - c) used to form the basis for the development of the care plan and;
 - d) documented clearly in the medical record.
2. Based on results of the risk assessment and the individual woman's increased risk for a poor pregnancy outcome, the prenatal care provider shall refer the pregnant woman for follow-up care. Referrals for such care may include but are not limited to: prenatal case management programs provided by managed care plans, other case management programs, home visitation agencies, or community-based programs for prenatal care coordination.
 3. In accordance with Public Health Law section 2530-a 2.3. Prenatal care providers shall complete a standardized New York State Prenatal Care Risk Screening Form, which summarizes the results of the comprehensive risk assessment (as described in C.1.) for each new pregnancy. The completion of this risk screening form once during the pregnancy and reporting of the information shall be with the pregnant woman's informed written consent and shall be in a format to be developed by the Commissioner. If consent and voluntary participation is obtained, prenatal care providers shall complete the New York State Prenatal Care Risk Screening Form at the earliest prenatal care visit and transmit the information in a confidential manner to be determined by the Commissioner.

D. PSYCHOSOCIAL RISK ASSESSMENT, SCREENING, COUNSELING AND REFERRAL FOR CARE

Prenatal care providers shall conduct a psychosocial risk assessment of all pregnant women during the first prenatal care visit. The assessment should be reviewed at each visit and formally repeated early in the third trimester and postpartum to identify important issues that may have developed over time. The assessment shall include a broad range of social, economic, psychological and emotional problems. Screening should include but not be limited to assessment of barriers to care, unstable housing, communication barriers (i.e. language and /or cultural barriers), nutrition, tobacco use, substance use, depression or other psychiatric illness, safety, domestic abuse, sexual abuse, and stress. Based on the results of this assessment the providers shall identify areas of concern, validate major issues with the patient, provide information, and if indicated, provide treatment or make appropriate referral(s).

The psychosocial risk assessment shall include but not be limited to screening for the following⁶:

1. Tobacco Use – Prenatal care providers shall assess all pregnant women about their past and present use of tobacco and exposure to second hand smoke. All pregnant women should be

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advised to avoid or minimize time spent in the presence of tobacco smoke. The patient who smokes should be strongly advised to stop smoking and be provided with tailored counseling to assist in smoking cessation. Patients who smoke shall be offered a referral to an appropriate smoking cessation education and/or treatment program.⁷

2. Substance Use – Prenatal care providers shall assess all pregnant women about their past and present use of all substances, including drugs, alcohol, or the use of any prescription or nonprescription medications, including herbal supplements. The possible effects of any substances used before or during pregnancy should be discussed. A woman who acknowledges the use of any substances should be counseled about the implications of their use during pregnancy, and strongly encouraged to refrain from use of any substances that may negatively affect her or her fetus. If appropriate the woman should be offered a referral to a treatment program.
3. Domestic Violence – Prenatal care providers shall screen all pregnant women for domestic violence. Descriptions of domestic abuse from the patient should be documented in the patient’s medical record, safety of the patient and family shall be ascertained and referrals made to appropriate counseling, legal and social-service advocacy programs.
4. Depression – Prenatal care providers shall screen pregnant and postpartum women for depression utilizing an appropriate screening tool, and should have a system in place to ensure that positive screening results are followed by accurate diagnosis, implementation of treatment, and follow-up either within the practice or through referral.

E. NUTRITIONAL SCREENING, COUNSELING AND REFERRAL FOR CARE

Prenatal care providers shall provide or arrange for the provision of nutritional and physical activity screening, counseling and referral which includes:

1. Individual nutritional risk assessment including an assessment of pre-pregnancy BMI, weight gain to date, if any, and specific nutritional risks at the initial prenatal care visit and continuing reassessments as needed;
2. Documentation of the nutritional assessment, risk status and the plan of care in the patient’s medical record;
3. Referral of pregnant women identified as being at nutritional risk for specific nutritional counseling, monitoring and follow-up;
4. Provision of basic nutrition education and counseling for each pregnant woman which includes:

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- a) appropriate dietary intake and recommended dietary allowances during normal pregnancy;
 - b) recording of height and weight at the initial prenatal visit to allow for the calculation of the BMI and sequential weight monitoring at each visit. Parameters of appropriate weight gain should be made based on the pre-pregnancy BMI categories recommended in the 2009 Institute of Medicine (IOM) guidelines⁸;
 - c) a focused approach to nutrition counseling based on AAP/ACOG guidelines which includes exercise and lifestyle changes for all women, but particularly for women with a BMI in the obese (BMI>30) or underweight (BMI<18.5)⁹ range; and
 - d) counseling and education regarding infant feeding choices discussed with the woman during prenatal visits and immediately postpartum. Prenatal care providers should support breast feeding by counseling the patient regarding the nutritional advantages of human breast milk and should provide her with information regarding the benefits of breast feeding for both the mother and infant. Exclusive breastfeeding is recommended for the first 6 months of life and should be continued along with supplemental foods through the second half of the first year of life and for as long as desired thereafter. Breastfeeding is not recommended for HIV positive women and may be medically contraindicated in other situations. Income eligible women considering breastfeeding should be referred to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) for breastfeeding education and support.
5. Referral of pregnant women identified as needing to access proper nutrition and assistance in obtaining supplemental food to programs such as the Supplemental Nutritional Assistance Program (SNAP) or the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).
6. Special considerations for underweight and/or overweight/obese women:
- a) Prenatal care providers shall assess and counsel underweight and overweight/obese women regarding the increased risk for pregnancy complications related to their weight and encourage these women to participate in a lifestyle improvement program, including diet, exercise, and behavior modification.
 - b) Prenatal care providers shall consider screening obese patients for gestational diabetes upon presentation or in the first trimester, and repeat screening later in the pregnancy if results are initially negative.¹⁰

F. HEALTH EDUCATION

Prenatal care providers shall provide or arrange for the provision of health and childbirth education based on an assessment of the pregnant woman's individual needs. Prenatal care

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providers should focus on the pregnant woman's ability to comprehend the information and use materials appropriate to the educational, cultural and language needs of the patient as well as her gestational history. Such services shall be provided by professional staff, documented in the medical record and shall include but not be limited to the following:

1. Rights and responsibilities of the pregnant woman;
2. Signs and symptoms of complications of pregnancy;
3. Physical activity, exercise and recommended weight gain during pregnancy;
4. Avoidance of harmful behaviors including the use of alcohol, drugs, non-prescribed medications and nicotine;
5. Sexuality during pregnancy;
6. Occupational and environmental concerns including lead exposure;
7. Risks of HIV infection and risk reduction behaviors;
8. Signs of labor;
9. Labor and delivery process and availability of various delivery options;
10. Relaxation techniques in labor;
11. Obstetrical anesthesia and analgesia;
12. Preparation for parenting including infant development and care, options for feeding and the benefits of breast feeding;
13. Newborn screening program, including the distribution of newborn screening literature;
14. Family planning and optimum inter-pregnancy interval.

G. DEVELOPMENT OF A CARE PLAN AND CARE COORDINATION

Prenatal care providers shall develop a care plan jointly with each pregnant woman which addresses the problems identified as a result of the initial and ongoing risk assessments. The care plan shall describe the implementation and coordination of all services required by the pregnant woman, be routinely updated and implemented jointly by the pregnant woman, her family and the appropriate members of the health care team.

1. Care shall be coordinated to:
 - a) Ensure that relevant information is exchanged between the prenatal care provider and other providers, health plan case managers or sites of care including the anticipated delivery site.
 - b) Ensure that the pregnant woman and her family or other designated representative, with her consent, have continued access to information resources and are encouraged to participate in the decisions involving the care and services being provided.
 - c) Encourage and assist the pregnant woman in obtaining necessary medical, dental, nutritional, psychosocial, drug and substance abuse services appropriate to her identified needs.

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- d) Provide the pregnant woman with an opportunity to receive prenatal and postpartum home visitation when medical and/or psychosocial benefits may be derived from the visits.
 - e) Provide to or refer the pregnant woman for needed services as identified in the risk assessment.
 - f) Obtain special tests and services that may be recommended or required by the Commissioner of Health, when necessary to protect maternal and/or fetal health. Pregnant women shall be provided appropriate medical care, counseling and education based on test results.
2. The prenatal care provider shall coordinate labor and delivery services by developing agreements with planned delivery sites which address, at a minimum, the following:
- a) a system for sharing prenatal medical records, including HIV test results;
 - b) pre-booking of women for delivery by 36 weeks gestation for low risk pregnancies and by 24 weeks gestation for high risk pregnancies;
 - c) scope of services; and
 - d) sharing of delivery/birth outcome information.
3. The prenatal care provider shall arrange for postpartum home visitation care as necessary and available when the mother and/or newborn may derive medical, physical and/or psychosocial benefits from such visits.

H. PRENATAL CARE SERVICES

Prenatal care providers shall provide or make arrangements for the provision of comprehensive prenatal care services in accordance with generally accepted standards of professional practice, as outlined by the AAP and ACOG.¹¹

1. Prenatal diagnostic and treatment services shall include but not be limited to the following:
- a) Comprehensive assessment – An initial comprehensive assessment including history, review of systems, and physical examination.
 - b) Standard and special laboratory tests – Based on AAP/ACOG recommendations, standard and special laboratory tests and procedures should be performed at the recommended gestational age.

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- c) Follow-up, evaluation of results and referral – Follow-up shall be conducted as indicated based on abnormal findings from the comprehensive assessment, results of preliminary abnormal laboratory test findings and repeat testing of women considered to be at high risk. Prenatal care providers shall discuss the following with the pregnant woman:
 - i) findings from the comprehensive assessment,
 - ii) results of all laboratory tests,
 - iii) recommendations for additional testing,
 - iv) treatment options and obtaining informed consent for treatment,
 - v) technological support and referrals as necessary.

2. HIV Services

a) Prenatal HIV Counseling and Testing

Prenatal care providers shall provide HIV counseling to all pregnant women as early as possible in the pregnancy without regard to risk. Counseling shall be provided and informed consent obtained prior to HIV testing and shall be consistent with the requirements described in Article 27F of the Public Health Law and NYCRR Title 10 Section 63.3. A repeat third trimester test, preferably at 34 – 36 weeks should be routinely recommended to all pregnant women who tested negative early in prenatal care to identify sero-conversion after an initial negative prenatal HIV test.¹² The New York State Department of Health Informed Consent to Perform HIV Testing (DOH Form – 2556), allows the pregnant woman to receive counseling for both tests at the initial counseling and to sign for both tests at that time.

The pregnant woman should be counseled about benefits to knowing her HIV status, specifically the significant reduction in risk of mother-to-child HIV transmission with the provision of antiretroviral (ARV) prophylaxis to HIV-positive women during pregnancy, at delivery and to the newborn. The pregnant woman should be informed that if she does not have a prenatal test, she will be HIV-counseled again when she presents for delivery, and that expedited testing will be done on her, with her consent, or on the newborn, without her consent. She should also be told that all newborns are routinely screened for HIV as part of the Newborn Screening Program, as a final safety net to identify exposed infants.

Pregnant women who receive negative test results should be provided with their results and if at continued risk for developing HIV, encouraged to access HIV prevention programs and services appropriate to their risk(s). Pregnant women who receive positive HIV test results should be provided with post-test counseling consistent with Public Health Law section 2781 and Part 63 regulations and will be provided necessary care and/or appropriate referrals for services.¹³

Prenatal care providers should transfer information regarding a prenatal patient's HIV counseling and testing status, including a copy of the result, if one exists, to the delivery setting. Routine consent procedures for the transfer of medical records are sufficient to authorize the transfer of HIV-related information to health care providers.

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b) Care of an HIV-Positive Pregnant Woman

Management of antiretroviral (ARV) medications during pregnancy should be done by, or in consultation with, an experienced HIV specialist familiar with state and federal clinical guidelines for the care of HIV-positive pregnant women and the prevention of mother-to-child HIV transmission. Breastfeeding is not recommended for HIV-positive women where there are good alternatives.

3. Dental care

The prenatal care provider shall conduct an assessment of the woman's oral health care needs at the first prenatal care visit. The assessment shall include but not be limited to interviewing the patient regarding current oral health problems, previous dental problems, and the availability of a dental provider. Pregnant women identified as having a current oral health problem or not having a dental visit in the past six months should be referred to a dentist as soon as possible, preferably before 20 weeks gestation. The prenatal care provider shall educate the pregnant woman about the importance of oral health and that dental care is safe during pregnancy. Oral health care should be coordinated between the prenatal care provider and the dentist.¹⁴

4. Immunizations

Pregnancy is not an absolute contraindication to any vaccination. Some vaccines are strongly recommended for pregnant women during the prenatal period. Many women will not be up-to-date and each pregnant woman should be evaluated for immunization status. Guides for immunizing during and after pregnancy are available from the Centers for Disease Control and Prevention (CDC)¹⁵ and the New York State Department of Health Bureau of Immunization.¹⁶

- a) All pregnant women shall be evaluated for serologic evidence of immunity to rubella at their first prenatal visit, unless known to be immune by documentation of a previous test. Varicella immunity shall also be assessed by either a reliable history of disease, laboratory evidence of previous disease or documented receipt of two doses of vaccine.
- b) Influenza vaccine is strongly recommended for all pregnant women due to the increased risk of influenza-related complications among pregnant women. Pregnant women should only receive the trivalent inactivated influenza vaccine (TIV), and not the live attenuated influenza vaccine (LAIV), the nasal spray.
- c) The following immunizations are recommended for women at risk for these diseases and who do not have a history of immunity:
 - i) Hepatitis B - A pregnant woman's risk of acquiring Hepatitis B Virus (HBV) should be assessed along with her risk of acquiring other sexually-transmitted infections. Pregnant women who have been identified as being at risk for HBV infection should be vaccinated. Pregnancy is not a contraindication for HBV vaccination, and limited evidence does not suggest any fetal harm from the HBV vaccine.

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- ii) Tetanus, Diphtheria/Tetanus, Diphtheria, Pertussis booster (Td/Tdap) - Pregnant women who have not received a Td booster within the last 10 years and require immediate protection against tetanus and diphtheria (ie. wound prophylaxis) should be vaccinated with Td based on the severity of the risk of tetanus and the need to be immunized. Immunization with Td during pregnancy is preferred in the 2nd or 3rd trimester.
 - iii) Tdap may be administered during pregnancy if the woman requires protection from pertussis. Tdap is not contraindicated during pregnancy; however, data on its safety and effect on newborn immune response to the primary DTaP series is limited.
- d) Other pregnancy related immunization issues:
- i) New York State Public Health Law 2500-e requires that every pregnant woman be tested for the presence of hepatitis B surface antigen (HBsAg) and that the test results and the date are documented in the prenatal record. It also requires that infants of women who are hepatitis B surface antigen positive or whose test results are unknown receive treatment at birth with hepatitis B vaccine and hepatitis B immunoglobulin (HBIG).
 - ii) New York State Public Health Law 2112 (effective July 1, 2008) prohibits the administration of vaccines containing more than trace amounts of thimerosal, a mercury-containing preservative, to pregnant women, unless the supply is insufficient. There is no evidence that thimerosal causes harm to the pregnant woman or her fetus.
- e) Postpartum Period – The following vaccinations or a history of immunity are recommended for all postpartum women: influenza, MMR (measles, mumps, rubella), Tdap, varicella and human papilloma virus. An adult schedule should be checked for appropriate indications in regard to age, previous history of disease or prior history of vaccination.¹⁷

Women who plan to breastfeed can and should receive vaccinations as no evidence exists of any risk to a mother or her infant if she is vaccinated while breastfeeding.

Breastfeeding is not a contraindication to any vaccination, with the exception of vaccinia vaccine.

5. Lead Poisoning Prevention, Testing and Management

As required by NYS Public Health Law and Regulations (NYCRR Subpart 67-1.5), prenatal health care providers shall provide all pregnant women with anticipatory guidance on preventing lead poisoning, information on the major sources of lead and the means to prevent exposure. At the initial prenatal visit, each pregnant woman shall be assessed for exposure to lead by using a risk assessment questionnaire recommended by the State Commissioner of Health.¹⁸ If the pregnant woman responds “yes” to even one of the questions, she is considered to be at risk, and

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should have a blood lead test and be counseled on how to eliminate lead exposure. Pregnant women found to have a confirmed blood lead level of 10 micrograms per deciliter (mcg/dL) or greater should be provided with risk reduction counseling and follow-up testing in accordance with NYS Department of Health guidelines. In addition, all pregnant women with a confirmed blood lead level of 10 mcg/dL or greater who may have been occupationally exposed to lead should be referred to an occupational health clinic for individual guidance. All women should receive anticipatory guidance on the prevention of childhood lead poisoning at their postpartum visits. Consultation for medical management of a lead poisoned pregnant woman is available from the Regional Lead Resource Centers (RLRC).¹⁹

Prenatal care providers are required to adhere to the most current New York State Department of Health guidelines for the prevention, identification and management of lead poisoning in pregnancy, as described in *Lead Poisoning Prevention Guidelines for Prenatal Care Providers – NYSDOH & ACOG District II, June, 2009*.²⁰

6. Use of Ultrasound

Prenatal care providers must document the medical indication for performing an ultrasound examination of a pregnant patient based on identified need. Ultrasound for gestational dating is recommended, especially before 20 weeks, if there is a size-date discrepancy or imprecise menstrual dates.²¹ Ultrasonography shall be provided only by physicians or technologists who have undergone training and only when there is a valid medical indication for the examination documented in the woman's medical record by a qualified prenatal care provider.²² AAP/ACOG guidelines should be followed when recommending an ultrasound exam. Common indications for ultrasound include but are not limited to evaluation for gestational age; fetal number, viability, placenta location, abnormal amniotic fluid volume, fetal growth disturbances, fetal anomalies and aneuploidy screening.²³

7. Screening for Genetic Disorders

Prenatal care providers shall offer all pregnant women additional maternal/fetal screenings to identify fetal abnormalities/genetic problems as follows:

- a) Birth defects – Prenatal care providers shall offer all pregnant women screening tests to identify birth defects at specific times throughout the prenatal period based on AAP/ACOG recommendations.
- b) Invasive diagnostic testing for aneuploidy should be available to all women regardless of maternal age. Early amniocentesis (at less than 15 weeks gestation) should not be performed.²⁴
- c) Pregnant women should be counseled regarding the differences between screening and invasive diagnostic testing for aneuploidy including a discussion of the risks and benefits of the invasive test compared with other available screening tests. Pregnant women who

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choose not to undergo invasive diagnostic testing for aneuploidy shall be offered aneuploidy screening before 20 weeks gestation regardless of maternal age.²⁵

- d) Prenatal care providers should offer information on cystic fibrosis screening to all couples and cystic fibrosis carrier screening should be offered to all couples regardless of race or ethnicity.²⁶
- e) Prenatal genetic screening or diagnosis should be offered to pregnant women based on personal and family history. Genetic screening and counseling criteria should be based on AAP/ACOG recommendations. This includes screening for genetic disorders based on racial and ethnic background, such as hemoglobinopathies (sickle cell, α -thalassemia, β -thalassemia), Tay-Sachs disease, Canavans disease and familial dysautonomia, cystic fibrosis and other genetic disorders based on family history.²⁷

8. Fetal Well-Being

Tests of fetal well-being are indicated in the presence of specific maternal and pregnancy-related conditions and shall be performed based on the judgment of a qualified prenatal care provider according to individual patient need.²⁸ There are several tests used in clinical practice to assess fetal status, each test has advantages, disadvantages as well as risks. The prenatal care provider, based on clinical judgment and recommended AAP/ACOG guidelines should choose the test that best meets the needs of the pregnant woman and her fetus and initiate testing at the appropriate gestational age. The test results and the interpretation shall be discussed with the pregnant woman, documented in the medical record and appropriate referrals initiated as soon as possible.

I. POSTPARTUM SERVICES

The prenatal care provider shall schedule a postpartum visit based on the woman's identified needs and in accordance with AAP/ACOG's recommended schedule, (approximately 4 – 6 weeks after delivery but no later than eight weeks after delivery; women with a complicated gestation or delivery by cesarean section should have a visit scheduled within 7 – 14 days of delivery). The visit should include an interval history and a physical examination to evaluate the patient's current status and her adaptation to the newborn.

1. The visit shall include but not be limited to the following:
 - a) identify whether any medical, dental, psychosocial (including depression), nutritional (including breastfeeding), tobacco/smoking cessation needs, alcohol and drug treatment needs of the mother or infant are being met;
 - b) provide anticipatory guidance on the prevention of childhood lead poisoning;
 - c) refer the mother or other infant caregiver to resources available for meeting identified needs and provide assistance in meeting such needs where appropriate;

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- d) assess family planning/contraceptive needs and provide advice and services or referral when indicated;
 - e) provide appropriate inter-conception counseling including information such as recommended preconception daily intake of folic acid (400 mcg) as per CDC and ACOG guidelines and encourage a preconception visit prior to subsequent pregnancies;
 - f) refer the infant to preventive and special care services appropriate to his/her needs;
 - g) advise the mother/caregiver of the availability of Medicaid eligibility for infants; and
 - h) advise or refer the mother for assistance with an application for on-going medical care assistance for herself, in accordance with her financial status, health assistance program eligibility and the policies and procedures established by the Commissioner of Health and the State of New York.
 - i) recommend that overweight/obese women continue a nutrition and exercise regimen after pregnancy to encourage weight loss before attempting another pregnancy.²⁹
2. The prenatal care provider shall arrange for postpartum home visitation as necessary when the mother and/or newborn may derive medical, physical and/or psychosocial benefits from such visits.
3. Postpartum documentation by the prenatal provider shall include: delivery outcome, maternal physical exam, health status of the mother/infant including medical, nutritional, psychosocial needs with referrals.

References

¹ American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (AAP/ACOG). *Guidelines for Perinatal Care, Sixth Edition*. October, 2007.

² AAP/ACOG, Chapter 2, pgs. 2 and 8.

³ ACOG Guidelines Appendix B and C pages 385 -388.

⁴ Maternal Fetal Medicine Society. *Recommendations to Address Documentation Guidelines for level of Involvement in Consultation/co-management of Obstetric Patients*, pgs. 1 – 3.

⁵ AAP/ACOG Guidelines, pg. 87.

⁶ ACOG Committee on Health Care for Underserved Women. Committee Opinion. *Psychosocial Risk Factors: Perinatal Screening and Intervention*, Vol. 108 (2), August, 2006; pgs. 469 – 477.

⁷ Medicaid currently covers up to six (6) smoking cessation counseling sessions within a 12-month period. Effective January 1, 2010, Medicaid will cover smoking cessation counseling for up to 180 days postpartum.

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⁸ Institute of Medicine (IOM). *Weight Gain During Pregnancy: Reexamining the Guidelines*. Washington, DC: The National Academies Press. Posted online May 28, 2009.

⁹ IOM. *Weight Gain During Pregnancy: Reexamining the Guidelines*. Washington, DC: The National Academies Press. Posted online May 28, 2009.

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