



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Dear Colleagues:

The weeks after birth are a critical period for a woman and her infant, setting the stage for long-term health and well-being. There is a need to educate health care providers and patients on the importance of attending postpartum visits and leveraging postpartum care as a doorway to future to future health. During my presidential term, I convened a task force with the goal of redefining the concept of the postpartum visit by reevaluating the timing and content of postpartum care.

The Redefining the Postpartum Visit Task Force revised the American College of Obstetricians and Gynecologists' Committee Opinion on postpartum care (Committee Opinion No. 732, *Optimizing Postpartum Care*) to reflect the importance of the "fourth trimester" period. Instead of a single visit, the new Committee Opinion recommends that services and support should be tailored to each woman's individual needs. It is recommended that all women have contact with their health care providers within the first 3 weeks of the postpartum period. This initial assessment should be followed up with individualized ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth. The Committee Opinion also highlights the importance of health care providers counseling women who have experienced pregnancy complications, as well as women who may have chronic conditions, to receive timely follow-up care with their obstetrician-gynecologists or primary care providers to reduce the risks of short-term and long-term complications.

We recognized the importance of educational tools to help health care providers implement more comprehensive postpartum care in their practices. To this end, the task force developed the online ACOG Postpartum Toolkit that serves as a companion piece to the revised Committee Opinion. The toolkit includes resources on the key components of postpartum care such as long-term weight management, pregnancy complications, reproductive life-planning, and a sample postpartum checklist for patients to complete before their visit. Reimbursement guidance also is provided in the toolkit.

I would like to thank the members of the Redefining Postpartum Care Task Force, which included Alison Stuebe, MD, MSc; George Saade, MD; Diana Ramos, MD, MPH; Tamika Auguste, MD; Maria Manriquez, MD; Wanda Nicholson, MD, MPH; Carolyn Zelop, MD; John P. Keats, MD, CPE; Mary Rosser, MD, PhD; Martha Gulati, MD, MS; Judette Louis, MD; Elizabeth M. Alderman, MD; Catherine McCarthy, MD; Ira Kantrowitz-Gordon, PhD; Jamille Nagtalon-Ramos, EdD, MSN, WHNP, IBCLC; Florence Momplaisir, MD, MSHP; Zsakeba Henderson, MD; David Chelmow, MD; Tina Sherman; and ACOG staff, including Christopher Zahn, MD; Debra Hawks, MPH; Ijeoma Obidegwu, MPH; Donna Tyler; and Nevina Jakopin. The efforts of the task force, individually and collectively, were coordinated by Alison Stuebe, MD, MSc.

Sincerely,

Haywood L. Brown, MD



Introduction

Childbirth and the postpartum period are exciting and special life experiences for many women and their families. This is also a period of physical, mental, and social change. Although many women and infants transition through this time uneventfully, some women find it overwhelming or develop significant health issues that may persist for weeks and months after giving birth. This “fourth trimester” period can present considerable challenges for women, including lack of sleep, fatigue, pain, breastfeeding difficulties, lack of sexual desire, and urinary incontinence.

Postpartum depression is common and often is associated with physical and relationship problems. Women with postpartum depression are less likely to attend their postpartum visits or vaccinate their children in a timely manner. Nearly 70% of women describe at least one physical problem during the first 12 months in the postpartum period (1). For 25% of these women, the problem is deemed to be of moderate severity and 20% have severe problems (2). As the severity of postpartum problems increases, there is a corresponding increase in women’s functional limitations, including their ability to work, look after children, or undertake household tasks.

The standard postpartum visit has traditionally been a single visit. This visit was typically scheduled 6 weeks after birth. Currently, as many as 40% of women do not attend a postpartum visit (3). There are several barriers for women who seek postpartum services, including lack of child care, inability to get an appointment, mistrust of health care providers, and limited understanding of the value of the visit (4). These barriers are even more challenging for low-resource populations. More than one half of U.S. women receive prenatal care through Medicaid, and in states that have not expanded Medicaid under the Affordable Care Act, women lose insurance coverage by 60 days after birth.

Optimal postpartum care provides an opportunity to promote overall health and well-being. The American College of Obstetricians and Gynecologists recommends that postpartum care should be an ongoing process, rather than a single encounter, with services and support tailored to each woman’s individual needs. The ACOG Postpartum Care Toolkit includes resources on the key components of postpartum care such as long-term weight management, pregnancy complications, and reproductive life-planning to support adoption and implementation of improved postpartum care.

References

1. Cheng CY, Fowles ER, Walker LO. Continuing education module: postpartum maternal health care in the United States: a critical review. *J Perinat Educ* 2006;15:34–42.
2. Haran C, van Driel M, Mitchell BL, Brodribb WE. Clinical guidelines for postpartum women and infants in primary care—a systematic review. *BMC Pregnancy Childbirth* 2014;14:51.
3. Optimizing postpartum care. ACOG Committee Opinion No. 736. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2018;131:e140–50.
4. Verbiest SB, Tully KP, Stuebe AM. Promoting maternal and infant health in the 4th trimester. *Zero to Three* 2017;37:34–44.



Immunization During the Postpartum Period

General Principles

- Immunization in the postpartum period is a simple and effective way to protect the woman and her child from certain infections, particularly when the woman was not immunized during pregnancy. Although obstetrician–gynecologists encourage women of childbearing age to be current with their immunizations before the peripartum period, postpartum maternal immunization can prevent acute maternal infection and potential spread of illness from the woman to her newborn. Infants of breastfeeding women acquire maternal antibodies through breast milk.
- It is recommended that all household members and caregivers who will be in contact with the newborn be up to date with routine vaccines, particularly influenza and tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap).
- All vaccines except smallpox can be given to breastfeeding women. The yellow fever and meningococcal (MenB) vaccines must be administered cautiously and only in cases for which the benefits outweigh the risks. Avoid administering yellow fever vaccine to women who are breastfeeding because of the theoretical risk of transmitting the 17D virus to the breastfed infant. If travel to regions where yellow fever is endemic or epidemic cannot be postponed, the woman should receive yellow fever vaccine. There are limited data about the use of meningococcal vaccines in lactating women. Vaccination should be deferred unless the woman is at increased risk.

Vaccine Recommendations for Postpartum Women

General guidance for vaccine administration for women in the postpartum period is provided as follows. However, for specific recommendations, refer to the Centers for Disease Control and Prevention links provided below:

- Women without documentation of previous Tdap vaccination need to receive the Tdap vaccine. <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6207a4.htm>
- Women who did not receive influenza vaccination during pregnancy need to be vaccinated during the flu season (October through May).
- Women may need other adult vaccines, including hepatitis A, hepatitis B, pneumococcal, or meningococcal, depending on their health history, risk factors, or where they work. <https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html>
- Women who tested susceptible to rubella during prenatal testing need to receive a single dose of the measles–mumps–rubella (MMR) vaccine. <https://www.cdc.gov/vaccines/pregnancy/hcp/guidelines.html>

- Women who are not immune to chicken pox need to receive two doses of single-antigen varicella vaccine, 4–8 weeks apart. Evidence of immunity to varicella includes documentation of age-appropriate varicella vaccination, laboratory evidence of immunity or laboratory confirmation of the disease, or birth in the United States before 1980.
<https://www.cdc.gov/vaccines/pregnancy/hcp/guidelines.html>
- Because of the importance of rubella and varicella immunity among women of childbearing age, the postpartum vaccination of women who do not have evidence of immunity to rubella or varicella with MMR, varicella, or MMR, vaccines should not be delayed because of receipt of anti-Rho(D) globulin or any other blood product during the last trimester of pregnancy or at delivery. Any reduction in immunity caused by anti-Rho(D) globulin or other blood products is outweighed by the opportunity to generate immunity.
- The human papillomavirus (HPV) vaccine is not recommended during pregnancy. Women inadvertently vaccinated during pregnancy should wait until after pregnancy to finish any remaining HPV vaccine dose. For women 26 years and younger who have not received the HPV vaccine, the series should be initiated in the postpartum period.
- Live vaccines are safe to administer to breastfeeding women. Should multiple live vaccines be indicated in the postpartum period, the vaccines should be administered during the same visit or at least 28 days apart. <https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html>
- The American College of Obstetricians and Gynecologists has developed toolkits for [HPV](#), [Tdap](#), [influenza](#), and a [comprehensive immunization toolkit](#) that includes coding guidance. The American College of Obstetricians and Gynecologists also has an immunization applet found within the [ACOG app](#).

References

1. Centers for Disease Control and Prevention. Chickenpox (varicella): clinical overview. Atlanta (GA): CDC; 2016. Available at: <https://www.cdc.gov/chickenpox/hcp/clinical-overview.html>. Retrieved June 27, 2018.
2. Centers for Disease Control and Prevention. Guidelines for vaccinating pregnant women. Atlanta (GA): CDC; 2017. Available at: <https://www.cdc.gov/vaccines/pregnancy/hcp/guidelines.html>.
3. Center for Disease Control and Prevention. Recommended Immunization Schedule for Adults Aged 19 Years or Older, United States, 2018. Atlanta (GA): CDC; 2018. Available at: <https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html>.
4. Updated recommendations for use of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap) in pregnant women--Advisory Committee on Immunization Practices (ACIP), 2012. Centers for Disease Control and Prevention (CDC). MMWR Morb Mortal Wkly Rep 2013;62:131-5. Available at: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6207a4.htm?s_cid=mm6207a4_w.

Resources

The American College of Obstetricians and Gynecologists Clinical Guidelines

- ❖ Human papillomavirus vaccination. Committee Opinion No. 704. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2017;129:e173–8.

Covers the role of HPV vaccine in the prevention of cervical cancer, as well as other anogenital cancers and genital warts. It includes information about the timing, safety, and efficacy of bivalent, quadrivalent, and 9-valent HPV vaccines, as well as specific recommendations for pregnant and lactating women.

- ❖ Influenza vaccination during pregnancy. ACOG Committee Opinion No. 732. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2018;131:e109–14.
Recommends obstetrician–gynecologists and all obstetric care providers advocate for influenza vaccination, provide the influenza vaccine to pregnant patients during any trimester, and receive the influenza vaccine themselves every season.
- ❖ Integrating immunizations into practice. Committee Opinion No. 661. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2016;127:e104–7.
Covers the role of obstetrician–gynecologists and other health care providers in vaccine administration and disease prevention. This guideline includes information about how obstetrician–gynecologists and other health care providers initiate and improve immunization programs in their practice.
- ❖ Update on immunization and pregnancy: tetanus, diphtheria, and pertussis vaccination. Committee Opinion No. 718. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2017;130:e153–7.
Covers the critical role of Tdap vaccination during pregnancy for the prevention of pertussis in newborns before they can get their own vaccines. This updated guidance includes information about the recommended timing for Tdap vaccination during pregnancy, and the safety and efficacy of Tdap vaccination during pregnancy.

Health Care Provider Resources for Patient Care

- ❖ American College of Obstetricians and Gynecologists. Immunization for women. Available at: <http://www.immunizationforwomen.org/>. Retrieved March 1, 2018.
ACOG’s immunization website features the latest news and information on vaccinations for women.
- ❖ Centers for Disease Control and Prevention. ACIP: guidance for vaccine recommendations for pregnant and breastfeeding women. Atlanta (GA): CDC; 2017. Available at: <https://www.cdc.gov/vaccines/acip/committee/guidance/rec-vac-preg.html>. Retrieved March 1, 2018.
- ❖ Centers for Disease Control and Prevention. Create a circle of protection around babies. Atlanta (GA): CDC; 2016. Available at: <https://www.cdc.gov/vaccines/pregnancy/family-caregivers/index.html>. Retrieved March 1, 2018.
- ❖ Centers for Disease Control and Prevention. FDA approval of an extended period for administering VariZIG for postexposure prophylaxis of varicella. *MMWR Morb Mortal Wkly Rep* 2012;61:212.
- ❖ Centers for Disease Control and Prevention. Maternal vaccines: part of a healthy pregnancy. Atlanta (GA): CDC; 2016. Available at: <https://www.cdc.gov/vaccines/pregnancy/pregnant-women/index.html>. Retrieved March 1, 2018.
- ❖ Immunization Action Coalition. Available at: <http://www.immunize.org/>. Retrieved March 1, 2018.
Provides more than 250 CDC-reviewed staff educational materials and patient handouts in several languages.

Coding

See [Coding for Immunization](#) (HPV, MMR, Varicella)



Postpartum Complications

Introduction

- The effects of pregnancy on many organ systems begin to resolve spontaneously after birth of the infant and delivery of the placenta. The timeline for resolution is not necessarily linear and not the same for all organs or tissues. Women in the postpartum period should be monitored for postpartum complications. Frequency of follow-up depends on specific issues encountered during childbirth and the immediate postpartum period.
- A thorough understanding of the labor and delivery process, including procedures (eg, perineal lacerations repair, episiotomies, operative vaginal deliveries, and cesarean deliveries) used for specific circumstances, is especially helpful when caring for the patient who develops a postpartum complication. Box 1 provides sample guidance for patients on how to perform pelvic floor exercises that will strengthen the muscles that surround the openings of the urethra, vagina, and rectum.
- Comprehensive prenatal care incorporates key elements of the postpartum phase into patient counseling. Anticipatory counseling in the prenatal period guides patient expectations regarding routine procedures and postpartum changes, both normal and abnormal. Equipping women with knowledge of the childbirth process and the postpartum period empowers them to understand what to expect, recognize changes, and be able to advocate for their health care needs.

Urinary Incontinence

Background

- The prevalence of urinary incontinence (UI) varies widely in the postpartum period, ranging from 3% to 40%.
- For many women, urinary incontinence resolves spontaneously during the first 3 months of the postpartum period and the prevalence decreases to a range of 11–23% in the 3–12 months of the postpartum period.
- Risk factors include vaginal delivery, increased duration of second stage of labor, older age, greater parity, increased body mass index, excess maternal weight gain during pregnancy, fetal weight (more than 4 kg), family history, and UI during pregnancy.

Screening and Diagnosis

- Women's health care providers should routinely discuss incontinence at the postpartum visit to confirm spontaneous resolution or evaluate the need for further therapy in those with persistent UI symptoms.
- A urine culture should be obtained to rule out urinary tract infection.

Treatment

- Pelvic floor muscle (Kegel) exercises are effective at strengthening the muscles that surround the urethra, vagina, and anus and should be recommended for women with symptoms of UI who are in the postpartum period.
- Health care providers can instruct and coach women on Kegel exercises (see Box 1).
- Health care providers should consider focusing on modifiable risk factors, such as obesity and smoking, to decrease the incidence of UI.
- Current data are conflicting, but physical therapy with pelvic floor muscle training may be used to treat women with persistent postpartum UI at 3 months after delivery.

Anticipatory Guidance and Follow-up

- Anticipatory counseling in the antepartum period is necessary to educate patients and set expectations.
- Consider referral to urogynecology if UI is persistent and disturbing to the patient.
- Urogynecology assessment
 - helps to identify issues that require more immediate action (eg, revision of an obstetric laceration breakdown)
 - affords an opportunity to educate patients about the pelvic floor, the role of Kegel exercises, and biofeedback training or pelvic floor physical therapy, or both, if deemed appropriate
 - provides reassurance to the patient
 - The American College of Obstetricians and Gynecologists has developed a Patient FAQ on Urinary Incontinence.
- Long-term follow-up is necessary to assess stability of results

Box 1. Kegel Exercises

Patient Education FAQ-012

<https://www.acog.org/Patients/FAQs/Pelvic-Support-Problems>

- With an empty bladder, squeeze muscles used to stop flow of urine
- Hold for 3 seconds, then relax for 3 seconds
- Do 10 contractions at least three times a day
- Increase hold by 1 second each week up to 10-second holds
- Breathe normally through these exercises

Fecal Incontinence

Background

Up to 10% of women report fecal incontinence during pregnancy.

- Obstetric anal sphincter injuries (OASIS) occurs in 18% of vaginal deliveries, and 13–25% of women experience fecal incontinence or flatus incontinence after childbirth.
- Significant improvement occurs in women by 3–6 months in the postpartum period; some women may experience fecal incontinence 2 or more years after delivery.
- Risk factors for fecal incontinence include vaginal delivery, length of second stage of labor, large birth weight, increasing maternal age, forceps delivery, OASIS by anal sphincter laceration or episiotomy, and maternal position during childbirth.
- The lateral position affords a slightly protective effect from OASIS in the nulliparous woman, compared with standing, squatting, or lithotomy.

Screening and Diagnosis

- Studies reveal that women are not asked about incontinence by their health care providers at the postpartum visit. Women may not seek treatment because of embarrassment and shame.
- Health care providers should routinely discuss fecal incontinence at the postpartum visit to confirm spontaneous resolution or evaluate the need for further therapy in those with persistent fecal incontinence symptoms.
- Anal sphincter injury that is not apparent immediately after delivery is referred to as an occult sphincter laceration, and physical examination can identify the disrupted anal sphincter complex in most women.
- Endoanal ultrasonography is the gold standard tool used by the urogynecologist to evaluate anal sphincter pathology in the investigation of fecal incontinence. Anal sphincter disruption can be identified on sonogram because external and internal sphincters can be visualized on ultrasonography.

Treatment

- Anal sphincter repair immediately after delivery reduces the risk of fecal incontinence.
- A fiber-rich diet, adequate hydration, and use of a stool softener started immediately after childbirth can control consistency of the stool and prevent constipation and straining, which allows optimal healing.
- Pelvic floor muscle (Kegel) exercises are not only effective for stress urinary incontinence but also have been shown to improve symptoms of fecal incontinence in postpartum women. Health care providers can instruct and coach patients on the use of Kegel exercises (see Box 1).
- Inadequate anal sphincter repair immediately after delivery or break down of repair requires sphincteroplasty, which is most effective in women with moderate or severe fecal incontinence.
- Sphincteroplasty also is used in women with occult sphincter lacerations.
- A sacral nerve stimulator may be implanted in women who do not desire surgical therapy or in those in whom sphincteroplasty has failed.

Anticipatory Guidance and Follow-up

- Anticipatory counseling in the antepartum period is necessary for educating patients and setting expectations.
- For the patient with symptomatic fecal incontinence after 2 weeks in the postpartum period, refer to urogynecology or colorectal surgery.
- Early assessment
 - helps to identify issues that require more immediate action (eg, revision of an obstetric laceration breakdown or repair of an occult sphincter laceration)
 - affords an opportunity to educate patients about the pelvic floor, the role of Kegel exercises and biofeedback training or pelvic floor physical therapy, or both, if deemed appropriate
 - helps educate patients about perianal skin care and dietary changes that affect stool consistency. The American College of Obstetricians and Gynecologists has developed a patient FAQ on Accidental Bowel Leakage
 - provides reassurance to the patient
- Long-term follow-up is necessary to assess stability of results.
- The mode of delivery in subsequent pregnancies after OASIS has not been established. If fecal incontinence persists, it is reasonable to offer the patient a cesarean delivery, with a full discussion of the risks of abdominal surgery.

Perineal Pain, Dyspareunia, and Sexual Function

Background

- Perineal pain, dyspareunia, and low libido may occur after childbirth and, if persistent and not treated, may lead to long-term physical and psychological difficulties, including relationship discord.
- Prolonged postpartum perineal pain is common and has been reported in up to 10% of women 1 year after vaginal delivery. Scar tissue at the introitus from an episiotomy is a common cause.
- *Dyspareunia* is defined as genital pain that occurs just before, during, or after sexual intercourse. Physical factors, psychological factors, or both, may be involved. Postpartum dyspareunia has been reported in 50–60% of women 6–7 weeks after delivery, in 30% of women at 3 months after delivery, and in 17% of women 6 months after delivery.
- Risk factors that increase the risk of postpartum perineal pain and dyspareunia include infection, operative vaginal delivery, third- and fourth-degree laceration, wound separation of episiotomy or laceration repairs, pelvic organ prolapse, and breastfeeding.
- Vaginal atrophy secondary to the hypoestrogenic state during breastfeeding leads to inadequate lubrication and dyspareunia.
- Studies reveal no difference in the risk of dyspareunia in women with spontaneous perineal lacerations versus those women receiving episiotomies; however, avoidance or selective use of episiotomy decreases perineal trauma.

- A reduction in libido after childbirth is normal; however, many women are not aware of this. Contributors to reduced postpartum libido include hormonal alterations associated with breastfeeding, the adjustment and demands of a new infant, and fatigue. Studies have found that 50% of women at 3 months and 30% at 6 months after giving birth experience loss of libido.
- A high prevalence of postnatal sexual health issues occur during the postpartum period, and these are rarely discussed by women's health care providers at the postpartum visit.

Postpartum Test and Screening

- Women rarely discuss sexual health issues unless health care providers ask them directly.
- Given the high prevalence of postpartum perineal trauma and subsequent dyspareunia, routine and direct inquiry by women's health care providers is warranted.
- Providing questionnaires before the office visit may be helpful; however, direct inquiries during the office visit is essential.
- Consider a pelvic examination in women with severe perineal pain, or dyspareunia, or both. Topical lidocaine (jelly or spray) may be used as an anesthetic for the following:
 - Inspection of the perineum
 - Careful and gentle digital vaginal and rectal examination if warranted.
 - Use of vulvodinia and sensory mapping examination (use of moistened cotton swab to gently check for specific, localized areas of pain in the vulvar region).

Management Considerations

- The management of perineal pain, dyspareunia, and sexual function depends on the cause.
- Education and reassurance of the patient can include the following:
 - Inform the patient that it is normal for libido to decrease immediately after birth.
 - Encourage the patient to communicate openly and honestly with her partner about reasons for low libido, including physiologic changes postpartum, fatigue, and lack of time.
 - Suggest consultation with a certified therapist if or when the couple decides the issue necessitates the need to seek help or if a sexuality issue becomes problematic to the relationship.
 - Consider ablation of granulation tissue.
 - Use of a water-based lubricant for sexual relations.
 - How pelvic floor physical therapy may benefit women with persistent perineal pain and dyspareunia at 3 months after giving birth, but data are scarce and conflicting.
 - Transcutaneous electrical nerve stimulation (TENS) therapy and ultrasound therapy have been shown to decrease perineal pain and dyspareunia. However, consistent evidence is lacking, trials are of variable quality, and some studies lack adequate controls.
 - Consider revision of perineoplasty as a treatment in women with persistent and severe perineal pain or dyspareunia unresponsive to physical therapy.

Follow-up Goals

- Anticipatory counseling in the antepartum period is necessary to educate patients and set expectations.
- Because perineal laceration and dyspareunia are common, particularly in the primiparous woman, routine inquiry is warranted.
- Long-term follow-up and counseling are needed for persistent issues with dyspareunia and sexual health.

References

1. American College of Obstetricians and Gynecologists. Accidental bowel leakage. ACOG FAQ 139. Washington, DC: American College of Obstetricians and Gynecologists; 2014. Available at: <https://www.acog.org/Patients/FAQs/Accidental-Bowel-Leakage>.
2. American College of Obstetricians and Gynecologists. Pelvic support problems. ACOG FAQ 012. Washington, DC: American College of Obstetricians and Gynecologists; 2017. Available at: <https://www.acog.org/Patients/FAQs/Pelvic-Support-Problems>.
3. American College of Obstetricians and Gynecologists. Urinary incontinence. ACOG FAQ 081. Washington, DC: American College of Obstetricians and Gynecologists; 2016. Available at: <https://www.acog.org/Patients/FAQs/Urinary-Incontinence>.

Resources

American College of Obstetricians and Gynecologists Clinical Guidance

- ❖ Prevention and management of obstetric lacerations at vaginal delivery. Practice Bulletin No. 198. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2018;132:e87–102.
Provides evidence-based guidelines for the prevention, identification, and repair of obstetric lacerations and for episiotomy.
- ❖ Urinary incontinence in women. Practice Bulletin No. 155. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2015;126:e66–81.
Reviews information on the current understanding of urinary incontinence in women and includes guidelines for diagnosis and management that are consistent with the best available scientific evidence.

Health Care Provider Resources for Patient Care

- ❖ Burgio KL, Zyczynski H, Locher JL, Richter HE, Redden DT, Wright KC. Urinary incontinence in the 12-month postpartum period. *Obstet Gynecol* 2003;102:1291–8.
Describes prevalence and severity of urinary incontinence in the 12-month postpartum period and relates this incontinence to several potential risk factors including body mass index, smoking, oral contraceptives, breastfeeding, and pelvic floor muscle exercise.

Coding

See [Coding for Postpartum Complications](#)



Reproductive Life Planning, Contraception, and Sexual Health

Background

Reproductive life planning and contraception are issues for virtually all patients in the postpartum period. Sexual health is an issue for all patients in the postpartum period whose life plans include remaining sexually active. Most of the data from observational studies in the United States would suggest a modest increase in risk associated with intervals of fewer than 18 months and more significant risk with intervals of fewer than 6 months between birth and the start of the next pregnancy. The National Center for Health Statistics reports 37% of pregnancies are unintended (<https://www.cdc.gov/nchs/data/nhsr/nhsr055.pdf>), further emphasizing the importance of contraception counseling. A total of 35.1% of pregnancies have interpregnancy intervals fewer than 18 months, which is associated with adverse pregnancy outcomes, and 6.7% within 6 months (1).

Screening

- Ask about the patient's reproductive life plan, including whether the patient has completed childbearing. Tools such as "One Key Question" ("Would you like to become pregnant in the next year?" or "When do you want to have another baby?") can be used to assess pregnancy intentions.
- Assess whether the patient is sexually active with men, women, or both.
- Tailor contraceptive recommendations to future pregnancy plans, patient preference, and medical comorbidities (eg, hypertension, diabetes).
- Screen sexual health by history and review of systems. Screening should include assessment of readiness for sex, sexually transmitted infection risk, sexual abuse, and sexual dysfunction. For suggested screening questions about symptoms, see Committee Opinion No. 654, *Reproductive Life Planning to Reduce Unintended Pregnancy*.

Counseling

- Reproductive life planning
 - Prepregnancy counseling
 - Planned reproductive endocrinology and infertility referral if indicated
 - Contraception counseling
 - Counseling regarding risks of short interpregnancy interval (fewer than 18 months, with risk increasing as interval decreases) and potential benefits of longer interpregnancy interval
- Provision of information regarding the full array of contraceptive services
 - Every woman should be provided information on the full range of contraceptive options so that she can select the method best-suited to her needs, including natural family planning,

lactational amenorrhea, combined hormonal contraceptives, male and female sterilization, progestin-only pills, birth control injection, birth control implant, intrauterine devices

- Counsel regarding breastfeeding and hormonal contraception, including the Centers for Disease Control and Prevention's (CDC) recommendations that the advantages outweigh the risks of progestin-only contraception immediately after birth and of combined hormonal methods at 1 month postpartum (CDC MEC); however, there are theoretic concerns about the effect on milk production (see [Committee Opinion 658, *Optimizing Support of Breastfeeding as Part of Obstetric Practice*](#)). Obstetric care providers should discuss these concerns within the context of each woman's desire to breastfeed and her risk of unplanned pregnancy, so that she can make an autonomous and informed decision.
- Include options for permanent sterilization in counseling women who are certain they have completed their childbearing. Contraceptive counseling should be sensitive to the complex history of sterilization and abuse and fertility control among marginalized women (see <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/Sterilization-of-Women-Ethical-Issues-and-Considerations>).
- Ensure equitable implementation of immediate postpartum long-acting reversible contraception (LARC); develop policies that ensure access to immediate postpartum LARC if desired, without targeting of marginalized women; respect each woman's right to decline LARC; and provide access to affordable LARC device removal at any point, independent of insurance status (1).
- Sexual health
 - Assess readiness for resuming intercourse in context of wide range of "normal"
 - Sexually transmitted diseases should be screened and treated per CDC guidelines
 - Offer legal and safety resources for victims of sexual assault and abuse. Discuss safety plan.
 - Assist patients in achieving their goals for readiness and satisfaction. For couples who have postpartum issues likely related to fatigue and life change related to the new infant, provide support and counseling. Recommend lubricant or topical estrogen for dyspareunia due to estrogen deficiency related to lactational amenorrhea. Provide treatment for postpartum depression.

Anticipatory Guidance and Follow-up

- Expected response to treatment
 - Reproductive life planning
 - Achievement of reproductive life goals
 - Contraception
 - Women should be advised to avoid interpregnancy intervals shorter than 6 months and should be counseled about the risks and benefits of repeat pregnancy before 18 months
 - Prevention of undesired pregnancies
 - Sexual health
 - STDs—treatment and tests of cure or reinfection per CDC guidelines
 - Sexual assault—ensuring patient safety
 - Achieve patient goals for frequency, quality, and satisfaction with sex

- Referrals
 - Reproductive life planning
 - Providers of postpartum care should be able to provide appropriate counseling
 - Contraception
 - Providers of postpartum care should be able to provide prescription contraceptives
 - Referral to qualified health care provider for male or female sterilization
 - May require referral for implantable or intrauterine contraception. Optimal care includes availability of same-day placement for implantable and intrauterine contraception.
 - Sexual health
 - Referral to sexual medicine specialist, therapist, or psychiatrist, as appropriate, if sexual dysfunction is diagnosed and management is beyond the scope of care of the postpartum care provider.

For more information on dyspareunia, see the section on Postpartum Complications.

Reference

1. Moniz MH, Spector-Bagdady K, Heisler M, Harris LH. Inpatient postpartum long-acting reversible contraception: care that promotes reproductive justice. *Obstet Gynecol* 2017;130:783–7.

Resources

American College of Obstetricians and Gynecologists Clinical Guidance

- ❖ Optimizing support for breastfeeding as part of obstetric practice. Committee Opinion No. 658. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2016;127:e86–92. *Outlines ways obstetrician–gynecologists can support women in achieving their breastfeeding goals.*
- ❖ Long-acting reversible contraception: implants and intrauterine devices. Practice Bulletin No. 186. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2017;130:e251–69. *This Practice Bulletin provides recommendations for the use of IUDs and contraceptive implants in addition to information for appropriate candidate selection and the management of clinical issues and complications associated with LARC methods.*
- ❖ Reproductive life planning to reduce unintended pregnancy. Committee Opinion No. 654. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2016;127:e66–9. *Addresses the use of comprehensive and culturally appropriate reproductive life planning to avoid unintended pregnancy and reviews the cultural and economic barriers to prevent unintended pregnancy.*
- ❖ Sterilization of women: ethical issues and considerations. Committee Opinion No. 695. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2017;129:e109–16. *Discusses the ethical responsibilities of obstetrician–gynecologists in sterilization for women.*

Health Care Provider Resources for Patient Care

- ❖ American College of Obstetricians and Gynecologists. Birth control (contraception): resource overview. Available at: <https://www.acog.org/Womens-Health/Birth-Control-Contraception>. Retrieved March 7, 2018.
List of key publications from ACOG and other sources for ob-gyns, other women's health care providers, and patients.
- ❖ Before, Between and Beyond Pregnancy. Family planning and contraception. Available at: <https://beforeandbeyond.org/toolkit/desires-pregnancy/family-planning-and-contraception/#ffs-tabbed-12>. Retrieved March 9, 2018.
The resource guide was developed by the Clinical Work Group of the National Preconception Health and Health Care Initiative, a public-private partnership that works to advance pre-pregnancy knowledge and care of all women and men of reproductive age in the United States.
- ❖ Gemmill A, Lindberg LD. Short interpregnancy intervals in the United States. *Obstet Gynecol* 2013;122:64–71.
Investigates the prevalence of short pregnancy intervals in the United States.
- ❖ Planned Parenthood Federation of America. All about birth control methods. Available at: <https://www.plannedparenthood.org/learn/birth-control>. Retrieved March 7, 2018.
Bedsider providers. Available at: <https://providers.bedsider.org>. Retrieved March 7, 2018.
- ❖ Sexual Medicine Society of North America. SexHealthMatters: find a provider in your area. Available at: <http://www.sexhealthmatters.org/resources/find-a-provider>. Retrieved March 7, 2018.
- ❖ Tepper NK, Krashin JW, Curtis KM, Cox S, Whiteman MK. Update to CDC's U.S. Medical Eligibility Criteria for Contraceptive Use, 2016: Revised recommendations for the use of hormonal contraception among women at high risk for HIV infection. *MMWR Morb Mortal Wkly Rep* 2017;66:990–4.
Recommendations in this report are intended to assist health care providers when they counsel women, men, and couples about contraceptive method choice.

Health Care Provider Resources for Advocacy

- ❖ Jackson A. Racism in family planning care. Washington, DC: Bedsider; 2016. Available at: <https://providers.bedsider.org/articles/racism-in-family-planning-care>. Retrieved March 7, 2018.

Patient Resources

- ❖ Dehn B. Sex during and after pregnancy. National Women's Health Resource Center, Inc. Available at: <http://www.healthywomen.org/content/article/sex-during-and-after-pregnancy>. Retrieved March 7, 2018.
- ❖ Power to decide. Available at: <https://powertodecide.org/select360-consulting>. Retrieved March 7, 2018.
Resources for health care providers, parents, and young adults.

Coding

See [Coding for Counseling](#)



Support Team for New Mothers (Resource Guide for the Postpartum Visit)

Background

The first few days and weeks with a newborn are rewarding and challenging. The mother's partner or support person also deserves some attention during medical visits because he or she is likely to be a major source of support for the newborn and the mother. Regardless of the relationship with the mother, the partner's involvement has a positive effect on the child's development. The patient and her support team members should be reminded about how to care for each other.

Screening

- How has everyone been adjusting? Acknowledge the new demands on the family. Screen women and their partners for depression. Family members may recognize these symptoms and encourage the woman and her partner to seek help. Research shows that 2–25% of fathers are depressed, and this increased to 50% when the mother experiences postpartum depression. The Postpartum Depression Screening Scale is a validated screening tool for the carrying parent, the Edinburgh Postnatal Depression Scale has been validated useful for new male and female parents.
- Does every family member have a role? The mother may want to do everything for the newborn, but often she is not physically able to because she is recovering from childbirth. Encourage others to assume a role in the care of the child. For the partner, alone time with the child will build confidence and foster a relationship that will have a lifelong effect on the child's well-being.
- How is breastfeeding going? The support from the partner and grandparents will often make the difference in the mother's confidence. The [ACOG Physician Conversation Guide on Support for Breastfeeding](#) recommends asking directly about the support from family and the partner. Share the benefits for the woman and her infant for breastfeeding, such as weight loss and parental bonding, and work with families to find solutions for breastfeeding challenges.
- Did every family member get the appropriate immunizations? Pertussis and influenza are two diseases that can make newborns very sick, but the newborn cannot be immunized before 2 months of age for pertussis and 6 months of age for influenza. It is recommended that all household members and caregivers in contact with the newborn be up to date with routine vaccines, particularly influenza and tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap).
- When was the last time the woman, her parenting partner, or grandparent smoked? Encouraging family members to abstain from smoking is crucial for the health of the infant as well as their own health.

- Has the couple decided when or if they will have another child? If they would like some space between children, provide counseling to the couple on how this can be achieved.

Counseling

- Encourage each family member to have a role in caring for the mother and the newborn. Often grandparents and older siblings can be recruited to help with routine tasks as well as tend to other children.
- Educate the partner on breastfeeding. Research has shown that family and friends need to be more aware of the importance of breastfeeding. Remind families that lactation consultants and the child's pediatrician are great resources to consider between visits to the obstetrician–gynecologist.
- Have resources available for immunizations deficiencies and depression treatment when identified.
- Ensure that the mother and her partner understand and can exercise their rights under policies such as the Family Medical Leave Act and the Fair Labor Standards Act break time requirement for nursing women.
- Discuss the effect childbirth may have on their sexual relationship and reinforce abstinence from sex until the woman is ready, physical and mentally, to resume this aspect of their relationship.
- Review contraception options with the couple.
- Provide smoking cessation resources to family members if needed.

Anticipatory Guidance and Follow-up

- Each parent will have a unique relationship with the infant. All loving relationships are welcomed. A statement paraphrased from the 2014 Dad 2.0 Summit is “Fathers don't parent like mothers nor are they replacements for mothers. Fathers provide a unique, dynamic, and important contribution to their children and families, which should be supported.”
- Encourage family support members to ask questions at the medical visits for the newborn.
- If the mother works outside of the home, the family should begin discussing this transition.
- Identify community resources, such as mothers' groups and community centers, for social support.
- Encourage participation of special prenatal classes geared toward spouses and partners.

Resources

American College of Obstetricians and Gynecologists Clinical Guidance

- ❖ Reproductive and sexual coercion. Committee Opinion No. 554. American College of Obstetricians and Gynecologists. [Obstet Gynecol 2013;121:411–5.](#)

ACOG guidance on screening for intimate partner violence and reproductive and sexual coercion, and interventions such as education and counseling on harm-reduction strategies; prevention of unintended pregnancies with long-acting reversible contraception (LARC).

Health Care Provider Tools for Patient Care

- ❖ American College of Obstetricians and Gynecologists. Breastfeeding toolkit. Washington, DC: American College of Obstetricians and Gynecologists; 2014. Available at: <https://www.acog.org/About-ACOG/ACOG-Departments/Toolkits-for-Health-Care-Providers/Breastfeeding-Toolkit>. Retrieved March 1, 2018.

Toolkit includes common breastfeeding codes, a physician conversation guide on support for breastfeeding, and patient education materials.

- ❖ American College of Obstetricians and Gynecologists. Depression and Postpartum Depression Resource Overview. <https://www.acog.org/Womens-Health/Depression-and-Postpartum-Depression#ExternalPub>

Key publications and resources for ob-gyns, other women's health care providers, and patients as identified by ACOG.

- ❖ Council on Patient Safety in Women's Health Care. Presentation of maternal mental health patient safety bundle: perinatal depression and anxiety. Washington, DC: American College of Obstetricians and Gynecologists; 2016. Available at: <http://safehealthcareforeverywoman.org/safety-action-series/presentation-of-maternal-mental-health-patient-safety-bundle-perinatal-depression-and-anxiety/>.

Bundle includes an approach for the recognition of early warning signs and symptoms, how to identify systems improvement opportunities, and support tools for patients, families, and staff.

- ❖ International Lactation Consultant Association. Available at: <http://www.ilca.org/home>. Retrieved March 1, 2018.

To find a lactation consultant.

- ❖ Fathers' roles in the care and development of their children: the role of pediatricians. Committee on Psychosocial Aspects of Child and Family Health. *Pediatrics* 2016;138: e20161128. Epub 2016 Jun 13.

Report reviews new studies of the epidemiology of father involvement, including nonresidential as well as residential fathers.

Health Care Provider Tools for Advocacy

- ❖ American College of Obstetricians and Gynecologists. Paid parental leave. Statement of Policy. Washington, DC: American College of Obstetricians and Gynecologists; 2016. Available at: <https://www.acog.org/-/media/Statements-of-Policy/Public/92ParentalLeaveJuly16.pdf?dmc=1&ts=20180216T1342384350>. Retrieved March 1, 2018.

ACOG Statement of Policy endorsing paid parental leave at 100% with benefits for at least 6 weeks for all workers.

- ❖ Clifford J, McIntyre E. Who supports breastfeeding? *Breastfeed Rev* 2008;16:9–19.

Literature review of quantitative and qualitative studies conducted to determine who supports women to breastfeed successfully in the current environment.

Patient Resources

- ❖ American College of Obstetricians and Gynecologists. It's time to quit smoking. ACOG FAQ 065. Washington, DC: American College of Obstetricians and Gynecologists; 2014. Available at: <https://www.acog.org/Patients/FAQs/Its-Time-to-Quit-Smoking>.

Coding

See [Coding for Support Teams for New Mothers](#)

See the sections on Breastfeeding, Returning to Work and Paid Leave, Immunization During the Postpartum Period; and Postpartum Depression for more information on these topics.



Newborn Care

There are a number of different aspects of newborn care outlined in [Table 1](#) that should be discussed during postpartum visits.

Resources

Daily Care and Bathing

- ❖ Ready, set, bath! American Academy of Pediatrics. Available at: <https://www.healthychildren.org/English/ages-stages/baby/bathing-skin-care/Pages/Ready-Set-Bath.aspx>. Retrieved March 1, 2018.
- ❖ American Academy of Pediatrics. Tips for Grandparents of a Newborn. Available at: <https://www.healthychildren.org/English/ages-stages/baby/Pages/Tips-for-Grandparents-of-a-Newborn.aspx>. Retrieved March 1, 2018.

Heading Out With Baby

- ❖ American Academy of Pediatrics. Heading Out With Baby. Available at: <https://www.healthychildren.org/English/ages-stages/baby/Pages/Heading-Out-With-Baby.aspx>. Retrieved March 1, 2018.
- ❖ American Academy of Pediatrics. Car Seats: Information for Families. Available at: <https://www.healthychildren.org/English/safety-prevention/on-the-go/Pages/Car-Safety-Seats-Information-for-Families.aspx>. Retrieved March 1, 2018.

Feeding

- ❖ American Academy of Pediatrics. Practical Bottle Feeding Tips. Available at: <https://www.healthychildren.org/English/ages-stages/baby/feeding-nutrition/Pages/Bottle-Feeding.aspx>. Retrieved March 1, 2018.
- ❖ American Academy of Pediatrics. Breastfeeding. Available at: <https://www.healthychildren.org/English/ages-stages/baby/breastfeeding/Pages/default.aspx>. Retrieved March 1, 2018.
- ❖ American Academy of Pediatrics. "Dining in" with a Newborn. Available at: <https://www.healthychildren.org/English/ages-stages/prenatal/delivery-beyond/Pages/Dining-In-with-a-Newborn.aspx>. Retrieved March 1, 2018.
- ❖ Holt K. Bright Futures: Nutrition. 3rd ed. Elk Grove Village (IL): American Academy of Pediatrics; 2011. Available at: <https://brightfutures.aap.org/Bright%20Futures%20Documents/BFNutrition3rdEditionSupervision.pdf>. Retrieved March 1, 2018.
- ❖ U.S. Food and Drug Administration. FDA Takes Final Step on Infant Formula Protections. Silver Spring (MD): USDA; 2014. Available at: <https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm048694.htm>. Retrieved March 1, 2018.

Sleeping

- ❖ American Academy of Pediatrics. How to Keep Your Sleeping Baby Safe: AAP Policy Explained. Available at: <https://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx>. Retrieved March 1, 2018.
- ❖ Task Force on Sudden Infant Death Syndrome. SIDS and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment. *Pediatrics* 2016; 138:e20162938.

Visiting Pediatrician

- ❖ American Academy of Pediatrics. Visiting the Pediatrician: The First Year. Why does my baby need to see the pediatrician so often? Available at: <https://www.healthychildren.org/English/family-life/health-management/Pages/Visiting-The-Pediatrician-The-First-Year.aspx>. Retrieved March 1, 2018.

Coding

See [Coding for Newborn Care](#)

Table 1. Daily Care of the Newborn

Background and Definition	Screening and Diagnosis	Treatment and Anticipatory Guidance	Follow-up
<ul style="list-style-type: none"> Bathing and grooming should be performed in a safe way. Transport of the newborn in cars should be done with an approved infant car seat with the newborn rear facing, in the back of the car. 	<ul style="list-style-type: none"> Assess caregivers' comfort with daily activities with the newborn, including bathing and grooming. Ask about how the newborn is transported and, if by car, ownership of a car seat. 	<ul style="list-style-type: none"> Counsel about daily care of the newborn. Counsel about the need for a car seat, if not being used. 	<ul style="list-style-type: none"> At subsequent visits, inquire how woman and other caregivers are adjusting to the care of the newborn.
Feeding the Newborn			
<ul style="list-style-type: none"> Breastfeeding is recommended, but many newborns are bottle fed. 	<ul style="list-style-type: none"> The woman should be asked whether she is breastfeeding, feeding her newborn with formula, or bottle, or both. If the woman is breastfeeding, then inquire how long the newborn is nursing, how often, and if she is having any problems. If the newborn is bottle-fed, determine if the woman has tried to breastfeed and what the obstacles to nursing have been. 	<ul style="list-style-type: none"> If the woman is breastfeeding <ul style="list-style-type: none"> praise her and support her—any breastfeeding should be applauded. coach her, or refer her to an International Board-Certified Lactation Consultant, or both, if she is expressing concern about any problems she is having nursing. If the newborn is being bottle-fed: <ul style="list-style-type: none"> assuage any guilt the woman may feel about not nursing (if she expresses this) reinforce that to safely prepare formula, parents and caregivers should follow these six recommendations per the American Academy of Pediatrics' (AAP) Bright Futures and the U.S. Food and Drug Administration. <p><i>Per the American Academy of Pediatrics' Bright Futures:</i></p> <ol style="list-style-type: none"> Before preparing formula, wash hands Area of where formula is being prepared should be washed with a nontoxic biodegradable cleaner Clean and disinfect bottles, nipples, and caps before every use Wash and dry the top of the formula container before opening <p><i>Per the U.S. Food and Drug Administration:</i></p> <ol style="list-style-type: none"> When mixing formula, use water that has been boiled for at least 1 minute and then cooled to body temperature (approximately 98 degrees F). Refrigerate water immediately if not used immediately. Do not use bottled water. Use the exact amount of water written on formula packaging 	<ul style="list-style-type: none"> At subsequent visits, inquire as to whether the woman is still breastfeeding the infant and assess for any problems such as sore nipples, mastitis, lack of milk production. Assess what resources she must have to continue nursing if she is working outside the home or attending school.
Safe Sleeping Practices			
<ul style="list-style-type: none"> The AAP recommends newborns are placed on their backs to sleep for the first year and that there are no other objects on or in the crib or bassinette. A firm mattress should be provided. Parents often fall asleep while feeding the infant. 	<ul style="list-style-type: none"> Determine whether the infant is placed on his/her back for sleep and that there are no toys, bumpers, blankets, or pillows in the bassinette. Inquire where infant feeding occurs and whether infant is co-sleeping with an adult. 	<ul style="list-style-type: none"> Instruct the mother and any other caregiver present that safe sleeping includes no toys, blankets, pillows, or toys in the newborn's sleep area. Advise that co-sleeping with an adult or child is dangerous to the newborn because there is a risk of suffocation. The infant should sleep in the same room as caregivers for the first 6 months, ideally for the first year. Counsel that if the parent falls asleep while feeding the infant, after the parent awakens, the infant should be placed on a separate sleep surface. It is less dangerous if a parent falls asleep in a bed while feeding the infant than in a chair or couch. 	<ul style="list-style-type: none"> At subsequent visits, ask where the newborn is sleeping and continue to reinforce safe sleep practices as aforementioned.
Assurance of Outpatient Medical Care Arrangements for the Newborn			
<ul style="list-style-type: none"> According to the AAP, a newborn should be seen by a health care provider for routine visits 2–5 days after being discharged from the hospital, then at 1, 2, 4, 6, 9, and 12 months the first year of life. The infant may need to be seen more often if there are any problems. 	<ul style="list-style-type: none"> Inquire how the infant is doing, who the infant's health care provider is, and when the infant's next medical visit is. 	<ul style="list-style-type: none"> Ask for permission to speak to the infant's health care provider if there are any issues the mother has that would be important for the infant's health care provider to know. Consider requesting written permission to copy the infant's health care provider on the postpartum visit note. 	<ul style="list-style-type: none"> At subsequent visits, inquire how the infant is doing and if the infant's medical visits are going well.



Breastfeeding

Background

- Mounting evidence supports the substantial benefits of breastfeeding for women and their infants. Breastfeeding rates in the United States continue to increase as 81% of infants born after 2013 started to breastfeed and more than one half were breastfed at 6 months. However, studies show disparities in breastfeeding rates in women who are young, low-income, African American, American Indian, or Alaska Native, or Native Hawaiian.
- Adequate evidence indicates that interventions to support breastfeeding increase the duration and rates of breastfeeding, including exclusive breastfeeding.

Recommendations

- Consideration of patient's health history, including but not limited to chronic and pregnancy-related medical conditions, herbal and homeopathic therapies (eg, fenugreek, ginger, and blessed thistle), caffeine and alcohol intake, tobacco use, and nutritional needs, and how these might affect breastfeeding outcomes.
- Review of patient's medications (prescribed, over-the-counter, or borrowed) before delivery and again at discharge to determine compatibility with lactation. The obstetric health care provider should use a reliable database for drugs and lactation such as the National Institute of Medicine's website and smartphone app, LactMed, for the most up-to-date information on individual medications.
- Discussion of contraceptive options, including the Centers for Disease Control and Prevention's statement that advantages of a progestin-only form of contraception (eg, levonorgestrel uterine device, progestin-only pills, and medroxyprogesterone acetate injection) outweigh the risks. However, there are theoretic concerns about the effect on milk production. Postpartum women are recommended to wait 1 month if they are considering the combined forms of contraception (eg, combined contraceptive pills, the ring, and the patch). Another option for contraception is the lactational amenorrhea method. Although breast-feeding without introducing any complementary solids or formula will in most cases prevent ovulation and, thus, pregnancy for up to 6 months postpartum, it will do so only when women are fully or nearly fully breastfeeding and there is continued amenorrhea. Obstetric care providers should discuss these concerns within the context of each woman's desire to breastfeed and her risk of unplanned pregnancy so that she can make an autonomous and informed decision.
- Provision of culturally sensitive care for women who desire to breastfeed, particularly for groups with lower rates of breastfeeding. Studies have shown that support groups, one-on-one support and mentoring in the postpartum period, and social marketing campaigns that promote positive images of breastfeeding may have an effect on particular groups of women, specifically African American women.

- Referral to lactation support groups in the patient's community, with thoughtful consideration of how the patient identifies across the racial, cultural, gender, religious, peer, and professional spectrum.
- Education for women who choose to supplement with formula should include information regarding types of formula, formula preparation, feeding systems, and water supply.

Recommendations for Policy and Systems

- Policies and practices should enable women to practice exclusive breastfeeding for the first 6 months of life with continued breastfeeding as complementary foods are introduced through the first year of life, or longer as mutually desired by the woman and her infant.
- Obstetric care providers should support women who desire to breastfeed their infants in integrating breastfeeding in their daily lives, in the community, and in the workplace.
- Implementation of the *Ten Steps to Successful Breastfeeding* and the *International Code of Marketing of Breast-Milk Substitutes* developed by global experts as a part of the Baby-Friendly Hospital Initiative endorsed by the World Health Organization and the United Nations' International Children's Emergency Fund (UNICEF).
- The U.S. Preventive Services Task Force (2016) makes the following three recommendations: 1) one-on-one counseling about breastfeeding provided by medical, nursing, or allied professionals at different stages during pregnancy, the hospital and birth center stay, and the postpartum period. This professional support may be conducted in the hospital or a health care facility, in the office, on the phone, or any combination of these. Most successful interventions include multiple sessions and are delivered at more than one point in time; 2) peer support by a layperson who has been trained how to provide support—typically a woman with a successful breastfeeding experience who shares the same background as the patient; 3) formal breastfeeding education throughout the prenatal and postpartum periods through group sessions, print materials or handouts, videos, electronic resources, and telephone support.
- Support of Healthy People 2020 targets to increase lactation programs for employees, reduce formula supplementation for breastfeeding infants in the first 48 hours of life, and increase the proportion of births in facilities that provide support for lactating women and their infants. Support public policies for breastfeeding.
- Health care providers of obstetric patients need knowledge and training on how to best support lactating women by using evidence-based curricula such as the American Academy of Pediatrics' Breastfeeding curriculum.

Follow-up

Before being discharged from the hospital or birth center, women should be provided with contact information for community-based lactation support for follow-up and telephone support information, if available. Women should be encouraged to contact their health plan regarding coverage of comprehensive lactation support and counseling in the postpartum period by a trained health care provider. Office staff should be prepared to triage common breastfeeding concerns and to refer women, as needed, to qualified lactation professionals in the community. Follow up can be done in person or by his can be done also with telehealth visits especially since

we are advocating postpartum following by 3 weeks for normal birth and sooner for problem births. Health care providers should make women aware that federal law requires employers to provide, "reasonable break time for an employee to express milk for her nursing child for 1 year after the child's birth each time such employee has need to express the milk." Employers also are required to provide "a place, other than a bathroom, that is shielded from the view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk.

Resources

American College of Obstetricians and Gynecologists Clinical Guidelines

- ❖ Breastfeeding in underserved women: increasing initiation and continuation of breastfeeding. Committee Opinion No. 570. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2013;122:423–8.
Through a multidisciplinary approach that involves practitioners, family members, and child care providers, obstetrician–gynecologists can help underserved women overcome obstacles and obtain the benefits of breastfeeding for themselves and their infants.
- ❖ Optimizing support for breastfeeding as part of obstetric practice. Committee Opinion No. 658. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2016;127:e86–92.
Outlines ways obstetrician–gynecologists can support women in achieving their breastfeeding goals.

Health Care Provider Resources for Patient Care

- ❖ American Academy of Pediatrics. Breastfeeding. Welcome to the Breastfeeding Residency Curriculum. Available at: <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Breastfeeding/Pages/Residency-Curriculum.aspx>. Retrieved March 1, 2018.
Designed to help residency program directors and faculty incorporate breastfeeding education into existing curriculum through implementation and evaluation strategies, useful tools, and other trusted resources.
- ❖ American College of Obstetricians and Gynecologists. Breastfeeding Resources. Available at: <https://www.acog.org/About-ACOG/ACOG-Departments/Breastfeeding>. Retrieved March 1, 2018.
- ❖ Berens P, Eglash A, Malloy M, Steube AM. ABM clinical protocol #26: persistent pain with breastfeeding. *Breastfeed Med* 2016;11:46–53.
Provides evidence-based guidance in the diagnosis, evaluation, and management of breastfeeding women with persistent nipple and breast pain.
- ❖ Breastfeeding. *J Obstet Gynecol Neonatal Nurs* 2015;44:145–50.
The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) position statement on breastfeeding.
- ❖ National Library of Medicine. Drugs and Lactation Database (LactMed). Available at: <https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm>. Retrieved March 1, 2018.
Contains information on drugs and other chemicals to which breastfeeding mothers may be exposed. It includes possible adverse effects in the nursing infant as well as suggested alternatives.

- ❖ Rosen-Carole C, Hartman S. ABM Clinical Protocol #19: Breastfeeding promotion in the prenatal setting, revision 2015. Academy of Breastfeeding Medicine. [Breastfeed Med 2015;10:451–7](#).
Academy of Breastfeeding Medicine protocol on how to improve breastfeeding promotion in the prenatal setting.
- ❖ U.S. Preventive Services Task Force. October 2016. Final Recommendation Statement: Breastfeeding: Primary Care Interventions. Available at: <https://www.uspreventiveservices.org/Page/Document/final-recommendation-statement154/breastfeeding-primary-care-interventions>
The U.S. Preventive Services Task Force recommends providing interventions during pregnancy and after birth to support breastfeeding.
- ❖ World Health Organization. Breastfeeding. Available at: <http://www.who.int/topics/breastfeeding/en/>. Retrieved March 1, 2018.
Breastfeeding resource page including fact sheets, technical resources on breastfeeding, and infographics.

Health Care Provider Resources for Advocacy

- ❖ Jones KM, Power ML, Queenan JT, Schulkin J. Racial and ethnic disparities in breastfeeding. [Breastfeed Med 2015;10:186–96](#).
The article reviews the literature on racial and ethnic disparities in breastfeeding rates and practices, addresses barriers to breastfeeding among minority women, conducts a systematic review of breastfeeding interventions, and provides obstetrician–gynecologists with recommendations on how they can help increase rates among minority women.

Patient Resources

- ❖ Department of Labor. Fact Sheet #73: Break Time for Nursing Mothers under the FLSA. Available at: <https://www.dol.gov/whd/regs/compliance/whdfs73.htm>
Fact sheet provides general information on the break time requirement for nursing mothers in the Patient Protection and Affordable Care Act.
- ❖ La Lech League International. Available at: <http://www.llli.org/>
Resources for finding peer counselors. Can help with nonmedical breastfeeding questions and support.

Coding

<https://www.acog.org/About-ACOG/ACOG-Departments/Toolkits-for-Health-Care-Providers/Breastfeeding-Toolkit/Breastfeeding-Coding>

Commonly used codes for breastfeeding.

For more information on supportive workplace policies, see section on Returning to Work and Paid Leave.

For more information on contraception, see section on Reproductive Life Planning, Contraception, and Sexual Health.

For additional resources on newborn care, please see section on [Newborn Care](#).



Postpartum Depression

Background

Prevalence

- According to the Centers for Disease Control and Prevention, 11–20% of women in the postpartum period have some form of depression

Major Risk Factors

- Depression during pregnancy
- Anxiety during pregnancy
- Experiencing stressful life events during pregnancy or the early postpartum period
- Preterm birth or infant admission to neonatal intensive care
- Low levels of social support
- Previous history of depression
- Breastfeeding problems

Presenting Symptoms and Signs

- Feeling sad, hopeless, empty, or overwhelmed
- Crying more often than usual for no apparent reason
- Worrying or feeling overly anxious
- Feeling moody, irritable, or restless
- Oversleeping or being unable to sleep even when the infant is asleep
- Having trouble concentrating, remembering details, and making decisions
- Experiencing anger or rage
- Losing interest in activities that are usually enjoyable
- Suffering from physical aches and pains, including frequent headaches, stomach problems, and muscle pains
- Eating too little or too much
- Withdrawing from or avoiding friends and family
- Having trouble bonding or forming an emotional attachment with her infant
- Persistently doubting her ability to care for her infant
- Thinking about harming herself or her infant

Screening and Diagnosis

The following are validated screening instruments:

- Edinburgh Postnatal Depression Scale
- Postpartum Depression Screening Scale
- Patient Health Questionnaire 9
- Beck Depression Inventory
- Beck Depression Inventory II
- Center for Epidemiologic Studies Depression Scale
- Zung Self-Rating Depression Scale
- Tests to evaluate for anemia and thyroid dysfunction

Treatment

- Peer counseling
- Cognitive behavioral therapy
- Antidepressants

Anticipatory Guidance and Follow-up

- Expected response to treatment—improvement in screening scale on repetitive testing
- “You are not alone. You are not to blame. With help, you will get better.”
- Referral to behavioral health care provider for suicidal ideation, severe symptoms, bipolar disorder
- Although screening is important for detecting perinatal depression, screening by itself is insufficient to improve clinical outcomes and must be coupled with appropriate follow-up and treatment when indicated; clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both.

Resources

American College of Obstetricians and Gynecologists Clinical Guidance

- ❖ Screening for perinatal depression. Committee Opinion No. 630. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2015;125:1268–71.
Overview of perinatal depression and discussion of several screening tools.

Health Care Provider Resources

- ❖ American College of Obstetricians and Gynecologists. ACOG Resources on Depression and Postpartum Depression. Washington, DC: American College of Obstetricians and Gynecologists. <https://www.acog.org/Womens-Health/Depression-and-Postpartum-Depression>
Key publications and resources on depression and postpartum depression from ACOG and other sources.

- ❖ American College of Obstetrician and Gynecologists. Breastfeeding Toolkit. <https://www.acog.org/About-ACOG/ACOG-Departments/Toolkits-for-Health-Care-Providers/Breastfeeding-Toolkit/Breastfeeding-Resources>
Toolkit includes common breastfeeding codes, a physician conversation guide on support for breastfeeding, and patient education materials.
- ❖ Council on Patient Safety in Women's Health Care. Maternal Mental Health: Perinatal Depression and Anxiety. Washington, D.C: American College of Obstetricians and Gynecologists; 2016. Available at: <http://safehealthcareforeverywoman.org/wp-content/uploads/2017/11/Maternal-Mental-Health-Bundle.pdf>. Retrieved March 1, 2018.
Bundle includes an approach for the recognition of early warning signs and symptoms, how to identify systems improvement opportunities, and support tools for patients, families, and staff.
- ❖ Gavin NI, Gaynes BN, Lohr KN, Meltzer-Brody S, Gartlehner G, Swinson T. Perinatal depression: a systematic review of prevalence and incidence. *Obstet Gynecol* 2005;106:1071–83.
Systematic review of evidence of the prevalence and incidence of perinatal depression compared with those with depression in women at nonchildbearing times.
- ❖ Yonkers KA, Vigod S, Ross LE. Diagnosis, pathophysiology, and management of mood disorders in pregnant and postpartum women. *Obstet Gynecol* 2011;117:961–77.
Mood disorders in perinatal women are common. Counseling can help with mild depression, but medication typically is required for women with severe depression or bipolar disorder.

Patient Resources

- ❖ Centers for Disease Control and Prevention. Depression Among Women. Available at: <https://www.cdc.gov/reproductivehealth/depression/index.htm>. Retrieved March 1, 2018.
- ❖ Postpartum Support International. <http://www.postpartum.net>
Information for families and professionals and a directory of peer and professional support providers.

Resources on Depression and Postpartum Depression

- ❖ National Institute for Child Health and Human Development. Patient Resource Page. Mom's Mental Health Matters: Depression and Anxiety Around Pregnancy
<https://www1.nichd.nih.gov/ncmhhep/initiatives/moms-mental-health-matters/moms/pages/default.aspx>
Resources for moms and moms-to-be about signs, symptoms, and treatment for depression and anxiety around pregnancy,

Coding

<https://www.acog.org/-/media/Departments/Coding/Perinatal-Depression-rev-2017.pdf?dmc=1&ts=20180522T1808402602>

A list of ICD-10 codes for perinatal depression.



Substance Use: Opioid Use Disorder, Alcohol Use Disorder, Tobacco Use

Opioid Use Disorder

- Opioid use has escalated dramatically in recent years. In 2012, U.S. health care providers wrote more than 259 million prescriptions for opioids, more than twice as many as in 1998. To combat this epidemic, all health care providers need to take active roles. A coordinated multidisciplinary approach without criminal sanctions has the best chance of helping infants and families.

Table 1. Substance Use and Opioid Use Disorder

Effects	Screening Tools	Behavioral Therapy	Medications	Follow-up
Impaired parenting	Early universal screening recommended	Cognitive behavioral therapy	Methadone* (individually titrated dose)	Prescription drug monitoring program http://www.pdmpassist.org
Other illicit substance use	NIDA Quick Screen https://www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen	Narcotics Anonymous	Buprenorphine* (individually titrated dose)	Behavioral health treatment SAMHSA: Behavioral Health Treatment Facility Locator https://findtreatment.samhsa.gov/locator
Associated depression and mental health disorders	SBIRT: Screening, Brief Intervention, Referral to Treatment http://www.sbirt.care/tools.aspx	Multidisciplinary approach most effective	Naltrexone (50 mg/day)*	Substance use and treatment, and relapse prevention program
Poor nutrition, homelessness, joblessness	CRAAFT (for women 21 years or younger) [†] https://www.integration.samhsa.gov/clinical-practice/sbirt/CRAAFT_Screening_interview.pdf	Alternatives for chronic pain: exercise, physical therapy	Treating chronic pain with nonopioids	Contraceptive counseling

*Considered safe in breastfeeding

[†]CRAAFT: A mnemonic acronym behavioral health screening tool for use in women younger than 21 years. The tool consists of six questions developed to screen adolescents for high risk alcohol and drug use.

Alcohol Use Disorder

- Third leading cause of preventable death in United States
- Less than 10% of women with alcohol use disorder are treated

Alcohol Effects	Screening Tools	Nonpharmacologic Treatment	Pharmacologic Treatment
Impaired parenting, infant care	Universal screening recommended	Motivational enhancement therapy (MET) 12-step facilitation	Acamprosate (666 mg/day)* – Reduces consumption – Best for maintaining abstinence
Breastfeeding contraindicated with heavy alcohol consumption	SBIRT: Screening Brief Intervention, and Referral sbirt.care/tools.aspx	Cognitive-behavioral coping skills therapy	Naltrexone (50mg/day)† – Reduces consumption – Increases abstinence – Not in opiate dependent patients
Poor decision-making abilities, irresponsible behaviors	AUDIT 10 or Audit https://pubs.niaaa.nih.gov/publications/Audit.pdf	Reflective listening therapy	Disulfiram (125–500 mg per day)* – Short treatment duration – Must be abstinent >12 hours
Associated depression and mental health disorders	NIDA Quick Screen https://bup.clinicalencounters.com/	Individual or group therapy	Combination therapy* – Acamprosate plus naltrexone – May benefit if monotherapy fails
Risks for future pregnancies			
*Not recommended in breastfeeding			
†Considered safe in breastfeeding			

Tobacco Use

- Cigarette smoking is a major modifiable health risk factor in the United States
- It is estimated that 17.5% of women in the United States smoke regularly

Box 1. Tobacco Use

Increased Risk to Children

- Sudden infant death syndrome (SIDS)
- Ear infections
- Asthma
- Dangers of second- and third-hand smoke

Nonpharmacologic Treatment

- 5 As Framework: Ask, Advise, Assess, Assist, Arrange <https://mdquit.org/cessation-programs/brief-interventions-5>
- Hypnotherapy
- Acupuncture
- Internet-based interventions www.smokefree.gov
- Smokers' quit line 1(800) QUIT-NOW

(continued)

Box 1. Tobacco Use (continued)

Pharmacologic Treatment

- **Nicotine Patches*** 21 mg, 14 mg, 7 mg
 - use 8–10 weeks with taper
- **Nicotine Inhaler*** 6–16 cartridges/day
 - use 6–12 weeks
 - taper dose 6–12 weeks
- **Bupropion†** 150mg/day
 - may use for up to 6 months
- **Varenicline*** 0.5–2mg
 - may use for 12–24 weeks

*Breastfeeding: Benefits considered to outweigh risks

†Breastfeeding: Caution advised—case reports of infant seizures

Substance Use and Opioid Use Resources

American College of Obstetricians and Gynecologists Clinical Guidance

- ❖ Substance abuse reporting and pregnancy: the role of the obstetrician–gynecologist. Committee Opinion No. 473. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2011;117:200–1.
Obstetrician–gynecologists should be aware of the reporting requirements related to alcohol and drug abuse within their state.
- ❖ Opioid use and opioid use disorder in pregnancy. Committee Opinion No. 711. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2017;130:e81–94.
Guidance on early universal screening, brief intervention (such as engaging a patient in a short conversation, providing feedback and advice), and referral for treatment of pregnant women with opioid use and opioid use disorder.

Health Care Provider Resources for Patient Care

- ❖ Reece-Stremtan S, Marinelli KA. ABM clinical protocol #21: guidelines for breastfeeding and substance use or substance use disorder, revised 2015. *Breastfeed Med* 2015;10:135–41.
Provides literature-based guidelines for the evaluation and treatment of the woman with substance use or a substance use disorder who is considering breastfeeding.
- ❖ Centers for Disease Control and Prevention. Overdose prevention. Atlanta (GA): CDC; 2017. Available at: <https://www.cdc.gov/drugoverdose/prevention/index.html>. Retrieved March 1, 2018.
Information on improving opioid prescribing, reducing exposure to opioids, preventing misuse, and treating opioid use disorder.

Alcohol Use Disorder Resources

American College of Obstetricians and Gynecologists Clinical Guidance

- ❖ Alcohol abuse and other substance use disorders: ethical issues in obstetric and gynecologic practice. Committee Opinion No. 633. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2015;125:1529–37.
Proposes an ethical framework for incorporating such care into obstetric and gynecologic practice and for resolving common ethical dilemmas related to substance use disorder.

Health Care Provider Resources for Patient Care

- ❖ Centers for Disease Control and Prevention. Alcohol and public health. Atlanta (GA): CDC; 2017. Available at: <https://www.cdc.gov/alcohol/index.htm>. Retrieved March 1, 2018.
- ❖ Winslow BT, Onysko M, Hebert M. Medications for alcohol use disorder. Leawood (KS): American Academy of Family Physicians. Available at: <https://www.aafp.org/afp/2016/0315/p457.pdf>. Retrieved March 9, 2018.

Tobacco Use Resources

Health Care Provider Resources for Patient Care

- ❖ American College of Obstetricians and Gynecologists. Tobacco and nicotine cessation toolkit. Washington, DC: American College of Obstetricians and Gynecologists; 2016. Available at: <https://www.acog.org/About-ACOG/ACOG-Departments/Toolkits-for-Health-Care-Providers/Tobacco-and-Nicotine-Cessation-Toolkit>. Retrieved March 1, 2018.
- ❖ Larzelere MM, Williams DE. Promoting smoking cessation. Leawood (KS): American Academy of Family Physicians. Available at: <https://www.aafp.org/afp/2012/0315/p591.pdf>. Retrieved March 9, 2018
- ❖ Centers for Disease Control and Prevention. Quit smoking. Atlanta (GA): CDC; 2017. Available at: https://www.cdc.gov/tobacco/quit_smoking/index.htm. Retrieved March 1, 2018.

Coding

See [Coding for Substance Use: Opioid Use, Alcohol Use, Tobacco Use](#)



Intimate Partner Violence

Background

Intimate partner violence (IPV) is a serious and preventable public health problem that affects millions of Americans and occurs across the lifespan. It can begin as soon as people start dating or having intimate relationships, often in adolescence.

Intimate partner violence is highly prevalent, affecting millions of people in the United States each year. Data from the National Intimate Partner and Sexual Violence Survey indicate that nearly one in four adult women (23%) experienced severe physical violence (ie, being kicked, beaten, choked, or burned on purpose, having a weapon used against them) from an intimate partner in their lifetime.

Screening

Box 1 shows sample screening questions from the American College of Obstetricians and Gynecologists' (ACOG) Committee Opinion No. 518, *Intimate Partner Violence*.

Box 1. Sample Intimate Partner Violence Screening Questions

While providing privacy, screen for intimate partner violence during new patient visits, annual examinations, initial prenatal visits, each trimester of pregnancy, and the postpartum checkup.

Framing Statement

"We've started talking to all of our patients about safe and healthy relationships because it can have such a large impact on your health."*

Confidentiality

"Before we get started, I want you to know that everything here is confidential, meaning that I won't talk to anyone else about what is said unless you tell me that...(insert the laws in your state about what is necessary to disclose)."

Sample Questions

"Has your current partner ever threatened you or made you feel afraid?"

(Threatened to hurt you or your children if you did or did not do something, controlled who you talked to or where you went, or gone into rages.)†

"Has your partner ever hit, choked, or physically hurt you?"

("Hurt" includes being hit, slapped, kicked, bitten, pushed, or shoved.)†

(continued)

Box 1. Sample Intimate Partner Violence Screening Questions (continued)

For women of reproductive age:

“Has your partner ever forced you to do something sexually that you did not want to do, or refused your request to use condoms?”*

“Does your partner support your decision about when or if you want to become pregnant?”*

“Has your partner ever tampered with your birth control or tried to get you pregnant when you didn’t want to be?”*

For women with disabilities:

“Has your partner prevented you from using a wheelchair, cane, respirator, or other assistive device?”‡

“Has your partner refused to help you with an important personal need such as taking your medicine, getting to the bathroom, getting out of bed, bathing, getting dressed, getting food or drink, or threatened not to help you with these personal needs?”‡

*Family Violence Prevention Fund. Reproductive health and partner violence guidelines: an integrated response to intimate partner violence and reproductive coercion. San Francisco (CA): FVPF; 2010. Available at: http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Repro_Guide.pdf. Retrieved October 12, 2011. Modified and reprinted with permission.

†Family Violence Prevention Fund. National consensus guidelines on identifying and responding to domestic violence victimization in health care settings. San Francisco (CA): FVPF; 2004. Available at: <http://www.futureswithoutviolence.org/userfiles/file/Consensus.pdf>. Retrieved October 12, 2011. Modified and reprinted with permission.

‡Center for Research on Women with Disabilities. Development of the abuse assessment screen-disability (AAS-D). In: Violence against women with physical disabilities: final report submitted to the Centers for Disease Control and Prevention. Houston (TX): Baylor College of Medicine; 2002. p. II-1–16. Available at <https://media.bcm.edu/documents/2015/12/abuse-assessment-screen-disability.doc>. Retrieved October 18, 2011. Modified and reprinted with permission.

Resources

American College of Obstetricians and Gynecologists Clinical Guidance

- ❖ Intimate partner violence. Committee Opinion No. 518. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2012;119:412–7.
American College of Obstetricians and Gynecologists’ guidance on screening for IPV, how to offer support, and available prevention and referral options.
- ❖ Reproductive and sexual coercion. Committee Opinion No. 554. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2013;121:411–5.
American College of Obstetricians and Gynecologists’ guidance on screening for IPV and reproductive and sexual coercion and interventions such as education, counseling on harm-reduction strategies, and prevention of unintended pregnancies by offering long-acting reversible contraception.
- ❖ Sexual assault. Committee Opinion No. 592. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2014;123:905–9.
American College of Obstetricians and Gynecologists’ guidance on routine screen for a history of sexual assault and offering victims emergency contraception and sexually transmitted infection prophylaxis.

Health Care Provider Tools for Patient Care

- ❖ Fisher D, Lang K, Wheaton J. Training professionals in the primary prevention of sexual and intimate partner violence: a planning guide; Atlanta (GA): Centers for Disease Control and Prevention; 2010. Available at: <https://stacks.cdc.gov/view/cdc/5760>. Retrieved March 1, 2018.

Guide describes how to develop, implement, and evaluate a training process taking into account available level of resources.

- ❖ Rabin RF, Jennings JM, Campbell JC, Bair-Merritt MH. Intimate partner violence screening tools: a systematic review. *Am J Prev Med* 2009;36:439–45.e4.

Systematic review summarizing IPV screen tools tested in health care settings, providing a discussion of existing psychometric data and an assessment of study quality.

Health Care Provider Tools for Advocacy

- ❖ American College of Obstetricians and Gynecologists. WEBTREATS: domestic violence. Washington, DC: American College of Obstetricians and Gynecologists; 2017. Available at: <https://www.acog.org/About-ACOG/ACOG-Departments/Resource-Center/WEBTREATS-Domestic-Violence>. Retrieved March 9, 2018.

List of resources on domestic violence identified by ACOG's Resource Center librarians.

- ❖ Centers for Disease Control and Prevention. Preventing intimate partner violence across the lifespan: a technical package of programs, policies, and practices. Atlanta (GA): CDC; 2017. Available at: <https://www.cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf>. Retrieved March 1, 2018.

Compilation of strategies to help communities and states focus on prevention activities with the greatest potential to prevent IPV.

Treatment

<https://www.cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf>

This technical package represents a select group of strategies based on the best available evidence to help communities and states sharpen their focus on prevention activities with the greatest potential to prevent intimate partner violence (IPV) and its consequences across the lifespan.

Readiness

https://www.acf.hhs.gov/sites/default/files/fysb/state_compendium.pdf

Identify resources in your community and be aware of local legislation. Compendium of State Statutes and Policies on Domestic Violence and Health.

Coding

See [Coding for Intimate Partner Violence](#)



Achieving a Healthy Weight in the Postpartum Patient

Background and Definition

- Overweight and obesity are based on categories of body mass index (BMI). *Overweight* is defined as a BMI of 25–29.9; *obesity* is defined as a BMI of 30 or greater.
- Approximately 65% of reproductive-aged women are overweight or obese at the time of pregnancy and are at risk of postpartum weight retention and chronic obesity.
- Risk factors for overweight and obesity include a sedentary lifestyle, high caloric dietary intake, family history, genetics, and individual metabolism.
- *Healthy weight loss* is defined as a weight loss of 1–2 pounds per week.
- Regular physical activity during an uncomplicated pregnancy and the postpartum period can improve cardio–respiratory fitness and reduce the risk and downstream health consequences (eg, heart disease, diabetes) of overweight and obesity.
- Postpartum women should follow the national guidelines for physical activity, which is 150 minutes of moderate exercise each week. Recommendations include a target of 20–30 minutes of exercise on most days of the week.

Diagnostic Evaluation

- The diagnosis of overweight or obesity is made by measuring the patient's height and weight. The BMI can then be calculated by entering the height and weight (English or Spanish) into the National Heart Lung and Blood Institute BMI calculator app (https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm).
- For practices using the electronic health record, the height and weight of a patient can be entered into the system, which will automatically calculate the BMI.

Assessment and Counseling

A key objective of the postpartum visit is to provide lifestyle recommendations that promote maternal health for long-term reduction in the risk of chronic obesity and its downstream sequelae of diabetes and cardiovascular disease. Such recommendations will also result in improved health in the interpregnancy period, if further childbearing is desired.

- At the postpartum visit, measure height and weight and calculate the BMI as outlined in diagnostic evaluation.
- Counsel women that the combination of healthy dietary intake and exercise can help them reduce postpartum weight retention and achieve and maintain a healthy weight.
- Assess the patient's readiness for exercise and write an exercise regimen for the woman to begin an exercise program using tools from the Exercise Is Medicine® Guide.

- Exercise Is Medicine® is a global initiative developed by the American Medical Association. http://www.exerciseismedicine.org/assets/page_documents/EIM%20Public%20Presentation_2016_07_07.pdf. The guide provides flyers for office practices to promote exercise, a brief physical activity readiness survey, and a first-step physical activity prescription for those patients beginning a new exercise program or resuming the exercise routines they had followed before pregnancy.
- Exercise routines can begin or resume gradually after a pregnancy based on the presence or absence of medical or surgical complications related to delivery.
- After an uncomplicated vaginal delivery, counsel patients that they can begin or resume an exercise program (eg, walking, jogging, strength conditioning) as soon as they feel able to engage in such activities. Women should not be discouraged from resuming physical activity before the 6-week postpartum visit.
- Pelvic floor exercises can be initiated to reduce symptoms of urinary incontinence in the postpartum period because urinary incontinence related to delivery can be a barrier to engaging in physical activities.
- In the absence of postoperative complications, counsel women that they can resume full physical activity in the 4–6 weeks after a cesarean delivery. Before that time, women are able to be physically active (eg, walking, stretching).
- Women who are lactating may have special concerns about the effects of dietary intake and physical activity on milk production and the ability to sustain successful breastfeeding for the desired time period.
 - Because of the additional energy expenditure for breastfeeding, counsel lactating women to increase their healthy caloric intake by 500 calories per day.
 - Current studies support the benefits of exercise in the postpartum period without adverse effects on milk production.
- Assess the patient's depression symptoms using a validated instrument (see Depression). Postpartum depression can be a barrier to healthy eating and regular exercise.
- Assess the patient's dietary intake and provide initial anticipatory guidance to patients about steps to improve her eating habits and begin an exercise program. The National Heart Lung and Blood Institute-supported booklet, *Aiming for a Healthy Weight*, (<https://catalog.nhlbi.nih.gov/sites/default/files/publicationfiles/14-7415.pdf>) [log in required] is a valuable resource for clinicians to use to provide initial guidance to patients.
- Refer women to a registered dietitian nutritionist who can take a detailed dietary history and provide a nutritional plan that promotes a healthy weight but is also tailored to the patient's specific needs and food preferences.
- The American College of Obstetricians and Gynecologists developed an **Obesity toolkit** that provides information about multiple aspects of obesity care, **coding guidance**, as well as links to additional resources to help patients reduce the effects of obesity.

Additional Efforts in Counseling

- If available, refer to a behavioral medicine expert who can provide ongoing counseling.
- Gather and share information on community and local venues that promote healthy lifestyle behaviors, including the local YMCA, churches, or other social groups.

Resources

American College of Obstetricians and Gynecologists Clinical Guidelines

- ❖ Challenges for Overweight and Obese Women. Committee Opinion No. 591. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2014;123:726–30.
Discusses how ob-gyns can help women overcome the barriers they face when adopting a healthy lifestyle. It concludes that physicians must address individual behaviors and the community environment to reduce obesity rates.
- ❖ Physical activity and exercise during pregnancy and the postpartum period. Committee Opinion No. 650. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2015;126:e135–42.
Discussion on the role of obstetrician–gynecologists in evaluating women with medical or obstetric complications before making recommendations on physical activity participation during pregnancy.
- ❖ Weight gain during pregnancy. Committee Opinion No. 548. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2013;121:210–2.
Recommends that ob-gyns follow the guidelines issued by the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine (previously known as the Institute of Medicine) regarding gestational weight gain. Ob-gyns should determine a woman’s body mass index during the first visit and discuss the need to limit exercise weight gain during pregnancy.

Health Care Provider Resources for Patient Care

- ❖ Lu MC, Kotelchuck M, Culhane JF, Hobel CJ, Klerman LV, Thorp JM Jr. Preconception care between pregnancies: the content of internatal care. *Matern Child Health J* 2006;10:S107–22.
Identifies core components of internatal care, which includes exercise and nutrition.
- ❖ National Lipid Association. Heart-healthy eating DASH style: advice from the National Lipid Association clinician’s lifestyle modification toolbox. Available at: https://www.lipid.org/sites/default/files/heart_healthy_eating_dash_style_final_1.pdf. Retrieved March 1, 2018.

Health Care Provider Resources for Advocacy

- ❖ Centers for Disease Control and Prevention. Overweight and obesity. Atlanta (GA): CDC; 2017. Available at: <https://www.cdc.gov/obesity/>. Retrieved March 1, 2018.

Patient Resources

- ❖ Centers for Disease Control and Prevention. Healthy weight. Atlanta (GA): CDC; 2017. Available at: <https://www.cdc.gov/healthyweight/index.html>. Retrieved March 1, 2018.
An online resource that outlines the benefits of achieving a healthy weight and includes links to physical activity trackers and dietary trackers.
- ❖ County of Los Angeles Public Health Maternal, Child and Adolescent Health. Welcome to a healthier you! Text LAMOMS to 55000. Available at: <http://publichealth.lacounty.gov/LAmoms/LAMOM.htm>. Retrieved March 7, 2018.
A program to help new mothers get to a healthy weight.

- ❖ National Heart, Lung, and Blood Institute. Calculate your body mass index. Available at: https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm. Retrieved March 1, 2018.

For more information on Postpartum Depression, see the section on Postpartum Depression.

For more information on Obesity-related issues, see the section on Long-term Follow-Up From Pregnancy Complications.



Chronic Diseases Involving the Cardiovascular and Renal Systems

Background

Chronic diseases have emerged as leading contributors to maternal morbidity and mortality, particularly in the postpartum period. All of these conditions increase the risk of maternal, fetal, and neonatal complications such as preterm birth and preeclampsia.

Screening

For recommended screening tests, laboratory tests, imaging studies, and other diagnostic tests, [see table](#).

Follow-up

Women with chronic medical conditions can have an exacerbation of their illnesses in the immediate postpartum period. These women may benefit from a visit within 2–4 weeks after delivery for evaluation, coordination of care, and treatment optimization. A multidisciplinary approach and care coordination using a patient-centered medical home care model will enhance a continuous, comprehensive care model that is managed by a team leader or health care navigator. Reproductive life planning conversations that should have been initiated during pregnancy should now be implemented to prevent unplanned, close-interval pregnancy.

Resources

Health Care Provider Resources for Patient Care

- ❖ Auger N, Fraser WD, Schnitzer M, Leduc L, Healy-Profitos J, Paradis G. Recurrent preeclampsia and subsequent cardiovascular risk. [Heart 2017;103:235–43](#).
Study of recurrent preeclampsia and long-term cardiovascular hospitalization.
- ❖ BMJ Publishing Group Ltd, British Cardiovascular Society. Heart. Available at: <http://heart.bmj.com/>. Retrieved March 6, 2018.
Heart is an international peer-reviewed journal that keeps cardiologists up-to-date with important research advances in cardiovascular disease.
- ❖ Brickner ME. Cardiovascular management in pregnancy: congenital heart disease. [Circulation 2014;130:273–82](#).
- ❖ Huang C, Chen S. Acute kidney injury during pregnancy and puerperium: a retrospective study in a single center. [BMC Nephrol 2017;18:4](#).
Study to investigate the incidence, characteristics, and outcomes of acute kidney injury during pregnancy and puerperium in a Chinese population.

- ❖ Williams D, Davison J. Chronic kidney disease in pregnancy. [BMJ 2008;336:211–5.](#)
- ❖ Wong JA, Rexrode KM, Sandhu RK, Conen D, Albert CM. Number of pregnancies and atrial fibrillation risk: the women’s health study. [Circulation 2017;135:622–4.](#)

Coding

See [Coding for Chronic Diseases Involving the Cardiovascular and Renal Systems](#)

Table 1. Chronic Conditions in the Postpartum Period

Condition	Background	Postpartum Test or Screening	Management Considerations	Follow-up Goals
Valvular heart disease	Congenital or rheumatic in origin	Pulse oximetry, daily weight, blood pressure, and pulse assessment auscultation, echocardiography and electrocardiography because arrhythmia also can be part of complex	Resolving physiologic changes may continue to place extra demands on function, multidisciplinary team approach Optimization of medications in the setting of breastfeeding*	Optimization of functional status, evaluate need for valvuloplasty or replacement
Atherosclerosis and ischemic heart disease	Comorbidities including obesity, and diabetes may increase risk of angina or myocardial infarction, or both	Pulse oximetry, daily weight, blood pressure, and pulse assessment auscultation in the immediate postpartum period Echocardiography, electrocardiography, stress testing, and cardiac catheterization, as needed, depending on baseline status	Optimization of medications in the setting of breastfeeding, including when to resume antilipids such as statins* Stent placement or bypass surgery	Management of comorbidities Weight control, nutritional consultation
Cardiomyopathy	Congenital, acquired, or peripartum Women may experience exacerbation in the postpartum period	Pulse oximetry, daily weight, blood pressure, and pulse assessment Serial echocardiography, B-Type Natriuretic Peptide Assay will help evaluate recovery of cardiac function	Multidisciplinary approach Medication optimization while breastfeeding, including inotropic agents, afterload reduction, and possible anticoagulants*	Optimization of functional status
Atrial fibrillation	Valvular or nonvalvular/idiopathic	Pulse oximetry, daily weight, blood pressure, and pulse assessment Electrocardiography, Holter monitor, electrophysiology studies may be needed ChA ₂ DS ₂ VASc score to assess stroke risk	Multidisciplinary approach Medication optimization while breastfeeding including antiarrhythmics and anticoagulation*	Optimization of functional status, electrophysiology studies
Nephrotic or nephritic syndrome	Idiopathic or related to underlying collagen vascular disorder or vasculitis Renal disease may worsen if pregnancy was complicated by preeclampsia	Daily weight, blood pressure assessment, renal function assessment As an outpatient, renal ultrasonography and protein-creatinine ratio, electrolytes, and other blood chemistries may be indicated to evaluate postpartum renal function and resolution of pregnancy-related impairment. A renal biopsy may be indicated.	Multidisciplinary approach Medication optimization while breastfeeding including biologics, steroids, and anticoagulation*	Optimization of renal function in the context of potential multiorgan involvement
Renal insufficiency	May result from acute or chronic insults Pregnancy-related insults include preeclampsia, hemolytic uremic syndrome, thrombotic thrombocytopenic purpura	Daily weight, monitor input and urinary output, blood pressure assessment, assessment of serum and urine electrolytes A renal ultrasound examination or renal biopsy, or both, may be indicated.	Multidisciplinary approach May need dialysis Medication optimization while breastfeeding*	Optimization of renal function: may require transplant
Renal transplant	Renal failure related to underlying vasculopathy, collagen vascular disorder, or vasculitis Hypertension may be present	Daily weight, monitor input and urinary output, blood pressure assessment, assessment of serum and electrolytes, renal ultrasound examination, renal biopsy	Multidisciplinary approach Medication dosages of antirejection/biologics will require levels and dosage changes	Transplant maintenance monitoring for rejection
Thyroid disease	Uncontrolled thyroid disease is associated with cardiovascular disease, arrhythmia, and depression Postpartum thyroiditis can occur in women who did not have thyroid disease	Monitor for symptoms of hyperthyroidism or hypothyroidism Repeat thyroid function tests at the postpartum visit	Adjust thyroid medication Referral for specialist treatment for women with newly diagnosed thyroid disease	Normalization of thyroid function tests Resolution of symptoms of thyroid dysfunction
Autoimmune disorders	Uncontrolled autoimmune disorders are associated with chronic morbidity, poor quality of life, disability and, in some cases, increased risk of cardiovascular disease The postpartum period may be marked by a flare of disease activity	Women should be asked about symptoms of a flare in the postpartum period	Multidisciplinary approach Medication optimization while breastfeeding* Medication dosages changed or adjusted as appropriate If underlying disorder affects activities of daily living, consider occupational therapy consultation to assist the woman in caring for her infant	Decrease disease activity Improve functional status Optimization of risk factors for cardiovascular disease.

*Consult LactMed for up-to-date information on individual medications.



Long-Term Follow-up From Pregnancy Complications

Background

- Pregnancy is a window to future health. Pregnancy-related complications predict risk of subsequent diabetes and cardiovascular disease. There are risk factors for cardiovascular disease that appear during pregnancy, and these risk factors are emerging as a predictor to future arteriosclerotic cardiovascular disease (ASCVD) risk. Complications, such as preterm delivery, gestational diabetes, gestational hypertension, and preeclampsia, are associated with greater risk of ASCVD (see table).
- Knowledge regarding these associations presents an opportunity for targeted management in the postpartum period.
- Optimization of health in the postpartum period may improve the health of the woman across the lifespan. For women having a subsequent pregnancy, they may be healthier at the start of the next pregnancy.
- Longer durations of breastfeeding are associated with a reduced cardiometabolic disease risk for women. Health care providers should support women to achieve their breastfeeding goals and optimize medical management using a high-quality resource such as LactMed and prescribing medications that are compatible with breastfeeding.

Resources

American College of Obstetricians and Gynecologists Clinical Guidelines

- ❖ Gestational diabetes mellitus. ACOG Practice Bulletin No. 190. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2018;131:e49–64.

This American College of Obstetricians and Gynecologists' (ACOG) document gives a brief overview of gestational diabetes mellitus, reviews management guidelines that have been validated with clinical research, and identifies gaps in current knowledge to help direct future research.

- ❖ American College of Obstetricians and Gynecologists Task Force Report: Hypertension in Pregnancy. <https://www.acog.org/Clinical-Guidance-and-Publications/Task-Force-and-Work-Group-Reports/Hypertension-in-Pregnancy>

Produced by ACOG's Presidential Task Force on Hypertension in Pregnancy, the report summarizes the current state of knowledge about preeclampsia and other hypertensive disorders in pregnancy, includes practice guidelines for health care providers who treat obstetric disorders, and identifies the most compelling areas of laboratory and clinical research to bridge gaps in current knowledge.

Health Care Provider Resources for Patient Care

- ❖ American College of Obstetricians and Gynecologists. Obesity Toolkit. <https://www.acog.org/About-ACOG/ACOG-Departments/Toolkits-for-Health-Care-Providers/Obesity-Toolkit>

This ACOG toolkit provides information about multiple aspects of obesity care as well as links to additional resources.

- ❖ American Diabetes Association. American Diabetes Association standards of medical care in diabetes—2018. Arlington (VA): ADA; 2018. Available at: <http://diabetesed.net/wp-content/uploads/2017/12/2018-ADA-Standards-of-Care.pdf>. Retrieved March 7, 2018.
This document is intended to provide clinicians, patients, researchers, payers, and other interested individuals with the components of diabetes care, general treatment goals, and tools to evaluate the quality of care.
- ❖ Council on Patient Safety in Women's Health Care. Postpartum care basics for maternal safety from birth to the comprehensive postpartum visit (+AIM). Washington, DC: American College of Obstetricians and Gynecologists; 2017. Available at: <https://safehealthcareforeverywoman.org/patient-safety-bundles/postpartum-care-basics/>. Retrieved March 6, 2018.
Bundle includes an approach for the recognition of early warning signs and symptoms, how to identify system-improvement opportunities, and support tools for patients, families, and staff.
- ❖ Go AS, Bauman MA, Coleman King SM, Fonarow GC, Lawrence W, Williams KA, et al. An effective approach to high blood pressure control: a science advisory from the American Heart Association, the American College of Cardiology, and the Centers for Disease Control and Prevention [published erratum appears in Hypertension 2014;63:e175]. *Hypertension* 2014;63:878–85.
Summary of 2017 guidelines for prevention, detection, evaluation, and management of hypertension in adults.

Patient Resources

- ❖ American College of Obstetricians and Gynecologists. Patient FAQ: Managing High Blood Pressure. <https://www.acog.org/Patients/FAQs/Managing-High-Blood-Pressure>
Patient FAQs on how to manage high blood pressure including information on how often blood pressure should be checked, recommended lifestyle changes, and treatment options.
- ❖ American Diabetes Association. Patient Resource Page: Living with Diabetes. <http://www.diabetes.org/living-with-diabetes/>
Information on what to do if recently diagnosed with diabetes, how to prevent or delay onset of complications, and treatment strategies.
- ❖ American Heart Association. Patient Resource Page: How to Prevent Heart Disease. <https://www.goredforwomen.org/fight-heart-disease-women-go-red-women-official-site/live-healthy/prevent-heart-disease/>
Information on lifestyle changes to reduce risk of heart disease.
- ❖ Centers for Disease Control and Prevention. Diabetes basics. Atlanta (GA): CDC; 2017. Available at: <https://www.cdc.gov/diabetes/basics/index.html>. Retrieved March 1, 2018.
- ❖ Centers for Disease Control and Prevention. High blood pressure. Available at: <https://www.cdc.gov/bloodpressure/index.htm>. Retrieved March 1, 2018.
- ❖ Centers for Disease Control and Prevention. Preventing high cholesterol. Available at: <https://www.cdc.gov/cholesterol/prevention.htm>. Retrieved March 1, 2018.

- ❖ Take Heart and Take Care: Preeclampsia May Be Associated with Heart Disease and Stroke Later in Life. Available at: <https://www.preeclampsia.org/health-information/heart-disease-stroke>

Patient information from the Preeclampsia Foundation on preeclampsia as an early warning sign for future heart disease.

Coding

See [Coding for Long-Term Follow-up From Pregnancy Complications](#)

Table 1. Pregnancy-Related Complications

Condition and Background	Postpartum Test and Screening	Management Considerations	Long-Term Goals
Gestational Diabetes			
Women with gestational diabetes have a sevenfold increased risk of developing type 2 diabetes.	Fasting plasma glucose or 75-g, 2-hour OGTT at 4–12 weeks postpartum; screening should happen every 3 years. If the initial test in the postpartum shows prediabetes, they should be screened for diabetes yearly.	Encourage breastfeeding Women with impaired fasting glucose, impaired glucose tolerance, or diabetes should be referred for preventive or medical therapy.	Early detection of overt diabetes; diabetes prevention
Diabetes			
Poorly controlled diabetes increases risk of nephropathy, neuropathy, retinopathy, cardiovascular disease, and other chronic morbidity. Poorly controlled diabetes is associated with birth defects in the next pregnancy.	Patients should demonstrate good control of blood sugars with hemoglobin A _{1c} <6.5	Weight management Referral for preventive and medical therapy For women with type 1 diabetes, thyroid screening once if never completed. In subsequent pregnancies, consider low-dose aspirin 81 mg QD to reduce pre-eclampsia risk	Goal Hemoglobin A _{1c} : 6.0–6.5% (42–48 mmol/L) recommended Achieve without hypoglycemia
Preeclampsia and Gestational Hypertension			
Women with preeclampsia have an increased risk of recurrence in subsequent pregnancies. These women also have a two-fold increased risk of subsequent cardiovascular disease.	Blood pressure monitoring for 72 hours postpartum Blood pressure monitoring 7–10 days after delivery Postpartum blood pressure check	In subsequent pregnancies, consider low-dose aspirin 81 mg QD to reduce preeclampsia risk	Maintain blood pressure <120/80 Maintain healthy weight
Chronic Hypertension			
Uncontrolled hypertension in the postpartum period increases risk of stroke. Long-term uncontrolled hypertension leads to end organ damage, renal disease, and cardiovascular disease such as heart attacks and strokes.	Blood pressure monitoring for 72 hours postpartum Postpartum blood pressure check Blood pressure increases above antepartum levels in the first 1–2 weeks postpartum	In subsequent pregnancies, consider low-dose aspirin 81 mg QD to reduce pre-eclampsia risk Postpartum adjust medications to maintain blood pressure in the safe range (less than 160 mmHg systolic and less than 100 mmHg diastolic)	Maintain blood pressure <120/80 Maintain healthy weight
Excessive Gestational Weight Gain and Obesity			
Excessive gestational weight gain is associated with higher weight retention and obesity. Obesity increases the risk of type 2 diabetes, hypertension, certain cancers, arthritis, and heart disease.	Measure BMI Preventive screening for diabetes, hypertension, and dyslipidemia if obese	Screen for modifiable risk factors for cardiovascular disease	Reach prepregnancy weight by 6–12 months postpartum; ultimately achieve near-normal BMI
Preterm Birth or Small-for-Gestational-Age Infant			
Preterm birth is associated with a twofold increased risk of future cardiovascular disease; the highest risk is associated with delivery <32 weeks or indicated preterm birth	Measure BMI	Screen for modifiable risk factors for cardiovascular disease	Reduction of modifiable risk factors for cardiovascular disease
Abbreviations: OGTT, oral glucose tolerance test; BMI, body mass index.			



Sample Postpartum Follow-up Checklist

To help us better care for you, please complete this survey and return it to us at your visit. Our discussions with you are private. Your information will not be shared with other people without permission unless we are concerned that someone is in danger.

Thank you for your time.

Note to Providers: In order to facilitate conversations about the many issues that affect maternal health and wellbeing in the early postpartum period, the Task Force drafted a checklist for women to complete at postpartum clinic encounters. This checklist is a framework that has not been tested in clinical care; therefore, health care providers are encouraged to modify for their clinical context.

NAME [Patient Name]	DOB	DATE OF DELIVERY
_____	_____	_____[date time]_____

What Would You Like to Talk About at Your Visit?

- Do you have any concerns, questions, or problems that you would like to discuss at your visit?

[Comments] _____

- What changes or challenges have there been at home since you gave birth?

[Comments] _____

- Have you called the office, visited the emergency room, or called your primary care provider for a problem or issue since you gave birth? If so, for what reason?

[Comments] _____

- Are you currently taking any medications? (prescribed, over-the counter, or herbal therapies)

[Comments] _____

Postpartum Checklist

We are interested in answering your questions.

Please check off the box for the main topics you would like to discuss at **today's visit**

Infant feeding	<input type="checkbox"/> Infant feeding is going well, but I still have questions <input type="checkbox"/> I have pain with breastfeeding <input type="checkbox"/> I am having difficulty breastfeeding my infant <input type="checkbox"/> I am worried that I will not be able to meet my breastfeeding goals <input type="checkbox"/> I have concerns about going back to work or school and maintaining my milk supply
Bleeding	<input type="checkbox"/> My bleeding has decreased in amount since the birth of my infant <input type="checkbox"/> I am concerned about the amount, color, odor of my bleeding
Bladder	<input type="checkbox"/> I am having pain while emptying my bladder <input type="checkbox"/> I have difficulty emptying my bladder <input type="checkbox"/> I have a hard time controlling my bladder (I leak or do not make it to the restroom) <input type="checkbox"/> I do not have any issues with my bladder
Bowels	<input type="checkbox"/> I am having pain while using the toilet to pass stool <input type="checkbox"/> I have difficulty moving my bowels (I am feeling constipated) <input type="checkbox"/> I have a hard time controlling my bowels (My stool leaks) <input type="checkbox"/> I am not having any issues
Incision or laceration	<input type="checkbox"/> My incision or laceration has been healing well; it does not bother me <input type="checkbox"/> I am concerned that my incision/laceration is not healing well
Other symptoms	I am feeling the following symptoms: <input type="checkbox"/> Lightheaded <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chest pain <input type="checkbox"/> Heart racing <input type="checkbox"/> Headache <input type="checkbox"/> Blurry vision <input type="checkbox"/> I am not feeling any symptoms
Safety	<input type="checkbox"/> I am concerned about keeping myself and my family safe <input type="checkbox"/> I am not concerned about keeping myself and my family safe
Nutrition and exercise	<input type="checkbox"/> I would like to learn more about eating healthy and incorporating exercise into my daily life
Emotions and well-being*	In the past 7 days, I have felt <input type="checkbox"/> anxious or worried for no good reason <input type="checkbox"/> scared or panicky for no very good reason I have been so unhappy that I have <input type="checkbox"/> had difficulty sleeping <input type="checkbox"/> been sad or miserable <input type="checkbox"/> been crying <input type="checkbox"/> had thoughts of harming myself

Emotions and well-being*	<input type="checkbox"/> I would like to discuss support groups/counseling services available in my area _____
Family planning and contraception	<input type="checkbox"/> I would like to be pregnant in the next year <input type="checkbox"/> I want to prevent pregnancy and discuss my options for birth control <input type="checkbox"/> I want to obtain a form of birth control at my visit
Sexuality	<input type="checkbox"/> I am interested in having sex and so is my partner. I still have questions <input type="checkbox"/> I am interested in having sex but my partner is not interested. <input type="checkbox"/> I am not interested in having sex but my partner is. <input type="checkbox"/> I am concerned about having sex again after having my infant. <input type="checkbox"/> I am not sexually active
Smoking	<input type="checkbox"/> I want to decrease/stop smoking <input type="checkbox"/> I am concerned about myself and my infant being exposed to other family members who smoke. <input type="checkbox"/> I do not smoke and I am not concerned about myself or my infant being exposed to other family members who smoke.
Alcohol and other drugs	<input type="checkbox"/> I would like to decrease the amount of alcohol I use and need help. <input type="checkbox"/> I need help with my drug use. <input type="checkbox"/> I do not have an alcohol or drug problem.
Infant care	<input type="checkbox"/> Caring for my infant is going well but I still have questions. <input type="checkbox"/> I am having difficulty caring for my infant
Sleep and rest	<input type="checkbox"/> I am not getting adequate sleep and rest. <input type="checkbox"/> I am getting adequate sleep and rest.
Support	<input type="checkbox"/> I have enough or some support at home, but would like more help. <input type="checkbox"/> I do not have enough support at home.
Resources	I need help with signing up for <input type="checkbox"/> Insurance <input type="checkbox"/> Women, Infants, and Children (WIC) program I do not have enough <input type="checkbox"/> food <input type="checkbox"/> diapers <input type="checkbox"/> clothes <input type="checkbox"/> I do not have access to clean water. <input type="checkbox"/> I do not have heat or air conditioning in my house. <input type="checkbox"/> I need help with housing.
Other questions and concerns	<input type="checkbox"/> I have other questions and concerns for this visit related to: _____

*In addition to the checklist, we recommend that patients be screened for postpartum depression using a validated instrument, such as the EPDS or the PHQ9.

For health care providers: If you use the checklist in your clinical setting, please share your experience with us at postpartum@acog.org, so that we can incorporate your feedback into revised versions.



Billing and Reimbursement

Background

- Postpartum care is typically considered part of global obstetric care and is reimbursed that way when rendered by the same obstetric care provider or practice that bills under the same Tax Identification Number (TIN).
- The obstetric care provider who bills a global delivery code is paid the same amount whether or not a patient returns for a postpartum visit. Although the rate of attendance at postpartum visits may be tracked as a quality measure by the Healthcare Effectiveness Data and Information Set (HEDIS) and health plans, without financial incentive, health care providers may be lax in their communication or outreach to patients regarding the importance of postpartum care.
- Postpartum visits that deal with problems or complications can be billed outside of the global obstetric fee.
- Problem visits can be billed outside the global obstetric care fee using E/M codes for outpatient care (eg, 99211–99215, see Coding section).

Varying Definitions

- Health plans define the postpartum period covered under the global obstetric fee in a wide variety of ways. This ranges from as short as 42 days to as long as 90 days for cesarean births under some commercial payers.
- What services are covered under the obstetric global fee during the postpartum period are quite vague for commercial payers. They are usually described as all outpatient issues related to the pregnancy, as well as contraception, for however many visits that takes.

Issues

- Attendance at postpartum visits is generally lower among women of lower socioeconomic status. Barriers to attending include access to childcare and transportation.
- Missing postpartum visits eliminates a prime opportunity to address reproductive life planning, follow-up for complications that occurred during pregnancy, and other issues.
- Different postpartum issues are most appropriately addressed at different times in the “fourth trimester” and, thus, require more than one postpartum visit for optimal care.
- Commercial payer reimbursement policies, both government and private, should align incentives so that obstetric care providers will stress the importance of postpartum care to their patients. This would include during antenatal visits, as well as through active outreach after the birth.

Possible Solutions

- Consider identifying separate intervals of postpartum care and goals for those visits:
 - 1–14 days—perineal/incision check, depression screening, blood pressure check, blood sugar check, review of other antepartum or intrapartum complication, lactation support
 - 15–60 days—contraception counseling, depression screening
 - 60–90 days—full examination and preventive screenings equivalent to annual well woman examination because this will be 1 year after the initial prenatal visit
- Advocate for uncoupling of postpartum care from global fee for obstetric care. Define the aforementioned intervals as eligible for separate reimbursement for postpartum visits with separate CPT codes
- Align incentive for health care providers to promote and encourage postpartum visits, perhaps through innovative programs of providing transportation, group visits, etc.
- Expect pushback from payers and self-funded employers who will resist paying more for global obstetric care. A case will need to be made for the value added of augmented postpartum care to address a multitude of short-term and long-term health issues.

For more information, see section on [Coding for Postpartum Services](#).



Coding for Postpartum Services

Postpartum Services Currently Valued Into the Global Codes (59400, 59510)

These services are included in calculating the global reimbursement for obstetric care.

- Routine hospital visits
 - Vaginal delivery; 1 inpatient visit, 1 discharge, 99231, 99238
 - Cesarean delivery; 2 inpatient visits, 1 discharge; 99231, 99232, 99238
- Routine office visits during global period
 - Vaginal delivery; 1 office visit, valued as a 99214
 - Cesarean delivery; 2 office visits, 1 valued as a 99213 and 1 valued as a 99214
- The postpartum visit should include
 - an interval history
 - a physical examination and Pap test, if needed
 - a review or initiation of birth control methods
 - discussions on breastfeeding, emotional status, counseling for future pregnancies, and any laboratory studies or immunizations appropriate for the specific patient
 - Postpartum counseling for conditions that occurred during pregnancy (ie, glucose tolerance testing in gestational diabetes mellitus, counseling for stillbirth).

Note: E/M code 99214 includes in its value, 25 minutes of physician time spent face-to-face with the patient.

Services Reported Separately During the Postpartum Period

- Treatment and management of complications requiring other services or visits during the postpartum period (eg, gestational diabetes mellitus, hypertension in pregnancy, preterm birth). For example, ordering the 2-hour oral glucose tolerance test for a woman with gestational diabetes mellitus would be included as part of postpartum care. Initiating treatment of newly diagnosed type 2 diabetes with metformin would be a service separately reported.
- Management of problems unrelated to the pregnancy (eg, hypertension, glucose intolerance, obesity).

Coding for Problem Visits

- Select an appropriate Current Procedural Terminology (CPT) Evaluation and Management (E/M) code (eg, 99211–99215), based on the service(s) performed and documented to assess and manage the problem(s) or complication(s). Append modifier 24 to the E/M code.

- Modifier 24 indicates that the E/M service for the problem is unrelated to typical postpartum care by the same physician during a global period.
- Link the E/M code to an *International Classification of Diseases, 10th Edition, Clinical Modification* (ICD-10-CM) code that provides the medical necessity for performing the service.
- Report any procedures performed with the appropriate CPT code linked to the ICD-10-CM code that describes the medical necessity. If both an E/M service and a procedure are performed during the same session, append modifier 25 to the E/M service.
- Modifier 25 indicates that a significant, separately identifiable E/M service was performed by the same physician or other qualified health care professional on the same day of the procedure. For example, an intrauterine device placement performed at a problem visit would be reported with CPT code – 58300 (Insertion of intrauterine device [IUD]) linked to ICD-10-CM code Z30.430 (Encounter for insertion of intrauterine contraceptive device). The E/M service would have modifier 25 added to indicate that a significant, separately identifiable E/M service was performed in addition to the level of E/M service valued into the procedure performed.
- If women continue to have problems or issues, visits to address those issues would be reported as problem visits with E/M codes linked to the diagnosis code for the issue or problem.

Coding for Adverse Pregnancy Outcomes

- Women with hypertension, gestational diabetes, or other pregnancy complications are at risk of future chronic disease. The first postpartum visit can be covered in a 99214 40-minute visit valued in the global. Women can return for problem visits billed outside the global for complications and then return for a well-women visit at 3 months postpartum using 99394–99397.
- Visits for adverse pregnancy outcomes can be coded like preventative service visits. These visits should be selected from the code range 99394–99397 (Periodic comprehensive preventive medicine reevaluation and management of an individual, including an age and gender appropriate history, examination, counseling or anticipatory guidance or risk factor reduction interventions, and the ordering of laboratory or diagnostic procedures, established patient) linked to the preventive services diagnosis code, Z01.411 (Encounter for gynecological examination [general] [routine] without abnormal findings).
- If there is a medically necessary reason for specific tests, those tests may be reported. Typically, the physician is ordering but not performing the test, so the diagnosis code to report on the laboratory request will be the reason the test was ordered (eg, glucose tolerance, lipid panel).

Additional Visits for “Uncomplicated” Postpartum Care

- Additional visits for “*uncomplicated*” postpartum care is considered to be included in the global obstetric package.

Resources

- ❖ American College of Obstetricians and Gynecologists. Coding: login to the support portal [after login]. Available at: <https://acogcoding.freshdesk.com/support/login>. Retrieved March 9, 2018.

- ❖ American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for perinatal care. 8th ed. Elk Grove Village (IL): AAP; Washington, DC: American College of Obstetricians and Gynecologists. 2017.
- ❖ American College of Obstetricians and Gynecologists. OB/GYN coding manual 2018: components of correct procedural coding. Washington, DC: ACOG; 2017.

For more information on Reimbursement, please see section on [Billing and Reimbursement](#).



Racial Disparities in Maternal Mortality in the United States: The Postpartum Period Is a Missed Opportunity for Action

Background

- In 2015, the maternal mortality rate in the United States was 26.4 deaths per 100,000 live births, the highest of any resource-rich country.
- Non-Hispanic black women experience maternal deaths at three to four times that of non-Hispanic white women. The risk of maternal mortality among black women persists after controlling for socioeconomic status.
- The leading causes of death among non-Hispanic black women include complications related to cardiovascular disease, preeclampsia, and eclampsia.
- According to the Centers for Disease Control and Prevention, nearly 60% of maternal deaths in the United States are preventable and most (44%) occur within 42 days of the postpartum period.
- Implicit bias may affect the way obstetrician–gynecologists counsel patients about treatment options such as contraception, vaginal birth after cesarean delivery, and the management of fibroids. For more information on implicit bias, see Vox Media's [video](#) on the effect of slavery on the U.S. medical system and NPR's [article](#) on the history of gynecology.
- Postpartum care is critical to addressing clinical complications and social determinants that prevent women from accessing adequate postpartum care. This currently represents a missed opportunity to help women at a critical time in their lives.

General Recommendations

- Provide anticipatory guidance and coordinated care for women undergoing the postpartum transition. Formulation of a postpartum care plan should begin during pregnancy and include identification of health care professionals who will comprise the postpartum care team for the woman and her infant.
- Recommend early postpartum follow-up for women with hypertensive disorders of pregnancy and other women at risk of complications.
- Use strategies for increasing attendance, particularly among women with limited access to care, such as discussing the importance of the postpartum visit during prenatal care; using peer counselors, intrapartum support staff, postpartum nurses, and discharge planners to encourage postpartum follow-up; scheduling postpartum visits during prenatal care or before hospital discharge; and using technology (ie, email, text, apps) to remind women to schedule postpartum follow-up.

- Ensure equity and respect for autonomy in delivery of care. Evidence suggests that factors such as stereotyping and implicit bias on the part of health care providers may contribute to racial and ethnic disparities in health. For example, to ensure equitable implementation of immediate postpartum long-acting reversible contraception (LARC), one study suggests that programs ensure access to immediate postpartum LARC if desired, without targeting of marginalized women; respect each woman's right to decline LARC, without judgment or pressure; and provide access to affordable LARC device removal at any point, independent of insurance status (1).

Reference

1. Moniz MH, Spector-Bagdady K, Heisler M, Harris LH. Inpatient postpartum long-acting reversible contraception: care that promotes reproductive justice. *Obstet Gynecol* 2017;130:783–7.

Resources

American College of Obstetrician and Gynecologists Clinical Guidance

- ❖ Racial and ethnic disparities in obstetrics and gynecology. Committee Opinion No. 649. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2015;126:e130–4. *Discusses factors at the patient, practitioner, and health care system levels that contribute to existing and evolving racial and ethnic disparities in women's health outcomes.*
- ❖ Importance of social determinants of health and cultural awareness in the delivery of reproductive health care. ACOG Committee Opinion No. 729. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2018;131:e43–8. *Discusses the social determinants of health including social, structural, economic, political, and environmental factors that contribute to differential access to health care and to inequities in health outcomes.*

Health Care Provider Resources for Patient Care

- ❖ Association for Maternal and Child Health Programs. Report from maternal mortality review committees: a view into their critical role. Building U.S. capacity to review and prevent maternal deaths Washington, DC: AMCHP; 2017. Available at: <https://www.cdcfoundation.org/sites/default/files/upload/pdf/MMRIReport.pdf>. Retrieved March 1, 2018. *Overview of an initiative funded by Merck for Mothers to help states improve maternal mortality surveillance.*
- ❖ Council on Patient Safety in Women's Health Care. Reduction of peripartum racial/ethnic disparities (+AIM). Washington, D.C: American College of Obstetricians and Gynecologists; 2016. Available at: <http://safehealthcareforeverywoman.org/wp-content/uploads/2017/11/Reduction-of-Peripartum-Disparities-Bundle.pdf>. Retrieved March 1, 2018. *Provides an overview of racial and ethnic disparities in pregnancy care and outcomes and how to customize the bundle for use in patient care.*
- ❖ Creanga AA, Berg CJ, Ko JY, Farr SL, Tong VT, Bruce FC, et al. Maternal mortality and morbidity in the United States: where are we now? *J Womens Health (Larchmt)* 2014;23:3–9. *Overview of the work conducted by the Division of Reproductive Health at the Centers for Disease Control and Prevention on severe maternal morbidity and mortality in the United States.*

Health Care Provider Tools for Advocacy

- ❖ American College of Obstetricians and Gynecologists. Statement of Policy: ACOG Statement of Policy on Racial Bias. Washington, DC: ACOG, 2017. Available at: <https://www.acog.org/-/media/Statements-of-Policy/Public/StatementofPolicy93RacialBias2017-2.pdf?dmc=1&ts=20180116T1946017910>. Retrieved March 15, 2018.
- ❖ Black Mamas Matter Alliance. Available at: <http://blackmamasmatter.org/>. Retrieved March 1, 2018.
Includes Black Mama's Toolkit, which identifies the rights of pregnant and birthing women and the corresponding role of government to ensure safe and respectful maternal health care for all.
- ❖ Centers for Disease Control and Prevention. Pregnancy Mortality Surveillance System. Available at: <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html>. Retrieved March 1, 2018.
- ❖ SisterSong. Long-acting reversible contraception statement of principles. Available at: <https://www.nwhn.org/wp-content/uploads/2017/02/LARCStatementofPrinciples.pdf>. Retrieved March 1, 2018.
SisterSong's support of inclusion of LARC as part of a well-balanced mix of options, including barrier methods, oral contraceptives, and other alternatives.
- ❖ SisterSong. Reproductive justice. Available at: <http://sistersong.net/reproductive-justice/>. Retrieved March 1, 2018.
SisterSong's support of inclusion of LARC as part of a well-balanced mix of options, including barrier methods, oral contraceptives, and other alternatives.
- ❖ Society for Maternal–Fetal Medicine. Diversity and inclusion in leadership: an official position statement of the Society for Maternal-Fetal Medicine. Washington, DC: SMFM; 2017. Available at: https://s3.amazonaws.com/cdn.smfm.org/media/1107/Leadership_-_January_2017.pdf. Retrieved March 1, 2018.



Returning to Work and Paid Leave

Background

- One in four women return to work within 10 days of giving birth.
- Only 14% of American workers—and only 5% of low-wage workers—have access to paid leave.
- The United States offers 12 weeks of unpaid leave under the 1993 Family Medical Leave Act, which covers approximately 60% of the workforce.
- The standard postpartum maternity leave, which lasts 6 weeks, may not be appropriate for all women. When maternity leave is unpaid, some women may need to return to work sooner than 6 weeks to minimize lost income. Other women may need longer postpartum leave to promote family well-being.
- Time off from work after childbirth benefits women by allowing time for physical recovery, establishing breastfeeding, developing a strong emotional bond with the newborn, and attending health care appointments.
- Paid family leave helps to eliminate the barriers to breastfeeding, particularly for women of color. Enabling optimal breastfeeding would prevent 2,619 maternal deaths and 721 fetal deaths annually in the United States.
- Paid leave can reduce risk for child abuse and neglect.
- Partners with access to paid leave are encouraged to take parental leave and serve as care-givers, which has several positive effects for families. Male partners are twice as likely to take paid leave if they have access to a broad paid family and medical leave program.
- More than 2 million college-aged women (ages 18–24 years) become pregnant each year. Women who give birth while in school face unique challenges when they return. Teenagers who give birth while in high school are at high risk of never graduating.

Assessment

The following are recommendations regarding prenatal care, family leave, and returning to work:

- During prenatal care
 - ask parents about their plans to return to work after the birth.
 - encourage parents to find out what family leave provisions are available from their employer.
 - ensure each parent is aware of his or her rights under the Family Medical Leave Act, state parental leave provisions, and the break time for breastfeeding women provision of the Fair Labor Standard Act
 - assist women with advocacy to employers for practices that promote well-being of new families. These can include structural support for breastfeeding, health care provider facilitation of child care, and accommodation of part-time work.

- Family leave paperwork for employers and insurance companies should be completed in cooperation with childbearing women to ensure that their needs are met without unintended consequences such as termination.
- Returning to work
 - There are no standardized or validated tools for assessing a woman's readiness to return to work after maternity leave.
 - Evaluation of readiness to return to work should include a comprehensive assessment of a woman's physical and psychological health, family needs, and work requirements.
 - New parents may benefit from referrals to social workers or community agencies for assistance in the transition back to work after childbirth.
- All health care providers who care for women and families should advocate for increased paid parental leave as a universal right that benefits child development, families, and society.

Resources

The American College of Obstetricians and Gynecologists Clinical Guidelines

- ❖ Employment considerations during pregnancy and the postpartum period. ACOG Committee Opinion No 733. American College of Obstetricians and Gynecologists. [Obstet Gynecol 2018;131:e115–23](#).

Provides information on employment during pregnancy and the postpartum period and covers topics such as work accommodations, medical leave considerations, and note-writing for obstetrician–gynecologists.

- ❖ Health care for pregnant and postpartum incarcerated women and adolescent females. Committee Opinion No. 511. American College of Obstetricians and Gynecologists. [Obstet Gynecol 2011;118:1198–202](#).

Outlines the special health care needs of pregnancy and incarcerated women and specific issues related to the use of restraints during pregnancy and the postpartum period.

- ❖ Health care for women in the military and women veterans. Committee Opinion No. 547. American College of Obstetricians and Gynecologists. [Obstet Gynecol 2012;120:1538–42](#).

Outlines how to assess the special health care needs of women serving in the military.

- ❖ Optimizing support for breastfeeding as part of obstetric practice. Committee Opinion No. 658. American College of Obstetricians and Gynecologists. [Obstet Gynecol 2016;127:e86–92](#).

Health Care Provider Resources for Patient Care

- ❖ Center for WorkLife Law. Helping patients seek breastfeeding accommodations. Available at: <https://www.pregnantatwork.org/healthcare-professionals/breastfeeding/>. Retrieved March 1, 2018.

Resource for health care professionals to help patients seek pregnancy and breastfeeding accommodations at work. Includes fact sheets and sample health care provider notes to employers.

- ❖ United States Breastfeeding Committee. Who is covered by the law? <http://www.usbreastfeeding.org/p/cm/ld/fid=231>

USBC details federal law relating to workplace accommodations for breastfeeding moms.

Health Care Provider Resources for Policy and Advocacy

- ❖ American College of Obstetricians and Gynecologists. Paid parental leave. Statement of Policy. Washington, DC: American College of Obstetricians and Gynecologists; 2016. Available at: <https://www.acog.org/-/media/Statements-of-Policy/Public/92ParentalLeaveJuly16.pdf?dmc=1&ts=20180216T1342384350>. Retrieved March 1, 2018.
ACOG Statement of Policy endorsing paid parental leave at 100% with benefits for at least 6 weeks for all workers.
- ❖ Appelbaum E, Milkman R. Leaves that pay. Employer and worker experiences with paid family leave in California. Washington, DC: Center for Economic and Policy Research; 2011. Available at: <http://cepr.net/documents/publications/paid-family-leave-1-2011.pdf>. Retrieved March 9, 2018.
This report examines California employees' experiences with paid family and medical leave.
- ❖ Desilver D. Access to paid family leave varies widely across employers, industries. Washington, DC: Pew Research Center; 2017. Available at: <http://www.pewresearch.org/fact-tank/2017/03/23/access-to-paid-family-leave-varies-widely-across-employers-industries/>. Retrieved March 1, 2018
Analysis of who has access to paid leave and who does not.
- ❖ National Partnership for Women and Families. Expecting better: a state-by-state analysis of laws that help expecting and new parents. Available at: <http://www.nationalpartnership.org/issues/work-family/expecting-better-a.html>. Retrieved March 1, 2018.
Comprehensive analysis of state laws and regulations governing paid leave, paid sick days, protections for pregnant workers and other workplace rights for expecting and new parents in the United States.
- ❖ U.S. Department of Labor. The cost of doing nothing: the price we all pay without paid leave policies to support America's 21st century working families. A report prepared by the U.S. Department of Labor. Washington, DC: DOL; 2015. Available at: <https://www.dol.gov/wb/resources/cost-of-doing-nothing.pdf>. Retrieved March 1, 2018.
The U.S. Department of Labor outlines the positive effect paid family and medical leave will have on families after birth (see pages 20–23).
- ❖ U.S. Equal Employment Opportunity Commission. Fact sheet for small businesses: pregnancy discrimination. Washington, DC: EEOC. Available at: https://www.eeoc.gov/eeoc/publications/pregnancy_factsheet.cfm. Retrieved March 1, 2018.
Fact sheet about pregnant women's rights under the Pregnancy Discrimination Act.

Patient Resources

- ❖ A Better Balance. Know your rights. Available at: <https://www.abetterbalance.org/know-your-rights/>. Retrieved March 1, 2018.
Patients' right and resources related to pregnancy and parenting in the workplace.
- ❖ Mayo Foundation for Medical Education and Research. Healthy lifestyle. Labor and delivery, postpartum care. Available at: <https://www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/in-depth/working-life/art-20045470>. Retrieved March 1, 2018.
Patient resource on how to ease the transition back to work.

- ❖ Office on Women's Health, U.S. Department of Health and Human Services. Breastfeeding and return to work. <https://www.womenshealth.gov/breastfeeding/breastfeeding-home-work-and-public/breastfeeding-and-going-back-work>.
Patient information on planning for breastfeeding at work.
- ❖ Share with women. Breastfeeding and working. *J Midwifery Womens Health* 2013;58:721–2.
Patient education handout.
- ❖ U.S. Department of Labor. The cost of doing nothing: the price we all pay without paid leave policies to support America's 21st century working families. A report prepared by the U.S. Department of Labor. Washington, DC: DOL; 2015. Available at: <https://www.dol.gov/wb/resources/cost-of-doing-nothing.pdf>. Retrieved March 1, 2018.
Information sheet about Title IX protections for pregnant or parenting students.

Coding

See [Coding for Returning to Work and Paid Leave](#)



Models of Care for Urban, Rural, and Low-Resource Areas

Background

- A full array of clinical services should be available throughout a woman's life, without delays or the imposition of cultural, geographic, financial, or legal barriers. Full access to care, however, can come with some barriers.
- Risk factors for not having adequate care or access to care include lower socioeconomic status, immigrant status or noncitizenship, physical and mental disabilities, homelessness, former military service, and non-English speaking status.
- Organizations can struggle with developing the proper model of care for the populations they are serving because of inability to meet the needs for translation services, mental health services, adequate staffing, and proper follow-up for the patients.

General Recommendations for Improving Access to Care

- Financial assistance to patients
- Financial incentives to organizations that serve at-risk populations
- Mandates associated with the Patient Protection and Affordable Care Act
- Incentives for health care providers to work in low-resource areas
- On-site resources for social services, pharmacy needs, legal services, and housing opportunities
- Legislation at local, state, and national levels to provide funding for organizations, health care providers, and patients
- Education to patient populations about the importance of receiving health care
- Advocacy for the low-resource areas to improve the access to health care
- Involvement of mental health care providers and services to collaborate on postpartum depression
- Resources for hypertensive management. Involvement of American College of Physicians, American Academy of Family Physicians, or similar organizations
- Resources for diabetes management postpartum. Involvement of American College of Physicians or American Academy of Family Physicians
- Work with local health department on improvement of services
- Development of telemedicine as a resource
 - High-risk postpartum care
 - Frequent follow-up
 - Emergency visits
 - Education tool
 - Nutrition counseling, psychotherapy

Resources

American College of Obstetricians and Gynecologists Clinical Guidance

- ❖ Health care for homeless women. Committee Opinion No. 576. American College of Obstetricians and Gynecologists. [Obstet Gynecol 2013;122:936–40](#).
Discussion on how health care providers can address the needs of homeless individuals and educate these patients about available resources in the community, treat their health problems, and offer preventive care.
- ❖ Health care for unauthorized immigrants. Committee Opinion No. 627. American College of Obstetricians and Gynecologists. [Obstet Gynecol 2015;125:755–9](#).
Recommendations for increasing access to quality health care to unauthorized immigrants and their children.
- ❖ Health disparities in rural women. Committee Opinion No. 586. American College of Obstetricians and Gynecologists. [Obstet Gynecol 2014;123:384–8](#).
Outlines rural health care disparities and the role of obstetrician–gynecologists.
- ❖ Health care systems for underserved women. Committee Opinion No. 516. American College of Obstetricians and Gynecologists. [Obstet Gynecol 2012;119:206–9](#).
Discussion on the Patient Protection and Affordable Care Act and underserved populations.

Health Care Provider Resources

- ❖ Center for Connected Health Policy. Research catalogues. Available at: <http://www.cchpca.org/about-cchp>. Retrieved March 1, 2018.
National telehealth policy resources



New Paradigms for Training in Postpartum Care as a Continuum of Women's Health

Background

- Board-certified health care provider education in obstetrics and gynecology is in part provided through a Maintenance of Certification program provided by the American Board of Obstetrics and Gynecology (ABOG).
- Accreditation Council for Graduate Medical Education requires faculty of residency programs to have current certification by ABOG.
- Accreditation Council for Graduate Medical Education's Obstetrics and Gynecology program requirements include the following:
 - Assessment should specifically monitor the resident's knowledge by use of a formal examination such as the Council on Resident Education in Obstetrics and Gynecology (CREOG) In-Training Examination or other cognitive examinations.
 - Expectations of trainees and health care providers in obstetrics and gynecology include coordinating patient care within the health care system relevant to their clinical specialty, working in interprofessional teams to enhance patient safety and improve patient care quality, and advocating for quality patient care and optimal patient care systems.

General Recommendations for Health Care Provider Dissemination

- Identify reviews and original research in postpartum care and recommend to ABOG for consideration to include in annual Maintenance of Certification offerings. These should include but are not limited to [Committee Opinion 736, Optimizing Postpartum Care](#).
- Include sessions (clinical seminars) at the American College of Obstetricians and Gynecologists' (ACOG) annual meeting that specify the postpartum visit as a continuum of care for cardiac health, obesity, diabetes, and substance use disorders.
- Revisit the Postpartum Care Plan; after specific interval care recommendations make available to fellows. <https://www.acog.org/-/media/Departments/Members-Only/Patient-Records/AA197-Postpartum-Form.pdf?dmc=1> (*Member access required*)
- Develop protocol or toolkit pieces that include algorithms that health care providers can use easily within ACOG materials.
- Organize toolkits or protocols for health care providers in subtopics.
- The Centers for Disease Control and Prevention can share information with clinicians through its partners: state Medicaid offices within public health departments (through memoranda and health care provider notices that highlight changes in billing, coding, reimbursement for services); Association of State and Territorial Health Officers; Health Resources and Services

Administration (manage Federally Qualified Health Centers and rural health centers); Office of Population Affairs (administers Title X/Family Planning Clinics); National Association of County and City Health Officials (Maternal and Child Health).

General Recommendations for Public Awareness

- Promote at the ACOG annual meeting in general sessions with invitations to district meetings and 2019—call for best practice in Postpartum Care as a continuum of women's health.
- Collaboratively provide materials similar to those listed in the section "General Recommendations for Health Care Provider Dissemination" for colleagues in family and community medicine, internal medicine, certified nurse midwifery, Association of Women's Health, Obstetric and Neonatal Nurses, and American Academy of Physician Assistants.
- Request Centers for Disease Control and Prevention to include information about updated postpartum care guidance on its website.

Follow-up

- Develop CREOG material learning objectives, independent learning modules, CREOG quiz items) for residency program directors and faculty to use.
- Use the media to increase public awareness of the importance of postpartum care.

Resource

- ❖ Accreditation Council for Graduate Medical Education. ACGME program requirements for graduate medical education in obstetrics and gynecology. Chicago (IL): ACGME; 2017. Available at: http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/220_obstetrics_and_gynecology_2017-07-01.pdf?ver=2017-05-25-084930-787. Retrieved March 1, 2018.



Care Coordination, Referral, and Collaboration With Hospitals and Health Care Systems

Background

Maternal morbidity and mortality are at their highest in 25 years. This health care crisis in the United States will require a multifaceted approach. A paradigm shift is needed to center postpartum care on the needs of women. Implementation will require coordination of current hospital and health system resources that become sustainable beyond a fixed visit or short-term peripartum period and lead to the creation of a health care medical home model.

Resources and Implementation Strategies

- The [American College of Obstetricians and Gynecologists' Postpartum Care Plan Form A](#) (*ACOG members only*) begins in the antepartum period, carries through peripartum and postpartum periods, and leads to ongoing care coordinated by a **health care navigator**.
- Care coordination using a patient-centered medical home care model will transform the episodic fragmented approach into a continuous comprehensive care model that is coordinated by a team leader or **health care navigator**.
- Implicit interpregnancy care proposed by family medicine interweaves ongoing maternal care into well baby visits. ([Implicit Network](#))
- Implementing team-based care can rely on novel telehealth and economic proposals. ([Collaboration in Practice: Implementing Team-Based Care](#), Task force report and executive summary p. 13–31).
- Patient safety bundles can guide care from birth to comprehensive postpartum health care. Patient bundles include a critical set of processes based on available guidance, tools, and resources that have been developed by trusted organizations. (www.safehealthcareforeverywoman.org)
- Association of Women's Health, Obstetric and Neonatal Nurses' postpartum discharge education plan targets major life-threatening complications and highlights that many are preventable, including severe hypertension, venous thromboembolism, infection, cardiac disease, and hemorrhage. Education regarding postbirth warning signs and use of checklists has the potential to be lifesaving. (<http://nwhjournal.org/cms/attachment/2075726627/2069832130/mmc1.pdf> [requires log in] and <https://www.perinatalqi.org/page/PPDischargeEdu>)
- Comprehensive postpartum care can facilitate the transition to well woman care as demonstrated by the Community Care initiative of North Carolina. Their novel approach to a pregnancy medical home care pathway serves as a model for best practice. It incorporates the following elements: postpartum depression screening, reproductive health planning, screening for chronic diseases, providing appropriate vaccinations, and promoting smoking cessation. (<https://www.communitycarenc.org/what-we-do/clinical-programs/pregnancy-medical-home/pmh-pathways/postpartum-care-and-transition-well-woman-care>)



Implementation of New Models of Care

Background

- Although there may be barriers to putting new models of care into practice, the American College of Obstetricians and Gynecologists has developed a variety of documents that can help in the standardization of the delivery of patient care. In addition to the resources of the American College of Obstetricians and Gynecologists, collaborations with state and local public health departments (for development of state and local policies and recommendations), state Medicaid programs (for development of value-based payment strategies), and state Perinatal Quality Collaboratives (to improve practice through use of quality improvement methodology) are useful for implementation and scale-up of new models of care. Some key principles that the following resources highlight include the following:
 - Plans for implementation should include resources to help practitioners develop a plan for personalized postpartum care; a plan for education of health care providers and patients, screening, and discharge from maternity care; and a plan to ensure access to treatment and referral for specialty care.
 - Incorporation of checklists and protocols into systems can help practitioners provide the best evidence-based care to their patients; however, health care providers must balance the need for standardized care with a patient centered, shared decision-making approach.
 - Patients should be actively involved in the planning of health care services to improve the quality of care.
 - Strategies to optimize postpartum health should encourage a higher level of coordination among services and linkage to well-woman care to improve women and infants' health outcomes.

Resources

American College of Obstetricians and Gynecologists Clinical Guidance

- ❖ Clinical guidelines and standardization of practice to improve outcomes. Committee Opinion No. 629. American College of Obstetricians and Gynecologists. [Obstet Gynecol 2015;125:1027–9.](#)
- ❖ Partnering with patients to improve safety. Committee Opinion No. 490. American College of Obstetricians and Gynecologists. [Obstet Gynecol 2011;117:1247–9.](#)
Discussion on involving patients in the planning of health care services is recommended as a means of improving the quality of care
- ❖ The use and development of checklists in obstetrics and gynecology. Committee Opinion No. 680. American College of Obstetricians and Gynecologists. [Obstet Gynecol 2016;128:e237–40.](#)

Health Care Provider Resources

- ❖ Centers for Medicare and Medicaid Services. Maternal and infant health care quality. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-and-infant-health/>. Retrieved March 6, 2018.
- ❖ Council on Patient Safety in Women's Health Care. Postpartum care basics for maternal safety from birth to the comprehensive postpartum visit (+AIM). Washington, DC: American College of Obstetricians and Gynecologists; 2017. Available at: <http://safehealthcareforeverywoman.org/wp-content/uploads/2017/11/Postpartum-Care-Basics-Bundle.pdf>. Retrieved March 6, 2018.
- ❖ Provider Resources Inc. Improving maternal and infant health outcomes, CMCS crosswalk of current activities and identified potential strategies. Erie (PA): PRI; 2013. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/crosswalk-of-activities.pdf>. Retrieved March 6, 2018.
- ❖ Rankin KM, Haider S, Caskey R, Chakraborty A, Roesch P, Handler A. Healthcare utilization in the postpartum period among Illinois women with Medicaid paid claims for delivery, 2009–2010. *Matern Child Health J* 2016;20:144–53.



Calls for Research

There is a need for more postpartum care research. The Postpartum Care Task Force developed potential research questions around clinical and health care systems-related topics outlined in Table 1.

Table 1. Postpartum Care Research	
Topic	Potential Research Questions and Areas of Research
Achieving a healthy weight	<ul style="list-style-type: none"> • Effective approaches to postpartum weight loss • When can women resume exercise in the postpartum period?
Models of care for urban, rural, and low-resource areas	<ul style="list-style-type: none"> • Does adherence to postpartum care lead to improvement in mental or physical health? • Is there increased long-term adherence to contraception with access to postpartum care?
Implementation of new models through collaboratives and public health agencies	<ul style="list-style-type: none"> • What significant barriers (payor, patient, and health care provider) exist with postpartum care?
Returning to work and paid leave	<ul style="list-style-type: none"> • What factors are associated with postpartum mental and physical health among women who return to paid work? • What interventions improve mental and physical well-being among women in the postpartum period who return to paid work? • Health disparities related to returning to work after giving birth and parental leave
Engagement with postpartum care	<ul style="list-style-type: none"> • What are effective and proven strategies to improve adherence to postpartum visits? • What is the effect of novel models such as dyad care on adherence? • What is the effect of different funding models on use of care?
Optimization of long-term health	<ul style="list-style-type: none"> • Screening and preliminary treatment recommendations for women with affective disorders • Strategies for prevention of cardiovascular disease through statins, diet, and exercise
Substance abuse	<ul style="list-style-type: none"> • Detection and management of tobacco use, substance use disorders, and alcohol misuse in the postpartum setting
Delivery of postpartum care	<ul style="list-style-type: none"> • How can postpartum care be restructured to decrease morbidity and increase well-being? • How can postpartum care become more family-centered? • How does the current health care funding environment, particularly the Medicaid spending cuts, affect the care and outcomes of women and children, particularly racial and ethnic minorities? • Interventions to decrease emergency room visits
Breastfeeding	<ul style="list-style-type: none"> • Assessment of breastfeeding knowledge for women of different socioeconomic, ethnic, and religious backgrounds • Exploration of how culture and religion play a role in breastfeeding • Effect of breastfeeding promotion in low-resourced communities and women of lower socioeconomic status • Breastfeeding knowledge and practices of health care providers of prenatal and postpartum care

(continued)

Table 1. Postpartum Care Research (continued)	
Topic	Potential Research Questions and Areas of Research
Postpartum complications	<ul style="list-style-type: none"> • Prospective studies regarding outcomes of pregnancy and postpartum complications • Survey of health care providers regarding knowledge, attitudes, and perceptions of postpartum complications and maternal health care • Better define health care needs by surveying women about their postpartum experiences and complications
Care coordination and referral, and collaboration with hospitals and health care systems and their relation to delivery of health care	<ul style="list-style-type: none"> • How use of checklists can translate into meaningful personalized care • Creating innovative collaborative programs that improve postpartum care through a coordinated delivery or algorithm tied to a cost-sharing performance feedback system* • Methods of implementation and sustainability of care plans • Reconsidering the scope and duration of postpartum care by comparing standard care to expanded postpartum care using decreased emergency department visits as an endpoint.[†] • How can telemedicine improve the implementation of postpartum care?
Other	<ul style="list-style-type: none"> • Initiating a Framingham study for postpartum patients • Comparative studies to determine the effectiveness of interventions to address postpartum health needs
<p>*Howell EA, Padron NA, Beane SJ, Stone J, Walther V, Balbierz A, et al. Delivery and payment redesign to reduce disparities in high risk postpartum care. Matern Child Health J 2017;21:432–8.</p> <p>[†]Batra, P; Fridman, M; Leng, M, et al. Emergency Department Care in the Postpartum Period: California Births, 2009–2011. Obstet Gynecol 2017;130:1073–81.</p>	



Coding for Counseling

The correct Evaluation and Management (E/M) code will depend on whether the encounter was for screening or treatment of the disease.

If the encounter was for screening for a patient *without* symptoms, report a preventive medicine code. These codes are selected according to the time spent in face-to-face counseling with the patient. Whether or not these codes will be reimbursed will vary.

Possible procedure codes are:

- 99401–99404 Preventive medicine, individual counseling
- 99411–99412 Preventive medicine, group counseling

Counseling codes list “typical times” in their descriptions. The times noted in the Current Procedural Terminology (CPT)® descriptions are only averages and represent a range of times that may be higher or lower depending on actual clinical circumstances. In most cases, time is used only as a reference and does not influence code selection.

Sometimes, a physician may perform a physical examination and obtain a history, but may spend either

- more than 50% of the total time with the patient providing counseling or
- the entire visit providing counseling for a patient and/or their families.

In these cases, the level of service may be determined using time alone. The Current Procedural Terminology states: “When **counseling** and/or coordination of care **dominates** (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then **time** may be considered the key or controlling factor to qualify for a particular level of E/M service. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (e.g., foster parents...). The extent of counseling and/or coordination of care must be documented in the medical record.”

Definition of Counseling

Counseling as used in the aforementioned definition is a discussion with a patient, or her family, or both, about the following

- Diagnostic results, impressions, or recommended studies, or a combination of these
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) or follow-up

- Importance of compliance with chosen management (treatment) options
- Risk factor reduction
- Patient and family education

Documenting Time

When time is the determining factor for the selection of the level of service, documentation should include the following:

- The total length of time spent by the physician with the patient
- The time spent in counseling or coordination of care activities
- A description of the content of the counseling or coordination of care activities

Measuring Time

The average times listed for the E/M services represent the “intraservice” time associated with providing the service. Only the time spent providing the time-based code can be used in the selection of the code. Time spent in other concurrent activities, such as procedures, should not be considered in the selection of the time-based code. Time for E/M services is measured as follows:

- **Face-to-Face Time (office and other outpatient E/M codes and office consultations):** Physician time spent face-to-face with the patient, or family, or both. This includes the time in which the physician obtains a history, performs a physical examination, and counsels the patient.
- **Unit or floor Time (hospital observation, inpatient hospital care, inpatient consultations):** Physician time spent with the patient and on the patient’s unit. This includes the time during which the physician establishes or reviews the patient’s chart, or both; examines the patient; writes notes; and communicates with other professionals and the patient’s family.

A unit of time is met when the midpoint is passed (eg, an hour is attained when 31 minutes has passed). Time that falls between two times for codes ranked in sequential typical times, such as some E/M service codes, is reported using the code with the closest actual time. Note that Medicare carriers may require that the time be equal to or greater than the typical time for the reported E/M code.

Time for services measured in units other than days are considered continuous times even if the service extends into another calendar date. An example is critical care services that begin before midnight and extend into the next calendar date. The date of service on which the service began should be reported as the date of service.



Coding for Chronic Diseases Involving the Cardiovascular and Renal Systems

Cardiovascular System

Valvular heart disease

Atherosclerosis and ischemic heart disease

Cardiomyopathy

Atrial fibrillation

In the case of *preexisting heart disease complicating puerperium*, code 099.43, Diseases of the circulatory system complicating the puerperium should be used.

An additional code is used to identify the specific disease of the circulatory system. Codes from the following categories should be applied:

- Q24.8 Other specified congenital malformations of heart
- I38 Endocarditis, valve unspecified
- I70 Atherosclerosis
- I20–I25 Ischemic heart diseases (use additional code to identify presence of hypertension [I10–I16])
- I48 Atrial fibrillation
- I42 Cardiomyopathy

Renal System

Nephrotic or nephritic syndrome

Renal insufficiency

Renal transport

Preexisting hypertensive chronic kidney disease

Preexisting hypertensive heart and chronic kidney disease

For chronic kidney disease with preexisting hypertension complicating the puerperium, codes from category **O10, Pre-existing hypertension complicating pregnancy, childbirth and the puerperium**, should be applied, as follows:

- O10.23 Pre-existing hypertensive chronic kidney disease complicating the puerperium
- O10.33 Pre-existing hypertensive heart and chronic kidney disease complicating the puerperium

When assigning one of the O10 codes that include hypertensive heart disease or hypertensive chronic kidney disease, a secondary code from the appropriate hypertension category must be added to specify the type of hypertensive chronic kidney disease (category I12) or hypertensive heart and chronic kidney disease (category I13).

In the case of preexisting renal system disease complicating pregnancy and puerperium, codes from subcategory **O99.89, Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium**, should be used.

An additional code from categories N00–N99 is used to identify the specific condition. Possible codes to use are the following:

- N00–N05 Nephritic syndrome/nephrotic syndrome
- N18 Chronic kidney disease
- N10–N16 Renal tubule-interstitial diseases



Coding for Immunization

According to the Current Procedural Terminology (CPT), report vaccine immunization administration codes 90460, 90461, and 90471–90474 in addition to the vaccine and toxoid code(s) 90476–90749.

Administration

- 90460 Immunization administration through 18 years of age by any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered
- 90461 Immunization administration through 18 years of age by any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)
- 90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine or toxoid)
- 90472 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine or toxoid) (List separately in addition to code for primary procedure)
- 90473 Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine or toxoid)
- 90474 Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine or toxoid) (List separately in addition to code for primary procedure)

Vaccine Codes

Human Papillomavirus

- 90649 Human papillomavirus vaccine, types 6, 11, 16, 18, quadrivalent (4vHPV), 3-dose schedule, for intramuscular use
- 90650 Human papillomavirus vaccine, types 16, 18, bivalent (2vHPV), 3-dose schedule, for intramuscular use
- 90651 Human papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2- or 3-dose schedule, for intramuscular use

Influenza

For the influenza virus vaccine, the following CPT codes are reported: 90630, 90653–90658
HCPCS codes Q2034–Q2039 are used to report influenza virus vaccine:

- Q2034 Influenza virus vaccine, split virus, for intramuscular use (Agriflu)
- Q2035 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (AFLURIA)
- Q2036 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (FLULAVAL)
- Q2037 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (FLUVIRIN)
- Q2038 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)
- Q2039 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)

For Medicare beneficiaries, the seasonal influenza vaccine is usually administered once a year during the fall or winter months. Additional influenza vaccines (ie, the number of doses of a vaccine or the type of influenza vaccine) are covered by Medicare when medically necessary. Influenza vaccine plus its administration is a covered Part B benefit. Influenza vaccine is NOT a Part D covered drug.

For the administration of the vaccine report the following HCPCS code:

- G0008 Administration of influenza virus vaccine

Tdap Vaccination

- 90715 Tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) vaccine, when administered to individuals 7 years or older, for intramuscular use

MMR

- 90707 Measles–mumps–rubella (MMR) virus vaccine, live, for subcutaneous use

Varicella

- 90716 Varicella (VAR) virus vaccine, live, for subcutaneous use

There is also combination MMR and varicella vaccine code:

- 90710 Measles–mumps–rubella–varicella (MMRV) vaccine, live, for subcutaneous use

Diagnosis Codes

International Classification of Diseases, 10th Edition, Clinical Modification, diagnosis code Z23 (Encounter for immunization) is appropriate when reporting these services.



Coding for Intimate Partner Violence

Counseling

Current Procedural Terminology Codes

According to the Current Procedural Terminology (CPT), codes 99384–99397 include age-appropriate counseling, anticipatory guidance, and risk factor reduction interventions provided at the time of the initial or periodic comprehensive preventive medicine examinations.

If the encounter was for screening for a patient *without* symptoms, report a preventive medicine code. These codes are selected according to the time spent in face-to-face counseling with the patient. Use codes 99401, 99402, 99403, 99404 for individual counseling, and codes 99411 and 99412 for group counseling as appropriate:

- 99401 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
- 99402 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
- 99403 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
- 99404 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
- 99411 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
- 99412 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes

Diagnosis Codes

- O9A.4 Sexual abuse complicating pregnancy, childbirth, and the puerperium
 - O9A.41 Sexual abuse complicating pregnancy
 - O9A.411 Sexual abuse complicating pregnancy, first trimester
 - O9A.412 Sexual abuse complicating pregnancy, second trimester
 - O9A.413 Sexual abuse complicating pregnancy, third trimester
 - O9A.42 Sexual abuse complicating childbirth
 - O9A.43 Sexual abuse complicating the puerperium

There is no specific ICD-10 or CPT code for domestic, sexual, and interpersonal violence screening, but code Z13.89, Encounter for screening for other disorder, could possibly be reported. In addition to abuse diagnosis codes, codes from category Y07, Perpetrator of assault, maltreatment and neglect, may be reported. Codes from this category may be used only in cases of confirmed abuse (T74.-) (T74–T74.92XS).

Medicare does not reimburse for consultation codes. Physicians providing consultation services to Medicare patients should report the E/M codes that represent where the visit occurs and that identify the complexity of the visit performed.



Coding for Long-Term Follow-up From Pregnancy Complications

Diabetes Coding

Because diabetes is a complicating condition in pregnancy, a pregnant woman with diabetes may be seen for additional services. It is important that the *International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM)* code reflects the appropriate condition in order to support these additional services. Pregnant women who are diabetic should be assigned a code from category O24 (Diabetes mellitus in pregnancy, childbirth, and the puerperium).

Subcategories O24.0-, O24.1-, O24.3-, and O24.8- are reported when a pregnant woman has preexisting diabetes. These subcategories distinguish between type 1, type 2, other specified, and unspecified diabetes. Each subcategory contains codes to describe services in childbirth and the puerperium as well as the antenatal period. Services provided in the antenatal period require identification of the trimester. The ICD-10-CM also instructs that a code from category E08–E13 be reported to further identify any manifestations.

Gestational Diabetes

Gestational diabetes occurs in women who develop diabetes in pregnancy but who were not diabetic before pregnancy. Gestational diabetes codes are found in subcategory O24.4-. When a code indicating gestational diabetes is reported, another diabetes code should not be reported.

The 5th character in the O24.4 (gestational diabetes) subcategory specifies whether the encounter occurs

- in pregnancy
- in childbirth
- in the puerperium

The 6th character indicates the method of diabetes control. There are diagnosis codes for diet, oral hypoglycemic, and insulin control. If a patient is controlled by diet and insulin, only the code for insulin-controlled is required.

There are no trimester designations in the subcategory for gestational diabetes because the condition occurs only in the second and third trimesters.

Abnormal glucose tolerance in pregnancy is assigned a code from the subcategory O99.81 (Abnormal glucose complicating pregnancy, childbirth, and the puerperium).

Subcategory O24.9 (Unspecified diabetes) is reported when the medical record does not indicate the type of diabetes.

A code from the Z3A category should be reported whenever a code from Chapter 15 is reported to identify the week of gestation.

To accurately assign ICD-10-CM codes for diabetes complicating pregnancy, the following information is needed:

Preexisting	Pregnancy-Induced
Type of Diabetes (Type 1, Type 2, or Other)	Condition (Abnormal glucose O99.81- or Gestational O24.4-)
Trimester	Maternal episode of care (pregnancy, childbirth, puerperium)
Any manifestations or complications (E08, E09, E10, E11, E13)	Method of control for gestational (diet, oral glycemic, insulin, unspecified)

Hypertension Coding

Categories O10–O11 contain codes for preexisting hypertension and require identification of the trimester. Category O10 also contains codes for hypertensive heart and chronic kidney disease. Most of these codes contain six characters. When assigning a code related to these conditions, it is necessary to add a secondary code to specify the type of heart failure or chronic kidney disease. Category O11 is for preexisting hypertension with preeclampsia and requires an additional code from category O10 to identify the type of hypertension.

In addition to essential hypertension, Category O10 includes the following subcategories:

- O10.1 Pre-existing hypertensive heart disease complicating pregnancy
- O10.2 Pre-existing hypertensive chronic kidney disease complicating pregnancy
- O10.3 Pre-existing hypertensive heart and chronic kidney disease complicating pregnancy
- O10.4 Pre-existing secondary hypertension complicating pregnancy
- O10.9 Unspecified pre-existing hypertension complicating pregnancy, childbirth, and the puerperium

Each subcategory indicates the condition in Chapter 9, Diseases of the Circulatory System, that applies to the specific subcategory. The instructions also state that an additional code from the circulatory chapter should be reported to identify the type of hypertension. It is important to be familiar with the codes that require an additional diagnosis in order to fully describe the patient's condition and circumstances.

Additionally, hypertension has distinct categories, subcategories, and codes to describe preexisting and pregnancy-related conditions.

Gestational Hypertension

Category O12 contains codes for gestational edema, gestational proteinuria, and gestational edema with proteinuria without hypertension. Codes from category O12 (Gestational [pregnancy-induced] edema and proteinuria without hypertension) are reported when patients develop edema and protein in their urine but do not develop hypertension. There are subcategories for edema alone, proteinuria alone, and both conditions together. Documentation for these conditions might be found in the examination or laboratory work, but it is advisable not to report these codes unless the physician clearly documents one of these conditions.

Category O13 is reported for hypertension without significant proteinuria and also can be used for hypertension not otherwise specified.

Preeclampsia

Category O14 is reported for preeclampsia without any preexisting hypertension and has subcategories to describe the severity of the condition, including hemolysis, elevated liver enzymes, and low platelet count (HELLP) syndrome.

Category O15 is reported for eclampsia.

Counseling

Per CPT, codes 99384–99397 include age-appropriate counseling, anticipatory guidance, and risk factor reduction interventions provided at the time of the initial or periodic comprehensive preventive medicine examinations.

If the encounter was for screening for a patient without symptoms, report a preventive medicine code. These codes are selected according to the time spent in face-to-face counseling with the patient. Use codes 99401, 99402, 99403, 99404 for individual counseling, and codes 99411 and 99412 for group counseling as appropriate:

- 99401 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
- 99402 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
- 99403 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
- 99404 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
- 99411 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes

- 99412 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes

These codes are not reported when the physician counsels an individual patient with symptoms or an established illness. In this case, a problem-oriented E/M service is reported. For counseling groups of patients with symptoms or established illness, see code 99078.



Coding for Newborn Care

Counseling

Services bundled as a part of the routine obstetrics care visits should not be billed separately. Those services include education on breastfeeding and lactation. Postpartum care includes inpatient and outpatient services. The typical inpatient stay is 2 days for a vaginal delivery and 3 days after a cesarean delivery. Outpatient services include one visit for a vaginal delivery and two visits for a cesarean delivery.

Current Procedural Terminology (CPT) includes the following services in the postpartum package:

- Routine outpatient visit(s) after delivery
- Routine inpatient visit(s) after delivery

Note that routine inpatient visit(s) immediately after delivery are considered part of the delivery and not reported separately.

The CPT global package does not include inpatient or outpatient Evaluation and Management (E/M) services or procedures performed to treat complications, illness, or disease unrelated to routine postpartum care.

Consultations on breastfeeding, lactation, and basic newborn care are considered a part of the global package and not billed separately. Only codes for complications, illness, or disease could be excluded from the routine postpartum care and billed separately.

Examples of complications that might require services in addition to the global obstetric code are:

- Infection of nipple associated with the puerperium (O91.02)
- Infection of nipple associated with lactation (O91.03)
- Abscess of breast associated with the puerperium (O91.12)
- Abscess of breast associated with lactation (O91.13)
- Nonpurulent mastitis associated with the puerperium (O91.22)
- Nonpurulent mastitis associated with lactation (O91.23)
- Retracted nipple associated with the puerperium (O92.02)
- Retracted nipple associated with lactation (O92.03)
- Cracked nipple associated with the puerperium (O92.12)
- Cracked nipple associated with lactation (O92.13)
- Unspecified disorder of breast associated with pregnancy and the puerperium (O92.20)
- Other disorders of breast associated with pregnancy and puerperium (O92.29)

- Agalactia (O92.3)
- Hypogalactia (O92.4)
- Suppressed lactation (O92.5)
- Galactorrhea (O92.6)
- Unspecified disorders of lactation (O92.70)
- Other disorders of lactation (O92.79)

For some high-risk pregnancies, a neonatal consultation during the antepartum period may be helpful in obstetric management and can assist the parents in understanding what to expect for their newborn. This is of particular importance when fetal anomalies are significant or the delivery of a very preterm infant is expected.

Current Procedural Terminology Codes

According to the CPT, codes 99384–99397 include age-appropriate counseling, anticipatory guidance, or risk factor reduction interventions provided at the time of the initial or periodic comprehensive preventive medicine examinations. For counseling provided at a separate time from the preventive medicine examination encounter, codes 99401, 99402, 99403, 99404, 99411, and 99412 could be used:

- 99401 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
- 99402 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
- 99403 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
- 99404 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
- 99411 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
- 99412 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes

Diagnosis Codes

- Z32.3 Encounter for child care instruction



Coding for Postpartum Complications

(O85–O92, Complications Predominantly Related to the Puerperium)

The Current Procedural Terminology (CPT) global package does not include inpatient or outpatient Evaluation and Management (E/M) services or procedures performed to treat complications, illnesses, or diseases unrelated to routine postpartum care. Postpartum services that are not routine (not part of the global obstetrics package) can be reported separately with E/M codes and codes for services provided to treat complications, if there were any.

Postpartum complications could be described by codes O8–O92. If there is no specific code to describe the complication, code **O90.89, Other complications of the puerperium, not elsewhere classified**, should be applied as principal diagnosis, with an additional code assigned for the specific complication.

Fecal Incontinence

Diagnosis Codes

Fecal incontinence could be caused by disruption of a perineal obstetric wound (laceration) that was repaired during labor. In this case, code from chapter 15, **O90.1, Disruption of perineal obstetric wound**, should be assigned as principal diagnosis, with code **R15.9, Full incontinence of feces**, as an additional diagnosis. If fecal incontinence was not caused by perineal wound disruption, use complication code O90.89.

- O90.89 Other complications of the puerperium, not elsewhere classified
- O90.1 Disruption of perineal obstetric wound
- R15.9 Full incontinence of feces

Urinary Incontinence

Diagnosis Codes

Postpartum urinary incontinence may be caused by urinary tract infection. The following codes from category **O86.2-, Urinary tract infection following delivery**, may be applied:

- O86.20 Urinary tract infection following delivery, unspecified
- O86.21 Infection of kidney following delivery
- O86.22 Infection of bladder following delivery
- O86.29 Other urinary tract infection following delivery

Use additional code (B95–B97) to identify infectious agent.

Other diagnosis codes

- O90.89 Other complications of puerperium, not elsewhere classified
- N39.3 Stress incontinence (female) (male)
- N39.498 Other specified urinary incontinence
- N36.42 Intrinsic sphincter deficiency (ISD)

Perineal Pain

Diagnosis Codes

- O90.89 Other complications of puerperium, not elsewhere classified
- R10 Abdominal and pelvic pain
- L03 Cellulitis and acute lymphangitis
- N73 Other female pelvic inflammatory diseases
- N74 Female pelvic inflammatory disorders in diseases classified elsewhere
- N76 Other inflammation of vagina and vulva
- L02 Cutaneous abscess, furuncle, and carbuncle
- N94 Pain and other conditions associated with female genital organs and menstrual cycle
- R329 Other and unspecified symptoms and signs involving the genitourinary system

Dyspareunia

Dyspareunia is painful intercourse. Treatment depends on the underlying cause of the symptom and may include prescribing of topical or oral medications.

Diagnosis Codes

- O90.89 Other complications of puerperium, not elsewhere classified
- N94.10 Unspecified dyspareunia
- N94.11 Superficial (introital) dyspareunia
- N94.12 Deep dyspareunia
- N94.19 Other specified dyspareunia

Sexual Dysfunction

Diagnosis Codes

- O90.89 Other complications of puerperium, not elsewhere classified
- R37 Sexual dysfunction

Counseling

CPT Codes

According to the CPT, codes 99384–99397 include age appropriate counseling, anticipatory guidance, and risk factor reduction interventions provided at the time of the initial or periodic comprehensive preventive medicine examinations.

If the encounter was for screening for a patient without symptoms, report a preventive medicine code. These codes are selected according to the time spent in face-to-face counseling with the patient. Use codes 99401, 99402, 99403, and 99404 for individual counseling, and codes 99411 and 99412 for group counseling as appropriate:

- 99401 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
- 99402 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
- 99403 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
- 99404 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
- 99411 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
- 99412 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes



Coding for Returning to Work and Paid Leave

Current Procedural Terminology Codes

Counseling regarding paid leave or returning to work could be billed with preventive services codes. Per Current Procedural Terminology (CPT), Evaluation and Management (E/M) preventive services codes 99384–99397 include age appropriate counseling, anticipatory guidance, and risk factor reduction interventions provided at the time of the initial or periodic comprehensive preventive medicine examinations. Preventive medicine services are reported for comprehensive E/M services provided to patients without current symptoms or diagnosed illness. Preventive codes are used to report annual well woman examinations and include the following:

- Counseling, anticipatory guidance, and risk factor reduction interventions
- Age and gender appropriate comprehensive history
- Age and gender appropriate comprehensive physical examination including, in most cases but not limited to gynecologic examination, breast examination, and collection of a Pap test specimen
- Discussions about the status of previously diagnosed stable conditions
- Ordering of appropriate laboratory or diagnostic procedures and immunizations
- Discussions about tissues related to the patient's age or lifestyle

For counseling provided at an encounter *separate from the preventive medicine examination encounter*, codes 99401, 99402, 99403, 99404, 99411, and 99412 could be used:

- 99401 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
- 99402 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
- 99403 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
- 99404 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
- 99411 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
- 99412 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes

Diagnosis Codes

Categories Z00–Z02 include codes for routine examinations (general check-up) or administrative examinations (eg, preemployment physical). These codes are not used if the visit is for the diagnosis of a suspected condition or for treatment of a problem.

If a condition is found during a routine visit, then it is coded as an additional diagnosis. Any pre-existing and chronic conditions and history codes may also be reported as long as the encounter is not for treatment or management of those problems.

The *International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM)* states that the counseling codes are used when a patient or her family member receives assistance in the aftermath of an illness or when support is required in coping with family or social problems. *Counseling codes are not used in conjunction with a diagnosis code when counseling is considered integral to standard treatment.*

Possible ICD-10-CM codes to use are the following:

- Z02.1 Encounter for preemployment examination
- Z00.0- Encounter for general adult medical examination
- Z39.2 Encounter for routine postpartum follow-up
- Z71.89 Other specified counseling

Online Communications and Consultations

Discussions to return to work activities can be provided online in the form of email and *only to established patients*. This type of service can be billed only when personally made by the following:

- Attending health care provider
- Consultant
- Psychologist
- Physical or occupational therapist

Current Procedural Terminology Codes

If services were provided by the physician, then E/M code 99444 from the Non-Face-to-Face Services section should be applied:

- 99444 Online evaluation and management service provided by a physician or other qualified health care professional who may report E/M services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic network

For services provided by nonphysician, apply CPT code 98969 from Medicine/Non-Face-to-Face Services section:

- 98969 Online assessment and management service provided by a qualified nonphysician health care professional to an established patient or guardian, not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network

Documentation for electronic communications must include the date, the participants and their titles, the nature of the communication, and all decisions made.

Billing for Telephone Services

According to the CPT, telephone services are non-face-to-face E/M services provided to a patient using the telephone by a physician or other qualified health care professional, who may report E/M services.

- 99441 Telephone evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion
- 99442 11–20 minutes of medical discussion
- 99443 21–30 minutes of medical discussion

For services provided by nonphysicians, apply CPT codes 98966–98968 from the Medicine/Non-Face-to-Face Services section:

- 98966 Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian, not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion
- 98967 11–20 minutes of medical discussion
- 98968 21–30 minutes of medical discussion

Back-to-Work Physical

For job-related physical examinations, preventive service codes should be used from the series (99381–99387 or 99391–99397). These codes should be used with a well-visit diagnosis code (Z00.00, Encounter for general adult medical examination without abnormal findings).

Because Medicare does not pay for preventive medicine services, most of these situations occur with commercial plan patients. If a full physical is required for returning to work or school, then a complete preventive service visit would be performed. However, if the patient has already had her annual preventive service exam and the employer or school is demanding another, then the patient will have out of pocket expenses for the service.

If the patient has already had the physical for that year, and the employer or school is demanding another, then the patient has to pay from his or her own pocket.



Coding for Substance Use: Opioid Use, Alcohol Use, Tobacco Use

Tobacco Use

Prevention of Fetal Alcohol Spectrum Disorder Basics:

<https://www.acog.org/-/media/Departments/Tobacco-Alcohol-and-Substance-Abuse/Coding/1-Prevention-of-FASD-Coding-Basics-Guide--FINAL-1-11-18.pdf?dmc=1&ts=20180329T1806227401>

Alcohol or Substance (Other than Tobacco) Abuse Current Procedural Terminology (CPT) and International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) (Maternal Record Codes):

<https://www.acog.org/-/media/Departments/Tobacco-Alcohol-and-Substance-Abuse/Coding/3-FASD-Maternal-Codes-Table-FINAL-1-11-18.pdf?dmc=1&ts=20180329T1756148796>

Tobacco Use and Smoking Cessation:

<https://www.acog.org/-/media/Departments/Toolkits-for-Health-Care-Providers/Smoking-Cessation-Toolkit/Smoking-Cessation-Tool-Coding.pdf?dmc=1&ts=20180131T1328372091>

Opioid Use

For any case of pregnancy in which a woman uses opioids during the pregnancy or postpartum period, codes from subcategory **O99.32, Drug use complicating pregnancy, childbirth, and the puerperium**, should be assigned. A secondary code from category **F11, Opioid-related disorders**, should also be assigned to identify manifestation of the opioid use.

Possible ICD-10-CM codes:

- O99.320 Drug use complicating pregnancy, unspecified trimester
- O99.321 Drug use complicating pregnancy, first trimester
- O99.322 Drug use complicating pregnancy, second trimester
- O99.323 Drug use complicating pregnancy, third trimester
- O99.324 Drug use complicating childbirth
- O99.325 Drug use complicating puerperium
- F11.10 Opioid abuse, uncomplicated
- F11.11 Opioid abuse, in remission
- F11.12- Opioid abuse with intoxication
- F11.14 Opioid abuse with opioid-induced mood disorder

- F11.15- Opioid abuse with opioid-induced psychotic disorder
- F11.18- Opioid abuse with other opioid-induced disorder
- F11.19 Opioid abuse with unspecified opioid-induced disorder
- F11.2- Opioid dependence
- F11.9- Opioid use, unspecified

Counseling

Procedure codes such as Evaluation and Management (E/M) codes are a method of documenting what service or procedure was performed. The most appropriate E/M code to select will depend on whether the encounter was for screening or treatment of the condition.

If the encounter was for screening the patient, report a preventive medicine code. These codes are selected according to the time spent in face-to-face counseling with the patient. Whether or not these codes will be reimbursed will vary. Possible procedure codes are the following:

<u>Code Description</u>	<u>Code</u>
• Preventive medicine, individual counseling	99401–99404
• Preventive medicine, group counseling	99411–99412

Specific CPT codes have been developed for tobacco cessation counseling. These services are reported as follows:

<u>Code Description</u>	<u>Code</u>
• Preventive medicine, Smoking/tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	99406
• Preventive medicine, Smoking/tobacco use cessation counseling visit; intensive, greater than 10 minutes	99407

For counseling groups of patients with symptoms or established illness, use CPT code 99078.

If the encounter was for other treatment for a patient with a diagnosis of tobacco use or nicotine dependence, report an office or other outpatient E/M code. These codes list a “typical time” in the code descriptions. Codes with typical times listed may be reported based on time, rather than the key E/M components of history, examination, and medical decision-making. If the health care provider spends more than 50% of the visit counseling the patient, the E/M code may be selected based on time. Time spent providing face-to-face counseling with the patient must be documented in the medical record. The record should document total time and that either all of the encounter or more than 50% of total time was spent counseling the patient. The patient record also must provide details on the topics discussed.



Coding for Support Teams for New Mothers

Counseling

Current Procedural Terminology (CPT) Codes

According to the CPT, codes 99384–99397 include age appropriate counseling, anticipatory guidance, and risk factor reduction interventions provided at the time of the initial or periodic comprehensive preventive medicine examinations.

For counseling provided at an encounter separate from the preventive medicine examination encounter, codes 99401, 99402, 99403, 99404, 99411, and 99412 could be used. Codes 99411 and 99412 are used for *counseling provided in group sessions*:

- 99411 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
- 99412 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes

Diagnosis Codes

- Z32.3 Encounter for child care instruction

It may be possible to bill for the counseling and education sessions for these patients, but you should contact your specific payers for guidance.