APEC FAQs

Frequently Asked Questions

1. **How are the prenatal care visit frequencies to be interpreted? Does "*at least every 4 weeks*" and *"at least every 2 weeks"* mean 4 weeks and 1 day or 2 weeks and 2 days do not meet the recommendations?**
   Answer: The goal is to see each pregnant mom at regular intervals throughout her pregnancy. It was not intended for the visit window recommendations to be interpreted as a strict time period i.e. At least every 2 weeks or at least every 4 weeks should not be interpreted as 14 or 28 days respectively, patients can be scheduled anytime during the 2nd or 4th week time period. The guidelines have been changed to clarify the visit schedule.

2. **ACOG PNC guidelines give a window of 2-3 weeks for the 28-36 week visit schedules. Why do the APEC guidelines differ?**
   Answer: The lower socio-economic status of our Alabama Medicaid population is a risk factor for many adverse pregnancy outcomes, thus the guidelines reflect more frequent visits to monitor for possible risks. In lower-risk women, we agree that there can be some flexibility with the 28 to 36 week visits and have changed the guideline to say visit every 2-3 weeks. The 3 week window should be applied to women at lower-risk only. In addition, the gestational window prior to 20 weeks has been updated to ideally every 4 weeks but no less than every 6 weeks for lower-risk women.

3. **ACOG does not mandate rescreening for STDs in the third trimester. Why do the APEC PNC guidelines differ?**
   Answer: The ACOG Guidelines for PNC state "Tests for STDs may be repeated in the third trimester if the women has specific risk factors for these diseases". The lower socio-economic status of our Alabama Medicaid population is a risk factor for many adverse pregnancy outcomes including STD transmission. The 32-34 week guidelines have been updated to say: VDRL/RPR: Given the high prevalence of syphilis throughout Alabama, the ease of testing, and the potential fetal effects, repeat testing is warranted in this patient population; HIV: should be repeated in the third trimester for women diagnosed with a STD during pregnancy or for those with high risk behavior; GC/CT: testing should be strongly considered.

4. **Is the third trimester panel of labs paid outside the global fee?**
   Answer: Hct and Hgb are included in the global fee. VDRL/RPR, GC/CT, and HIV are reimbursed fee for service in addition to the global payment. Providers should submit claims to Medicaid with a pregnancy diagnosis for SOBRA eligible patients.

5. **What are the specific drug therapies UAB and USA offer for smoking cessation?**
   Answer: Behavior therapy using the 5 A's and "Quickline" referrals are the recommended approaches used for smoking cessation. In rare circumstances (heavy smokers ≥ 1 ppd) when the risk of smoking outweighs the risk of drug therapy, nicotine patch, gum or Bupropion may be offered.

6. **Our electronic medical record addresses questions of depression and domestic abuse issues. This medical record is completed by the patient and reviewed by the Physician. Is it the recommendation of APEC that additional "assessment scales" be completed?**
   Answer: As long as the issues are being addressed, APEC considers the system to be adequate.

7. **It has been customary practice at our location to obtain screening sonograms for fetal anatomy between 20 and 22 weeks. This is due to the fact that many of our providers and sonographers have noted scans between 20 and 22 weeks to be more accurate at detecting fetal anomalies than scans performed at an earlier gestational age. What is the APEC and ACOG recommendation regarding detection of fetal anomalies?**
   Answer: While it is optimal to perform anatomy ultrasounds at an earlier GA, thus allowing the patient to maximize her reproductive options, the anatomy scans can occur between 17-22 weeks GA. The guidelines have been updates to reflect the expanded anatomy ultrasound GA of 17-22 weeks.

8. **The PNC guidelines do not address discussion of infant feeding plans with mothers to be. Breast milk provides immunologic protection against infection and should be encouraged during the prenatal care period. Why is this not addressed in the PNC guidelines?**
   Answer: Discussions on feeding plans have been added to the PNC guidelines with an emphasis on provider encouragement and support of breastfeeding in the first, second and third trimesters.

9. *Added 5/14/2013*
   Why do the APEC prenatal care guidelines state a urine dipstick for protein, glucose, and ketones needs to be performed at all prenatal visits when the ACOG Guidelines for Prenatal Care Seventh Edition October 2012 states:

   "The time-honored inclusion of routine urine dipstick assessment for all pregnant women can be modified according to site-specific protocols. A base-line screen for urine protein content to assess renal status is recommended. However, in the absence of risk factors for urinary tract infections, renal disease, and preeclampsia (such as diabetes, hypertension, and autoimmune disorders) and in the absence of symptoms of urinary tract infection, hypertension or unusual edema, there has not been shown to be a benefit in routine urine dip-stick testing during prenatal care for women at low risk."

   Answer: While the recent guidelines suggest that site-specific protocols for urine dipstick testing may be appropriate in select settings, the lower socio-economic status of the Alabama Medicaid population is a risk factor for many adverse pregnancy outcomes including preeclampsia, UTIs, diabetes, and hypertension. Given the high prevalence of these adverse outcomes throughout Alabama, when the ease of testing, the minimal cost, and the potential fetal effects are considered, the evidence continues to support routine dipstick testing for proteinuria during prenatal care of women in the Medicaid patient population. In fashion similar to gestational diabetes screening, where in reality only those with risk factors need testing, the number of patients who would be excluded is small and the amount of time required to identify them large,

from a cost-effective and safety standpoint it is simpler and more logical to screen all patients. This applies to the use of urine dipsticks as well. In addition, prior to the development of the APEC program, the Alabama Medicaid Maternity Care Program established urine dipstick testing as a benchmark for the assessment of adequacy of prenatal care. This was an element of the Maternity Care Contract and approved by CMS. Given the current contract, this element continues to be an essential element of prenatal care.