

## Prenatal and Postpartum Care (PPC)

### Description

The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

- *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.
- *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

### Definitions

<b>Preterm*</b>	Any neonate whose birth occurs through the end of the last day of the 37th week (259th day) following the onset of the last menstrual period.
<b>Post-term*</b>	Any neonate whose birth occurs from the beginning of the first day (295th day) of the 43rd week following the onset of the last menstrual period.
<b>Start date of the last enrollment segment</b>	For women with a gap in enrollment during pregnancy, the last enrollment segment is the enrollment start date during the pregnancy that is closest to the delivery date.  Refer to <i>Medicaid Continuous Enrollment in General Guidelines</i> for information about handling administrative one-day enrollment gaps.

\* These definitions are from the *Guidelines for Perinatal Care, Fifth Edition*. American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

### Eligible Population

<b>Product lines</b>	Commercial, Medicaid (report each product line separately).
<b>Age</b>	None specified.
<b>Continuous enrollment</b>	43 days prior to delivery through 56 days after delivery.

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<b>Allowable gap</b>	No allowable gap during the continuous enrollment period.
<b>Anchor date</b>	Date of delivery.
<b>Benefit</b>	Medical.
<b>Event/ diagnosis</b>	<p><i>Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year.</i> Women who delivered in a birthing center should be included in this measure. Refer to Tables PPC-A and PPC-B for codes to identify live births.</p> <p><i>Multiple births.</i> Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the measurement year and November 5 of the measurement year should be counted twice. Women who had multiple live births during one pregnancy should be counted once in the measure.</p>

**Administrative Specification**

**Denominator** Follow the first two steps below to identify the eligible population, which is the denominator for both rates.

**Step 1** Identify live births. Identify all women with a live birth between November 6 of the year prior to the measurement year, and November 5 of the measurement year, using Method A and Method B below.

**Method A** Codes listed in Table PPC-A identify a delivery *and* indicate that the outcome of the delivery was a live birth. Women who are identified through the codes listed in Method A are automatically included in the eligible population and require no further verification of the outcome.

**Table PPC-A: Codes to Identify Live Births**

Description	ICD-9-CM Diagnosis
Identify live births	650, V27.0, V27.2, V27.3, V27.5, V27.6, V30-V37*, V39*

\*These codes are assigned to the infant and should only be used if the organization is able to link infant and mother records.

**Method B** Identify deliveries and verify live births. Codes in Table PPC-B, step A, identify deliveries but do not indicate the outcome. The organization must use step B to eliminate deliveries that did not result in a live birth.

**Table PPC-B: Codes to Identify Deliveries and Verify Live Births**

Description	CPT	ICD-9-CM Diagnosis	ICD-9-CM Procedure
<b>Step A:</b> Identify deliveries	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622	640.x1, 641.x1, 642.x1, 642.x2, 643.x1, 644.21, 645.x1, 646.x1, 646.x2, 647.x1, 647.x2, 648.x1, 648.x2, 649.x1, 649.x2, 651.x1, 652.x1, 653.x1, 654.x1, 654.02, 654.12, 654.32, 654.x2, 655.x1, 656.01, 656.11, 656.21, 656.31, 656.51, 656.61, 656.71, 656.81, 656.91, 657.01, 658.x1, 659.x1, 660.x1, 661.x1, 662.x1, 663.x1, 664.x1, 665.01, 665.x1, 665.x2, 666.x2, 667.x2, 668.x1, 668.x2, 669.x1, 669.x2, 670.02, 671.x1, 671.x2, 672.02, 673.x1, 673.x2, 674.x1, 674.x2, 675.x1, 675.x2, 676.x1, 676.x2, 678.x1, 679.x1, 679.x2	72.0-73.99, 74.0-74.2, 74.4, 74.99
<b>Step B:</b> Exclude deliveries not resulting in a live birth		630-637, 639, 656.4, 768.0, 768.1, V27.1, V27.4, V27.7	

**Step 2** Identify continuous enrollment. For women identified in step 1, determine if enrollment was continuous between 43 days prior to delivery and 56 days after delivery, with no gaps.

**Numerator**

**Timeliness of prenatal care** A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in the organization and any gaps in enrollment during the pregnancy.

*Include only visits that occur while the member was enrolled.*

**Step 3** Determine enrollment status during the first trimester. Determine if women identified in step 2 were enrolled on or before 280 days prior to delivery (or estimated date of delivery [EDD]). For these women, go to step 4. For women not enrolled on or before 280 days prior to delivery (or EDD), who were therefore pregnant at the time of enrollment, proceed to step 6.

**Step 4** Determine continuous enrollment for the first trimester. Determine if women identified in step 3 were continuously enrolled during the first trimester (176–280 days prior to delivery [or EDD]) with no gaps in enrollment. For these women, use one of the four decision rules in Table PPC-C to determine if there was a prenatal visit during the first trimester.<sup>4</sup> For women who were not continuously enrolled during the first trimester, proceed to step 5.

<sup>4</sup> If the member identified in step 3 was continuously enrolled for the first trimester (176–280 days prior to delivery with no gaps during this period), the organization has sufficient opportunity to provide prenatal care in the first trimester. The organization must use the Table PPC-C. Any enrollment gaps in the second and third trimesters are incidental.

**Step 5** For women who had a gap between 176 and 280 days prior to delivery, proceed to step 6.

**Step 6** For women identified in step 3 and step 5, determine the start date of the last enrollment segment.<sup>5</sup> For women not enrolled in the organization on or before 280 days prior to delivery (or EDD) and for women who had a gap between 176 and 280 days prior to delivery (step 5), determine the start date of the last enrollment segment.

For women whose last enrollment started on or between 219 and 279 days prior to delivery, proceed to step 7. For women whose last enrollment started less than 219 days prior to delivery proceed to step 8.

**Step 7** Determine if enrollment started on or between 219 and 279 days prior to delivery. If the last enrollment segment started on or between 219 and 279 days prior to delivery, determine numerator compliance using the numerator criteria in Table PPC-D and find a visit between the last enrollment start date and 176 days prior to delivery.<sup>6</sup>

**Step 8** Determine if enrollment started less than 219 days prior to delivery (i.e., between 219 days prior to delivery and the day of delivery). If the last enrollment segment started less than 219 days prior to delivery, determine numerator compliance using Table PPC-D numerator criteria for a visit within 42 days after enrollment.

**Table PPC-C: Markers for Early Prenatal Care Obtainable From Administrative Data**

Decision Rule 1
Marker Event
Any prenatal care visit to an OB practitioner, a midwife or family practitioner or other PCP with documentation of when prenatal care was initiated.
Administrative
<i>Any one code:</i> <ul style="list-style-type: none"> <li>• CPT: 59400*, 59425*, 59426*, 59510*, 59610*, 59618*</li> <li>• CPT Category II: 0500F, 0501F, 0502F</li> </ul>

\* Generally, these codes are used on the date of delivery, not the first date for OB care, so this code is useful only if the claim form indicates when prenatal care was initiated.

Source: Harvard Pilgrim Health Care

<sup>5</sup> See definition of **last enrollment segment**.

<sup>6</sup> The 176 days prior to delivery includes the 42-day period after enrollment. For example, a member who had a last enrollment segment 225 days prior to delivery would have until the end of the first trimester (176 days prior to delivery) instead of the 183 days prior to delivery under the 42-day criteria. Table PPC-D allows more flexibility for identifying prenatal care visits occurring later in the pregnancy.

Decision Rule 2		
Marker Event		
<p>Any visit to an OB practitioner or midwife with one of the following:</p> <ul style="list-style-type: none"> <li>• Obstetric panel</li> <li>• TORCH antibody panel</li> <li>• Rubella antibody/titer with Rh incompatibility (ABO/Rh blood typing)</li> <li>• Ultrasound (echocardiography) of pregnant uterus</li> <li>• Pregnancy-related diagnosis code</li> </ul>		
Administrative		
<p>The member must meet criteria in [Part A <b>and</b> (Part B <b>or</b> Part C)] <b>or</b> Part D.</p> <p><b>Part A:</b> Any one code.</p> <ul style="list-style-type: none"> <li>• CPT: 99201-99205, 99211-99215, 99241-99245</li> <li>• UB Revenue: 0514</li> </ul> <p><b>Part B:</b> Any one code.</p> <ul style="list-style-type: none"> <li>• CPT: 76801, 76805, 76811, 76813, 76815-76818, 80055</li> <li>• ICD-9-CM Diagnosis: 640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3, V22-V23, V28</li> <li>• ICD-9-CM Procedure: 88.78</li> </ul>		
<p><b>Part C:</b> One of the following.</p> <p><b>TORCH:</b> A code for each of the four infections must be present for this component</p>	Cytomegalovirus	<ul style="list-style-type: none"> <li>• CPT: 86644</li> <li>• LOINC: 5121-9, 5122-7, 5124-3, 5125-0, 5126-8, 5127-6, 7851-9, 7852-7, 7853-5, 9513-3, 13225-8, 13949-3, 15377-5, 16714-8, 16715-5, 16716-3, 22239-8, 22241-4, 22244-8, 22246-3, 22247-1, 22249-7, 24119-0, 30325-5, 32170-3, 32791-6, 32835-1, 34403-6, 47307-4, 45326-6, 47363-7, 47430-4, 49539-0, 52976-8, 52984-2</li> </ul>
	Herpes simplex	<ul style="list-style-type: none"> <li>• CPT: 86694, 86695, 86696</li> <li>• LOINC: 5202-7, 5203-5, 5204-3, 5205-0, 5206-8, 5207-6, 5208-4, 5209-2, 5210-0, 7907-9, 7908-7, 7909-5, 7910-3, 7911-1, 7912-9, 7913-7, 9422-7, 10350-7, 13323-1, 13324-9, 13501-2, 13505-3, 14213-3, 16944-1, 16949-0, 16950-8, 16954-0, 16955-7, 16957-3, 16958-1, 17850-9, 17851-7, 19106-4, 21326-4, 21327-2, 22339-6, 22341-2, 22343-8, 24014-3, 25435-9, 25837-6, 25839-2, 26927-4, 27948-9, 30355-2, 31411-2, 32687-6, 32688-4, 32790-8, 32831-0, 32834-4, 32846-8, 33291-6, 34152-9, 34613-0, 36921-5, 40466-5, 40728-8, 40729-6, 41149-6, 41399-7, 42337-6, 42338-4, 43028-0, 43030-6, 43031-4, 43111-4, 43180-9, 44008-1, 44480-2, 44494-3, 44507-2, 45210-2, 47230-8, 48784-3, 49848-5, 50758-2, 51915-7, 51916-5, 52977-6, 52981-8, 53377-8, 53560-9</li> </ul>
	Rubella	<ul style="list-style-type: none"> <li>• CPT: 86762</li> <li>• LOINC: 5330-6, 5331-4, 5332-2, 5333-0, 5334-8, 5335-5, 8013-5, 8014-3, 8015-0, 13279-5, 13280-3, 17550-5, 22496-4, 22497-2, 24116-6, 25298-1, 25420-1, 25514-1, 31616-6, 34421-8, 40667-8, 41763-4, 43810-1, 49107-6, 50694-9, 51931-4, 52986-7</li> </ul>
	Toxoplasma	<ul style="list-style-type: none"> <li>• CPT: 86777</li> <li>• LOINC: 5387-6, 5388-4, 5389-2, 5390-0, 5391-8, 8039-0, 8040-8, 11598-0, 12261-4, 12262-2, 13286-0, 17717-0, 21570-7, 22577-1, 22580-5, 22582-1, 22584-7, 23485-6, 23486-4, 23784-2, 24242-0, 25300-5, 25542-2, 33336-9, 34422-6, 35281-5, 35282-3, 40677-7, 40678-5, 40697-5, 40785-8, 40786-6, 41123-1, 41124-9, 42949-8, 47389-2, 47390-0</li> </ul>

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Decision Rule 2		
Marker Event		
<b>Rubella/ABO/Rh:</b> A code for Rubella <b>and</b> (ABO <b>or</b> Rh) must be present for this component	Rubella	<ul style="list-style-type: none"> <li>• <b>CPT:</b> 86762</li> <li>• <b>LOINC:</b> 5330-6, 5331-4, 5332-2, 5333-0, 5334-8, 5335-5, 8013-5, 8014-3, 8015-0, 13279-5, 13280-3, 17550-5, 22496-4, 22497-2, 24116-6, 25298-1, 25420-1, 25514-1, 31616-6, 34421-8, 40667-8, 41763-4, 43810-1, 49107-6, 50694-9, 51931-4, 52986-7</li> </ul>
	ABO	<ul style="list-style-type: none"> <li>• <b>CPT:</b> 86900</li> <li>• <b>LOINC:</b> 883-9</li> </ul>
	Rh	<ul style="list-style-type: none"> <li>• <b>CPT:</b> 86901</li> <li>• <b>LOINC:</b> 10331-7, 34961-3</li> </ul>
	ABO and Rh	<ul style="list-style-type: none"> <li>• <b>LOINC:</b> 882-1, 884-7</li> </ul>
<b>Part D:</b> Any one code. <ul style="list-style-type: none"> <li>• <b>HCPCS:</b> H1000-H1004, H1005*</li> </ul>		

Decision Rule 3		
Marker Event		
Any visit to a family practitioner or other PCP with a pregnancy related ICD-9-CM Diagnosis code <b>AND</b> one of the following: <ul style="list-style-type: none"> <li>• Obstetric panel</li> <li>• TORCH antibody panel</li> <li>• Rubella antibody/titer with Rh incompatibility (ABO/Rh blood typing)</li> <li>• Ultrasound of the pregnant uterus</li> </ul>		
*When using a visit to a family practitioner or other PCP, it is necessary to determine that prenatal care was rendered and that the member was not merely diagnosed as pregnant and referred to another practitioner for prenatal care.		
Administrative		
The member must meet criteria in Part A <b>and</b> (Part B <b>or</b> Part C). <b>Part A:</b> Any CPT or UB revenue code <b>with</b> any ICD-9-CM Diagnosis code: (CPT with ICD-9-CM) or (UB with ICD-9-CM). The ICD-9-CM Diagnosis code must be on the same claim as the CPT or UB revenue code. Alternatively, an HCPCS code does not require a diagnosis code. <ul style="list-style-type: none"> <li>• <b>CPT:</b> 99201-99205, 99211-99215, 99241-99245</li> <li>• <b>HCPCS:</b> H1000-H1004, H1005*</li> <li>• <b>UB Revenue:</b> 0514</li> <li>• <b>ICD-9-CM Diagnosis:</b> 640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3, V22-V23, V28</li> </ul> <b>Part B:</b> Any one code. <ul style="list-style-type: none"> <li>• <b>CPT:</b> 76801, 76805, 76811, 76813, 76815-76818, 80055</li> <li>• <b>ICD-9-CM Procedure:</b> 88.78</li> </ul>		
<b>Part C:</b> One of the following. <b>TORCH:</b> A code for each of the four infections must be present for this component	Cytomegalovirus	<ul style="list-style-type: none"> <li>• <b>CPT:</b> 86644</li> <li>• <b>LOINC:</b> 5121-9, 5122-7, 5124-3, 5125-0, 5126-8, 5127-6, 7851-9, 7852-7, 7853-5, 9513-3, 13225-8, 13949-3, 15377-5, 16714-8, 16715-5, 16716-3, 22239-8, 22241-4, 22244-8, 22246-3, 22247-1, 22249-7, 24119-0, 30325-5, 32170-3, 32791-6, 32835-1, 34403-6, 47307-4, 45326-6, 47363-7, 47430-4, 49539-0, 52976-8, 52984-2</li> </ul>

\*H1005 is a code that indicates bundled services and is useful only if the claim form indicates when prenatal care was initiated.

Decision Rule 3 (continued)		
Administrative		
	Herpes simplex	<ul style="list-style-type: none"> <li>• <b>CPT:</b> 86694, 86695, 86696</li> <li>• <b>LOINC:</b> 5202-7, 5203-5, 5204-3, 5205-0, 5206-8, 5207-6, 5208-4, 5209-2, 5210-0, 7907-9, 7908-7, 7909-5, 7910-3, 7911-1, 7912-9, 7913-7, 9422-7, 10350-7, 13323-1, 13324-9, 13501-2, 13505-3, 14213-3, 16944-1, 16949-0, 16950-8, 16954-0, 16955-7, 16957-3, 16958-1, 17850-9, 17851-7, 19106-4, 21326-4, 21327-2, 22339-6, 22341-2, 22343-8, 24014-3, 25435-9, 25837-6, 25839-2, 26927-4, 27948-9, 30355-2, 31411-2, 32687-6, 32688-4, 32790-8, 32831-0, 32834-4, 32846-8, 33291-6, 34152-9, 34613-0, 36921-5, 40466-5, 40728-8, 40729-6, 41149-6, 41399-7, 42337-6, 42338-4, 43028-0, 43030-6, 43031-4, 43111-4, 43180-9, 44008-1, 44480-2, 44494-3, 44507-2, 45210-2, 47230-8, 48784-3, 49848-5, 50758-2, 51915-7, 51916-5, 52977-6, 52981-8, 53377-8, 53560-9</li> </ul>
<b>TORCH:</b> A code for each of the four infections must be present for this component	Rubella	<ul style="list-style-type: none"> <li>• <b>CPT:</b> 86762</li> <li>• <b>LOINC:</b> 5330-6, 5331-4, 5332-2, 5333-0, 5334-8, 5335-5, 8013-5, 8014-3, 8015-0, 13279-5, 13280-3, 17550-5, 22496-4, 22497-2, 24116-6, 25298-1, 25420-1, 25514-1, 31616-6, 34421-8, 40667-8, 41763-4, 43810-1, 49107-6, 50694-9, 51931-4, 52986-7</li> </ul>
	Toxoplasma	<ul style="list-style-type: none"> <li>• <b>CPT:</b> 86777</li> <li>• <b>LOINC:</b> 5387-6, 5388-4, 5389-2, 5390-0, 5391-8, 8039-0, 8040-8, 11598-0, 12261-4, 12262-2, 13286-0, 17717-0, 21570-7, 22577-1, 22580-5, 22582-1, 22584-7, 23485-6, 23486-4, 23784-2, 24242-0, 25300-5, 25542-2, 33336-9, 34422-6, 35281-5, 35282-3, 40677-7, 40678-5, 40697-5, 40785-8, 40786-6, 41123-1, 41124-9, 42949-8, 47389-2, 47390-0</li> </ul>
<b>Rubella/ABO/Rh:</b> A code for Rubella <b>and</b> (ABO <b>or</b> Rh) must be present for this component	Rubella	<ul style="list-style-type: none"> <li>• <b>CPT:</b> 86762</li> <li>• <b>LOINC:</b> 5330-6, 5331-4, 5332-2, 5333-0, 5334-8, 5335-5, 8013-5, 8014-3, 8015-0, 13279-5, 13280-3, 17550-5, 22496-4, 22497-2, 24116-6, 25298-1, 25420-1, 25514-1, 31616-6, 34421-8, 40667-8, 41763-4, 43810-1, 49107-6, 50694-9, 51931-4, 52986-7</li> </ul>
	ABO	<ul style="list-style-type: none"> <li>• <b>CPT:</b> 86900</li> <li>• <b>LOINC:</b> 883-9</li> </ul>
	Rh	<ul style="list-style-type: none"> <li>• <b>CPT:</b> 86901</li> <li>• <b>LOINC:</b> 10331-7, 34961-3</li> </ul>
	ABO and Rh	<ul style="list-style-type: none"> <li>• <b>LOINC:</b> 882-1, 884-7</li> </ul>

Decision Rule 4	
Marker Event	
Any visit to a family practitioner or other PCP with diagnosis-based evidence of prenatal care in the form of a documented LMP or EDD with either a completed obstetric history or risk assessment and counseling/education.	
Administrative	
<p>The member must meet criteria in (Part A <b>and</b> Part B) <b>or</b> Part C.</p> <p><b>Part A:</b> Any one code.</p> <ul style="list-style-type: none"> <li>• <b>CPT:</b> 99201-99205, 99211-99215, 99241-99245</li> <li>• <b>UB Revenue:</b> 0514</li> </ul> <p><b>Part B:</b></p> <ul style="list-style-type: none"> <li>• Any internal organization code for LMP or EDD with an obstetrical history</li> <li>• Any internal organization code for LMP or EDD with risk assessment and counseling/education</li> </ul> <p><b>Part C:</b> Any one code.</p> <ul style="list-style-type: none"> <li>• <b>HCPCS:</b> H1000-H1004, H1005*</li> </ul>	

\*H1005 is a code that indicates bundled services and is useful only if the claim form indicates when prenatal care was initiated.

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**Table PPC-D: Markers for Prenatal Care Obtainable From Administrative Data**

Marker Event
Any visit to an OB/GYN, family practitioner or other PCP with either an ultrasound or a principal diagnosis of pregnancy.
Administrative
<p>The member must meet criteria in Part A <i>or</i> (Part B <i>and</i> Part C).</p> <p><b>Part A:</b> <i>Any one code.</i></p> <ul style="list-style-type: none"> <li>• <b>CPT:</b> 59400*, 59425*, 59426*, 59510*, 59610*, 59618*</li> <li>• <b>HPCPS:</b> H1000-H1004, H1005**</li> <li>• <b>CPT Category II:</b> 0500F, 0501F, 0502F</li> </ul> <p><b>Part B:</b> <i>Any one code.</i></p> <ul style="list-style-type: none"> <li>• <b>CPT:</b> 76801, 76805, 76811, 76813, 76815-76818</li> <li>• <b>ICD-9-CM Diagnosis:</b> 640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3, V22-V23, V28</li> <li>• <b>ICD-9-CM Procedure:</b> 88.78</li> </ul> <p><b>Part C:</b> <i>Any one code.</i></p> <ul style="list-style-type: none"> <li>• <b>CPT:</b> 99201-99205, 99211-99215, 99241-99245</li> <li>• <b>UB Revenue:</b> 0514</li> </ul> <p><b>Note:</b> <i>If using an ICD-9-CM Diagnosis code from Part B with a CPT or UB revenue code from Part C, the ICD-9-CM Diagnosis code must be on the same claim as the CPT or UB revenue code.</i></p>

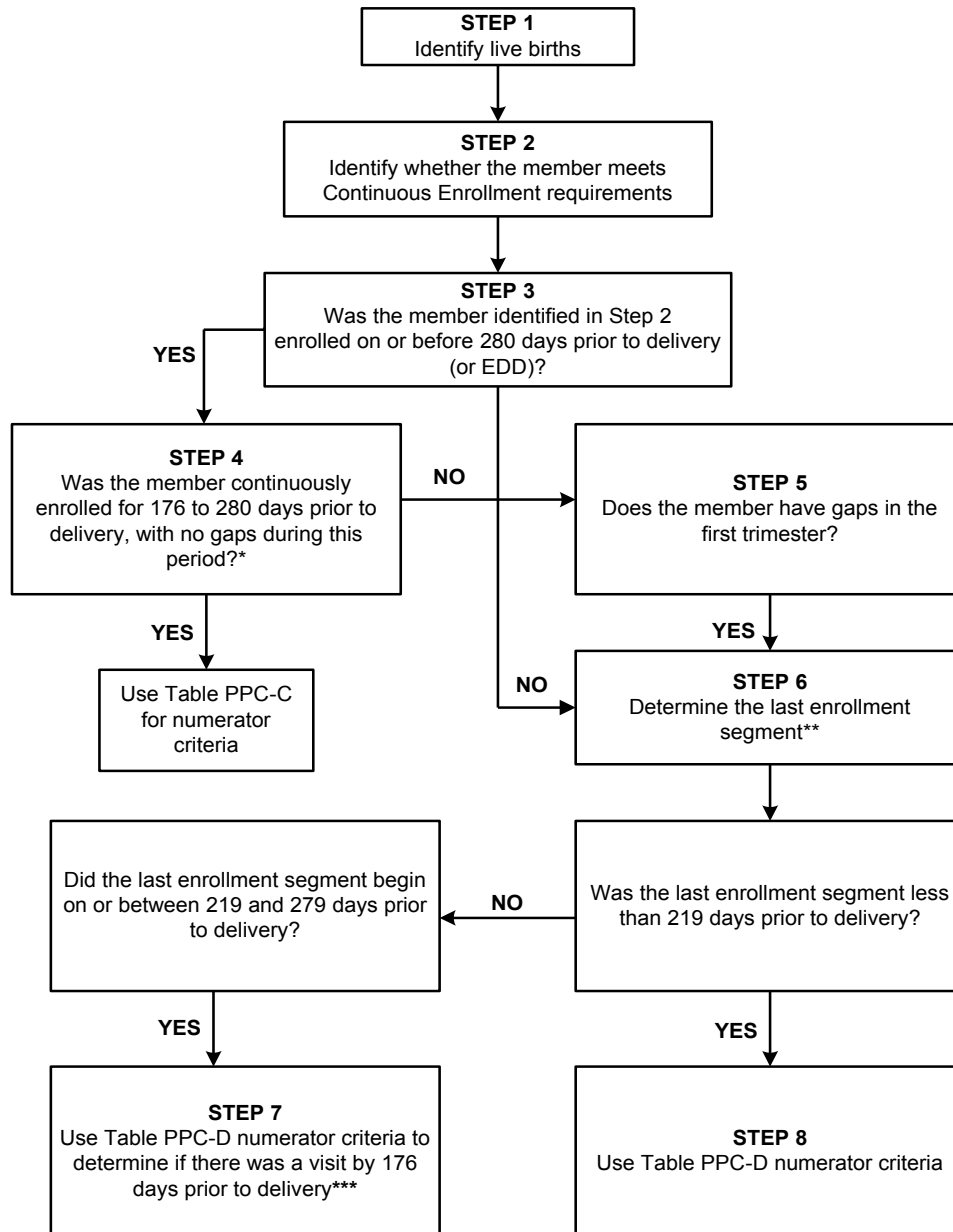
\* Generally, these codes are used on the date of delivery, not the first date for OB care, so this code is useful only if the claim form indicates when prenatal care was initiated.

\*\* **H1005** is a code that indicates bundled services and is useful only if the claim form indicates when prenatal care was initiated.

Source: Harvard Pilgrim Health Care



**Prenatal and Postpartum Care  
Timeliness of Prenatal Care Numerator**



\* If the member identified in step 3 was continuously enrolled for the first trimester (176–280 days prior to delivery), there is no need to look for gaps occurring during other times in the pregnancy. Use the criteria in Table PPC-C to determine numerator compliance. For example, if a member was enrolled during the first trimester, 176–280 days prior to delivery with a gap between the 125–150 days prior to delivery, the organization must still meet the PPC-C first trimester criteria for numerator compliance. The gap and last enrollment segment are incidental because the member meets the first trimester enrollment test.

\*\* See the definition of **last enrollment segment**.

\*\*\* The 176 days prior to delivery includes the 42-day period following enrollment. For example, a member who had a last enrollment segment 225 days prior to delivery has until the end of the first trimester (176 days prior to delivery), instead of the 183 days prior to delivery under the 42-day criteria. Table PPC-D also has greater flexibility to identify a prenatal care visit.

**Postpartum care** A postpartum visit (Table PPC-E) for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.

**Table PPC-E: Codes to Identify Postpartum Visits**

CPT	CPT Category II	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue	LOINC
57170, 58300, 59400*, 59410*, 59430, 59510*, 59515*, 59610*, 59614*, 59618*, 59622*, 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175	0503F	G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	V24.1, V24.2, V25.1, V72.3, V76.2	89.26, 91.46	0923	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5

\* Generally, these codes are used on the date of delivery, not on the date of the postpartum visit, so this code may be used only if the claim form indicates when postpartum care was rendered.

### Hybrid Specification

**Denominator**

A systematic sample drawn from the eligible population for each product line. The organization may reduce the sample size using the current year's lowest product line-specific administrative rate of these two indicators and the >81% indicator from *Frequency of Ongoing Prenatal Care* or the prior year's lowest audited product line-specific rate for these two indicators and the >81% indicator from *Frequency of Ongoing Prenatal Care*.

**Numerator**

***Timeliness of prenatal care***

A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in the organization and any gaps in enrollment during the pregnancy. Includes only visits that occur while the member was enrolled.

**Administrative**

Refer to *Administrative Specification* to identify positive numerator hits from the administrative data.

**Medical record**

*Prenatal care visit to an OB/GYN practitioner or midwife, family practitioner or other PCP.* For visits to a *family practitioner or PCP*, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date on which the prenatal care visit occurred, and evidence of the *one* of the following.

- A basic physical obstetrical examination that includes auscultation for fetal heart tone, **or** pelvic exam with obstetric observations, **or** measurement of fundus height (a standardized prenatal flow sheet may be used)
- Evidence that a prenatal care procedure was performed, such as:
  - Screening test in the form of an obstetric panel (e.g., hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh[D] and ABO blood typing), **or**
  - TORCH antibody panel alone **or**
  - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, **or**
  - Echography of a pregnant uterus

- Documentation of LMP or EDD in conjunction with *either* of the following.
  - Prenatal risk assessment and counseling/education, **or**
  - Complete obstetrical history

**Note:** For members whose last enrollment segment was after 219 days prior to delivery (i.e., between 219 days prior to delivery and the day of delivery), count any documentation of a visit to an OB/GYN, family practitioner or other PCP with a principal diagnosis of pregnancy.

**Postpartum care** A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery, as documented through either administrative data or medical record review.

**Administrative** Refer to *Administrative Specification* to identify positive numerator hits from the administrative data.

**Medical record** Documentation in the medical record must include a note indicating the date on which a postpartum visit occurred and *one* of the following.

- Pelvic exam, **or**
- Evaluation of weight, BP, breasts and abdomen, **or**
  - Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component
- Notation of postpartum care, including but not limited to the following:
  - Notation of “postpartum care,” “PP care,” “PP check,” “6-week check”
  - A preprinted “Postpartum Care” form in which information was documented during the visit.

### **Note**

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- *When counting prenatal visits, include visits with physician assistants, nurse practitioners, midwives and registered nurses, provided that a cosignature by a physician is present, if required by state law.*
- *Services that occur over multiple visits count toward this measure as long as all services are within the time frame established in the measure.*
- *A pap test alone does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of prenatal care rate. For the Postpartum care rate, a pap test would be acceptable. A colposcopy alone is not considered numerator compliant for either rate.*
- *Refer to Appendix 3 for the definition of PCP and OB/GYN and other prenatal practitioners.*

## Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

**Table PPC-1/2: Data Elements for Prenatal and Postpartum Care**

	Administrative	Hybrid
Measurement year	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>
Data collection methodology (Administrative or Hybrid)	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>
Eligible population	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>
Number of numerator events by administrative data in eligible population (before exclusions)		<i>For each of the 2 rates</i>
Current year's administrative rate (before exclusions)		<i>For each of the 2 rates</i>
Minimum required sample size (MRSS) or other sample size		<i>For each of the 2 rates</i>
Oversampling rate		<i>For each of the 2 rates</i>
Final sample size (FSS)		<i>For each of the 2 rates</i>
Number of numerator events by administrative data in FSS		<i>For each of the 2 rates</i>
Administrative rate on FSS		<i>For each of the 2 rates</i>
Number of original sample records excluded because of valid data errors		<i>For each of the 2 rates</i>
Number of employee/dependent medical records excluded		<i>For each of the 2 rates</i>
Records added from the oversample list		<i>For each of the 2 rates</i>
Denominator		<i>For each of the 2 rates</i>
Numerator events by administrative data	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>
Numerator events by medical records		<i>For each of the 2 rates</i>
Reported rate	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>
Lower 95% confidence interval	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>
Upper 95% confidence interval	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>