Health Net

2017 Prenatal/Perinatal Health Guidelines

INITIAL EVALUATION	UP TO 28 WEEKS	28-36 WEEKS	36+ WEEKS
The first prenatal visit should be within the first 12 weeks of pregnancy	Visits should be every four weeks *	Visits should be every two weeks*	Visits should be weekly *
Complete physical exam, including review of systems	Visit should include: • Blood pressure*** • Weight • Urine for presence of protein and glucose** • Uterine size for progressive growth and consistency with estimated date of delivery (EDC) • Fetal heart rate • Fetal movement assessment	Visit should include: • Blood pressure*** • Weight • Urine for presence of protein and glucose** • Uterine size for progressive growth and consistency with estimated date of delivery (EDC) • Fetal heart rate • Fetal movement assessment	Visit should include: • Blood pressure*** • Weight • Urine for presence of protein and glucose** • Uterine size for progressive growth and consistency with estimated date of delivery (EDC) • Fetal heart rate • Fetal movement assessment • Fetal presentation
Complete medical history of expectant mother including menstrual history and previous pregnancies	Assessed at the first visit	Assessed at the first visit	Assessed at the first visit
Genetic screening/counseling of expectant mother and father and any pertinent family history	Assessed at the first visit	Assessed at the first visit	Assessed at the first visit
Lab tests: • Blood group and RH type • Antibody screen • Complete blood count • Varicella • Rubella	Lab tests (when indicated) • Repeat antibody tests in unsensitized, D-negative patient at 28-29 weeks and prophylactic anti-D immune globulin should be administered. • Screen for gestational diabetes	Lab tests: • Hct/Hgb • Screen at 35-37 wks for Group B strep Additional Lab tests (when indicated): • Ultrasound	

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• VDRL/RDR (syphilis) • Urinalysis • Urine culture & sensitivity • Chlamydia Screen • Hepatitis B surface antigen • Cervical cytology (as needed) • Human immunodefiency virus (HIV) counseling/ testing (offered) • Gonorrhea	mellitus at 24-28 wks • Repeat hematocrit & hemoglobin • The USPSTF recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at their first prenatal visit, if later.	• VDRL • Gonorrhea • Chlamydia (Women younger than 25yrs or at high risk) • HIV (Women at high risk for HIV)	
Optional lab test offered or recommended based on history: (May not be all inclusive) • Hemoglobin Electophoresis • PPD • Screen for Cystic Fibrosis • Tay-Sachs Genetic screening tests • Ultrasound at 8-10 weeks (when indicated) • Prenatal genetic diagnosis • Mantoux tuberculin skin test or interferon –gamma release assay	Second and third trimester ultrasound examinations (i.e., standard, limited and specialized) should be performed only when there is a valid medical indication for the exam.	Second and third trimester ultrasound examinations (i.e., standard, limited and specialized) should be performed only when there is a valid medical indication for the exam.	Second and third trimester ultrasound examinations (i.e., standard, limited and specialized) should be performed only when there is a valid medical indication for the exam.
• A discussion of the risks, benefits, and alternatives of various methods of prenatal screening and diagnostic testing, including the option of no testing, should occur with all patients	Integrated screening or sequential screening should be offered to women who seek prenatal care in the first trimester. Integrated screening uses both the first-trimester and second-trimester markers.		

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• 1st trimester aneuploidy risk assessment • MSAFP/multiple markers** • Patients at increased risk of aneuploidy can be offered testing with cell free fetal DNA after pretest counseling and informed patient choice (Cell free fetal DNA testing should not be part of routine prenatal laboratory assessment, nor should it be offered to low risk women or women with multiple gestation) **All women presenting for prenatal care before 20 weeks of gestation should be offered screening for aneuploidy. All women, regardless of age, should have the option of invasive prenatal diagnosis (ie, CVS or amniocentesis) for fetal aneuploidy. Cell free fetal DNA does not replace the accuracy and diagnostic precision of prenatal diagnosis with CVS or amniocentesis, which remain an option for women.	Results are reported only after both first- and second-trimester screening tests are completed. In sequential screening, the patient is informed of the first-trimester screening result. Those at highest risk might opt for an early diagnostic procedure and those at lower risk can still take advantage of the higher detection rate achieved with additional second-trimester screening. • First-trimester combined serum screening (pregnancy associated plasma protein-A and free B-hCG) with nuchal translucency measurement (10-13 weeks of gestation) • Second-trimester triple (alpha-fetoprotein (AFP), estriol, B-hCG) or Quadruple (AFP,estriol, B-hCG, inhibin-A) marker serum screening (15- 20 weeks of gestation) • The options for women who are first seen during the second trimester are limited to quadruple (or "quad") screening and ultrasound examination. • First trimester nuchal translucency testing alone for multiple gestations (Serum screening tests are not as sensitive in multiple gestations) • If nuchal translucency measurement is not available or cannot be		

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	obtained in an individual patient, a reasonable approach is to offer serum integrated screening to patients who present early and second-trimester screening to those who present later.
	
	• Women found to be at increased risk of aneuploidy with first-trimester screening should be offered genetic counseling and option of CVS or second trimester amniocentesis.
	
	• Indications for Considering the Use of Cell Free Fetal DNA:
	
	  • Maternal age 35 years or older at delivery;
	  • Fetal ultrasonographic findings indicating an increased risk of aneuploidy;
	  • History of a prior pregnancy with a trisomy;
	  • Positive test result for aneuploidy, including first trimester, sequential, or integrated screen, or a quadruple screen;
	  • Parental balanced robertsonian translocation with increased risk of fetal trisomy 13 or trisomy 21.		

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Counsel regarding: • Prenatal Vitamins and folic acid • HIV and other prenatal tests • Risk factors identified by history • Anticipated course of prenatal care • Nutrition and weight gain • Toxoplasmosis precautions • Sexual Activity • Exercise • Seasonal Influenza vaccine (All pregnant women, regardless of trimester, should receive the inactivated influenza vaccination during the flu season) • Other vaccines recommended in pregnancy, if indicated, include Tdap, hepatitis A, Hepatitis B, and pneumococcal (recommended for pregnant women with prior splenectomy or functional asplenia). According to CDC, pregnancy should not preclude vaccination with meningococcal polysaccharide vaccine, if indicated. • Smoking counseling • Environmental/work hazards • Travel • Tobacco use (advise to stop using tobacco, provide	Counsel regarding: • Signs & symptoms of preterm labor • Abnormal lab values • Injectable Influenza vaccine (for all pregnant women who will be pregnant during the influenza season) • Selection of pediatrician • Smoking counseling • Postpartum family planning/tubal sterilization • Depression screening	Counsel regarding: • Anesthesia/analgesia plans • Fetal movement monitoring • Labor signs • VBAC counseling (if indicated) • Signs & symptoms of pregnancy induced hypertension • Post term counseling • Circumcision • Breast or bottle feeding • Depression screening • Postpartum depression • Depression screening (during and postpartum • Influenza vaccine • Smoking counseling • Domestic Violence • Newborn education • Family medical leave	

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behavioral interventions for cessation to pregnant women who use tobacco) • Alcohol use • Illicit/recreational drugs • Use of any medications (supplements, OTC etc) • Indications for ultrasound • Domestic violence • Seat belt use • Childbirth classes and choosing newborn care provider • Air travel during pregnancy • Umbilical cord blood banking • Breastfeeding (promote & support) • Circumcision • Vaginal Birth after Cesarean delivery (VBAC) • Newborn screening • Dental care in pregnancy • Depression Screening			

*The frequency of follow up visits is determined by the individual needs of the woman and assessment of her risk. Women with medical or obstetric problems, as well as women at the extremes of reproductive age, will likely require closer surveillance.

**Inclusion of routine dipstick assessment for all pregnant women can be modified. A baseline 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 be shown to be a benefit in routine dipstick testing during prenatal care for women at low risk.

***The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy

Postpartum Visit:

4-6 weeks after delivery but may be modified according to the needs of the patient. A visit within 7-14 days after delivery may be advised for cesarean delivery or complicated gestation.

Postpartum review should include:

- Interval history
- Physical exam
- Pap smear if indicated
- Review of family planning/birth control/preconceptional care
- Screen for depression
- Review of immunization status and recommendations as necessary

Preconception Care:

Consists of the identification of those conditions that could affect a future pregnancy or fetus and that maybe amenable to intervention. Counseling to optimize pregnancy outcomes should include:

- Family planning and pregnancy spacing
- Family HX
- Genetic history (both maternal and paternal)
- Medical, surgical, and psychiatric history
- Current medication (prescription and non prescription)
- Substance use, including alcohol, tobacco and recreational and illicit drugs
- Exposure to violence and intimate partner violence
- Nutrition
- Teratogen; Environmental and occupational exposures
- Immunity and immunization status and offer vaccine if indicated (influenza, measles, mumps, rubella, varicella, hepatitis A & B, meningococcus and pneumococcus). The HPV vaccine can be offered to appropriate non-pregnant women. However, the vaccine is not recommended during pregnancy, completion of the vaccine series may be delayed until the postpartum period. Avoiding pregnancy within 1 month of receiving a live attenuated viral vaccine (e.g. rubella) is recommended.
- Risk factors for sexually transmitted diseases
- Obstetric history
- Gynecologic history
- General physical exam
- Assessment of socioeconomic, educational and cultural context
- Testing for specific diseases can be performed when indicated such as with genetic disorders.

Patients should be counseled regarding exercise, weight, nutrition, prevention of HIV infection, abstaining from alcohol, tobacco and illicit drugs use before and during pregnancy, determining the time of conception by accurate menstrual history, folic acid 0.4mg - 0.8 mg daily while attempting pregnancy and during three months of pregnancy for prevention of neural tube defects and maintaining good control of any preexisting conditions. Based on racial and ethnic background, screening for genetic disorders may be performed.

References:

1. ACOG Practice Bulletin. Clinical Management Guidelines for Obstetrician-Gynecologists. Screening for Fetal Chromosomal Abnormalities. Number 77, January 2007. Reaffirmed 2013
2. The U.S. Preventive Services Task Force (USPSTF) Obstetric and Gynecologic Conditions. Available at: http://www.ahrq.gov/clinic/cps3dix.htm#obstetric
3. American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care. 5th edition.
4. Kirkham C, Harris S, Grzybowski S. Evidence-Based Prenatal Care: Part I. General Prenatal Care and Counseling Issues. American Family Physician. 2005 Apr 1;71(7):1307-16. Available at: http://www.aafp.org/afp/20050401/1307.html
5. Kirkham C, Harris S, Grzybowski S. Evidence-based prenatal care: part II. Third-trimester care and prevention of infectious diseases. Am Fam Physician. 2005 Apr 15; 71(8): 1555-60 Available at: http://www.aafp.org/afp/20050415/1555.html
6. Centers for Disease Control and Prevention. (CDC) Sexually Transmitted Diseases Treatment Guidelines, 2006. August 4, 2006 / 55(RR11);1-94. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5511a1.htm
7. American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care. 6th edition
8. ACOG Practice Bulletin. Clinical Management Guidelines for Obstetrician-Gynecologists. Invasive Prenatal Testing for Aneuploidy. Number 88, December 2007. Reaffirmed 2009. Reaffirmed 2013. Reaffirmed 2014.
9. Centers for Disease Control and Prevention. 2009 H1N1 Influenza Vaccine and Pregnant Women: Information for Healthcare Providers. Jan 2010. Available at: http://www.cdc.gov/h1n1flu/vaccination/providers_qa.htm
10. The American College of Obstetricians and Gynecologists. Committee Opinion Number 468. Influenza Vaccination during Pregnancy. October 2010.
11. American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care. 7th edition. October 2012
12. The American College of Obstetricians and Gynecologists Committee on Genetics. The Society for Maternal-Fetal Medicine Publications Committee. Committee Opinion Number 545. Noninvasive Prenatal Testing for Fetal Aneuploidy. December 2012.
13. ACOG Practice Bulletin. Gestational Diabetes Mellitus. Number 137. August 2013
14. The American College of Obstetricians and Gynecologists Committee on Genetics. The Society for Maternal-Fetal Medicine Publications Committee. Committee Opinion Number 581. The Use of Chromosomal Microarray Analysis in Prenatal Diagnosis. Dec 2013. Reaffirmed 2015
15. American College of Obstetricians and Gynecologists Committee Opinion. Influenza Vaccination During Pregnancy. Number 608. Sept 2014 (Replaces No. 468, October 2010)

16. The American College of Obstetricians and Gynecologists Committee on Genetics. Society for Maternal-Fetal Medicine. Cell-free DNA Screening for Fetal Aneuploidy. Number 640, September 2015 (Replaces Committee Opinion Number 545)

Important Note
Health Net's Prenatal/Perinatal Health Guidelines provide recommendations are for the general population, based on the best available medical evidence at the time of release. A Health Net member's medical history and physical examination may indicate that further medical tests are needed. Guidelines may also differ from state to state based on state regulations and requirements. As always, the judgment of the treating physician is the final determinant of member care. Your benefit plan may or may not cover all the services listed here. Please refer to your certificate of coverage for complete details or contact the customer service number listed on your ID card.

Review History: February 2007, February 2008, March 2009. February 2010, February 2011, February 2012, February 2013, February 2014, February 2015, February 2016, May 2017