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Alabama Care Network
SOUTHEAST Medical
Management Meeting

February/March 2026



AGGENDA

Low Birth Weight and Perinatal
Mortality
Supplemental Claims
Quality Reports



Reducing Low Birth Weight
and Perinatal Mortality:
Evidence Based Interventions
for Primary Care



The Problem

- Low birth weight (LBW) and perinatal mortality remain critical quality measures affecting Medicaid populations disproportionately.
- LBW associated with neonatal mortality and lifelong health sequelae
- Social determinants of health represent up to 80% of factors directly affecting maternal-child health outcomes[1]

Alabama's Challenge

The Data

- Rural Alabama faces higher rates of adverse birth outcomes
- Infant mortality in rural counties without local OB care: 9.23 per 1,000 vs. 7.89 with local care[2]
- Low birth weight: 10.61% without local care vs. 9.86% with local care[2]
- Perinatal mortality: 10.82 per 1,000 without local care vs. 8.89 with local care[2]
- Alabama was one of only 3 states with increased perinatal mortality from 2022-2023 [NCHS Data Brief 2025]

2. Effect of Access to Obstetrical Care in Rural Alabama on Perinatal, Neonatal, and Infant Outcomes: 2003-2017. Annals of Family Medicine. 2020. Waits JB, Smith L, Hurst D.

Impact of Access to Care Pickens County Example

- Local obstetrical services by family physicians dramatically improved outcomes
- Timeline of infant mortality rates in Pickens County:
 - 1986-1991 (no local OB services): 17.9 per 1,000 live births[3]
 - 1993-2001 (FPs providing OB care): 7.2 per 1,000 live births[3]
 - 2005-2013 (OB unit closed): 16.0 per 1,000 live births[3]
- Key takeaway: Access to local prenatal and obstetrical care is associated with lower infant mortality in rural Alabama[3]

Our Role as Primary Care Physicians

- We are the frontline for preventing adverse birth outcomes in rural Alabama
- Why primary care matters:
- **Early prenatal care initiation is critical** - most preventive interventions can be achieved at first contact[5]
- Family physicians providing obstetrical care improved infant mortality by 60% in rural Alabama[3]
- **Regular antenatal care visits are the most critical measure** to prevent stillbirths and neonatal deaths[6]
- Primary care can address social determinants that account for up to 80% of maternal-child health outcomes[4]

National Disparities

What We Must Address

- Racial and ethnic disparities persist even after controlling for other risk factors
- Black women: 14.39% preterm birth rate vs. 9.26% for White women[4]
- Black infant mortality is 2.2 times higher than White infant mortality[4]
- Self-reported experiences of discrimination are associated with higher rates of preterm birth and low birth weight[4]
- Exposure to racism is "a highly plausible, major upstream contributor" to disparities through multiple pathways[4]

The Evidence-Based Package of Care

- **Full implementation of 8 proven interventions could prevent substantial morbidity and mortality**
 - multiple micronutrient supplementation, balanced protein and energy supplementation, low-dose aspirin, progesterone provided vaginally, education for smoking cessation, malaria prevention, treatment of asymptomatic bacteriuria, and treatment of syphilis
- Global impact estimates:
- Could prevent **>5 million preterm/small-for-gestational-age births annually**[7]
- Could prevent **>500,000 stillbirths** and nearly 500,000 neonatal deaths[7]
- Could reduce **low birth weight prevalence by 17.9%** and neonatal mortality by **20%**[7]
- **In Alabama:** These interventions are particularly critical given our rural access challenges and rising perinatal mortality rates

Before Birth

Early Prenatal Care Matters

- Care initiated at 10 weeks or earlier improves outcomes[1]
- Key actions for primary care:
- **Early pregnancy contact can achieve most preventive interventions:** screening for syphilis/HIV, gestational age estimation, supplement provision, dietary counseling, and obstetric history review[7]
- Universal screening for depression, anxiety, intimate partner violence, substance use, and food insecurity early in pregnancy[1]
- Intimate partner violence is the leading cause of pregnancy-related death in the U.S. [1]

Nutrition Intervention

- **Multiple micronutrient supplementation and balanced protein-energy supplements are among the most effective interventions[2]**
- Evidence-based recommendations:
- **Multiple micronutrients (vs. iron-folic acid alone):** reduces stillbirth by 9% and small-for-gestational-age birth by 7%[7]
- **Balanced protein-energy supplements:** reduces stillbirth by 61%, perinatal mortality by 50%, and small-for-gestational-age births by 29%[5]
- These two interventions account for 67% of the total effect on preventing LBW births[7]
- Folic acid 400-800 mcg daily decreases neural tube defects[1]

Infection Prevention and Treatment

- Detecting and treating infections prevents preterm birth
- Priority interventions:
- **Asymptomatic bacteriuria treatment:** reduces preterm birth risk by 66%[5]
- **Syphilis screening and treatment:** essential component of comprehensive care[7]
- Screen all patients for sexually transmitted infections[1]

High-Risk Pregnancy Management

- Low-dose aspirin for patients at risk of preeclampsia[1-7]
- Key interventions:
- **81 mg aspirin daily starting at 12 weeks** for those at risk of preeclampsia, including patients diagnosed with COVID-19 in pregnancy[1]
- Aspirin accounts for a substantial portion of preterm birth prevention[7]
- **Treat chronic hypertension** to blood pressure <140/90 mm Hg[1]
- Screen for gestational diabetes between 24-28 weeks[1]

Lifestyle and Behavioral Interventions

- Addressing modifiable risk factors
- Evidence-based counseling:
- **Smoking cessation:** psychosocial support is a proven intervention[7]
- Pre-pregnancy BMI >25 kg/m² associated with gestational diabetes, hypertension, miscarriage, and stillbirth[1]
- Substance use increases risk of IUGR, preterm delivery, stillbirth, and fetal malformations[1]
- Opioid use in pregnancy increased 131% from 2010-2017 in the U.S.[1]

After Birth Supporting the Newborn

- Immediate and ongoing care for LBW infants
- Hospital-based interventions:
- Kangaroo mother care for preterm/LBW infants[8]
- Delayed cord clamping reduces complications of preterm birth[7]
- Thermal care and appropriate feeding support[8-9]
- Breastfeeding support and clean postnatal practices [8]

After Birth Supporting the Family

- Primary care's role in preventing recurrence
- Post-discharge interventions:
- **Postpartum visit attendance** is a key quality measure (Medicaid covers almost half of U.S. births)
- Screen for postpartum depression and anxiety—rates increased after COVID-19 pandemic[1]
- **Contraceptive counseling**, including long-acting reversible contraception, during prenatal care[7]
- Address ongoing social determinants: food insecurity, housing stability, intimate partner violence[1]
- Interconception care: optimize maternal health before next pregnancy

Action Steps for Your Practice

- **What you can do starting today:**
- Ensure early prenatal care initiation (<10 weeks)
- Universal screening for social determinants, depression, IPV, substance use
- Prescribe multiple micronutrients and counsel on nutrition
- Screen and treat asymptomatic bacteriuria and STIs
- Initiate low-dose aspirin at 12 weeks for high-risk patients
- Provide smoking cessation counseling
- Ensure postpartum follow-up and interconception care planning



Conclusion

One Thing



References

1. Prenatal Care: An Evidence-Based Approach.

- American Family Physician. 2023. Ramírez SI.

2. Effect of Access to Obstetrical Care in Rural Alabama on Perinatal, Neonatal, and Infant Outcomes: 2003-2017 - PubMed

- Annals of Family Medicine. 2020. Waits JB, Smith L, Hurst D.

3. Obstetric Care by Family Physicians and Infant Mortality in Rural Alabama - PubMed

- Journal of the American Board of Family Medicine : JABFM. 2018. Powell J, Skinner C, Lavender D, Avery D, Leeper J.

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4. Society for Maternal-Fetal Medicine Consult Series #62: Best Practices in Equitable Care Delivery-Addressing Systemic Racism and Other Social Determinants of Health as Causes of Obstetrical Disparities.

- American Journal of Obstetrics and Gynecology. 2022. Greenberg MB, Gandhi M, Davidson C, Carter EB.

5. What Can Work and How? An Overview of Evidence-Based Interventions and Delivery Strategies to Support Health and Human Development From Before Conception to 20 Years.

- Lancet. 2022. Vaivada T, Lassi ZS, Irfan O, et al

6. Antenatal Interventions for Preventing Stillbirth, Fetal Loss and Perinatal Death: An Overview of Cochrane Systematic Reviews.

- The Cochrane Database of Systematic Reviews. 2020. Ota E, da Silva Lopes K, Middleton P, et al

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7. Evidence-Based Antenatal Interventions to Reduce the Incidence of Small Vulnerable Newborns and Their Associated Poor Outcomes.

- Lancet. 2023. Hofmeyr GJ, Black RE, Rogozińska E, et al.

8. Can Available Interventions End Preventable Deaths in Mothers, Newborn Babies, and Stillbirths, and at What Cost?.

- Lancet. 2014. Bhutta ZA, Das JK, Bahl R, et al.

A L E R T

**Supplemental
Claims via CPT
99499**

Alabama Medicaid Alert
12/18/2025



Why This Matters: The Big Picture

- **Challenges with Current Diagnosis Submission**
 - Many patients have complex health profiles, but standard claims limit the number of diagnosis codes.
 - This leads to incomplete health status pictures, resulting in less accurate risk scores for patient panels.
 - Impacts cost effectiveness measures, potentially affecting reimbursements and performance metrics.
- **Especially Relevant For:**
 - Practices with large patient panels (e.g., high-volume primary care).
 - Pediatric practices: Often overwhelmed by procedure codes for vaccinations, screenings, and labs, leaving little room for diagnoses.
- **Benefit of the New Option:**
 - Enables a fuller representation of patient health, improving risk adjustment and supporting better resource allocation under ACHN.

Overview of the New Policy

- **Key Update from Alabama Medicaid Agency *Effective January 1, 2026***
 - Eligible Providers: Physicians, Nurse Practitioners (NPs), Physician Assistants (PAs), and EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) screening providers.
 - Purpose: Submit up to **24 additional diagnosis codes** per date of service.
- **Method: Use CPT code 99499 (unlisted/unspecified) for supplemental claims.**
 - Submit up to **two claims** for CPT 99499 per date of service as a claim detail.
 - These claims should **NOT include other procedure codes**.
- **Reimbursement: Medicaid will pay \$0.00 on claims for CPT 99499 (informational only).**
- **Special Notes for FQHCs and RHCs:**
 - Bill CPT 99499 as a **fee-for-service claim**.
 - Prospective payment rates will **NOT** be reimbursed for these claims.

How to Implement Step-by-Step Guide

- **Identify Need:** Review patient encounters where more than the standard diagnosis codes are required (e.g., chronic conditions, comorbidities).
- **Prepare Claim:** For the date of service, create a supplemental claim using CPT 99499.
 - Add up to 12 diagnosis codes per claim (total of 24 across two claims).
 - Ensure **no other procedure codes** are included to avoid rejection.
- **Submit:** File up to two separate claims per date of service.
 - Use your standard billing system or EHR integration.
- **Track and Verify:** Monitor for \$0.00 payments as confirmation of acceptance.
- **Tips for Success:**
 - Integrate this into your workflow for high-risk or pediatric patients.
 - Train staff on avoiding mixed procedure codes to prevent denials.

Expected Impact and Best Practices

- **Benefits for Your Practice**
- **More Accurate Risk Scores:** Full diagnosis capture leads to better panel assessments, aiding ACHN cost effectiveness goals.
- **Improved Patient Care Insights:** Helps in population health management and value-based care.
- **Efficiency for Pediatrics/Large Panels:** Overcomes limitations from vaccine/screening/lab codes.
- **Best Practices:**
 - Start with pilot patients to test the process.
 - Document all diagnoses thoroughly in patient records for audit support.
 - Review claims data quarterly to measure improvements in risk scores.
- **Manual Updates:**
 - Check Section 21.5.2 (Chapter 21 - Certified Registered Nurse Practitioners and Physician Assistants).
 - Check Section 28.6.2 (Chapter 28 - Physicians).
- Available in the January 2026 Provider Billing Manual.

Resources and Next Steps

- **Questions or Support?**

- For billing inquiries: Contact the Provider Assistance Center at 1-800-688-7989.
- Access the updated Provider Billing Manual on the Alabama Medicaid website.
- ACHN Resources: Reach out to your regional coordinator for tailored guidance.

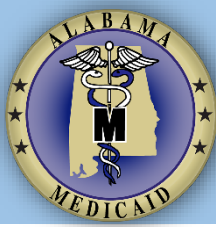
- **Next Steps for Your Team:**

- Schedule a quick training session on CPT 99499 usage.
- Update your EHR templates to flag opportunities for supplemental claims.
- Monitor January 2026 claims for any initial issues.

Quality Report Review

Dietitian Referral Reminder





Quality Measures Rates by Region - LBW

Measure	My Care Alabama Northwest	North Alabama Community Care	My Care Alabama East	Alabama Care Network Midstate	Gulf Coast Total Care	My Care Alabama Central	Alabama Care Network Southeast
Live Births < 2,500g Denominator	3,368	3,097	3,446	3,263	4,248	2,810	3,185
Live Births < 2,500g Numerator	369	300	277	423	560	383	356
Live Births < 2,500g Rate	11.0%	9.7%	8.0%	13.0%	13.2%	13.6%	11.2%
Baseline	11.9%	10.5%	9.6%	13.3%	10.6%	13.5%	12.7%
Timeliness of Prenatal Care Denominator	3,075	2,949	3,247	2,926	3,849	2,598	3,046
Timeliness of Prenatal Care Numerator	2,261	1,439	2,161	2,134	2,912	1,863	2,331
Timeliness of Prenatal Care Rate	73.5%	48.8%	66.6%	72.9%	75.7%	71.7%	76.5%
Baseline	71.3%	64.3%	65.0%	75.9%	79.4%	68.7%	76.2%



Quality Measures Rates by Region - WCV

Measure	My Care Alabama Northwest	North Alabama Community Care	My Care Alabama East	Alabama Care Network Midstate	Gulf Coast Total Care	My Care Alabama Central	Alabama Care Network Southeast
Well Child Visits 1 st 15 Months Denominator (Child)	3,332	3,805	3,620	3,736	4,093	3,334	3,570
Well Child Visits 1 st 15 Months Numerator	2,056	2,702	2,523	2,302	2,583	2,009	2,773
Well Child Visits 1st 15 Months Rate	61.7%	71.0%	69.7%	61.6%	63.1%	60.3%	77.7%
Baseline	51.2%	59.2%	62.2%	56.6%	64.4%	55.5%	52.4%
Well Child Visits 15 – 30 Months Denominator (Child)	3,454	3,701	3,820	3,654	4,095	3,445	3,593
Well Child Visits 15 – 30 Months Numerator	2,444	2,768	2,846	2,615	2,771	2,426	2,883
Well Child Visits 15 – 30 Months Rate	70.8%	74.8%	74.5%	71.6%	67.7%	70.4%	80.2%
Baseline	64.7%	70.9%	72.9%	69.0%	73.2%	66.5%	61.2%

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Referrals - (334) 466-
4609 - Fax referral form
or Face Sheet with
Patient information and
contact information

Thank You For Your Time

Medical Management Meeting Schedule

- All meetings will be via webinar at 12:00 p.m. Central Time
- Meeting dates: February 24th, March 4th, March 10th

