Quality ID #336: Maternity Care: Postpartum Follow-up and Care Coordination

2026 COLLECTION TYPE:
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of patients, regardless of age, who gave birth during a 12-month period who were seen for postpartum care before or at 12 weeks of giving birth and received the following at a postpartum visit: breastfeeding evaluation and education, postpartum depression screening, intimate partner violence screening, postpartum glucose screening for gestational diabetes patients, family and contraceptive planning counseling, tobacco use screening and cessation education, healthy lifestyle behavioral advice, and an immunization review and update.

INSTRUCTIONS:

Reporting Frequency:
This measure is to be submitted a minimum of once per performance period for denominator eligible cases as defined in the denominator criteria patients seen during the performance period.

Intent and Clinician Applicability:
This measure is intended to reflect the quality of services provided for patients seen for postpartum care before or at 12 weeks of giving birth. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions as defined by the numerator based on the services provided and the measure-specific denominator coding.

Measure Strata and Performance Rates:
This measure contains one strata defined by a single submission criteria.
This measure produces a single performance rate.

Implementation Considerations:
For the purposes of MIPS implementation, this patient-process measure is submitted a minimum of once per patient for the performance period. The most advantageous quality data code will be used if the measure is submitted more than once.

Telehealth:
NOT TELEHEALTH ELIGIBLE: This measure is not appropriate for nor applicable to the telehealth setting. Patient procedures for this measure conducted via telehealth should be removed from the denominator eligible patient population. Therefore, if the patient meets all denominator criteria but the encounter is conducted via telehealth, it would be appropriate to remove them from the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:
The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP)

website.

DENOMINATOR:
All patients, regardless of age, who gave birth during a 12-month period and were seen for postpartum care at a visit before or at 12 weeks of giving birth.

Denominator Criteria (Eligible Cases):
All patients, regardless of age
AND
Patient procedure during performance period (CPT): 59400, 59410, 59430, 59510, 59515, 59610, 59614, 59618, 59622
AND
Postpartum care visit before or at 12 weeks of giving birth: M1445

NUMERATOR:
Patients receiving the following at a postpartum visit:

- Breastfeeding evaluation and education, including patient-reported breastfeeding
- Postpartum depression screening
- Intimate partner violence screening
- Postpartum glucose screening for gestational diabetes patients
- Family and contraceptive planning counseling
- Tobacco use screening and cessation education
- Healthy lifestyle behavioral advice
- Immunization review and update

Definitions:
Breastfeeding Evaluation and Education – Patients who were evaluated for and educated about breastfeeding before or at 12 weeks postpartum.
Postpartum Depression Screening – Patients who were screened for postpartum depression before or at 12 weeks postpartum. Questions may be asked either directly by a health care provider or in the form of self- completed paper- or computer-administered questionnaires, and results should be documented in the medical record. Depression screening should include a self-reported validated depression screening tool (e.g., PHQ-9, Beck Depression Inventory, Beck Depression Inventory for Primary Care, Edinburgh Postnatal Depression Scale (EPDS)).
Intimate Partner Violence Screening – Patients who were screened for intimate partner violence before or at 12 weeks postpartum. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer-administered questionnaires, and results should be documented in the medical record. Intimate partner violence screening should include a self-reported validated intimate partner violence screening tool (e.g., Abuse Assessment Screen (AAS), Extended – Hurt, Insult, Threaten, Scream (E-HITS), Humiliation, Afraid, Rape, Kick (HARK)).
Postpartum Glucose Screening for Gestational Diabetes – Patients who were diagnosed with gestational diabetes during pregnancy and were screened with a glucose screen before or at 12 weeks postpartum.
Family and Contraceptive Planning Counseling – Patients who were provided family and contraceptive planning counseling (*including contraception, if necessary*) before or at 12 weeks postpartum.
Tobacco Use Screening and Cessation Education – Patients who were screened for tobacco use before or at 12 weeks postpartum. Patients who used any type of tobacco who were given brief counseling (3 minutes or less) and/or pharmacotherapy.
Healthy Lifestyle Behavioral Advice – Clinicians should use discretion to determine which patients they deem appropriate for healthy lifestyle counseling. Clinicians may take into account the number of weeks that have passed since childbirth, whether the mother is breastfeeding, the degree to which the mother's body mass index (BMI) exceeds the normal range, whether postpartum depression is present, and the mother's own feelings and perceptions of her body weight. Counseling should include suggestions around healthy eating and staying active. If deemed necessary by the clinician, the conversation about healthy lifestyle choices could include a follow-up plan,

including a referral to a specialist such as a registered dietitian nutritionist, primary care provider, or mental health professional for lifestyle/behavioral therapy, pharmacological interventions, dietary supplements, exercise counseling or nutrition counseling.
Immunization Review and Update – Patients whose immunization records were reviewed and who were provided with indicated immunizations, including completing series initiated antepartum or postpartum, at or before 12 weeks postpartum.

Numerator Instructions:
To satisfactorily meet the numerator ALL components (breastfeeding evaluation and education, postpartum depression screening, intimate partner violence screening, postpartum glucose screening for patients with gestational diabetes, family and contraceptive planning counseling, tobacco use screening and cessation education, healthy lifestyle behavioral advice, and immunization review and update) must be performed according to the definitions provided above.

NUMERATOR OPTIONS:

Performance Met:	Postpartum screenings, evaluations, and education performed (G9357)

OR

Performance Not Met:	Postpartum screenings, evaluations and education not performed (G9358)

RATIONALE:
Managing and ensuring concrete postpartum follow-up after delivery is a critical challenge to the health care system impacting the quality of care mothers receive. The American College of Obstetricians and Gynecologists (ACOG) sees the weeks following birth as a critical period for a woman and her child that sets the stage for long-term health and well-being. As such, this "fourth trimester" should include a comprehensive postpartum visit with a full assessment of physical, social, and psychological well-being.

Postpartum follow-up for depression screening, breastfeeding evaluation and education, family and contraceptive planning counseling, glucose screening for gestational diabetes, tobacco use screening and cessation education, healthy lifestyle behavioral advice, and immunization review and update are important risk factors to evaluate after childbirth. Maternal depression is one of the most common perinatal complications; however, the disorder remains under recognized, underdiagnosed, and undertreated. The various maternal depression disorders are defined by the severity of the depression and the timing and length of the episode. Studies report that 3 to 25 percent of women experience major depression during the year following childbirth.

Approximately forty-one percent of women experience intimate partner violence in their lifetimes, and sexual and gender minorities are at greater risk of experiencing intimate partner violence [1]. Intimate partner violence significantly affects physical and mental health [2]. In a systematic review of high-income country data, intimate partner violence tripled the odds of postpartum depression [3].

Establishing the diagnosis of gestational diabetes mellitus offers an opportunity not only to improve pregnancy outcomes, but also to decrease risk factors associated with the subsequent development of type 2 diabetes. The ACOG Committee on Obstetric Practice recommends that all women with gestational diabetes mellitus be screened at 6–12 weeks postpartum and managed appropriately.

Tobacco and nicotine use is still a major contributor to morbidity and mortality in women and men. Women who stop using tobacco and nicotine receive an immediate health and financial benefit.
ACOG acknowledges that unintended pregnancies are common and that pregnancy spacing is important for healthy families. In addition, the greatest risk of low birth weight and preterm birth occurs when the interconception interval is less than 6 months. The ACOG sees the weeks following birth as a critical period for a woman and her child that set the stage for long-term health and well-being.

The ACOG 2018 Postpartum Toolkit states that 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.

This measure is a measure of the adequacy of the care provided for those that come for postpartum care, as patients who do not have postpartum visits are excluded from this measure.
Although certain postpartum conditions, such as depression, remain an underrecognized and undertreated condition for all low-income women, this is especially the case for those from racial and ethnic minority groups. A retrospective study of New Jersey's Medicaid program found that Black and Latina women had particularly low treatment initiation rates for postpartum depression [4]. Postpartum care disparities similarly existed for general postpartum care, postpartum glucose screening, and family and contraceptive planning counseling among racial and ethnic minority groups [5,6]. Access to care barriers, health literacy variations, and care coordination challenges may also play a role in postpartum care disparities [7]. Potential solutions to improve postpartum testing rates included proactively contacting patients, establishing educational programs, and distributing mailings [8]. These studies suggest that successful implementation of this measure's intent may have positive downstream impacts on disparities in postpartum care and maternal and children's outcomes overall.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted from the referenced clinical guidelines.

Postpartum Care

The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains [9]:
Mood and emotional well-being
Infant care and feeding
Sexuality, contraception, and birth spacing
Sleep and fatigue
Physical recovery from birth
Chronic disease management
Health maintenance

Breastfeeding Evaluation and Education

The USPSTF recommends interventions during pregnancy and after birth to support breastfeeding (Grade B recommendation) [10].
This recommendation applies to pregnant women, new mothers, and young children. In rare circumstances involving health issues in mothers or infants, such as human immunodeficiency virus (HIV) infection or galactosemia, breastfeeding may be contraindicated, and interventions to promote breastfeeding may not be appropriate.
Interventions to promote and support breastfeeding may also involve a woman's partner, other family members, and friends.

Postpartum Depression Screening

A screening for postpartum depression should be included in the postpartum visit [11,12]. The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool. Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week. In doubtful cases it may be useful to repeat the tool after 2 weeks.

Intimate Partner Violence Screening

The U.S. Preventive Services Task Force recommends that clinicians screen for intimate partner violence in women of reproductive age and provide or refer women who screen positive to ongoing support services (Grade B recommendation) [13].

Postpartum Glucose Screening for Gestational Diabetes Patients

Up to one-third of women who experienced GDM will have impaired glucose metabolism postpartum and 15% to 50% of women will develop type 2 diabetes within the decades following the affected pregnancy [14]. Postpartum follow-up with treatment has been proven to postpone or prevent this occurrence. Glucose testing should be included in the postpartum visit for patients who had pregnancies complicated by gestational diabetes [11]. ACOG recommends either a 75 g, 2-hour oral glucose tolerance test, or a fasting plasma glucose test [9]. Refer to the VA/DoD Clinical Practice Guideline for the Management of Diabetes Mellitus in Primary Care (2017) for more information regarding glucose screening techniques [15].

Family and Contraceptive Planning Counseling

Women should be advised to avoid interpregnancy intervals shorter than 6 months and should be counseled about the risks and benefits of repeat pregnancy sooner than 18 months. Short interpregnancy intervals also are associated with reduced vaginal birth after cesarean success for women undergoing trial of labor after cesarean [9]. Family planning and contraception should be discussed at the postpartum visit [11].

A woman's future pregnancy intentions provide a context for shared decision making regarding contraceptive options. Shared decision making brings two experts to the table: the patient and the health care provider. The health care provider is an expert in the clinical evidence, and the patient is an expert in her experiences and values. As affirmed by the World Health Organization (WHO), when making choices regarding the timing of the next pregnancy, "Individuals and couples should consider health risks and benefits along with other circumstances such as their age, fecundity, fertility aspirations, access to health services, child-rearing support, social and economic circumstances, and personal preferences." Given the complex history of sterilization abuse and fertility control among marginalized women, care should be taken to ensure that every woman is provided information on the full range of contraceptive options so that she can select the method best suited to her needs [9].

Tobacco Screening and Cessation Education

One component of postpartum care be assessing mood and emotional well-being, which includes screening for tobacco use and counseling regarding relapse risk in the postpartum period [9]. An ACOG Work Group created a Tobacco and Nicotine Cessation Toolkit to support clinicians in discussing tobacco and smoking cessation with patients.

Healthy Lifestyle Behavioral Advice

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 [16].

Risk factors for being overweight or obese include a sedentary lifestyle, high caloric dietary intake, family history, genetics, and individual metabolism. Regular physical activity during an uncomplicated pregnancy and the postpartum period can improve cardiorespiratory fitness and reduce the risk and downstream health consequences (e.g., heart disease, diabetes) of being overweight or obese. 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. Providing lifestyle recommendations to promote maternal health for long-term reduction in the risk of chronic obesity and its downstream sequelae of diabetes and cardiovascular disease is a key objective of the postpartum visit. Such recommendations will also result in improved health in the interpregnancy period, if further childbearing is desired [15].

The postpartum period is an opportune time for obstetrician–gynecologists and other obstetric care providers to recommend and reinforce a healthy lifestyle. Resuming exercise or incorporating new exercise routines after delivery is important in supporting lifelong healthy habits. Exercise routines may be resumed gradually after pregnancy as soon as medically safe, depending on the mode of delivery (vaginal or cesarean birth) and the presence or absence of medical or surgical complications. Some women are capable of resuming physical activities within days of delivery. Pelvic floor exercises can be initiated in the immediate postpartum period. Abdominal strengthening exercises, including abdominal crunch exercises and the drawing-in exercise, a maneuver that increases abdominal pressure by pulling in the abdominal wall muscles, have been shown to decrease the incidence of diastasis recti abdominus and decrease the inter-rectus distance in women who gave birth vaginally or by cesarean birth [16].

Immunization Review and Update

One component of postpartum care includes reviewing vaccination history and providing indicated immunizations, including completing series initiated antepartum or postpartum [9]. The postpartum visit should include a review of current vaccination status in accordance with CDC Pregnancy and Maternal Vaccination guidance, including a review of immunization status against pertussis, influenza, varicella, and rubella [11].

REFERENCES:

1. Centers for Disease Control and Prevention. "Fast Facts: Preventing Intimate Partner Violence." October 11, 2022. Fast Facts: Preventing Intimate Partner Violence |Violence Prevention|Injury Center|CDC.
2. Chisholm, C., Bullock, L., and Ferguson 2nd, J. "Intimate Partner Violence and Pregnancy: Epidemiology and Impact." *American Journal of Obstetrics & Gynecology*, vol. 217, no. 2., 2017, pp. 141-144. doi: 10.1016/j.ajog.2017.05.042
3. Tran, T., Murray, L., and Vo, T. "Intimate Partner Violence During Pregnancy and Maternal and Child Health Outcomes: A Scoping Review of the Literature from Low-and-Middle Income Countries from 2016-2021." *BMC Pregnancy and Childbirth,* vol. 2, 2022. Intimate partner violence during pregnancy and maternal and child health outcomes: a scoping review of the literature from low-and-middle income countries from 2016 - 2021 - PMC (nih.gov). doi: 10.1186/s12884-022-04604-3
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5. Howell, E.A., Padrón, N.A., Beane, S.J. *et al.* (2017). Delivery and payment redesign to reduce disparities in high risk postpartum care. *Maternal Child Health J, 21(3),* 432–438. https://doi.org/10.1007/s10995-016-2221-8.
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7. Parekh, N., Jarlenski, M., Kelley, D. (2018). Prenatal and postpartum care disparities in a large Medicaid program. *Matern Child Health J, 22*, 429–437. https://doi.org/10.1007/s10995-017-2410-0.
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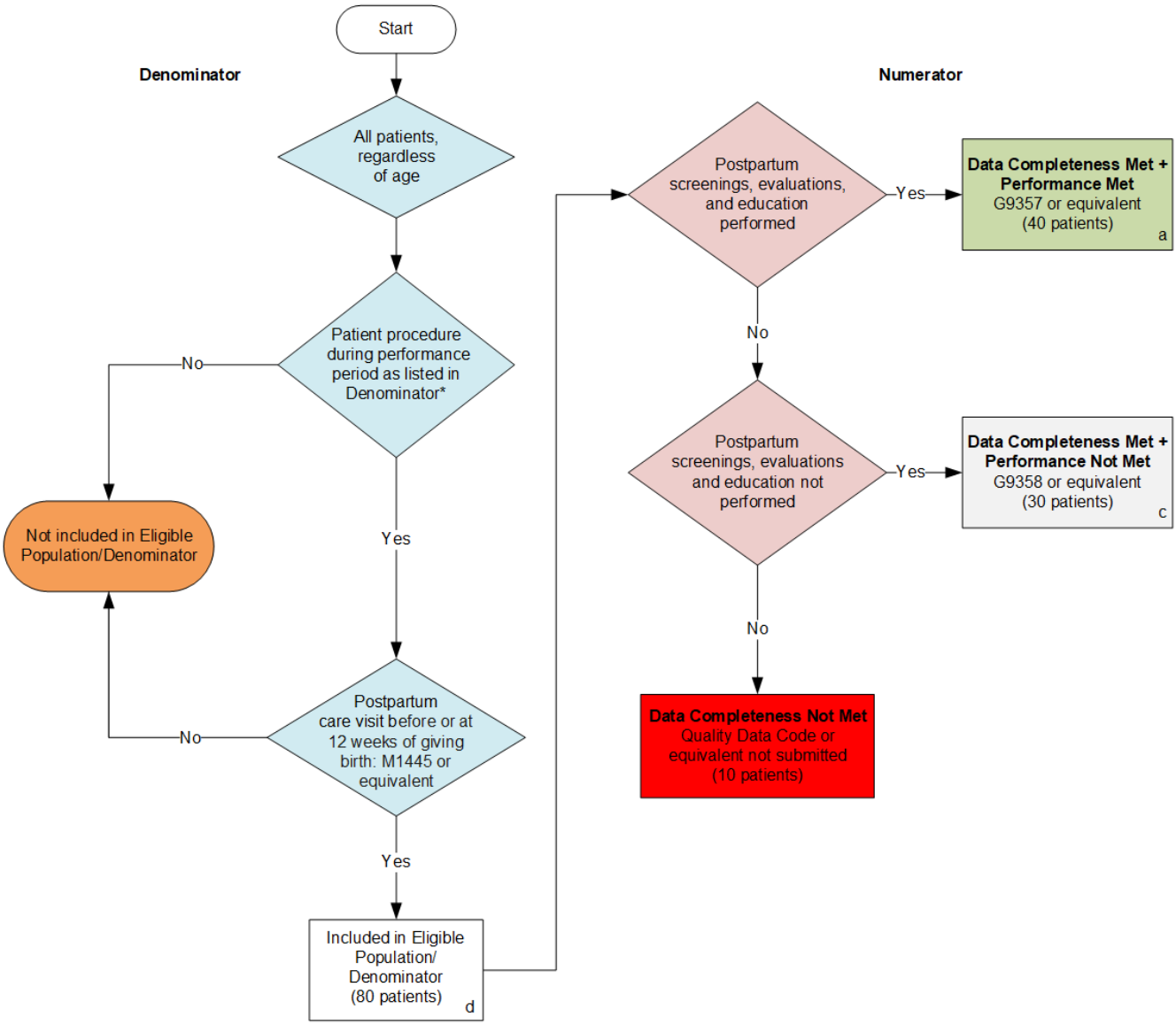
9. ACOG Committee Opinion No. 736: Optimizing Postpartum Care (2018, reaffirmed 2021)
10. USPSTF Final Recommendation Statement: Breastfeeding: Primary Care Interventions (2016)
11. VA/DoD Clinical Practice Guideline for the Management of Pregnancy Version 3.0 (2018)
12. ACOG Committee Opinion No. 757: Screening for Perinatal Depression (2018)
13. USPSTF Final Recommendation Statement: Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening (2018).
14. ACOG Tool for Postpartum Gestational Diabetes Mellitus (GDM) Follow-up
15. VA/DoD Clinical Practice Guideline for the Management of Diabetes Mellitus in Primary Care (2017)
16. ACOG Postpartum Toolkit (2018)

2026 Clinical Quality Measure Flow for Quality ID #336: Maternity Care: Postpartum Follow-up and Care Coordination

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=
Performance Met (a=40 patients) + Performance Not Met (c=30 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=
Performance Met (a=40 patients) = 40 patients = **57.14%**
Data Completeness Numerator (70 patients) = 70 patients

*See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Patient-Process

2026 Clinical Quality Measure Flow Narrative for Quality ID #336: Maternity Care: Postpartum Follow-up and Care Coordination

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.

1. Start with Denominator
2. Check *All patients, regardless of age*
3. Check *Patient procedure during performance period as listed in Denominator**:
    a. If *Patient procedure during performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient procedure during performance period as listed in Denominator** equals Yes, proceed to check *Postpartum care visit before or at 12 weeks of giving birth*.
4. Check *Postpartum care visit before or at 12 weeks of giving birth*:
    a. If *Postpartum care visit before or at 12 weeks of giving birth* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Postpartum care visit before or at 12 weeks of giving birth* equals Yes, include in *Eligible Population/Denominator.*
5. Denominator Population:
    - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
6. Start Numerator
7. Check *Postpartum screenings, evaluations, and education performed*:
    a. If *Postpartum screenings, evaluations, and education performed* equals Yes, include in *Data Completeness Met and Performance Met.*
        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 40 patients in the Sample Calculation.
    b. If *Postpartum screenings, evaluations, and education performed* equals No, proceed to *Postpartum screenings, evaluations and education not performed*.
8. Check *Postpartum screenings, evaluations and education not performed*:
    a. If *Postpartum screenings, evaluations and education not performed* equals Yes, include in *Data Completeness Met and Performance Not Met.*
        - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 30 patients in the Sample Calculation.
    b. If *Postpartum screenings, evaluations, and education not performed* equals No, proceed to check *Data Completeness Not Met.*

9. Check *Data Completeness Not Met*:

    - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from Data Completeness Numerator in the Sample Calculation.

Sample Calculations:

Data Completeness equals Performance Met (a equals 40 patients) plus Performance Not Met (c equals 30 patients) divided by Eligible Population / Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.