Clinical Policy: Home Births

Reference Number: WNC.CP.124
Last Review Date: 07/22

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description

A planned home birth is an elective alternative to delivery in a birthing center or hospital setting. Women are encouraged to make medically informed decisions about home delivery, and provision of home births will be considered when coverage is mandated by law or member's/enrollee's benefit language.

Policy/Criteria

I. It is the policy of WellCare of North Carolina® that home births are medically necessary when the following criteria are met:

A. The birth is overseen by a participating and credentialed provider of the Plan who meets **one** of the following criteria:

1. If home birth services are being *managed by a midwife*, **all** of the following criteria must be met:
   a. The midwife must be certified by the American Midwifery Certification Board (or its predecessor organizations) or the certified nurse–midwife's, certified midwife's, or midwife's education and licensure meet International Confederation of Midwives Global Standards for Midwifery Education, and practicing within an integrated and regulated health system;
   b. The written plan for emergency care includes documentation that emergency transportation to the nearest appropriate hospital can be accomplished within 15 minutes from the onset of an emergency condition;
2. If home birth services are being *managed by a physician*, **all** of the following must be met:
   a. The physician practices obstetrics within an integrated and regulated health system;
   b. If the physician is not an obstetrician or family practice physician that has completed an obstetrics fellowship, there is documented proof of back-up supervision and coverage by a board certified or an active candidate for certification by the American Board of Obstetrics and Gynecology;
   c. Emergency care is planned at a facility where the supervising obstetrician has admitting privileges;
   d. The written plan for emergency care includes documentation that emergency transportation to the nearest appropriate hospital can be accomplished within 15 minutes from the onset of an emergency condition;

B. Two care providers are planned to be present at the birth, including **both** of the following:

1. One who has primary responsibility for the mother;

2. One who has primary responsibility for the infant, is certified in the Neonatal Resuscitation Program and has the equipment to perform a full resuscitation of the infant in accordance with the principles of the Neonatal Resuscitation Program;

C. No preexisting medical condition(s) that increase pregnancy risk;
D. No prior cesarean delivery;
E. Absence of significant disease during pregnancy;
F. A singleton pregnancy, estimated to be appropriate for gestational age;
G. Fetal presentation is cephalic;
H. Either of the following:
   1. Spontaneous labor in a pregnancy that has lasted at least 37 0/7 weeks but no more than 41 6/7 weeks;
   2. Induced as an outpatient in a pregnancy that has lasted at least 39 0/7 weeks but no more than 41 6/7 weeks;
I. There is a preexisting arrangement for emergency transportation to a nearby hospital if needed.

II. It is the policy of WellCare of North Carolina® that home births are considered **not medically necessary** for any circumstances other than those specified above.

Background

Home birth remains a controversial issue, with safety as the primary focus. Although many countries have established lists based on specific patient characteristics and risks that might compromise the safety of out of hospital births, no specific list exists for the United States. Planned home birth must include a system that allows for collaboration, and referral and transfer to hospital care if problems arise. Appropriate risk screening is paramount in evaluating which home births may lead to positive outcomes. [3, 7]

American College of Obstetricians and Gynecologists (ACOG)

ACOG does not support planned home births given the published medical data and believes that hospitals and birthing centers are the safest settings for birth. However, ACOG respects the right of a woman to make a medically informed decision about delivery. Women inquiring about planned home birth should be informed of its risks and benefits based on recent evidence. This includes the appropriate selection of candidates for home birth; the appropriate certification for midwifes, as noted in the policy statement; practicing obstetrics within an integrated and regulated health system; ready access to consultation; and access to safe and timely transport to nearby hospitals. Specifically, women should be informed that although the absolute risk may be low, planned home birth is associated with a twofold to threefold increased risk of neonatal death when compared with planned hospital birth. [3]

American Academy of Pediatrics (AAP)

The AAP does not recommend planned home birth, which has been reported to be associated with a twofold to threefold increase in infant mortality in the United States. However, the AAP recognizes that women may choose to plan a home birth. The most recent policy statement concurs with ACOG, affirming that hospitals and birthing centers are the safest settings for birth in the United States while respecting the right of women to make a medically informed decision about delivery. They note travel times longer than 15 to 20 minutes to a medical facility have been associated with increased risk for adverse neonatal outcomes, including mortality. The AAP recommends that provisions for the potential resuscitation of a depressed newborn infant and immediate neonatal care be optimized in the home setting. Thus, each delivery should be

attended by two care providers, one who has primary responsibility for the mother and one who has primary responsibility for the infant.[1] At least one should have the appropriate training, skills, and equipment to perform a full resuscitation of the infant in accordance with the principles of the Neonatal Resuscitation Program. [18]

American College of Nurse Midwives & American Public Health Association

These two organizations have policy statements supporting the practice of planned out-of-hospital birth in select populations of women.[2, 4]

A meta-analysis was completed comparing maternal and newborn outcomes in planned home birth versus planned hospital births. Planned home births were associated with fewer maternal interventions including labor induction or augmentation, regional analgesia, electronic fetal heart rate monitoring, episiotomy, operative vaginal delivery, and cesarean delivery. These women were less likely to experience lacerations, and infections. Neonatal outcomes of planned home births revealed less frequent prematurity, low birthweight, and assisted newborn ventilation. Although planned home and hospital births exhibited similar perinatal mortality rates, planned home births were associated with significantly elevated neonatal mortality rates. [3, 12]

In the Netherlands and the United Kingdom, some large observational studies suggest that elevated neonatal mortality rates were associated with first time births in the home versus other birth settings, and that multiparous, low-risk births at home did not have an increased risk of maternal or neonatal complications.[13, 14] In contrast, a retrospective cohort study of Canadian patients found no risk of increased adverse neonatal outcomes for infants of primiparous or multiparous women with planned home births, and for both primiparous and multiparous women, rates of intrapartum interventions were lower.[15] A prospective study in the Netherlands similarly found no increased risk of perinatal complications for infants of primiparous women planning to deliver at home, and for infants of multiparous women, planned home delivery resulted in significantly better perinatal outcomes.[16]

There is a paucity of randomized, controlled trials of planned home birth. Most information on planned home births comes from observational studies, which are often limited by methodological problems, including small sample sizes, lack of an appropriate control group, reliance on voluntary submission of data or self-reporting, limited ability to distinguish accurately between planned and unplanned home births, variation in the skill, training, and certification of the birth attendant, and an inability to account for and accurately attribute adverse outcomes associated with antepartum or intrapartum transfers. [6, 10]

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and / or forceps) and postpartum care
59409	Vaginal delivery only (with or without episiotomy and/or forceps)
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
59414	Delivery of placenta

HCPCS ®* Codes	Description
No applicable codes.	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
O80	Encounter for full-term uncomplicated delivery

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	03/21	05/21
CPT and ICD-10-CM codes reviewed.	07/21	08/21
Added obstetrics fellowship criteria to I.A.2.b. Edited language in I.A.2.d. regarding emergency facility access. Reformatted I.B. and clarified the Neonatal Resuscitation Program criteria. Added I.H.2. Removed WHO background information on home birth and supporting reference. References reviewed and updated.	07/22	

References

1. American Academy of Pediatrics. Planned Home Birth. *Pediatrics* 2013;131(5):1016–1020. doi: https://doi.org/10.1542/peds.2013-0575
2. American College of Nurse-Midwives. Planned Home Birth. December 2005. (Updated December 2016) Accessed December 7, 2021.
3. American College of Obstetricians and Gynecologists. Planned Home Birth. Committee Opinion No. 697.. Published April 2017. (reaffirmed 2020) Accessed December 7, 2021.
4. APHA. Increasing access to out-of-hospital maternity care services through state-regulated and nationally-certified direct-entry midwives. APHA Public Policy Statements, 1948 to present, cumulative Washington, DC 2001.
5. Chervenak FA, McCullough LB, Brent RL, Levene MI, Arabin B.. Planned home birth: The professional responsibility response. *Am J Obstet Gynecol*. 2013;208 (1):31-38. doi:10.1016/j.ajog.2012.10.002

6. Cheyney M, Bovbjerg M, Everson C, Gordon W, Hannibal D, Vedam S.. Outcomes of care for 16,924 planned home births in the United States: the Midwives Alliance of North America Statistics Project, 2004 to 2009. *J Midwifery Womens Health* 2014;59:17–27.
7. Declercq E, Stotland NE. Planned home birth. UpToDate. www.uptodate.com. Published August 10, 2021. Accessed December 7, 2021.
8. Grunebaum A, McCullough LB, Sapra KJ, et al. Early and total neonatal mortality in relation to birth setting in the United States, 2006-2009. *Am J Obstet Gynecol*. 2014;211(4):390.e1- e7. 390.e3907. doi:10.1016/j.ajog.2014.03.047
9. Olsen O, Jewell D. Planned hospital birth versus planned home birth. *Cochrane Database Syst Rev*.2012 ;9(9):CD000352. Published 2012 Sep 12.doi:10.1002/14651858.CD000352.pub2
10. Snowden JM, Tilden EL, Snyder J, Quigley B, Caughey AB, Cheng YW. Planned out-of-hospital birth and birth outcomes. *N Engl J Med*. 2015;373(27):2642-2653. doi:10.1056/NEJMsa1501738
11. Wax JR, Lucas FL, Lamont M, Pinette MG, Catin A, Blackstone J. Maternal and newborn outcomes in planned home births vs planned hospital births: a metaanalysis. [published correction appears in Am J Obstet Gynecol. 2011 Apr;204(4):e7-13].*Am J Obstet Gynecol* 2010;203(3):243. e1-243.e2438. doi:10.1016/j.ajog.2010.05.028.
12. Birthplace in England Collaborative Group. Brocklehurst P, Hardy P, et al. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ*. 2011;343; d7400.
13. de Jonge, van der Goes BY, Ravelli AC, et al. Perinatal mortality and morbidity in a nationwide cohort of 529 688 low-risk planned home and hospital births. *BJOG*. 2009;116(9):1177-1184. doi: 10.1111/j.1471- 0528.2009.02175.x.
14. Hutton E, Cappelletti A, Reitsma AH, et al. Outcomes associated with planned place of birth among women with lowrisk pregnancies. *CMAJ*. 188(5): E80–E90. doi: 10.1503/cmaj.150564.
15. Wiegers TA, Keirse MJ, van der Zee J, Berghs GA. Outcome of planned home and planned hospital births in low risk pregnancies: prospective study in midwifery practices in The Netherlands. *BMJ*.;313(7068): 1309–1313. doi:10.1136/bmj.313.7068.1309
16. Bachilova S, Czuzoj-Shulman N, Abenhaim HA. Effect of Maternal and Pregnancy Risk Factors on Early Neonatal Death in Planned Home Births Delivering at Home. *J Obstet Gynaecol Can*. 2018;40(5):540-546.. doi: 10.1016/j.jogc.2017.07.029.
17. Watterberg K; COMMITTEE ON FETUS AND NEWBORN. Providing Care for Infants Born at Home. *Pediatrics*. 2020;145(5):e20200626. doi: 10.1542/peds.2020-0626.
18. Snowden JM, Tilden EL, Snyder J, Quigley B, Caughey AB, Cheng YW. Planned out-ofhospital birth and birth outcomes. *N Engl J Med*. 2015;373(27): 2642–2653. doi:10.1056/NEJMsa1501738

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise); or

2. the NC Health Choice (NCHC is NC Health Choice program, unless context clearly indicates otherwise) Program on the date of service and shall meet the criteria in this policy.

b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

EPSDT does not apply to NCHC beneficiaries.

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the, NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the

Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan
   For NCHC refer to NCHC State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan
g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.