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Corporate Payment Policy 18
HOME BIRTHS
Updated January 1, 2021 REVISED 11/17/2020

Description

A planned home birth is an elective alternative to delivery in a birthing center or hospital setting. Coverage of professional fees for a home birth (i.e., elective, planned delivery in the home setting) is subject to the terms, conditions and limitations of the applicable benefit plan and may be limited based on health care professional certification/licensure requirements.[1]

Policy/ Eligible Services/Billing Guidelines

BCBSVT reimburses a qualified healthcare professional for home birth services for low-risk pregnancies, including routine antenatal care, delivery, and postpartum care, according to the terms and conditions of this policy.

I. Global Maternity/Obstetric Package

When the qualified healthcare professional provider provides all components of obstetric care, report the applicable code for the Global Obstetric/Maternity Package:

a. Routine obstetric care including all antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care should be billed with CPT® Code 59400; or

b. Routine obstetric care including all antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after a previous cesarean delivery, should be billed with CPT® 59610.

II. Antepartum, Vaginal Delivery And Postpartum Care When Global Services Not Provided

a. Antepartum Care Only

i. For 1 – 3 antepartum visits, see and bill with appropriate Evaluation and Management (E/M) code(s).

ii. For antepartum care only, 4-6 visits, bill CPT® Code 59425.

iii. For antepartum care only, 7 or more visits, bill CPT® Code 59426.

[1] For example, for more information regarding professional standards for midwives, see 26 V.S.A. §§ 4181-4191.

iv. NOTE: If the provider did not render all of the patient's routine antepartum care (or the antepartum care provided is less than the typical number of visits (usually 13)), the provider must bill using one of the options listed in (a)(i) – (iii) above for antepartum care provided, even if the provider also rendered delivery and postpartum care.

b. Vaginal Delivery including Postpartum Care (excluding antepartum care)

i. For vaginal delivery only with (with episiotomy and /or forceps); and postpartum care, bill CPT® Code 59410.

1. Note: the vaginal delivery includes the labor time component.

ii. For vaginal delivery only, after previous cesarean delivery (with or without episiotomy/forceps); including postpartum care bill CPT® Code 59614.

c. Postpartum care only

For postpartum care only (separate procedure) bill CPT® Code 59430.

d. Vaginal Delivery only

i. For vaginal delivery only (with or without episiotomy and/or forceps) bill CPT® Code 59409.

1. Note: the vaginal delivery includes the labor time component.

ii. For vaginal delivery only, after previous cesarean delivery (with or without episiotomy/forceps), bill CPT® code 59612.

1. Note: the vaginal delivery includes the labor time component.

III. Newborn Assessment (separately reimbursable when certified nurse midwife/licensed midwife (CNM/LM) delivers newborn infant at home)

a. For initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center, bill CPT® 99461 for one visit only.

i. If newborn was delivered in the hospital setting or birthing center the CNM/LM cannot bill for this assessment. If the CNM/LM bills for the assessment, the claim will be denied. This assessment would be done in the facility/hospital.

b. For Periodic comprehensive preventive medicine, established patient, CPT® code 99391:

i. CNMs may bill CPT ® code 99391 up to four times during the first 28 days of newborn well care.
ii. LMs may bill CPT® code 99391 once for newborn well care.

iii. Except as stated in (b)(i) and (b)(ii) above, ongoing assessments are to be done by pediatrician or family practice provider.

IV. Services Excluded from the Global Maternity/Obstetric Package for Home Births

BCBSVT will reimburse specific medically indicated services outside the Global Maternity/Obstetric Package, including, but not limited to:

a. Medically necessary laboratory tests (excluding routine chemical urinalysis)

b. Administration of IV infusions including but not limited to hydration (CPT® codes 96360, 96361)

c. Therapeutic, prophylactic, or diagnostic injection, specify substance, or drug; subcutaneous or intramuscular (CPT® codes 96372, 96374)

d. Administration of injections (CPT® code 96372) including but not limited to RhoGAM (CPT® codes 90384, 90385) and Injection, phytonadione (vitamin K, 1 MG)

e. Drugs administered during labor (see J-codes in Attachment I)

V. Place of Service

Use place of service 12 (Home) for home births.

Not Eligible for Payment

I. BCBSVT does not reimburse for any of the following services associated with a home birth:

a. Duplication of services (e.g., services provided by a qualified health care provider and CNM/LM simultaneously);

b. Supplies (e.g., emergency kits), supplies specifically related to home birth (e.g., birthing tubs), modifications to the home, standby services (e.g., support personnel), non-medical charges;

c. Facility charges for the home setting;

d. Additional prenatal counseling sessions or prenatal evaluation/management services specifically related to home birth;

e. Charges related to prolonged personal attendance.

f. Additional prenatal Evaluation and Management services related to high risk pregnancies, as home births are expected to be uncomplicated;

g. Services for assistance from another licensed midwife, trained assistant, or Doula to attend birth; and

II. The following services are not eligible for separate reimbursement (as they are inclusive to the global, antepartum, delivery, or postpartum services listed in Section III under the Policy/Eligible Services/Billing Guidelines, above):

a. CPT® Codes- 99341 - 99345 (Home visit for new patient) is considered inclusive to the antepartum care for the mother and to the newborn assessment for the newborn and not separately reimbursed and should not be billed.

b. CPT® Codes- 99347-99350 (Home visit for established patient) is considered inclusive to postpartum care and not separately reimbursed and should not be billed.

c. CPT® code- 99500 (Home visits for pre-natal monitoring and assessment to include fetal heart rate, non-stress test, uterine monitoring and gestational diabetes monitoring) is considered inclusive to antepartum care and not separately reimbursed.

d. CPT® code 99501 (Home visit for postnatal assessment and follow up care) is considered inclusive to Vaginal delivery including postpartum care (CPT® code 59410) or Postpartum care only (CPT® code 59430) or the global billing package in CPT® code 59400 and should not be billed.

e. CPT® code 99502 (Home visit for newborn care and assessment) is considered inclusive to the reimbursement for the delivery and should not be billed.

f. CPT® code 59899 (Unlisted procedure, maternity care and delivery) is considered inclusive to the reimbursement for maternity care and delivery.

g. CPT® code 99417 prolonged services t) are considered inclusive to labor and delivery and/or global maternity services and are not separately reimbursed

h. CPT® code 99360 (standby services) is considered as inclusive to labor and delivery and/or global maternity services and is not separately reimbursed.

Benefit Determination Guidance

Payment for home birth services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible home birth services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP)

Members may have different benefits that apply. For further information, please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP)

In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (BCBSVT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

National Drug Code(s)

Health Care Procedure Coding System (HCPCS) codes related to chemotherapy drugs, drugs administered other than oral method, and enteral/parenteral formulas may be subject to National Drug Code (NDC) processing and pricing. The use of NDC on medical claims helps facilitate more accurate payment and better management of drug costs based on what was dispensed and may be required for payment. For more information on BCBSVT requirements for billing of NDC please refer to the provider portal at http://www.bcbsvt.com/provider-home for the latest news and communications.

Eligible Providers

Qualified healthcare professionals practicing within the scope of their license(s).

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the payment policy. If an audit identifies instances of non-compliance with this payment policy, BCBSVT reserves the right to recoup all non-compliant payments.

Legislative Guidelines

26 V.S.A. §§ 4181-4191
26 V.S.A. §§ 4121-4132

Related Policies

CPP_16 Global Maternity/Obstetric Package (excluding Home Births)

Document Precedence

The BCBSVT Payment Policy Manual was developed to provide guidance for providers regarding BCBSVT payment practices and facilitates the systematic application of BCBSVT member/employer contracts, provider contracts, BCBSVT corporate medical policies, and BCBSVT's claim editing solution. Document precedence is as follows:

1) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and the member contracts or employer benefit documents, the member contract/employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
3) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
4) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and BCBSVT's claim editing solution, BCBSVT's claim editing solution takes precedence.

Policy Implementation/Update Information

New Policy effective April 15, 2018
Updated effective September 1, 2018
Updated effective September 1, 2019
Updated effective January 1, 2021
Updated on November 17, 2020, for an effective date of January 1, 2021, as follows: (a) removed section IV under Policy/Eligible Services/Billing Guidelines (Billing for labor time when delivery not performed in home setting), as these services are no longer separately reimbursable; (b) removed codes from coding

table (99212-99215, 99354 & 99355); and (c) added a reference to new code 99417 (non-covered, provider liability).

References

1. American College of Obstetricians and Gynecologists (ACOG). Committee Opinion. Planned Home Births. Number 669, August 2016. American College of Obstetricians and Gynecologists. Obstet Gynecol. 2016 Aug;128(2):e26-31.

2. American Academy of Pediatrics. Planned home birth. Policy Statement. Committee on fetus and newborn. Pediatrics. Volume 131, Number 5, May 2013.

3. American College of Obstetricians and Gynecologists. Planned home birth. Committee opinion #476. Obstet Gynecol 2011 Feb;117(2):425-8 . Reaffirmed 2015 [http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Obstetric_Practice/Planned_Home_Birth] accessed 3/14/16.

Approved by **Date Approved: 11/30/2020**

Dawn Schneiderman, Vice President, Chief Operating Officer

Joshua Plavin, M.D., MPH, MBA, Vice President & Chief Medical Officer

Attachment I
Home Birth Coding Table

The following services will be reimbursed when policy criteria have been met:

CPT® Code	Description	Instructions
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/ or forceps) and postpartum care	Should be billed once as the "global billing" package when the provider is rendering all of these services to be billed after the patient has given birth.
59409	Vaginal delivery only (with or without episiotomy and/or forceps)	
59410	Vaginal delivery including postpartum care (this code includes the delivery)	
59414	Delivery of placenta (separate procedure) only billable when midwife only delivers the placenta and delivery of baby not performed)	
	Antepartum care only; 1-3 visits	See and bill with appropriate Evaluation and Management (E/M) code
59425	Antepartum care only; 4-6 visits	
59426	Antepartum care only; 7 or more visits	
59430	Postpartum care only (separate procedure)	
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after a previous cesarean delivery.	Should be billed once as the "global billing" package when the provider is rendering all of these services to be billed after the patient has given birth.
59612	For vaginal delivery only, after previous cesarean delivery (with or without episiotomy/forceps)	
59614	For vaginal delivery only, after previous cesarean delivery (with or without episiotomy/forceps) including postpartum care	
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	
96361	Intravenous infusion, hydration; each additional hour (list separately in addition to code for primary procedure)	
96372	Therapeutic, prophylactic, or diagnostic injection, specify substance, or drug; subcutaneous or intramuscular	
96374	Intravenous push, single or initial substance/drug	
+96375	Each additional sequential intravenous push of a new substance/drug	
99461	Newborn initial care, per day for the evaluation and management of normal newborn infant seen in other than hospital or birthing center	Can only be billed once and only if vaginal delivery occurred at home. Cannot be billed by CNM/LM if delivery

CPT® Code	Description	Instructions
		occurred at the hospital or birthing center
99391	Periodic comprehensive preventive medicine, established patient, infant (age younger than one year)	Certified nurse midwives (CNMs) may bill CPT ® code 99391 up to 4 times during the first 28 days of newborn well care. Licensed midwives (LMs) may bill CPT® code 99391 once for newborn well care. Otherwise, ongoing assessments are to be performed by a pediatrician or family practice physician. If not billed in accordance with the limitations above, the code will deny as provider not eligible to bill, provider liability.
81002	Urinalysis, by dip stick or tablet reagent, non-automated, without microscopy	
J2590	Injection, oxytocin, up to 10 units	
J2790	Injection, Rho D immune globulin, human, full dose, 300mcg (1500 IU)	
J2788	Injection, Rho D immune globulin, human, mini dose IM	
J3430	Injection, Phytonadione (vitamin K) 1 MG	
Services Not Eligible For Separate Reimbursement		
59899	[Unlisted procedure, maternity care and delivery] is considered inclusive to the reimbursement for maternity care and delivery.	Should not be billed. Provider liability
99341-99345	[Home visit for new patient] is considered inclusive to the antepartum care for the mother and to the newborn assessment for the newborn and not separately reimbursed and should not be billed.	Should not be billed, provider liability
99347-99350	[Home visit for established patient] is considered inclusive to postpartum care and not separately reimbursed and should not be billed.	Should not be billed, provider liability
99417	Prolong outpatient service (List separately in addition to code 99205, 99215 for services)	Should not be billed, provider liability
99500	[Home visits for pre-natal monitoring and assessment to include fetal heart rate, non-stress test, uterine monitoring and gestational diabetes monitoring] is considered inclusive to antepartum care and not separately reimbursed.	Should not be billed, provider liability
99501	[Home visit for postnatal assessment and follow up care] is considered inclusive to Vaginal delivery including	Should not be billed, provider liability

CPT® Code	Description	Instructions
	postpartum care (CPT® code 59410 or Postpartum care only (CPT® code 59430) or the global billing package in CPT® code 59400 and should not be billed.	
99502	[Home visit for newborn care and assessment] **is** considered inclusive to the reimbursement for the delivery and should not be billed.	Should not be billed, provider liability