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Origination: April 15, 2018
Last Review: February 05, 2026
Next Review: February 05, 2028
Effective Date: May 01, 2026

Description

Provide guidelines for the payment of eligible services for home births.

Policy & Guidelines

Policy Statement

Effective with dates of service on or after April 01, 2025, Blue Cross and Blue Shield of Vermont (Blue Cross VT) payment for services associated with Home Births will be considered based on applicable criteria set forth below in this policy.

Definition

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]

Eligible

Blue Cross VT reimburses a qualified healthcare professional for home birth services for low-risk pregnancies, including routine prenatal 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:

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

a. Routine obstetric care including all antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care bill with procedure 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, bill with procedure code 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 procedure code 59425.

iii. For antepartum care only, 7 or more visits, bill procedure code 59426.

iv. **Note**: If the provider did not render all of the member'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 procedure code 59410.

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 procedure code 59614.

c. Postpartum care only

For postpartum care only (separate procedure) bill procedure code 59430.

d. Vaginal Delivery only

i. For vaginal delivery only (with or without episiotomy and/or forceps) bill procedure code 59409.

Note: the vaginal delivery includes the labor time component.

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

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 procedure code 99461 for one visit only.

i. If a 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, bill procedure code 99391:

i. CNMs may bill code 99391 up to four times during the first 28 days of newborn well care.

ii. LMs may bill 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

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

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

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

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

d. Administration of injections (procedure codes 90384, 90385, 96372) as appropriate.

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

V. Place of Service

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

Not Eligible

I. Blue Cross VT does not provide additional payment for any of the following services associated with a home birth and will deny as provider liability:

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), nonmedical 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 E/M 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.

Note: Waivers (Informed consent) may be obtained for services that are considered not eligible for payment as noted in this payment policy which allows the member to be billed if certain steps are followed. (Refer to the Provider Handbook for more information).

II. The following services are NOT eligible for separate payment (as they are inclusive to the global, antepartum, delivery, or postpartum services listed in Section III under the Policy/Eligible Services/Billing Guidelines, above) and will deny as provider liability:

a. Procedure 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. Procedure codes (99347-99350) (Home visit for established patient) is considered inclusive to postpartum care and not separately reimbursed and should not be billed.

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

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

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

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

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

Provider Billing Guidelines and Documentation

Refer to Attachment 1: Home Birth Coding Table

Benefit Determination Guidance

Payment for 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 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 (Blue Cross VT 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.

Medicare Primary Policies: Blue Cross VT Payment policies do not apply to any policies where Medicare is primary.

Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network (participating/in- network) and any non-participating/out-of-network providers/facilities.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure adherence with the guidelines stated in the payment policy. If an audit identifies instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all non-adherence payments.

Legislative and Regulatory Guidelines

8 V.S.A. §§ 4099d
26 V.S.A. §§ 4181-4191
26 V.S.A. §§ 4121-4132

Related Policies

CPP_16 Global Maternity/Obstetric Package (Excluding Home Births)
Corporate Provider Handbook

Document Precedence

The Blue Cross VT Payment Policy Manual was developed to provide guidance for providers regarding Blue Cross VT payment practices and facilitates the systematic application of Blue Cross VT member contracts and employer benefit documents, provider contracts, Blue Cross VT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

1) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the Blue Cross VT 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 Blue Cross VT 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 Blue Cross VT Payment Policy Manual and the Plan's claim editing solutions, the Plan's claim editing solution takes precedence.

Policy Implementation/Update Information

This policy was originally implemented on April 15, 2018.

Date of Change	Effective Date	Overview of Change
September 1, 2018	September 1, 2018	
September 1, 2019	September 1, 2019	
November 17, 2020	January 1, 2021	a. Removed section IV under Policy/Eligible Services/Billing Guidelines (billing for labor time when delivery was not performed in a 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).
December 19, 2024	April 01, 2025	Payment policy updated new template format, reference added. Minor editorial refinements to policy statements; intent unchanged. Added Provider Handbook language for patient obtained consent (waivers).
February 05, 2026	May 01, 2026	Payment policy reviewed no changes to policy statement.

Approved by **Update Approved: 02/05/2026**

Tom Weigel, MD

Tom Weigel, MD, Chief Medical Officer

Attachment 1
Home Birth Coding Table

Code	Description	Instructions
The following services will be eligible for benefits when policy criteria have been met.		
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 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	Bill with appropriate (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 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	

Code	Description	Instructions
	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 occurred at the hospital or birthing center
99391	Periodic comprehensive preventative medicine, established patient, infant (age younger than one year)	CNMs may bill code 99391 up to 4 times during the first 28 days of newborn well care. (LMs) may bill 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 (1500IU)	
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	Will deny provider liability
99341-99345	[Home visit for new patient] is considered inclusive to the antepartum care for the mother and the newborn assessment for the newborn and not separately reimbursed and should not be billed	Will deny provider liability
99347-99350	[Home visit for established patient] is considered inclusive to postpartum care and not separately reimbursed and should not be billed	Will deny provider liability
99417	Prolong outpatient service (list separately in addition to code 99205, 99215 for services)	Will deny 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	Will deny provider liability
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	Will deny provider liability
99502	[Home visit for newborn care and assessment] **is** considered inclusive to the reimbursement for the delivery and should not be billed	Will deny provider liability