

MEDICAL POLICY



SUBJECT: HOME BIRTH BY CERTIFIED NURSE MIDWIVES	EFFECTIVE DATE: 12/11/08 REVISED DATE: 12/10/09, 12/09/10, 12/08/11, 05/15/12, 04/25/13, 04/24/14, 04/23/15, 04/28/16, 10/26/17, 10/25/18
POLICY NUMBER: 11.01.23 CATEGORY: Contract Clarification	PAGE: 1 OF: 7
<ul style="list-style-type: none">• <i>If a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.</i>• <i>If a commercial product (including an Essential Plan product) or a Medicaid product covers a specific service, medical policy criteria apply to the benefit.</i>• <i>If a Medicare product covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.</i>	

POLICY STATEMENT:

- I. Based upon our criteria, home birth by a certified nurse midwife (CNM) is **medically appropriate** when the member is essentially healthy. (**Refer to the Description section for further information on medical conditions and other factors indicating increased risk suggesting planned birth at a hospital or birthing center.*)

In order for a midwife to manage normal pregnancies, childbirth and postpartum care as well as primary preventive reproductive health care of essentially healthy women and shall include newborn evaluation, resuscitation and referral for infants, a midwife shall have collaborative relationships with:

- A. A licensed physician who is board certified as an obstetrician-gynecologist by a national certifying body; or
 - B. A licensed physician who practices obstetrics, has obstetric privileges at a general hospital licensed under article twenty-eight of the public health law and is credentialed to perform a C-section; or
 - C. A hospital, licensed under article twenty-eight of the public health law, that provides obstetrics through a licensed physician having obstetrical privileges at such institution, that provide for consultation, collaborative management and referral to address the health status and risks of his or her patients and that include plans for emergency medical gynecological and/or obstetrical coverage. A midwife shall maintain documentation of such collaborative relationships and shall make information about such collaborative relationships available to his or her patients. Failure to comply with the requirements found in this subdivision shall be subject to professional misconduct provisions as set forth in article one hundred thirty of this title.
- II. If there are no participating CNMs who perform home births, the member can request a referral to a non-participating CNM. (For purposes of this policy, CNM also includes certified midwives.)
- In order for a referral to a non-participating CNM to be **eligible for coverage** the following criteria must be met:
 - 1. The CNM has a current license for the state in which they practice, AND
 - 2. The CNM has a collaborative relationship with:
 - a. a licensed physician who is board-certified as an obstetrician-gynecologist by a national certifying body; or
 - b. a licensed physician who practices obstetrics, has obstetric admitting privileges at a general hospital and is credentialed to perform a C-section; where the patient will be referred by the CNM if there are complications with the pregnancy; or
 - c. a hospital that provides obstetrics through a licensed physician who has obstetrical admitting privileges that provide for consultation, collaborative management, and referral to address the health status and risks of his or her patients and that includes plans for emergency medical gynecological and/or obstetrical coverage;

AND

- 3. The CNM has professional liability/malpractice insurance for no less than \$1 million for each individual incident and \$3 million in any given insurance year for multiple incidents against the insured (typically stated as \$1 million/\$3 million) that expressly covers home births.

<p>SUBJECT: HOME BIRTH BY CERTIFIED NURSE MIDWIVES</p> <p>POLICY NUMBER: 11.01.23</p> <p>CATEGORY: Contract Clarification</p>	<p>EFFECTIVE DATE: 12/11/08</p> <p>REVISED DATE: 12/10/09, 12/09/10, 12/08/11, 05/15/12, 04/25/13, 04/24/14, 04/23/15, 04/28/16, 10/26/17, 10/25/18</p> <p>PAGE: 2 OF: 7</p>
--	---

B. Requests for referrals to non-participating CNMs will be evaluated on an individual case basis to determine if the requested home birth is appropriate. The evaluation shall include the patient’s health risk and the proximity of the back-up physician or local hospital.

For example, where the back-up physician and closest hospital are more than 30 miles from the patient’s home, a referral will be considered **not medically appropriate**.

C. Before a referral to a non-participating CNM is approved, documentation of the three requirements set forth in policy statement II A 1, 2, and 3 above (license, collaborative relationship and malpractice insurance) must be submitted for review. If documentation of these three requirements is received, and the request is determined to be appropriate based on the member’s health condition and proximity of providers, as well as the ability of the CNM to provide the services in a safe and appropriate manner, the referral will be approved.

DESCRIPTION:

According to the New York State Education Department (Article 140, §6951) , midwifery is defined as the management of normal pregnancies, childbirth and postpartum care as well as primary preventive reproductive health care of essentially healthy women and shall include newborn evaluation, resuscitation and referral for infants.

A midwife shall have collaborative relationships with:

- (i) a licensed physician who is board certified as an obstetrician-gynecologist by a national certifying body or
- (ii) a licensed physician who practices obstetrics and has obstetric privileges at a general hospital licensed under article twenty-eight of the public health law or
- (iii) a hospital, licensed under article twenty-eight of the public health law, that provides obstetrics through a licensed physician having obstetrical privileges at such institution, that provide for consultation, collaborative management and referral to address the health status and risks of his or her patients and that include plans for emergency medical gynecological and/or obstetrical coverage. A midwife shall maintain documentation of such collaborative relationships and shall make information about such collaborative relationships available to his or her patients. Failure to comply with the requirements found in this subdivision shall be subject to professional misconduct provisions as set forth in article one hundred thirty of this title.

Health Plan contracts provide coverage for maternity care for normal pregnancy when services are rendered by a licensed CNM.

As per the ACOG Committee Opinion No. 697: Planned Home Birth 2017, In the United States, approximately 35,000 births (0.9%) per year occur in the home. Approximately one fourth of these births are unplanned or unattended. Although the American College of Obstetricians and Gynecologists believes that hospitals and accredited birth centers are the safest settings for birth, each woman has the right to make a medically informed decision about delivery. Importantly, women should be informed that several factors are critical to reducing perinatal mortality rates and achieving favorable home birth outcomes.

These factors include:

- The appropriate selection of candidates for home birth;
- The availability of a certified nurse–midwife, certified midwife or midwife whose education and licensure meet International Confederation of Midwives’ Global Standards for Midwifery Education, or physician practicing Obstetrics within an integrated and regulated health system;
- Ready access to consultation; and
- Access to safe and timely transport to nearby hospitals.
- DHHS NIH defined a high-risk pregnancy say a pregnancy when the mother or the fetuses’ health are at a greater risk than an uncomplicated pregnancy. Pregnancy already places the body under circumstances of additional

<p>SUBJECT: HOME BIRTH BY CERTIFIED NURSE MIDWIVES</p> <p>POLICY NUMBER: 11.01.23</p> <p>CATEGORY: Contract Clarification</p>	<p>EFFECTIVE DATE: 12/11/08</p> <p>REVISED DATE: 12/10/09, 12/09/10, 12/08/11, 05/15/12, 04/25/13, 04/24/14, 04/23/15, 04/28/16, 10/26/17, 10/25/18</p> <p>PAGE: 3 OF: 7</p>
--	---

physical and emotional stress. Health conditions that a woman had previous or develops during pregnancy is an aspect that can cause a pregnancy to be considered high risk.

The NICHD is one of many federal agencies working to improve pregnancy outcome, prevent high-risk pregnancy, and improve health outcomes for pregnant women who are at high risk. For most women, early and regular prenatal care promotes a healthy pregnancy and delivery without complications. But some women are at an increased risk for complications even before they get pregnant for a variety of reasons. Risk factors for a high-risk pregnancy can include existing health conditions, such as high blood pressure, diabetes, or being HIV-positive.

According to the American Congress of Obstetricians and Gynecologists, more than half of all pregnant women in the United States are overweight or obese. Obesity increases the risk for high blood pressure, preeclampsia, gestational diabetes, stillbirth, neural tube defects, and cesarean delivery. NICHD researchers have found that obesity can raise infants' risk of heart problems at birth by 15%. The risk of complications is higher in women carrying more than one fetus (twins and higher-order multiples). Common complications include preeclampsia, premature labor, and preterm birth. More than half of all twins and as many as 93% of triplets are born at less than 37 weeks' gestation. Pregnancy in teens and women aged 35 or over increases the risk for preeclampsia and gestational high blood pressure. Women with high-risk pregnancies should receive care from a special team of health care providers to ensure that their pregnancies are healthy and that they can carry their infant or infants to term.

A clinical bulletin published by the American College of Nurse-Midwives addressing the *Criteria for Provision of Home Birth Services* states: "The goal of selection criteria in a home birth midwifery practice is to identify the client who, by all current scientific, medical, and midwifery knowledge and standards, has an excellent prognosis for a normal, healthy pregnancy, birth, and postpartum course".

Women with medical conditions (e.g., previous caesarean section [VBAC], diabetes, hypertension, seizure disorder, or other uterine surgery, premature labor, preeclampsia, multiple fetuses, breech position fetus, those who have not received the appropriate level of prenatal care) should not be considered for a planned home birth. All women planning a home birth should have a contingency plan for transfer to a properly-staffed and equipped hospital should complications arise.

According to a 2014 clinical guideline published by the National Institute for Health and Clinical Excellence (NICE) the following tables represent medical conditions or situations in which there is increased risk for the woman or baby during or shortly after labor, where care in a hospital or birthing center would be expected to reduce this risk.

*Medical conditions indicating increased risk suggesting planned birth at a hospital or birthing center

<u>Disease area</u>	<u>Medical condition</u>
Cardiovascular	Confirmed cardiac disease, Hypertensive disorders.
Respiratory	Asthma requiring an increase in treatment or hospital treatment, Cystic fibrosis.
Hematological	Hemoglobinopathies – sickle-cell disease, beta-thalassemia major, History of thromboembolic disorders, Immune thrombocytopenia purpura or other platelet disorder or platelet count below 100,000, Von Willebrand's disease, Bleeding disorder in the woman or unborn baby, Atypical antibodies which carry a risk of hemolytic disease of the newborn.
Infective	Risk factors associated with group B streptococcus whereby antibiotics in labor would be recommended, Hepatitis B or C with abnormal liver function tests, Carrier of or infected with HIV, Toxoplasmosis – woman receiving treatment, Current active infection of chicken pox, rubella, or genital herpes in the woman or baby, Tuberculosis under treatment.
Immune	Systemic lupus erythematosus, Scleroderma.
Endocrine	Hypothyroidism, Diabetes.

SUBJECT: HOME BIRTH BY CERTIFIED NURSE MIDWIVES	EFFECTIVE DATE: 12/11/08 REVISED DATE: 12/10/09, 12/09/10, 12/08/11, 05/15/12, 04/25/13, 04/24/14, 04/23/15, 04/28/16, 10/26/17, 10/25/18
POLICY NUMBER: 11.01.23 CATEGORY: Contract Clarification	PAGE: 4 OF: 7

Renal	Abnormal renal function, Renal disease requiring supervision by a renal specialist.
Neurological	Epilepsy, Myasthenia gravis, Previous cerebrovascular accident.
Gastrointestinal	Liver disease associated with current abnormal liver function tests.
Psychiatric	Psychiatric disorder requiring current inpatient care.

***Other factors indicating increased risk suggesting planned birth at a hospital or birthing center**

<u>Factor</u>	<u>Additional information</u>
Previous complications	Previous cesarean section (VBAC), Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty, Previous baby with neonatal encephalopathy, Pre-eclampsia requiring preterm birth, Placental abruption with adverse outcome, Eclampsia, Uterine rupture, Primary postpartum hemorrhage requiring additional treatment or blood transfusion, Retained placenta requiring manual removal, Shoulder dystocia.
Current pregnancy	Multiple birth, Placenta previa, Pre-eclampsia or pregnancy-induced hypertension, Preterm labor or preterm prelabor rupture of membranes, Placental abruption, Anemia – hemoglobin less than 8.5 g/dl at onset of labor, Confirmed intrauterine death, Induction of labor, Substance misuse, Alcohol dependency requiring assessment or treatment, Onset of gestational diabetes, Malpresentation – breech or transverse lie, Body mass index greater than 35 kg/m ² , Recurrent antepartum hemorrhage, Small for gestational age in current pregnancy (less than 5 th percentile or reduced growth velocity on ultrasound), Abnormal fetal heart rate (FHR) or Doppler studies, Ultrasound diagnosis of oligo- or poly-hydramnios. According to American Academy of Family Physicians, >41 weeks gestation is considered a factor indicating a high risk pregnancy
Previous gynecological history	Myomectomy, Hysterotomy.

Medical conditions indicating individual assessment when planning place of birth

<u>Disease area</u>	<u>Medical condition</u>
Cardiovascular	Cardiac disease without intrapartum implications
Hematological	Atypical antibodies not putting the baby at risk of hemolytic disease, Sickle-cell trait, Thalassemia trait, Anemia – hemoglobin 8.5–10.5 g/dl at onset of labor.
Infective	Hepatitis B or C with normal liver function tests.
Immune	Non-specific connective tissue disorders.
Endocrine	Unstable hypothyroidism such that a change in treatment is required.
Skeletal and neurological	Spinal abnormalities, Previous fractured pelvis, Neurological deficits.
Gastrointestinal	Liver disease without current abnormal liver function, Crohn’s disease, Ulcerative colitis.

SUBJECT: HOME BIRTH BY CERTIFIED NURSE MIDWIVES	EFFECTIVE DATE: 12/11/08 REVISED DATE: 12/10/09, 12/09/10, 12/08/11, 05/15/12, 04/25/13, 04/24/14, 04/23/15, 04/28/16, 10/26/17, 10/25/18
POLICY NUMBER: 11.01.23 CATEGORY: Contract Clarification	PAGE: 5 OF: 7

Other factors indicating individual assessment when planning place of birth

<u>Factor</u>	<u>Additional information</u>
Previous complications	Stillbirth or neonatal death with a known non-recurrent cause, Pre-eclampsia developing at term, Placental abruption with good outcome, History of previous baby more than 10 pounds/4.5 kg, Extensive vaginal, cervical, or third- or fourth-degree perineal trauma, Previous term baby with jaundice requiring exchange transfusion.
Current pregnancy	Antepartum bleeding of unknown origin (single episode after 24 weeks of gestation), Body mass index of 30 - 35 kg/m ² , Blood pressure of 140 mmHg systolic or 90 mmHg diastolic or more on two occasions, Clinical or ultrasound suspicion of macrosomia, Para 4 or more, Recreational drug use, Under current outpatient psychiatric care, Age over 35 at booking.
Fetal indications	Fetal abnormality.
Previous gynecological history	Major gynecological surgery, Cone biopsy or large loop excision of the transformation zone, Fibroids.

CODES: Number Description

Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.

CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.

Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

<u>CPT:</u>	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	including postpartum care
	59430	Postpartum care only (separate procedure)

Copyright © 2018 American Medical Association, Chicago, IL

HCPCS: No specific code(s)

<u>ICD10:</u>	Z33.1	Pregnant state, incidental
	Z34.00-Z34.93	Encounter for supervision of normal pregnancy (code range)
	Z37.00-Z37.9	Outcome of delivery

REFERENCES:

American Academy of Pediatrics. Committee on Fetus and Newborn. Policy statement – planned home birth. Pediatrics 2013 May;131(5):1016-20 [http://pediatrics.aappublications.org/content/131/5/1016 Reaffirmed December 2016]. Accessed 9/10/18.

*American College of Nurse-Midwives. Midwifery Provision of Home Birth Services: American College of Nurse-Midwives. J Midwifery Womens Health. 2016 Jan-Feb;61(1):127-33.

*American College of Nurse-Midwives. Planned Home Birth Position Statement. 2005 Dec, revised 2018 Apr accessed 9/10/18

<p>SUBJECT: HOME BIRTH BY CERTIFIED NURSE MIDWIVES</p> <p>POLICY NUMBER: 11.01.23</p> <p>CATEGORY: Contract Clarification</p>	<p>EFFECTIVE DATE: 12/11/08</p> <p>REVISED DATE: 12/10/09, 12/09/10, 12/08/11, 05/15/12, 04/25/13, 04/24/14, 04/23/15, 04/28/16, 10/26/17, 10/25/18</p> <p>PAGE: 6 OF: 7</p>
--	---

American College of Obstetricians and Gynecologists. Committee Opinion No. 697: Planned Home Birth. Obstet Gynecol. 2017 Apr;129(4):e117-e122.

[http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Obstetric_Practice/Planned_Home_Birth] accessed 9/10/18.

Bachilova S, et al. Effect of maternal and pregnancy risk factors on early neonatal death in planned home births delivering at home. J Obstet Gynaecol Can. 2018 May;40(5):540-546

*BlueCross BlueShield Association. Nurse-midwives – archived. Medical Policy Reference Manual Policy #10.01.02. 2010 Feb 11.

Grunebaum A, et al. Early and total neonatal mortality in relation to birth setting in the United States, 2006-2009. AJOG 2014, Oct 1;211 (4).

Grünebaum A, et al. Perinatal risks of planned home births in the United States. Am J Obstet Gynecol 2015 Mar;212(3):350.e1-6.

Grünebaum A, et al. Planned home births: the need for additional contraindications. Am J Obstet Gynecol. 2017 Apr;216(4):401.e1-401.e8.

Mayo Clinic. Home birth: know the pros and cons. 2014 Jun 20 [<http://www.mayoclinic.com/health/home-birth/MY01713>] accessed 9/10/18.

*National Institute for Health and Clinical Excellence. Clinical guideline 190. Intrapartum care: care of healthy women and their babies during childbirth. 2014 Dec. Last updated 2/2017 [<https://www.nice.org.uk/guidance/cg190>] accessed 9/10/18.

*New York State Education Department. Education Law Article 140, Midwifery. 2010 Nov 1 [<http://www.op.nysed.gov/prof/midwife/article140.htm>] accessed 9/10/18.

National Institute of Child Health and Human Development. What is a high-risk pregnancy? [<https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/Pages/high-risk.aspx>] accessed 9/10/18

National Institute of Child Health and Human Development. High-risk pregnancy: Overview [<https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/Pages/high-risk.aspx>] accessed 9/10/18

*Olsen O and Jewell D. Planned hospital birth versus planned home birth. Cochrane Database of Systematic Reviews 2012 Sep 12, Issue 9. Art. No.:CD000352.

Snowden JM, et al. Planned out-of-hospital birth and birth outcomes. N Engl J Med. 2016 Jun 2;374(22):2190-1.

Snyder A. Perinatal risks of planned home births in the United States. Am J Obstet Gynecol. 2016 Feb;214(2):295.

*Wax JR, et al. Maternal and newborn outcomes in planned home birth vs planned hospital births: a metaanalysis. Am J Obstet Gynecol 2010 Sep;203(3):243.e1-8.

Zafman, KB, et al. Trends in characteristics of women choosing contraindicated home births. J Perinat Med. 2018 Aug 28;46(6): 573-577.

Zielinski R, et al. Planned home birth: benefits, risks, and opportunities. Int J Womens Health. 2015 Apr 8;7:361-77. doi: 10.2147/IJWH.S55561. eCollection 2015.

KEY WORDS:

Home birth.

SUBJECT: HOME BIRTH BY CERTIFIED NURSE MIDWIVES	EFFECTIVE DATE: 12/11/08 REVISED DATE: 12/10/09, 12/09/10, 12/08/11, 05/15/12, 04/25/13, 04/24/14, 04/23/15, 04/28/16, 10/26/17, 10/25/18
POLICY NUMBER: 11.01.23 CATEGORY: Contract Clarification	PAGE: 7 OF: 7

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

There is currently no National Coverage Determination (NCD) or Local Coverage Determination (LCD) for home births by certified nurse midwives. However, Nurse Midwife services are addressed in the chapter on Covered Medical and Other Health Services, Section 180, in the Medicare Benefit Policy Manual. Please refer to the following website for Medicare Members: <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>.