

Clinical Policy: Home Births

Reference Number: CP.MP.136

Date of Last Revision: 01/24

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Description

A planned home birth is an elective alternative to delivery in a birthing center or hospital setting. Birthing individuals 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/enrollee's benefit language.

Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation® 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 criteria 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 birthing individual;
 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:
 - a. Spontaneous labor in a pregnancy that has lasted at least 37 0/7 weeks but no more than 41 6/7 weeks;
 - b. 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.

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.^{1,2}

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 the birthing individual to make a medically informed decision about delivery. Individuals 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 midwives, 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, birthing individuals 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.^{1,3}

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.^{1,3,4} However, the AAP recognizes that birthing individuals 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 individuals to make medically informed decisions 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 birthing individual, and one who has primary responsibility for the infant.^{1,4} At least one care provider 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.⁴

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.^{17,18}

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 interventions to birthing individuals, including labor induction or augmentation, regional analgesia, electronic fetal heart rate monitoring, episiotomy, operative vaginal delivery, and cesarean delivery. These birthing individuals 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.^{1,7}

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 complications to the birthing individual or the neonate.^{8,9} In contrast, a retrospective cohort study of Canadian patients found no risk of increased adverse neonatal outcomes for infants of primiparous or multiparous birthing individuals with planned home births, and for both primiparous and multiparous birthing individuals, rates of intrapartum interventions were lower.¹⁰ A prospective study in the Netherlands similarly found no increased risk of perinatal complications for infants of primiparous birthing individuals planning to deliver at home, and for infants of multiparous birthing individuals, planned home delivery resulted in significantly better perinatal outcomes.¹¹

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.^{3,12}

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 2023, 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.

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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 (separate procedure)

HCPCS Codes	Description
N/A	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy Adopted from Health Net NMP#216 Home Births	12/16	12/16
Clarified language in I.A.1.a. and I.A.2.b. References reviewed and updated. Specialist review.	08/19	09/19
Added to I.A.1.a., “and practicing within an integrated and regulated health system”; Added to I.E that singleton pregnancy “is estimated to be appropriate for gestational age.” Added criteria in I.B. that 2 caregivers are planned to attend the birth, and that the one responsible for providing care to the infant is trained in NRP. Revised criteria in I.H: Changed “Spontaneous labor in a pregnancy that has lasted at least 38 weeks” to specify 37 0/7 weeks clarified that no more than 41 weeks is no more than 41 6/7 weeks. Added separate criteria for home birth in a pregnancy induced as an outpatient. Updated section in background, American Academy of Pediatrics (AAP), with most current recommendations. References reviewed and updated. Replaced “members” with “members/enrollees” in all instances. Specialist review.	09/20	09/20
Annual review. Added to I.A.2.b an option for family practice physicians who have completed an OB fellowship to attend a home birth without a supervising OB. Removed WHO background information on home birth, and supporting reference. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” References reviewed, reformatted, and updated.	09/21	09/21
Annual review. Edited language regarding emergency facility access for physician-overseen care to match midwife-overseen care. Reformatted I.B and clarified that at least one provider is certified in the Neonatal Resuscitation Program. References reviewed and updated.	01/22	01/22
Annual review completed. Removed criteria II. regarding all other indications not medically necessary. Minor rewording with no clinical	01/23	01/23

Reviews, Revisions, and Approvals	Revision Date	Approval Date
significance. ICD-10 codes removed. References reviewed and updated. Internal and external specialist reviewed.		
Annual review. Minor rewording in Criteria and Background sections with no impact on policy criteria. References reviewed and updated.	01/24	01/24

References

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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.

CLINICAL POLICY

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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.

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Note: For Medicaid members/enrollees, 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.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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