Clinical Guideline

Guideline Number: CG038 Ver. 5

Home Births and Birth Centers

Disclaimer

Clinical guidelines are developed and adopted to establish evidence-based clinical criteria for utilization management decisions. Oscar may delegate utilization management decisions of certain services to third-party delegates, who may develop and adopt their own clinical criteria.

Clinical guidelines are applicable to certain plans. Clinical guidelines are applicable to members enrolled in Medicare Advantage plans only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of a prior authorization request. Services are subject to the terms, conditions, limitations of a member's policy and applicable state and federal law. Please reference the member's policy documents (e.g., Certificate/Evidence of Coverage, Schedule of Benefits) or contact Oscar at 855-672-2755 to confirm coverage and benefit conditions.

Summary

Oscar members who chose to have a home birth may be eligible for coverage of provider services. An expectant mother has options as to where she may plan to give birth including at home, at a birthing center, or at a hospital. The American College of Obstetricians and Gynecologists (ACOG) states that an at home birth is a twofold increased risk of perinatal death than a hospital birth; also, an accredited birthing center is safer than home birth. However, ACOG respects the right of the woman to make this decision. A planned home birth is not appropriate for all pregnancies, and a screening should be done with an in-network provider to evaluate if a pregnancy is deemed low-risk and a home birth could be appropriate. Screening may include evaluating medical, obstetric, nutritional, environmental and psychosocial factors. Appropriate planning should also include arrangements for care at an in-network hospital should an emergent situation arise.

Birth centers do not provide an acute level of care, but they have arrangements to transfer members to higher levels of care at hospitals. Birth centers provide peripartum care for low-risk women with uncomplicated singleton term vertex pregnancies who are expected to have an uncomplicated birth.

Definitions

"Certified Nurse-Midwife (CNM)" is a registered nurse who has completed education in a midwife program. All CNMs must pass a national certification examination by the American Midwifery Certification Board.

"Certified Midwife (CM)" is an individual who has completed education in a midwife program but is not a registered nurse. CMs must also pass a national certification examination by the American Midwifery Certification Board.

"Normal Pregnancy and childbirth" is defined by the California Business and Profession Code section 2507(b)(1) as a singleton fetus with cephalic presentation and the absence of any preexisting maternal disease or condition likely to affect the pregnancy or significant disease arising from the pregnancy.

"High Risk Pregnancy" describes a pregnancy in which the mother, fetus, or newborn is or will be at increased risk for morbidity or mortality before, after, or during delivery

"Perinatal Risk" is risk specifically relating to the time around birth, including both before and after.

"Placenta Previa" is a condition where the placenta covers the cervix opening.

Covered Services and Clinical Indications

Requirements Prior to Delivery

Women who are deemed at low risk for home births must meet **ALL** the following criteria:

1. Evaluated and classified as a normal pregnancy by a licensed MD, DO or NP who is trained in obstetrics and gynecology or family practice with obstetrical expertise; ***and***
2. Absence of preexisting conditions that may affect delivery, including:
    a. Medical conditions, such as high blood pressure or diabetes (including gestational or insulin dependent)
    b. A previous c-section or other uterine surgery (e.g., myomectomy)
    c. Pregnancy complications, such as premature labor, fetal intolerance of labor, preeclampsia, prolonged preterm premature rupture of membranes, intrauterine growth restriction, macrosomia, fetal anomaly, history of a previous postpartum hemorrhage, twins (or more), or a baby in the breech position at 37 weeks

d. Contraindication to a vaginal birth (e.g., placenta previa or accreta, active genital herpes, previous hysterotomy in the upper uterine segment)
e. Current history of substance abuse
f. High risk pregnancy, as defined in the exclusions below

3. Pre-existing arrangement for transfer to a nearby in-network hospital should an emergent situation arise.

Requirements at Time of Delivery

1. Have a State licensed and certified nurse-midwife, midwife, or physician practicing within an integrated and regulated health system in attendance; ***and***
2. Have ready access to consultation at an in-network facility at which the treating nurse-midwife or provider of choice is affiliated or practicing. Examples of which include, but are not limited to, electronic, telephone or personal consultation, collaborative management, shared management, referral or transfer of care; ***and***
3. Plan for transfer to a nearby in-network hospital should an emergent situation arise; ***and***
4. Pregnancy is between 37 weeks and 0/7 days and 42 weeks and 0/7 days at time of delivery; ***and***
5. Spontaneous labor or labor induced as an outpatient.

Freestanding Birth Centers (not within hospital systems)

For requests at accredited freestanding birthing centers, the above requirements prior to delivery and at the time of delivery will apply.

Experimental or Investigational / Not Medically Necessary

Duplicate Services

Duplicative services by health care providers are not medically necessary and will not be covered such as services of both a midwife and a physician concurrently in attendance at a home birth.

Home Births Further than 30-Minutes from an Emergency Facility

While access to emergency facilities is an important component of safety, it is hard to judge how close is required to be safest. Bastian et al. followed 7002 planned home births from 1985 to 1990 in Australia. For one of the authors' measurements, asphyxia deaths, there had been warning signs during most of the labors. The authors noted that these often occurred early enough to have allowed timely transfer.[1] From a more recent systematic review by Blix et al, the report risk of needing intrapartum transport to a

hospital varied from 9.9% to 31.9%. Common reasons for transport are labor not progressing, concerning fetal status or positioning, and maternal pain relief.[2] In general, an increased distance to emergency services is positively correlated with increased risk of adverse outcomes.[3,4]

Doula Services

ACOG and a Cochrane Review confirm that "continuous one-to-one emotional support" is associated with improved outcomes including lower rates of cesarean delivery. However, at this time, doulas are non-licensed, have no medical training, and are considered supportive. They have no official guidelines or standards, and professional certification is not required. Therefore, doula services are considered not medically necessary.

Changes in Condition or Risk Factor

If at any time the member presents with a maternal disease or condition which has arisen from the pregnancy, in order for the midwife to continue care, the midwife must provide the member with a referral for an examination by a in-network physician trained in obstetrics. Following the examination, if the physician determines that the risk factors presented by the member's disease or condition are not likely to significantly affect the course of pregnancy and childbirth, care can be resumed by the midwife. If the physician determines that the member's condition or concern has not been resolved, the midwife may not resume primary care of the member.

High Risk Pregnancies

Home births are not covered by Oscar for all pregnancies. Recent studies have shown that mortality rates among planned home and hospital births are comparable, but only when using strict exclusion criteria. When women who met these criteria are included, planned home births have a clear association with a higher risk of perinatal death.[12] A pregnancy may be classified as high risk for many reasons, as outlined below and as defined by applicable State midwifery practice guidelines. A current limitation is that not every risk factor has been separately studied to see associated mortality for a home birth versus a hospital birth, but as stated above, the safety of a planned home birth has been demonstrated only in the absence of these risk factors. Non-covered indications include, but are not limited to, the following:

- Breech or other fetal malpresentation
- Gestational Diabetes Mellitus (GDM)
- Gestational age <37 weeks and 0/7 days or >42 weeks and 0/7 days
- History of previous uterine surgery

- Multiple pregnancies (>1 fetus)
- Preeclampsia
- Prior cesarean delivery
- Age ≤17 years of age or >40 years of age
- Oligohydramnios or polyhydramnios
- Placental problems
- Pre-pregnancy weight issues: <100 lbs or BMI ≥35
- Presence of any medical or surgical condition that may put the mother and/or fetus at increased risk including but not limited to organ disease
- Presence of any psychiatric condition that may put the mother and/or fetus at increased risk
- Presence of fetal abnormality
- Presence of fibroids with characteristics associated with increased risk for pregnancy complications
- Substance abuse disorder
- Suspected fetal birth weight greater than or equal to 4500 grams (i.e., macrosomia)

Evidence for Non-Coverage of Above Indications

Breech or Other Fetal Malpresentation

Cheyney et al. performed a retrospective analysis of mothers receiving midwife care in the United States with a planned home birth or birth center. They included 16,924 pregnancies in between the years of 2004 and 2009. For breech presentations, the risk of intrapartum death compared to vertex presentations was significantly elevated (13.51/1000 breach to 1.09/1000 vertex, p<0.0004).[6]

Gestational Diabetes Mellitus (GDM)

Cheyney et al. found that the rates for intrapartum mortality were significantly elevated in a pregnancy complicated by gestational diabetes mellitus (15.15 per 1000 pregnancies with GDM vs 1.19 per 1000 pregnancies without GDM, p<0.013).[6]

Gestational Age <37 weeks and 0/7 days or >42 weeks and 0/7 days

Many studies include gestational age <37 weeks and 0/7 days or >42 weeks and 0/7 days a risk factor for perinatal mortality, and the ACOG finds it as one of the contradictions for home birth. As one example, Greenbaum et al studied births from 2006 to 2009 and found that the total neonatal mortality was significantly higher.[7]

Multiple Pregnancies (>1 fetus)

The ACOG finds that multiple gestations carry a significantly increased risk in rates of perinatal mortality. Due to this risk, multiple gestation pregnancies are considered an absolute contraindication to planned home births.[8]

Preeclampsia

Cheyney et al. found that the rates for intrapartum mortality were significantly elevated in a pregnancy complicated by preeclampsia as compared to a pregnancy not complicated by preeclampsia (34.48 per 1000 pregnancies with preeclampsia vs 1.24 per 1000 pregnancies without preeclampsia, $p < 0.037$).[6]

Prior Cesarean Delivery

Landon et al. in a prospective four-year observational study followed 45,988 women with singleton gestations and a history of cesarean delivery. The authors found that women with a history of cesarean delivery had a greater perinatal risk. While the authors did note that the absolute risks were low, the relative increase risk for mothers who undergo a trial of labor is significant.[10] ACOG supports vaginal birth attempts after cesarean, but due to the increased risk, the attempt should be in a healthcare setting capable of providing emergency cesarean services. [11]

Age ≤17 years of age or >40 years

Maternal age 17 years and younger and over 40 years has been linked to increased perinatal mortality. Fraser et al. conducted a retrospective analysis of 134,088 births that occurred from 1970 to 1990 in Utah. Maternal age ≤17 had a higher risk of adverse outcomes, these results held when controlling for prenatal care. The authors concluded that a younger maternal age was correlated with an increased risk of adverse outcomes.[13] Maternal age above 40 years of age has been showing by numerous authors as linked to increased perinatal mortality. One such study is by Jacobsson et al. who conducted a national prospective cohort study following 1,566,313 deliveries over a 15 year period. They saw a positive correlation between maternal age and increased risks.[14] Cleary-Goldman et al. similarly found that with maternal ages above 40, there were increased risks for placental abruption and perinatal mortality.[15]

Oligohydramnios and polyhydramnios

Oligohydramnios and polyhydramnios are both indications of a high-risk pregnancy. Oligohydramnios has been studied to see if the amniotic fluid index can be used to predict adverse outcomes in pregnancies. Three recent studies over the past decade have found that oligohydramnios amniotic fluid volumes are insufficient to predict adverse outcomes.[16,17,18] Recommendations for pregnancies complicated by oligohydramnios includes fetal monitoring during labor. Due to the unpredictability of oligohydramnios on outcomes and the recommendation for fetal monitoring during labor,

oligohydramnios are a contraindication for home birth.[18] Polyhydramnios were found by Khan and Donnelly in a retrospective case control study to be linked with adverse neonatal outcomes. The authors followed 288 women and found increased risk for cesarean delivery, fetal distress, and NICU admissions.[20] In practice, pregnancies complicated by polyhydramnios are monitored for spontaneous membrane rupture, and for fetal abnormalities.[21] As studied by Wiegand et al. who found an association between the severity of polyhydramnios and the risk for perinatal morbidity.[22]

Placental problems

Placental problems can be varied, but many have been linked to increased perinatal risk. One example is placenta previa. In a systematic review by Vanhanian et al., it was found that the rates of NICU admissions, neonatal death, and perinatal death were significantly increased in patients with placenta previa.[23]

Pre-pregnancy weight issues: <100 lbs or BMI ≥35

In a retrospective study, Ehrenberg et al. studied perinatal complication rates for low maternal weight. They found that when compared to a normal BMI, these mothers had increased risk for maternal delivery complications.[24] An increased BMI has also been associated with increased risk for maternal and fetal outcomes across a variety of measures including: increased length of labor, increased risk of cesarean delivery, increased risk of postpartum infection, and increased risk for asphyxia and death.[25]

Presence of any medical or surgical condition that may put the mother and/or fetus at increased risk

There are numerous medical or surgical conditions that can increase the perinatal risk. One such example is an expectant mother with chronic hypertension. In a systematic review and meta-analysis, Brahman et al. examined the adverse outcomes for pregnancies complicated by chronic hypertension and concluded that there were higher risks for many outcomes.[26]

Presence of severe fetal abnormalities or abnormalities for which full workup has not been performed to determine the extent

Home births in cases where the fetus has a known abnormality have not been extensively studied, but a recent case study discusses the ethical concerns of a home birth in this setting. The authors found that in the setting of fetal abnormalities, the pregnancy is not classified as a low risk pregnancy and delivery needs to be in a facility prepared for emergency intervention for the fetus.[27] In this line, if the extent of the fetal abnormality is unknown or if the abnormality is known to require intervention, a planned home birth is not suitable.

Presence of fibroids with characteristics associated with increased risk for pregnancy complications

The presence of large size, location, distortion of uterine cavity, or multiple fibroids has been linked in multiple studies, reviewed by Lee et al, to adverse perinatal outcomes such as placenta abruption, cesarean delivery, and postpartum hemorrhage. These outcomes have been reported to occur in as many as 10 to 30% of pregnancies.[28]

Substance abuse disorder

Substance abuse disorder including alcoholism and drug addiction during pregnancy is associated with adverse pregnancy outcomes. One example is opioid abuse, as explored by Maeda et al., who found increased perinatal morbidity and mortality with opioid use.[29]

Applicable Billing Codes

CPT/HCPCS Codes covered if criteria are met:	
Code	*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
ICD-10 codes covered if criteria are met:	
Code	*Description*
O80	Encounter for full-term uncomplicated delivery
ICD-10 codes not covered:	
Code	*Description*
D25.0 - D25.9	Leiomyoma of uterus
E08.00 - E13.9	Diabetes mellitus

F10.10 - F19.99	Mental and behavioral disorders due to psychoactive substance use [e.g., opioid, alcohol, sedative, hypnotic, or anxiolytic-related abuse]
I10 - I16.9	Hypertensive diseases
O24.011 - O24.93	Diabetes mellitus in pregnancy, childbirth, and the puerperium
O26.00 - O26.93	Maternal care for other conditions predominantly related to pregnancy
O29.01 - O29.93	Complications of anesthesia during pregnancy
O30.001 - O48.1	Maternal care related to the fetus and amniotic cavity and possible delivery problems [includes multiple gestations, gestational age, placental problems, late pregnancy, oligo/polyhydramnios]
O60.00 - O69.9	Complications of labor and delivery
O71.00 - O71.9	Other obstetric trauma
O75.0 - O75.89	Other complications of obstetric surgery and procedures
O76	Abnormality in fetal heart rate and rhythm complicating labor and delivery
O77.0 - O77.9	Other fetal stress complicating labor and delivery
O82	Encounter for cesarean delivery without indication
O94 - O9A.53	Other obstetric conditions, not elsewhere classified
O09.00 - O9A.53	Complications mainly related to pregnancy, normal delivery and other indications for care in pregnancy, labor, and delivery; complications occurring mainly in the course of labor and delivery; and complications of the puerperium [not covered for planned deliveries at home]
O32.0xx0 - O32.9xx9	Maternal care for malpresentation of fetus

Z37.2 - Z37.9	Outcome of delivery [not covered for planned deliveries at home]
Z39.0 - Z39.2	Encounter for maternal postpartum care and examination
Z79.4	Long term (current) use of insulin
Z98.89	Other specified postprocedural state [when used to indicate prior c-section or uterine surgery]

CPT/HCPCS codes not covered in the home:	
Code	*Description*
59412	External cephalic version, with or without tocolysis
59510 – 59525	Cesarean Delivery
59610 – 59622	Delivery after Previous Cesarean Delivery

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