Planned Out-of-Hospital Birth

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INSTRUCTIONS FOR USE: Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Company reserves the right to determine the application of medical policies and make revisions to medical policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PLAN PRODUCT AND BENEFIT APPLICATION

☒ **Commercial** ☒ **Medicaid/OHP*** ☐ **Medicare****

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

**Medicare Members

This *Company* policy may be applied to Medicare Plan members only when directed by a separate *Medicare* policy. Note that investigational services are considered **"not medically necessary"** for Medicare members.

COVERAGE CRITERIA

Note: *Member benefits, which address coverage or non-coverage of planned out-of-hospital birth, may vary. Member benefit contract language takes precedent over medical policy.*

I. Planned out-of-hospital birth may be considered a **medically appropriate** site of care for pregnant members who do not meet criteria II.-III. below and who are at low risk for adverse obstetric or birth outcomes.

High-risk Conditions

II. Planned out-of-hospital birth is considered **not medically appropriate** when **any** of the following high-risk conditions (II.A-D) are present at the time of initial prenatal care or develop anytime during the current pregnancy or delivery:

A. Member has a maternal medical history of any of the following:

1. Diabetes (type 1 or 2)
2. Maternal bleeding disorder or thrombocytopenia
3. History of thrombosis or thromboembolism
4. Chronic hypertension or significant cardiovascular disease
5. Neurologic disorders that would impact maternal or neonatal health (including epilepsy, myasthenia gravis, prior CVA)
6. Kidney disease requiring care by a renal specialist
7. Active gynecologic cancer
8. Drug or alcohol misuse with risk of adverse effects to fetal or maternal health

B. Member has had any of the following conditions in a prior pregnancy:
    1. Prior hysterotomy (i.e. uterine surgery penetrating the uterine wall) or known uterine abnormality (septate uterus, didelphys, obstructing fibroid) that may complicate pregnancy or labor
    2. Cesarean section
    3. Eclampsia
    4. HELLP Syndrome (Hemolysis, Elevated Liver enzymes, Low Platelets)
    5. Pre-eclampsia requiring delivery prior to 38 weeks gestation
    6. Retained placenta requiring surgical removal
    7. History of postpartum hemorrhage requiring transfusion of other surgical treatment (including D&C, Bakri balloon)
    8. Uterine rupture or inversion

C. Any of the following conditions occur in current pregnancy:
    1. Antepartum hemorrhage, recurrent
    2. Any of the following infectious conditions:
        a. HIV
        b. Hepatitis B
        c. Syphilis
        d. Rubella
        e. Tuberculosis
        f. Toxoplasmosis
        g. Genital herpes or Varicella active at term
        h. Chorioamnionitis or maternal fever > or = to 38.0C in labor/postpartum
        i. Other infections impacting management of pregnancy and delivery
    3. Blood group incompatibility or Rh sensitization
    4. Molar pregnancy
    5. Multiple gestation
    6. Gestational diabetes, uncontrolled or requiring medications
    7. Anemia with Hgb <8.5g/dL
    8. Suspected or diagnosed thrombosis or thromboembolism
    9. Thrombocytopenia
    10. Intrauterine Growth Restriction (IUGR)/Uteroplacental insufficiency—fetal weight <5th percentile using ethnically-appropriate growth tables, or reduced growth velocity on US
    11. Oligo- or Polyhydramnios
    12. Elevated blood pressure on two occasions 30 minutes apart (e.g. gestational hypertension or pregnancy-induced hypertension)
        a. Systolic ≥ 140 or diastolic ≥ 90
    13. Elevated blood pressure on one occasion
        a. Systolic ≥ 160 or diastolic ≥ 110 , or
        b. Systolic ≥ 140 or diastolic ≥ 90, with severe pre-eclampsia features
    14. Eclampsia, Pre-eclampsia, or Pregnancy induced hypertension (PIH) (definition below)

15. HELLP syndrome
16. Hemorrhage including any of the following: need for transfusion, hypovolemia, shock, vital sign instability
17. Preterm (before 37 weeks 0 days) rupture of amniotic membranes
18. Placenta previa, Vasa previa, or low lying placenta within 2 cm of cervical os at 38 weeks 0 days or later
19. Breech or non-cephalic presentation at term
20. Gestational age less than 37 weeks/0 days or greater than 42 weeks/0 days (unless already in active labor at 41 wks/6 days)
21. Induction of labor

D. Any of the following intrapartum conditions occur during delivery:
1. Failure to progress, lack of adequate progress in 2nd stage of labor
2. 4th degree laceration or 3rd degree laceration requiring care beyond expertise of attendant
3. Retained placenta >60 minutes
4. Placental abruption
5. Umbilical cord prolapse
6. Uterine rupture or inversion

Potentially risky conditions that require consultation

III. When any of the following conditions exist (III.A-C), planned out-of-hospital birth may only be considered **medically appropriate** when done in consultation with a physician specializing in high-risk pregnancy management*:

A. Member has a maternal medical history of any of the following:
1. Rheumatologic conditions (e.g. systemic lupus, scleroderma, rheumatoid arthritis, and other collagen-vascular diseases)
2. Endocrine conditions (e.g. thyroid disease)
3. Lung disease (e.g. cystic fibrosis, severe persistent asthma)
4. Maternal mental illness, including severe postpartum depression and schizophrenia
5. Hemoglobinopathy
6. Uterine anomaly (e.g. bicornuate, large fibroid) likely to impact delivery

B. Member has had any of the following conditions in a prior pregnancy:
1. Prior stillbirth, neonatal death, or neonatal encephalopathy in prior pregnancy
2. Rh sensitization in a prior pregnancy
3. Shoulder dystocia

C. Any of the following conditions occur in current pregnancy:
1. Uncertain Expected Date of Delivery (EDD)
2. Refractory hyperemesis gravidarum
3. Evidence of congenital anomalies requiring immediate assessment and management by a neonatal specialist**

4. Inappropriate uterine growth (size-dates discrepancy in fundal height)
5. Anemia with Hgb <10 g/dL but >8.5g/dL, unresponsive to treatment
6. Uncontrolled cholestasis of pregnancy or abnormal liver function tests

*__Note__: *Consultant should be an MD/DO physician specializing in the care of high-risk pregnancy, with hospital admitting privileges, and able to accept transfer of care if member requires specialty management.*

**__Note__: *Congenital anomalies determined to be non-compatible to life or for which no interventions are planned do not rule out home birth.*

Transfer to Hospital

IV. Transfer to a hospital may be considered **medically appropriate** for pregnant women who have developed high-risk conditions listed in criteria II. and III.

Link to Evidence Summary

POLICY CROSS REFERENCES

None

The full Company portfolio of current Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

DOCUMENTATION REQUIREMENTS

In order to determine the medical necessity of the request, the following documentation must be provided at the time of the request. Medical records to include documentation of all of the following:

- All medical records and chart notes pertinent to the request. This includes:
  - History (including medical, surgical, and past pregnancies)
  - Physical examination
  - Additional information as appropriate, including results of ultrasound, lab testing, and consultation (if applicable)

BACKGROUND

Low-risk pregnancy

The majority (92-94%) of pregnancies are considered low risk. In a low-risk pregnancy, there are no maternal or fetal factors that may increase risk for complications. Pregnancies are expected to proceed without problems, although risk can change throughout a pregnancy and there are always some risks in pregnancy and birth, even in those deemed to have a low risk.[1]

High-risk pregnancy

High-risk pregnancies occur in approximately 6-8% of all pregnancies. A pregnancy is considered high risk when a pregnant woman or fetus have increased likelihood or complications, adverse events, or poor outcomes during pregnancy or birth. Increased risk may be due to inherited or congenital conditions, chronic or acquired health problems (e.g. diabetes or high blood pressure), environmental factors, lifestyle factors, and other unforeseen issues that may occur before or during pregnancy. Risk can vary greatly by the present risk factors and comorbidities, with some conditions posing considerably higher risks than others. Monitoring, treatmen[2]t, and birthing options greatly depend on risk levels determined by providers.[1]

Planned out-of-hospital birth

The prevalence of home birth in the United States is around 1%, with 90% of these being planned home births. Demographics of women more likely to choose a planned out-of-hospital birth include older, multiparous, native born pregnant women with a normal body mass index range, living in a nonmetropolitan county. Women likely opt for planned out-of-hospital births in high-resource countries to avoid excessive medical intervention, because of concerns about iatrogenic complications of hospital birth, previous fear or dissatisfaction with hospital care, cultural or religious concerns, and desires for freedom, personal control, comfort, and familiar environmental surroundings, among other reasons. There is no completely risk-free birthing site, and safety of planned-out-of-hospital births depends on risk levels and the quality of the home birth programs available.

CLINICAL EVIDENCE AND LITERATURE REVIEW

EVIDENCE REVIEW

A review of the ECRI, Hayes, Cochrane, and PubMed databases was conducted regarding the safety and efficacy of planned home birth for low- to high-risk pregnancies.

- In 2020, Reitsma and colleagues published a systematic review and meta-analyses on maternal outcomes and birth interventions among women who begin labor intending to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital.[3] The review included 18 studies, and meta-analyses included 16 studies (500,000 home births). Fifteen of the studies took place in countries that were considered to have well-integrated healthcare systems, including the United States. There were no reported maternal deaths. After controlling for parity in well-integrated settings, the authors found that planned home births were less likely to experience cesarean section (OR: 0.58; 95% CI: 0.44, 0.77), operative vaginal birth (OR: 0.42; 95% CI: 0.23, 0.76), epidural analgesia (OR: 0.30; 95% CI: 0.24, 0.38), episiotomy (OR: 0.45; 95% CI: 0.28, 0.73), 3rd or 4th degree tear (OR: 0.57; 95% CI: 0.43, 0.75), oxytocin augmentation (OR: 0.37; 95% CI: 0.26, 0.51), and maternal infection (OR: 0.23; 95% CI: 0.15, 0.35). Two studies collected data on postpartum hemorrhage and found that planned home births had lower or similar rates to hospital births.

  All studies reviewed in the analyses were retrospective or prospective observational studies, and therefore potentially suffered from a number of patient selection biases. Yet due to the

nature of the intervention, observational studies are the most appropriate way to collect data. Study designs were slightly heterogenous across studies, although the authors noted that the differences were not important. The likelihood that women choosing planned home births are of lower risk than those choosing hospital birth is high, and introduces bias in the analysis. The authors conclude that home birth is safe for low-risk women in settings where home birth care is well-integrated in the local health care system, and begin labor with a plan to give birth at home.

- In 2019, using the same dataset as the systematic review summarized above by Reitsma and colleagues, Hutton and colleagues published results of a systematic review and meta-analysis on perinatal or neonatal mortality among women who intend at the onset of labor to give birth at home compared to women of low obstetrical risk who intend to give birth in a hospital.[4] The meta-analysis included 14 studies, totalling around 500,000 intended home births. The primary outcomes was any perinatal or neonatal death after the onset of labor. The authors found no difference in the primary outcome between those who intended home birth compared to those who intended hospital birth. Across study design and parity, the primary outcome remained similar between the two groups. In less integrated setting, the odds ratio of perinatal or neonatal mortality comparing home to hospital births for nulliparous women was 3.17 (95% CI, 0.73 to 13.76). Home births for nulliparous women in settings where midwives attending home birth are well-integrated in health services had an odds ratio of 1.07 (95% CI, 0.7 to 1.65). Among multiparous women, less integrated settings had an odds ratio of 1.58 (95% CI, 0.5-5.03) and well integrated settings had an odds ratio of 1.08 (95% CI, 0.84-1.38).

- Strengths of the study included large datasets from national registries, consistency in design and patient population across studies, and comparable outcome measures. While observational studies can introduce biases, randomized trials are not appropriate to compare home versus hospital births, and therefore observational studies are the best design to investigate safety of home births. The authors concluded that risk of perinatal or neonatal mortality was not different when birth was intended at home or in the hospital for low risk women.

CLINICAL PRACTICE GUIDELINES

American Academy of Pediatrics (AAP)

In 2020, AAP published guidelines on Providing Care for Infants Born at Home. The guidelines recommend the following:

"Potential candidate for home birth

- Absence of preexisting maternal disease
- Absence of significant disease arising during the pregnancy
- A gestation of 37 + 0/7 to 41 + 6/7 weeks
- A singleton fetus estimated to be appropriate for gestational age
- A cephalic presentation
- Labor that is spontaneous or induced as an outpatient

Reported risks to the newborn associated with planned home birth in the United States

- Increased fetal and/or neonatal mortality

- Increased incidence of neonatal seizures5,6,8
- Higher incidence of an Apgar score <4 at 5 min5

Systems needed to support planned home birth

- The availability of a physician or a midwife certified by the American Midwifery Certification Board (or its predecessor organizations) or whose education and licensure meet the International Confederation of Midwives Global Standards for Midwifery Education practicing within an integrated and regulated health system
- Attendance by at least 2 care providers, one of whom is an appropriately trained individual (see text) whose primary responsibility is the care of the newborn infant
- Availability of appropriate equipment for neonatal resuscitation
- Ready access to medical consultation
- Access to safe and timely transport to a nearby hospital with a preexisting arrangement

As stated in Guidelines for Perinatal Care, fetal malpresentation, multiple gestation, and previous cesarean delivery are considered absolute contraindications to planned home birth."[5]

American College of Nurse-Midwives (ACNM)

In 2015, the American College of Nurse-Midwives published the following recommendations for planned home births:

> "Based on a review of the available scientific evidence, considerations for assessing optimal place of birth from ACNM are provided in Table 1 and Table 2. The needs of an individual woman, resources and limitations of a particular setting, or type of practice may appropriately lead to variations in clinical care."[6]

Table 1. Conditions Indicating Increased Risk Suggesting Planned Birth in a Hospital Setting	**Table 2. Intrapartum, Postpartum, and Newborn Conditions that are Indications for Transfer from Home to a Hospital**
Prior pregnancy conditions • Previous stillbirth or neonatal death related to intrapartum event • Primary postpartum hemorrhage requiring additional procedures • Prior cesarean birth • Shoulder dystocia with resulting injury **Current pregnancy conditions** • Active preterm labor (before 37 0/7 weeks' gestation) or preterm, prelabor rupture of membranes • Essential or gestational hypertension • Evidence of congenital fetal anomalies requiring immediate assessment and/or management by a neonatal specialist • Fetal growth restriction 5th percentile • Insulin dependent diabetes or gestational diabetes requiring pharmacologic management • Malpresentation: breech, transverse lie	**Intrapartum indications** • Malpresentation: breech, transverse lie identified during labor • Development of signs or symptoms of gestational hypertension or preeclampsia • Evidence of chorioamnionitis • Evidence of fetal intolerance of labor or persistent Category II fetal heart tones that are unresponsive to intrauterine resuscitation when birth is not imminent or in the presence of meconium • Need for pharmacologic augmentation of labor • Signs of placental abruption or unexplained increased vaginal • bleeding

• Need for pharmacologic induction of labor • Postterm pregnancy more than 41 6/7 weeks' gestation • Multiple gestation • Oligohydramnios with additional complicating factors • Polyhydramnios • Placenta previa in the third trimester • Placental abruption • Preeclampsia • Rh isoimmunization **Medical conditions** • Evidence of active infection with hepatitis, HIV, genital herpes, syphilis, or tuberculosis • Psychiatric conditions that may affect intrapartum care management or maternal or neonatal transition following birth • Substantial medical conditions that have required acute medical supervision during the pregnancy and that could impact the birth such as cardiac disease, epilepsy, thromboembolic disease, hemoglobinopathy • Substance abuse/dependence	**Postpartum indications** • Management of lacerations beyond the expertise of the attending midwife • Postpartum hemorrhage unresponsive to initial treatments • Retained placenta • Unexplained vaginal bleeding **Newborn indications** • Unstable health status

American College of Obstetricians and Gynecologists (ACOG)

- In 2020, ACOG published updated guidelines on planned home births, recommending the following: "The Committee on Obstetric Practice considers fetal malpresentation, multiple gestation, or prior cesarean delivery to be an absolute contraindication to planned home birth."[7]

- In 2018, ACOG published guidelines on Thromboembolism in Pregnancy in which they state that the most important individual risk factor for VTE in pregnancy is a personal history of thrombosis.[8]

Oregon Health Authority's Health Evidence Review Commission (HERC)

In 2020, HERC published coverage guidance on planned out-of-hospital birth. The guidance states,

> "Planned out-of-hospital birth is recommended for coverage for pregnant women who are at low risk for adverse obstetric or birth outcomes (weak recommendation)… Coverage of prenatal, intrapartum, and postpartum care is recommended with the performance of appropriate risk assessments (at initiation of care and throughout pregnancy and delivery) and the out-of-hospital birth attendant's adherence to the consultation and transfer criteria as outlined below.
>
> Planned out-of-hospital birth is not recommended for coverage for pregnancies with identified high-risk factors necessitating a planned hospital birth, or when the listed criteria for consultation and transfer of care are not followed by the birth attendant (strong recommendation).

When a high-risk condition develops that requires transfer or planned hospital birth, coverage is recommended when appropriate care is provided until the point the high-risk condition is identified.
For women who have a high-risk condition requiring consultation, ongoing coverage of planned out-of-hospital birth care is recommended as long as the consulting provider's recommendations are then appropriately managed by the out-of-hospital birth attendant in a planned out-of-hospital birth setting."[9]

National Institute for Health and Care Excellence (NICE)

In 2022, NICE published guidance on intrapartum are for healthy women and babies. On choosing planned place of birth, the guidelines state:

"Explain to both multiparous and nulliparous women that they may choose any birth setting (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit), and support them in their choice of setting wherever they choose to give birth:

- Advise low-risk multiparous women that planning to give birth at home or in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.

Explain to low-risk multiparous women that:

- Planning birth at home or in a freestanding midwifery unit is associated with a higher rate of spontaneous vaginal birth than planning birth in an alongside midwifery unit, and these 3 settings are associated with higher rates of spontaneous vaginal birth than planning birth in an obstetric unit.
- There are no differences in outcomes for the baby associated with planning birth in any setting."[10]

EVIDENCE SUMMARY

Peer-reviewed literature and national guidelines suggest that planned out-of-hospital birth may be safe and appropriate for women with low-risk medical history and low-risk medical conditions at the time of pregnancy and labor. Women with medium-risk history and/or conditions may be at a higher risk for complications during birth and must be carefully evaluated on a case-by-case basis to determine whether out-of-hospital birth is safe and appropriate. Women with high-risk medical history and/or conditions are at higher risk for complications and hospital birth is the most appropriate and safest setting.

HEALTH EQUITY CONSIDERATIONS

The Centers for Disease Control and Prevention (CDC) defines health equity as the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving health equity requires addressing health disparities and social determinants of health. A health disparity is the occurrence of diseases at greater levels among certain population groups more than among others.

Health disparities are linked to social determinants of health which are non-medical factors that influence health outcomes such as the conditions in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life. Social determinants of health include unequal access to health care, lack of education, poverty, stigma, and racism.

The U.S. Department of Health and Human Services Office of Minority Health calls out unique areas where health disparities are noted based on race and ethnicity. Providence Health Plan (PHP) regularly reviews these areas of opportunity to see if any changes can be made to our medical or pharmacy policies to support our members obtaining their highest level of health. Upon review, PHP creates a Coverage Recommendation (CORE) form detailing which groups are impacted by the disparity, the research surrounding the disparity, and recommendations from professional organizations. PHP Health Equity COREs are updated regularly and can be found online here.

BILLING GUIDELINES AND CODING

CODES*		
CPT	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
	59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
	59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
	59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
	59425	Antepartum care only; 4-6 visits
	59426	Antepartum care only; 7 or more visits
HCPCS	None	

***Coding Notes:**

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for

Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

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POLICY REVISION HISTORY

DATE	REVISION SUMMARY
2/2023	Converted to new policy template.
7/2023	Annual update. No changes.
7/2024	Annual update. No changes.
7/2025	Annual update. No changes.
7/2026	Annual update. No changes.