Clinical Policy: Home Births

Reference Number: LA.CP.MP.136
Last Review Date: 08/2020

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

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

Policy/Criteria

I. It is the policy of Louisiana Healthcare Connections 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 doctor, all of the following must be met:
      a. The physician practices obstetrics within an integrated and regulated health system;
      b. If the physician is not an obstetrician, 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 facility for emergency care is within 15 minutes by emergency transportation from the site of delivery;

B. Two care providers are planned to be present at the birth, including one who has primary responsibility for the mother and one who has primary responsibility for the infant, along with the appropriate training, skills, and 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;

II. It is the policy of Louisiana Healthcare Connections that home births are considered **not medically necessary** for any circumstances other than those specified above.

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. [3, 7]

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 a woman to make a medically informed decision about delivery. Women 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 midwifes, 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, women 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. [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. However, the AAP recognizes that women 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 women to make a medically informed decision 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 mother and one who has primary responsibility for the infant.[1] At least one 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.[18]

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 of women.[2, 4]

World Health Organization
A recent policy statement indicates that women can choose to deliver at home if they have low-risk pregnancies, receive the appropriate level of care, and formulate contingency plans for transfer to a properly-staffed/equipped delivery unit if problems arise. [9]

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 maternal interventions including labor induction or augmentation, regional analgesia, electronic fetal heart rate monitoring, episiotomy, operative vaginal delivery, and cesarean delivery. These women 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. [3, 12]

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 maternal or neonatal complications.[13, 14] In contrast, a retrospective cohort study of Canadian patients found no risk of increased adverse neonatal outcomes for infants of primiparous or multiparous women with planned home births, and for both primiparous and multiparous women, rates of intrapartum interventions were lower.[15] A prospective study in the Netherlands similarly found no increased risk of perinatal complications for infants of primiparous women planning to deliver at home, and for infants of multiparous women, planned home delivery resulted in significantly better perinatal outcomes.[16]

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.[6, 10]

Coding Implications

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informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. 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

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
O80	Encounter for full-term uncomplicated delivery

Reviews, Revisions, and Approvals	Date	Approval Date
Converted corporate to local policy.	08/15/2020	

References

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2. American College of Nurse-Midwives. Position Statement on Planned Home Birth. December 2005. Updated December 2016.
3. American College of Obstetricians and Gynecologists. Committee on Obstetric Practice. ACOG Committee Opinion No. 697, Replaces 669: Planned Home Birth. Obstet Gynecol 2016. Reaffirmed 2020.
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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. LHCC 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.

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