

## Clinical Policy: Home Births

Reference Number: CP.MP.136

Effective Date: 12/16

Last Review Date: 12/17

[Coding Implications](#)  
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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 benefit language.

### Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that home births are **medically necessary** only for low-risk pregnancies when a qualified health care professional is present and 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 availability of a certified nurse–midwife, certified midwife, or midwife whose education and licensure meet International Confederation of Midwives Global Standards for Midwifery Education;
      - b. Certified nurse midwife's 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. Physician practices obstetrics within an integrated and regulated health system;
      - b. If the physician is not an obstetrician, there is documentation of proof of back-up supervision and coverage by a Board Certified or Board Eligible obstetrician;
      - 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. No preexisting medical condition(s);
  - C. No prior cesarean delivery;
  - D. Absence of significant disease during pregnancy;
  - E. A singleton pregnancy;
  - F. Cephalic presentation;
  - G. Pregnancy has lasted at least 38 weeks but no more than 41 weeks;
  - H. There is a preexisting arrangement for emergency transportation to a nearby hospital, should it be needed.

**II.** It is the policy of health plans affiliated with Centene Corporation 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.<sup>3, 7</sup>

#### *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 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, 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.<sup>3</sup>

#### *American Academy of Pediatrics (AAP)*

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. In addition, in the United States, the AAP recommends that the delivery be attended by at least two individuals, one who has primary responsibility for the mother and one who has primary responsibility for the infant.<sup>1</sup>

#### *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.<sup>2, 4</sup>

#### *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.<sup>9</sup>

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.<sup>3, 12</sup>

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.<sup>13, 14</sup> 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.<sup>15</sup> 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.<sup>16</sup>

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.<sup>6, 10</sup>

**Coding Implications**

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<b>CPT® Codes</b>	<b>Description</b>
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
54914	Delivery of placenta

<b>HCPCS Codes</b>	<b>Description</b>
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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
Policy Adopted from Health Net NMP#216 Home Births	12/16	12/16
Minor wording change in I.A.2.c. for clarity. Added criteria that women planning home birth should not have had a previous cesarean, per ACOG committee opinion updated 2017. Minor wording changes in background per ACOG update. Reworded I.F. from head down to cephalic presentation. Removed CPT code 54192, external cephalic version	11/17	12/17

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3. American College of Obstetricians and Gynecologists. Committee on Obstetric Practice. ACOG Committee Opinion No. 697, Replaces 669: Planned Home Birth. Obstet Gynecol 2017.
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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.

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

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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. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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**Note: For Medicaid members**, 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**, 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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