Health Plan of Nevada
A UnitedHealthcare Company

United Healthcare

HOME BIRTH

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INSTRUCTIONS FOR USE
This medical policy provides assistance in interpreting UnitedHealthcare Medicaid benefit plans. When deciding coverage, the member specific benefit plan document or state guidance must be referenced. The terms of the member specific benefit plan [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), Summary Plan Description (SPD), and/or Medicaid Covered Services] may differ greatly from the standard benefit plan upon which this medical policy is based. In the event of a conflict, the member specific benefit plan supersedes this medical policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this medical policy. Other policies and guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its policies and guidelines as necessary. This medical policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use nationally recognized clinical guidelines such as MCG® or Interqual® to assist us in administering health benefits. These guidelines are intended to be used in coordination with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

BACKGROUND

Approximately 35,000 births occur in the home each year in the United States (0.9% of all births). One quarter of these home births are unplanned or unattended (ACOG).

As an alternative to a hospital setting or birthing center, a medically informed decision to deliver in the home setting (home birth) may be chosen by some women. Planned home birth should only be considered for women who are low risk for pregnancy complication and when a qualified health care professional is present.

Consistent with the American College of Obstetricians and Gynecologist (ACOG) and the American Academy of Pediatrics (AAP), Health Plan of Nevada considers a hospital or freestanding birthing center the safest setting for labor, delivery and postpartum care.

COVERAGE RATIONALE

From the Medicaid Services Manual (MSM) Chapter 600 (Physician Services. Accessed 5/19/25, Current Effective Date 10/30/2024)

Maternity care is a program benefit which includes antepartum care, labor and delivery, and postpartum care provided by a physician, physician assistant, APRN, and/or a nurse midwife. Maternity care services can be provided in the home, office, hospital or freestanding birthing center settings. All maternity care providers are allowed to provide services within all settings that are allowed per their scope of practice and licensure.

Providers shall follow current national guidelines, recommendations, and standards of care for maternity care services, including but not limited to, USPSTF, ACOG, Society of Maternal-Fetal Medicine, and the American College of Nurse Midwives.

It is the responsibility of the treating provider to employ a care coordination mechanism to facilitate the identification and treatment of high-risk pregnancies. Home births and corresponding pregnancy services are appropriate for recipients with low-risk pregnancies, intended vaginal delivery, and no reasonably foreseeable expectation of complication.

ELIGIBILITY/SCREENING CRITERIA
A woman may be eligible for a home birth if:

1) She has completed at least 37 weeks and not more than 42 weeks of gestation;
2) She has no major medical problems;
3) She has no previous history of major uterine wall surgery, cesarean section, or other obstetrical complications which are likely to recur;
4) She has parity of under six;
5) She is not less than 15 years or more than 40 years of age and is not a nullipara;
6) She has no clinically significant signs or symptoms of:
    a. Pregnancy-induced hypertension;
    b. Polyhydramnios or oligohydramnios;
    c. Abruptio placenta;
    d. Chorioamnionitis;
    e. Multiple gestation;
    f. Intrauterine growth retardation;
    g. Meconium-stained amniotic fluid associated with signs of fetal intolerance of labor;
    h. Fetal intolerance of labor;
    i. Active substance use disorder;
    j. Placenta previa;

   k. Diabetes mellitus; or
   l. Anemia;
7) While in active labor, she demonstrates no clinically significant signs or symptoms of:
   a. Intrapartum hemorrhage;
   b. Active Herpes Simplex II of the genitals; or
   c. Malpresentation of the fetus including breech presentation;
8) She is in labor and progressing normally;
9) Her membranes were not ruptured more than 24 hours prior;
10) She has no evidence of infection;
11) Her pregnancy is appropriate for a setting where analgesia is limited.

The American Academy of Pediatrics recommends the following systems are in place to support home birth:

1) 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.
2) Attendance by at least two care providers, one of whom is an appropriately trained individual whose primary responsibility is the care of the newborn infant.
3) Availability of appropriate equipment for neonatal resuscitation.
4) Ready access to medical consultation.
5) Access to safe and timely transport to a nearby hospital with a preexisting arrangement.

STAGES OF MATERNITY CARE

1) Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery totaling approximately 13 routine visits. Any other visits or services within this time period for non-routine maternity care should be coded separately. Non-emergency antepartum care is not a covered benefit for non-U.S. citizens/aliens who have not lawfully been admitted for permanent residence in the United States or permanently residing in the United States under the color of the law. Refer to *MSM Chapter 200, Hospital Services* for more information.
2) Labor and delivery services (including home delivery) include the admission history and physical examination, management of uncomplicated labor, vaginal delivery. Medical problems complicating labor and delivery management may require additional resources and should be billed utilizing appropriate CPT codes.
   a) Provider responsibilities for the initial newborn examination and subsequent care includes the following:
      i) The initial physical examination done in the home is a rapid screening for life threatening anomalies that may require immediate billable attention.
      ii) Complete physical examination is done within 24 hours of delivery but after the six-hour transition period when the infant has stabilized. This examination is billable.
      iii) Medicaid will reimburse newborn follow-up visits in the provider's office or recipient's home up to four days post-delivery.
      iv) All newborns must receive a hearing screen in accordance with NRS 442.540 and corresponding NAC 442.850. Hearing screening is not required if parent or legal guardian

objects in writing. If a nurse midwife does not have the necessary equipment to conduct the hearing screen in the home, a referral can be made to a hearing specialist.

v) All newborns must receive a newborn screening blood analysis in accordance with NRS 442.008 and corresponding NAC 442.020 – 442.050. Newborn screening is not required if the parent or legal guardian objects in writing.

3) Postpartum care includes office or home visits following vaginal delivery. Recipients who are eligible for Medicaid on the last day of their pregnancy remain eligible for full Medicaid coverage for 12 months immediately following the last day of pregnancy, including the entire month in which the 365th day falls.
4) Reimbursement: If a provider provides all or part of the antepartum and/or postpartum care but does not perform delivery due to termination of the pregnancy or referral to another provider, the reimbursement is based upon the antepartum and postpartum care CPT codes. A global payment will be paid to the delivering provider, when the recipient has been seen seven or more times with or without delivery. If the provider has seen the recipient less than seven time with or without delivery, the provider will be paid according to the Fee-for-Service (FFS) visit schedule using the appropriate CPT codes. Please refer to *MSM Chapter 700, Rates and Supplemental Reimbursement* for more information.

DOULA SERVICES

1) Doula Provider Qualifications
   a) Certification as a doula must be obtained through the Nevada Certification Board.
2) Coverage and Limitations

   Doula services may be provided upon the confirmation of pregnancy. Doulas should encourage recipients to receive prenatal/antepartum and postpartum care.

   a) Covered Services:
      i) Emotional support, including bereavement support.
      ii) Physical comfort measures during peripartum (i.e., labor and delivery).
      iii) Facilitates access to resources to improve health and birth-related outcomes.
      iv) Advocacy in informed decision-making (i.e. patient rights for consent and refusal).
      v) Evidence-based education and guidance, including but not limited to, the following:
         (1) General health practices, including but not limited to, reproductive health.
         (2) Child birthing options.
         (3) Newborn health and behavior, including but not limited to, feeding (i.e., bottle feeding), sleep habits, establishing routines, and pediatric care.
         (4) Infant care, including but not limited to, soothing, coping skills, and bathing.
         (5) Family dynamics, including but not limited to, sibling education and transition.
         (6) Breastfeeding, chestfeeding, lactation support, and providing related resources.
   b) Non-Covered Services:
      i) Travel time and mileage.
      ii) Services rendered requiring medical or clinical licensure.
   c) Service Limitations:

      Doula services for the same recipient and pregnancy are limited to a maximum of the following:

      i) Four visits during the prenatal/antepartum and/or postpartum period up to 90 days postpartum (procedure code S9445). Code S9445 also has a limitation of one (1) visit per day. Refer to *Nevada Billing Guidelines* for PT 90.

ii) One (1) visit at the time of labor and delivery (procedure codes 59409, 59514, 59612 or 59620).
iii) Prior authorization is required for Doula Services after the initial limitations have been exhausted.

DEFINITIONS

Doula: non-medical trained professional who provides education, emotional and physical support during pregnancy, labor/delivery, and postpartum period.

High Risk Pregnancy: probability of an adverse outcome to the birthing person and/or the baby greater than the average occurrence in the general population.

Nurse Midwives: Advanced practice registered nurses who have advanced education and midwifery training and certification. Nurse midwives provide care during pregnancy, childbirth and postpartum period (including home settings), sexual and reproductive health, gynecologic health, family planning including preconception care. Maternity care services are only available with a nurse midwife for low-risk pregnancies.

Planned Home Birth: A natural birth that take place in a home setting and is assisted by a qualified licensed midwife, certified nurse midwife, or a practitioner licensed to provide maternity care.

US FOOD AND DRUG ADMINISTRATION (FDA)

Home births are procedures, and therefore, not subject to FDA regulation. However, medical devices, drugs, biologics or tests used as a part of these procedures may be subject to FDA regulation. See the following website to search by product name. Available at: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed May 21, 2025)

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other policies and guidelines may apply.

Code	Description
99202 - 99205	New patient, office or other outpatient visit
99211 – 99215	Established patient, office or other outpatient visit
99242 – 99245	Office consultation
99281 – 99285	Emergency department visit
99341 – 99345	New patient, home visit
99347 – 99350	Established patient, home visit

Code	Description
99381, 99384 – 99387	Initial new patient, preventive medicine evaluation
99391, 99394 – 99397	Established patient, preventive medicine evaluation
99401	Preventive medicine counseling (approximately 15 minutes)
99415 – 99418	Prolonged office or other outpatient service by clinical staff
99460 – 99465	Newborn care services
59020, 59025	Fetal tests
59050, 59051	Fetal monitoring during labor (home birth only)
59200	Insert cervical dilator
z38.1 59400	Routine obstetric care including antepartum care, vaginal delivery and postpartum care, outside of hospital setting
z38.1 59409	Vaginal delivery only, outside of hospital setting
z38.1 59410	Vaginal delivery including postpartum care, outside of hospital setting
59425 – 59426	Antepartum care only
59430	Postpartum care only
96156 – 96171	Lactation services
11981 – 11983	Insertion/removal of non-biodegradable drug delivery implant
57170	Diaphragm or cervical cap fitting with instructions
58300, 58301	Insertion/removal of IUD
96127	Brief emotional/behavioral assessment
96156, 96158, 96159	Health behavior assessment/re-assessment/intervention
96160, 96161	Administration and interpretation of patient-focused/caregiver-focused health risk assessment
96164, 96165, 96167, 96168, 96170, 96171	Health behavior intervention
99406, 99407	Smoking and tobacco counseling
99408, 99409	Alcohol and/or substance abuse screening and intervention
G0442, G0443	Alcohol misuse counseling
G0444	Depression screening
G0445	Behavioral counseling to prevent sexually transmitted infections
H0049	Alcohol and/or drug screening
80305 – 80307	Presumptive drug class screening
81000 – 81003	Urinalysis
81025	Urine pregnancy test
82948, 82950	Blood glucose test
83036	Hemoglobin A1c level
84703	Gonadotropin, chorionic (hCG), qualitative
85013, 85014, 85016, 85018	Red blood cell/blood count tests
86318	Immunoassay infectious agent
87081	Screening for pathogenic organisms
87210	Smear wet mount saline/ink

Code	Description
87480, 87510, 87660	Detection test for candida, gardnerella vaginalis, trichomonas vaginalis, direct probe
87661	Infectious agent detection, trichomonas vaginalis
87797	Detection test by nucleic acid for organism, direct probe
87804	Infectious agent detection, influenza
87806	Infectious agent detection, HIV-1 antigen with HIV-1 and HIV-2 antibodies
87880	Infectious agent detection, Streptococcus
10060	Simple or single drainage of skin abscess
11200, 11201	Removal of skin tags
36415, 36416	Insertion of needle/puncture of skin for collection of blood sample
40806	Incision of tissue joining lip and gum
41010	Incision of tissue connecting tongue and floor of mouth
56405, 56420	Incision and drainage of female genital abscess, gland abscess
56605	Biopsy of external female genitals
58100	Biopsy of lining of uterus
90460, 90461, 90471-90474	Immunization administration
92558	Newborn hearing screen (allowed only for home births with proper equipment)
92950	Cardiopulmonary resuscitation (CPR)
94640	Inhalation treatment for acute airway obstruction or sputum induction
94760	Measurement of oxygen saturation in blood using ear or finger device
96360, 96361	Hydration
96365, 96366	Intravenous infusions
96372, 96374	Therapeutic, prophylactic or diagnostic injection
97022	Application of whirlpool therapy
98960 – 98962	Education and training for patient self-management, individual, group
99050	Medical services after hours
99070	Provision of supply and material by physician
A4550	Surgical trays
G0101	Cervical or vaginal cancer screening, pelvic and clinical breast examination
Q0091	Screening pap smear; obtaining, preparing, and conveyance of cervical or vaginal smear to laboratory
59409 Modifier U1	Doula: Vaginal delivery only
s9445 Modifier U1	Doula: Patient education not otherwise classified non physician provider, individual per session

REFERENCES

American Academy of Pediatrics, Providing Care for Infants Born at Home Policy Statement (accessed 5/21/25)

Medicaid Services Manual (MSM) Section 603, pages 9-13 and 17-18 (accessed 5/21/25)

Nevada Administrative Code Chapter 442, 442.020-442.050, 442.850 (accessed 5/21/25)

Nevada Department of Health and Human Services Provider Type 74 Billing Guide (accessed 5/21/25)

Nevada Department of Health and Human Services Provider Type 90 Billing Guide (accessed 5/21/25)

Nevada Department of Health and Human Services Provider Type 20, 24 and 77 Billing Guide (accessed 5/21/25)

The American College of Obstetricians and Gynecologists, Planned Home Birth Committee Opinion (accessed 5/21/25)

POLICY HISTORY/REVISION INFORMATION

Date	Name	Comments
3/30/23	Krystal Marshall	Initial Review by: HPN/SHL Utilization Management Committee
4/24/24	Arletta Bendschneider	Revision/Review *Stages of Maternity Care*, number (3)-section 603 of MSM changed 'Woman who are eligible for Medicaid on the last day of their pregnancy, remain eligible for all pregnancy related and postpartum medical assistance including family planning education services for **60 days** immediately following the last day of pregnancy, including the entire month in which the **60th day** falls …….' to '**365 days**' and '**365th day**' *Stages of Maternity Care*, number (4)-section 603 of MSM changed '**pregnant women**' to '**recipient**'

6/19/25	Arletta Bendschneider	Revision/Review Removal of NAC 449.61134 as a source for *Eligibility* requirements for Home Births (the state has removed this entire section of the NAC). Removed **iii** and **iv** from *Service Limitations* under *Doula Services* (have been removed from source document: MSM, section 603). Changed **v** from *Service Limitations* under *Doula Services*, from 'Prior authorization is not required' to 'Prior authorization is required for Doula Services after the initial limitations have been exhausted.' Definition for **planned home birth** added to list of definitions. CPT codes **99241, 99354, 99355, 99356, 99357, 96166, 96169, 85015, 85017, 90462-90470** removed from *Applicable Codes* list (no longer active codes in the most recent edition of ICD-10). Clarification of CPT codes **59400, 59409, 59410** by including them under **z38.1** code for 'single liveborn infant birth outside of a hospital setting'. Removed CPT code **59412, External Cephalic version** at the request of network provider Dr. Carl Allen, OB/GYN (this procedure code should not be used in home birth setting). Removed CPT code **59414, Delivery of placenta** (this procedure code is specific to manual removal of afterbirth by a provider other than the one who performed delivery. Unassisted delivery of placenta is covered under 59400, 59409, and 59410 codes).