Washington State Health Care Authority

Washington Apple Health (Medicaid)

Planned Home Births & Births in Birth Centers Billing Guide

October 1, 2019

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This guide takes effect October 1, 2019, and supersedes earlier billing guides to this program.

The Health Care Authority (agency) is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call (800) 562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

Refer also to the agency's ProviderOne billing and resource guide for valuable information to help you conduct business with the agency.

*This guide is a billing instruction.

What has changed?

Subject	Change	Reason for Change
Entire document	Changed "birthing" centers to "birth" centers.	Appropriate terminology, industry standard.
Definitions	Updated the definition of "planned home birth" by revising language about what type of provider can assist with a planned home birth.	To align with WAC 246-834-140.
What are the requirements to be an agency-approved birth center facility?	Added a reference to Chapter 246-329 WAC.	Clarification
What are the requirements to be an agency approved planned home birth provider or birth center provider?	Revised this entire section to update what documentation providers must submit at enrollment, updated information that must be shared with parents, and revised language to align with WAC.	Clarifications and program updates.
Risk screening criteria	Revised language about how the agency does not cover planned home births or births in a birth center for women identified with certain conditions. Also changed "cancer affecting site of delivery" to "cancer affecting the female reproductive system."	To align with WAC 182-533-0600. Clarification
Facility Fee Payment	Removed information about how facility payments are billed by and paid to the midwife, who must then reimburse the birth center.	Birth centers can bill for fees independent of the midwife.
Conditions requiring consultation	Removed "abnormal jaundice" from the list.	There are two charts in the billing guide: conditions requiring consultation and conditions requiring referral. Jaundice was identified in both (contradictory). Jaundice is still identified as requiring referral.
Conditions requiring referral	For clinical evidence of prematurity, changed 35 weeks to 36 weeks.	Correction

How can I get agency provider documents?

To access provider alerts, go to the agency's provider alerts webpage.

To access provider documents, go to the agency's provider billing guides and fee schedules webpage.

Table of Contents

Resources Available

Topic	Contact
Policy questions or exception to rule questions	Planned Home Births and Births in Birth Centers Program Manager Health Care Authority Program Mgmt & Authorization Section PO Box 45506 Olympia, WA 98504-5506 FAX (360) 725-1966
Newborn screenings	Department of Health (206) 361-2890 or (866) 660-9050 Email: nbs.prog@doh.wa.gov
Medical information	University of Washington Med Consultation Line (800) 326-5300 (toll free)
Maternity Support Services/Infant Case Management	See First Steps webpage Email: FirstSteps@hca.wa.gov Phone: (360) 725-1293
Which birth centers are agency-approved birth centers?	• Bellingham Birth Center - Bellingham, WA • Birth Inn - Tacoma, WA • Birthroot Midwives & Birth Center - Bellingham, WA • Cascade Birth Center - Everett, WA • Center for Birth LLC - Seattle, WA • Eastside Birth Center - Bellevue, WA • Greenbank Women's Clinic and Childbirth Center-Greenbank, WA • Lakeside Birth Center - Sumner, WA • Mount Vernon Birth Center - Mount Vernon, WA • Puget Sound Birth Center - Kirkland, WA • Salmonberry Community Birth Center – Poulsbo, WA • Seattle Home Maternity Services and Childbirth Center-Seattle, WA • Spokane Midwives Home & Birth Center, PLLC – Spokane • Sprout Birth Center - Mountlake Terrace, WA • The Birth House - Olympia, WA • Wenatchee Midwife and Childbirth Center - Wenatchee

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

Birth Center – A specialized facility licensed as a childbirth center by the Department of Health (DOH) (WAC 246-329-010)

Birth Center Provider – Any of the following individuals who have a Core Provider Agreement with the agency to deliver babies in a birth center:

- A midwife currently licensed in the State of Washington under chapter 18.50 RCW
- Nurse Midwife currently licensed in the State of Washington under chapter 18.79 RCW
- Physician licensed in the State of Washington under chapters 18.57 or 18.71 RCW

Bundled services – Services integral to the major procedure that are included in the fee for the major procedure. For the Planned Home Birth and Births in Birth Centers program, certain services which are customarily bundled must be billed separately (unbundled) when the services are provided by different providers.

Chart - A compilation of medical records on an individual patient.

Consultation – The process whereby the provider, who maintains primary management responsibility for the client's care, seeks the advice or opinion of a physician (MD/DO) on clinical issues that are patient-specific. These discussions may occur in person, by electronic communication, or by telephone.

A consulting relationship may result in:

- Telephone, written or electronic mail recommendations by the consulting physician.
- Co-management of the patient by the birth center provider and the consulting physician.
- Referral of the patient to the consulting physician for examination and/or treatment.
- Transfer of patient's care from the birth center or home birth provider to the consulting physician.

Facility fee – The portion of the agency's payment for the hospital or birth center charges. This does not include the agency's payment for the professional fee.

Global fee – The fee the agency pays for total obstetrical care. Total obstetrical care includes all bundled prenatal care, delivery services, and postpartum care.

High-risk pregnancy – Any pregnancy that poses a significant risk of a poor birth outcome.

Home birth kit – A kit that contains disposable supplies that are used in a planned home birth (**see** list of recommended or required supplies).

Home Birth Provider -

- A midwife currently licensed in the State of Washington under chapter 18.50 RCW
- A nurse-midwife currently licensed in the State of Washington under chapter 18.79 RCW
- A physician licensed in the State of Washington under chapters 18.57 or 18.71 RCW who has qualified to become a home birth provider who will deliver babies in a home setting, and has signed a core provider agreement with the Health Care Authority

Midwife – An individual possessing a valid, current license to practice midwifery in the State of Washington as provided in chapter 18.50 RCW, or an individual recognized by the Washington Nursing Care Quality Assurance Commission as a certified nurse midwife as provided in chapter 18.79 RCW and chapter 246-834 WAC.

Planned home birth – A natural birth that takes place in a home setting and is assisted by a qualified licensed midwife, certified nurse midwife, or a practitioner licensed to provide maternity care. (WAC 246-834-140)

Professional Fee – The portion of the agency's payment for services that rely on the provider's professional skill, or training, or the part of the reimbursement that recognizes the provider's cognitive skill.

Record – Dated reports supporting claims for medical services provided in an office, nursing facility, hospital, outpatient, emergency room, or other place of service.

Program Overview

What does the Planned Home Births and Births in Birth Centers program provide?

The Planned Home Births and Births in a Birth Center program provides a safe alternative delivery setting to pregnant agency clients who are at **low-risk** for adverse birth outcomes. These services promote access to care by allowing low-risk clients to give birth in an out-of-hospital setting.

When does the agency cover planned home births and births in a birth center?

(WAC 182-533-0600(1))

The agency covers planned home births and births in a birth center for its clients when the client and the maternity care provider choose to have a home birth or to give birth in an agency-approved birth center and the client:

- Is eligible for categorically needy (CN) or medically needy (MN) scope of care (see Client Eligibility).
- Has an agency-approved home birth provider who has accepted responsibility for the planned home birth or a provider who has accepted responsibility for a birth in an agency-approved birth center.
- Is expected to deliver the child vaginally and without complication (i.e., with a low risk of adverse birth outcome).
- Passes agency's risk screening criteria. (For risk screening criteria, see Prenatal Management/Risk Screening Guidelines).

What are the requirements to be an agency-approved birth center facility?

(WAC 182-533-0600(3))

An agency-approved birth center facility must:

- Be licensed as a childbirth center by the Department of Health (DOH) as defined in Chapter 246-329 WAC.
- Be specifically approved by the agency to provide birth center services (see Resources Available for a list of approved centers).
- Have a valid core provider agreement (CPA) with the agency.
- Maintain all standards of care required by DOH for licensure as defined in Chapter 246-329 WAC.

What are the requirements to be an agency-approved planned home birth provider or birth center provider?

(WAC 182-533-0600)

Agency-approved planned home birth providers and birth center providers must:

- Have a core provider agreement (CPA) with the agency.
- Follow WAC 182-533-0400 and WAC 182-533-0600.
- Have a signed agency midwife attestation form.
- Be licensed in the State of Washington as a:
  - ✓ Midwife under chapter 18.50 RCW
  - ✓ Nurse midwife under chapter 18.79 RCW
  - ✓ Physician under chapters 18.57 or 18.71 RCW
- Have evidence of current cardiopulmonary resuscitation (CPR) training for:
  - ✓ Adult CPR
  - ✓ Neonatal resuscitation

- Obtain from the client a signed informed consent form, including the criteria listed in Authorization, in advance of the birth.

- Make appropriate referral of the newborn for pediatric care and medically necessary follow-up care. (WAC 246-834-255)

- Inform parents of the benefits of a newborn screening test for heritable or metabolic disorders and offer to send the newborn's blood sample to DOH for testing (the parent may refuse this service). DOH will bill the agency for payments of HCPCS code S3620. (WAC 246-650-020 and RCW 70.83.020)

- Inform parents of and provide newborn screening for congenital heart defects. (RCW 70.83.090)

- Inform parents of the benefits and risks of vitamin K injections and required prophylactic eye ointment for newborns. (WAC 246-100-202).

What equipment, supplies, and medications are recommended or required for a planned home birth?

Nondisposable equipment:

Adult mask and oral airway
Fetoscope and/or Doppler device (with extra batteries if only Doppler)
Oxygen tank with tubing and flow meter
Neonatal resuscitation mask and bag
Portable light source
Portable oral suction device for infant
Sterile birth instruments
Sterile instruments for episiotomy and repair
Stethoscope and sphygmomanometer
Tape measure
Thermometer
Timepiece with second hand
O2 saturation monitor

Medications available:

Pitocin, 10 U/ml
Methergine, 0.2 mg/ml
Epinephrine, 1:1000
MgSO4, 50% solution, minimum 2-each of 5gms in 10 cc vials
Local anesthetic for perineal repair
Vitamin K, neonatal dosage (1 mg/0.5 ml)
IV fluids, one or more liters of LR

Recommended home-birth-kit supplies:

IV set-up supplies
Venipuncture supplies
Urinalysis supplies - clean catch cups and dipsticks
Injection supplies suitable for maternal needs
Injection supplies suitable for neonatal needs
Clean gloves
Sterile gloves: pairs and/or singles in appropriate size
Sterile urinary catheters
Sterile infant bulb syringe
Sterile cord clamps, binding equipment or umbilical tape
Antimicrobial solution(s) for cleaning exam room and client bathroom
Antimicrobial solution(s)/brush for hand cleaning
Sterile amniohooks or similar devices
Cord blood collection supplies
Appropriate device for measuring newborn's blood sugar values
Suture supplies
Sharps disposal container, and means of storage and disposal of sharps
Means of disposal of placenta

Required home-birth-kit supplies:

Neonatal ophthalmic ointment (or other approved eye prophylaxis)

Client Eligibility

Most Apple Health clients are enrolled in an agency-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See the agency's Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Is the client enrolled in an agency-contracted managed care organization (MCO), in a behavioral health organization (BHO), or is the client receiving services through fee-for-service (FFS) Apple Health?

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health.** For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's ProviderOne billing and resource guide.

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see the agency's Program benefit packages and scope of services webpage.

Note: Patients who are not Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org

2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)

3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

Are clients enrolled in an agency-contracted managed care organization eligible?

(WAC 182-533-0400(2))

Yes. When verifying eligibility using ProviderOne, if the client is enrolled in an agency-contracted managed care organization (MCO), managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

All services must be requested directly through the client's Primary Care Provider (PCP), except in the area of women's health care services. For certain services, such as maternity and gynecological care, clients may go directly to a specialist in women's health without a referral from the client's PCP. However, the provider must be within the client's MCO's provider network.

The client must obtain all medical services covered under an agency-contracted MCO through designated facilities or providers. The MCO is responsible for:

- Payment of covered services.
- Payment of services referred by a provider participating with the MCO to an outside provider.

Contact the agency-contracted MCO and the PCP for additional information on providers, including participating hospitals and birth facilities. Clients can contact their MCO by calling the telephone number provided to them.

If the client's obstetrical provider is not contracted with the client's agency-contracted MCO, the provider will not be paid for services unless a referral is obtained from the MCO. For assistance or questions, the client can call the phone number provided by the MCO.

> **Note:** To prevent billing denials, check the client's eligibility prior to scheduling services and at the time of the service and make sure proper authorization or referral is obtained from the agency-contracted MCO. See the agency's ProviderOne billing and resource guide for instructions on how to verify a client's eligibility.

Managed care enrollment

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's Get help enrolling page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Behavioral Health Organization (BHO)

The Health Care Authority (agency) manages the contracts for behavioral health services (mental health and substance use disorder) for the following three Regional Service Areas (RSAs):

- **Great Rivers:** Includes Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties
- **Salish:** Includes Clallam, Jefferson, and Kitsap counties
- **Thurston-Mason**: Includes Thurston and Mason counties

To view a map and table of the integrated managed care plans available within each region, please see Changes coming to Washington Apple Health. You may also refer to the agency's Apple Health managed care webpage. See the agency's Mental health services billing guide for details.

Apple Health – Changes for July 1, 2019

Effective July 1, 2019, HCA is continuing to shift to whole-person care to allow better coordination of care for both body (physical health) and mind (mental health and drug or alcohol treatment, together known as "behavioral health"). This delivery model is called Integrated Managed Care (formerly Fully Integrated Managed Care, or FIMC, which still displays in ProviderOne and Siebel).

Agency-contracted managed care organizations (MCOs) in certain Regional Services Areas (RSAs) have expanded their coverage of behavioral health services (mental health and substance use disorder treatment), along with continuing to cover physical health services. The RSAs are outlined in the Integrated managed care regions section.

Apple Health clients who are not enrolled in an agency-contracted MCO for their physical health services (e.g., dual-eligible Medicare-Medicaid clients) will still receive their behavioral health services through one of the agency-contracted MCOs. The MCO will provide only behavioral health services for the client.

Most clients will remain with the same health plan, except in regions where client's plan will no longer be available. The agency will auto-enroll these clients to one of the offered plans.

Clients can change their plan at any time by:

- Visiting the ProviderOne client portal.
- Calling Apple Health Customer Service toll-free at 1-800-562-3022. This automated system is available 24 hours a day, 7 days a week.
- Requesting a change online through our secure Contact us – Apple Health (Medicaid) client web form. Select the topic "Enroll/Change Health Plans."
- Visiting the Washington Healthplanfinder (only for clients with a Washington Healthplanfinder account).

Integrated managed care

For clients who live in an integrated managed care region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client's agency-contracted MCO. The BHO will not provide behavioral health services in these regions.

Clients living in an integrated managed care region will enroll with an MCO of their choice that is available in that region. If the client does not choose an MCO, the client will be automatically enrolled into one of the available MCOs, unless the client is American Indian/Alaska Native (AI/AN). Clients currently enrolled in one of the available MCOs in their region may keep their enrollment when the behavioral health services are added.

American Indian/Alaska Native (AI/AN) clients living in an integrated managed care region of Washington may choose to enroll in one of the agency-contracted MCOs available in that region or they may choose to receive all these services through Apple Health fee-for-service (FFS). If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency's American Indian/Alaska Native webpage.

For more information about the services available under the FFS program, see the agency's Mental health services billing guide and the Substance use disorder billing guide.

For full details on integrated managed care, see the agency's Apple Health managed care webpage and scroll down to "Changes to Apple Health managed care."

Integrated managed care regions

Clients who reside in the following integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Details, including information about mental health crisis services, are located on the agency's Apple Health managed care webpage.

Region	Counties	Effective Date
North Sound	Island, San Juan, Skagit, Snohomish, and Whatcom	July 1, 2019
Greater Columbia	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman	January 1, 2019
King	King	January 1, 2019
Pierce	Pierce	January 1, 2019
Spokane	Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens	January 1, 2019
North Central	Grant, Chelan, Douglas, and Okanogan	January 1, 2018 January 1, 2019 (Okanogan)
Southwest	Clark, Skamania, and Klickitat	April 2016 January 1, 2019 (Klickitat)

Integrated Apple Health Foster Care (AHFC)

Effective January 1, 2019, children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington's (CCW) Apple Health Foster Care program will receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement).
- Under the age of 21 who are receiving adoption support.
- Age 18-21 years old in extended foster care.
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni).

These clients are identified in ProviderOne as "**Coordinated Care Healthy Options Foster Care.**"

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Administrative Services Organization (BH-ASO). For details, see the agency's Mental health services billing guide, under *How do providers identify the correct payer*?

First Steps Program Services

The First Steps program helps low-income pregnant clients get the health and social services they may need. These services help healthy mothers have healthy babies and are available as soon as a client knows the client is pregnant. First Steps services are supplemental services that include Maternity Support Services (MSS), Childbirth Education, and Infant Case Management (ICM). Eligible pregnant clients may receive Maternity Support Services (MSS) during pregnancy and through the post pregnancy period (the last day of the month from the 60th day after the pregnancy ends).

Maternity Support Services (MSS)/Infant Case Management (ICM)

Maternity Support Services (MSS) are preventive health services for clients to have healthy pregnancies. Services include an assessment, education, intervention, and counseling. A team of community health nurses, nutritionists, behavioral health specialists and, in some agencies, community health workers, provide the services. The intent is to provide MSS as soon as possible in order to promote positive birth and parenting outcomes.

Pregnant clients with First Steps coverage can receive MSS during pregnancy and through the end of the second month following the end of the pregnancy. MSS can begin during the prenatal, delivery, or postpartum period.

Sometimes there are situations that may place infants at a higher risk of having problems. Infant Case Management (ICM) starts after the mother's MSS eligibility period ends (generally in the baby's third month). ICM can help a client's family learn to use the resources in the community so that the baby and family can thrive. ICM may start at any time during the child's first year. It will continue through the month of the infant's first birthday.

For further information on the MSS/ICM program, visit the First Steps webpage and see the agency's MSS/ICM billing guide.

Childbirth Education

Childbirth education classes are available to all Medicaid eligible clients. Instruction takes place in a group setting and may be completed over several sessions. Childbirth education is intended to help the client and the client's support person to understand the changes the client is experiencing, what to anticipate prior to and during labor and delivery, and to help develop positive parenting skills. For further information on Childbirth Education, visit the First Steps webpage.

Also, see the agency's Childbirth education billing guide.

For more information about First Steps services or to receive a list of contracted providers, contact the First Steps Program Manager at (360) 725-1293 or the visit the First Steps webpage.

Prenatal Management and Risk Screening Guidelines

What are the risk screening criteria?

(WAC 182-533-0600(1)(d))

Providers must screen their clients for high-risk factors. The provider must consult with consulting physicians when appropriate. Follow the agency's Risk screening criteria and Indications for consultation and referral on the following pages.

To be reimbursed for CPT® codes 99211 through 99215 with HCPCS modifier TH (Increased Monitoring Prenatal Management), the client's record must contain the appropriate ICD diagnosis code.

Risk screening criteria

(WAC 182-533-0600(6))

The following conditions are high-risk factors. The agency does not cover planned home births or births in a birth center for women identified with any of the following conditions:

- Previous cesarean section
- Current alcohol and/or drug addiction or abuse
- Significant hematological disorders/coagulopathies
- History of deep venous thrombosis or pulmonary embolism
- Cardiovascular disease causing functional impairment
- Chronic hypertension
- Significant endocrine disorders including pre-existing diabetes (type I or type II)
- Hepatic disorders including uncontrolled intrahepatic cholestasis of pregnancy and/or abnormal liver function tests

- Isoimmunization, including evidence of Rh sensitization/platelet sensitization
- Neurologic disorders or active seizure disorders
- Pulmonary disease
- Renal disease
- Collagen-vascular diseases
- Current severe psychiatric illness
- Cancer affecting the female reproductive system
- Multiple gestation
- Breech presentation in labor with delivery not imminent
- Other significant deviations from normal as assessed by the provider

Smoking cessation for pregnant women

(WAC 182-533-0400(23))

For information about smoking cessation, see Behavior change intervention – smoking cessation in the Physician-related services/health care professional services billing guide.

Prenatal management/consultation & referral

The definitions below apply to the following tables labeled Prenatal indications for consultation and referral.

Consultation - The process whereby the provider, who maintains primary management responsibility for the client's care, seeks the advice or opinion of a physician on clinical issues that are patient-specific. These discussions may occur in person, by electronic communication, or by telephone. A consulting relationship may result in:

- Telephonic, written, or electronic mail recommendations by the MD/DO.
- Co-management of the patient by both the midwife and the MD/DO.
- Referral of the patient to the MD/DO for examination and/or treatment.
- Transfer of care of the patient from the midwife to the MD/DO.

Referral - The process by which the provider directs the client to a physician (MD/DO) for management (examination or treatment) of a particular problem or aspect of the client's care.

Transfer of care – The process by which the provider directs the client to a physician for complete management of the client's care.

The client must meet the agency's risk screening criteria in order to be covered for a planned home birth or a birth in a birth center.

Note: Providers are expected to screen out high-risk pregnancy by following the agency's risk screening guidelines. The conditions in the following *Indications for consultation and referral prenatal* table may require either a consultation or referral. Providers should use professional judgment in assessing and determining appropriate consultation or referral in case of an adverse situation. If a physician is the provider, he or she should consult with another physician as needed. Referrals to ARNPs are appropriate for treatment of simple infections.

Prenatal indications for consultation and referral

(Refers to the mother's care prior to the onset of labor)

Conditions Requiring Consultation The agency requires physician (MD/DO) consultation and the client MAY require referral to a physician when the following conditions arise during the current pregnancy.
• Breech at 37 weeks • Polyhydramnios/Oligohydramnios • Significant vaginal bleeding • Persistent nausea and vomiting causing a weight loss of > 15 lbs. • Post-dates pregnancy (> 42 completed weeks) • Fetal demise after twelve completed weeks gestation • Significant size/dates discrepancies • Abnormal fetal NST(non stress test) • Abnormal ultrasound findings • Acute pyelonephritis • Infections, whose treatment is beyond the scope of the provider • Evidence of large uterine fibroid that may obstruct delivery or significant structural uterine abnormality • No prenatal care prior to the third trimester • Other significant deviations from normal, as assessed by the provider

Conditions Requiring Referral The agency requires physician (MD/DO) consultation and referral when the following conditions arise during current pregnancy.
• Evidence of pregnancy induced hypertension (BP > 140/90 for more than six hours with client at rest) • Hydatidiform mole (molar pregnancy) • Gestational diabetes not controlled by diet • Severe anemia unresponsive to treatment (Hgb < 10, Hct <2 8) • Known fetal anomalies or conditions affected by site of birth • Noncompliance with the plan of care (e.g., frequent missed prenatal visits) • Documented placental abnormalities, significant abruption past the 1st trimester, or any evidence of previa in the third trimester • Rupture of membranes before the completion of 37 weeks gestation • Positive HIV antibody test • Documented IUGR (intrauterine growth retardation) • Primary genital herpes past the 1st trimester • Development of any of the high-risk conditions that are listed in Risk screening criteria

Intrapartum

(Refers to the mother's care any time after the onset of labor, up to and including the delivery of the placenta)

Conditions Requiring Consultation The agency requires physician consultation and the client MAY require referral to a physician and/or hospital when the following maternal conditions arise intrapartum.
• Prolonged rupture of membranes (>24 hours and not in active labor) • Other significant deviations from normal as assessed by the provider

Conditions Requiring Referral
The agency requires physician consultation and referral to a physician or hospital when emergency conditions in the following list arise intrapartum. In some intrapartum situations, due to urgency, it may not be prudent to pause medical treatment long enough to seek physician consultation or initiate transport.
• Labor before the completion of 37 weeks gestation, with known dates • Abnormal presentation or lie at time of delivery, including breech • Maternal desire for pain medication, consultation or referral • *Persistent non-reassuring fetal heart rate • Active genital herpes at the onset of labor • Thick meconium stained fluid with delivery not imminent • *Prolapse of the umbilical cord • Sustained maternal fever • *Maternal seizure • Abnormal bleeding (*hemorrhage requires emergent transfer) • Hypertension with or without additional signs or symptoms of pre-eclampsia • Prolonged failure to progress in active labor • *Sustained maternal vital sign instability and/or shock

*** These conditions require emergency transport.**

Postpartum

(Refers to the mother's care in the first 24 hours following the delivery of the placenta)

Conditions Requiring Consultation
The agency requires physician consultation and the client MAY require referral to a physician when the following maternal conditions arise postpartum.
• Development of any of the applicable conditions listed under Prenatal or Intrapartum • Significant maternal confusion or disorientation • Other significant deviations from normal as assessed by the provider

Conditions Requiring Referral
The agency requires physician consultation and referral when the following conditions arise postpartum.
• *Anaphylaxis or shock • Undelivered adhered or retained placenta with or without bleeding • *Significant hemorrhage not responsive to treatment • *Maternal seizure • Lacerations, if repair is beyond provider's level of expertise (3rd or 4th degree) • *Sustained maternal vital sign instability and/or shock • Development of maternal fever, signs/symptoms of infection or sepsis • *Acute respiratory distress • *Uterine prolapse or inversion

*** These conditions require emergency transport.**

Newborn

(Refers to the infant's care during the first 24 hours following birth)

Conditions Requiring Consultation
The agency requires a pediatric physician be consulted. The client MAY require a referral to an appropriate pediatric physician when the following conditions arise in a neonate.
• Apgar score $\leq$ 6 at five minutes of age • Birth weight < 2500 grams • Other significant deviations from normal as assessed by the provider

Conditions Requiring Referral

The agency requires that a pediatric physician be consulted and a referral made when the following conditions arise in a neonate.

- Birth weight < 2000 grams
- *Persistent respiratory distress
- *Persistent cardiac abnormalities or irregularities
- *Persistent central cyanosis or pallor
- *Prolonged temperature instability when intervention has failed
- *Prolonged glycemic instability (per neonatal resuscitation guidelines (NRP))
- *Neonatal seizure
- Clinical evidence of prematurity (gestational age < 36 weeks)
- Loss of > 10% of birth weight /failure to thrive
- Birth injury requiring medical attention
- Major apparent congenital anomalies
- Jaundice prior to 24 hours

*** These conditions require emergency transport.**

Authorization

What is the expedited prior authorization (EPA) process?

The agency's EPA process is designed to eliminate the need to request authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an EPA number when appropriate.

When do I need to create an EPA number?

You need to create an EPA number when administering drugs that are listed as "Not billable by a Licensed Midwife" in the fee schedule. For licensed midwives to be reimbursed by the agency for the administration of these drugs, the licensed midwife must meet the EPA criteria listed below.

How do I create an EPA number?

Once the EPA criteria are met, you must create a 9-digit EPA number. The first six digits of the EPA number will be 870000**.** The last three digits must be **690**, which meets the EPA criteria listed below.

Note: This EPA number is ONLY for the procedure codes listed in the fee schedule as "Not billable by a Licensed Midwife."

Note: See the agency's ProviderOne billing and resource guide for more information on requesting authorization.

EPA criteria for drugs not billable by licensed midwives

To use an EPA to bill CPT® codes 90371, J2540, S0077, J0290, J1364, the licensed midwife must meet all of the following:

- Obtained physician or standing orders for the administration of the drug listed as **not billable by a licensed midwife**
- Placed the physician or standing orders in the client's file
- Will provide a copy of the physician or standing orders to the agency upon request

Note: Enter the EPA number (870000690) in the *Prior Authorization* section of the electronic professional claim. **Do not handwrite the EPA number on the claim.**

Coverage Table

Due to its licensing agreement with the American Medical Association, the agency publishes only the official, short CPT® code descriptions. To view the entire description, see your current CPT book.

Use the following CPT codes when billing for Birth Center services:

Routine Prenatal Care

CPT Code	Modifier	Short Description	Comments
59425		Antepartum care, 4-6 visits.	Limited to 1 unit per client, per pregnancy, per provider.
59426		Antepartum care, 7 or more visits.	Limited to 1 unit per client, per pregnancy, per provider.
99211	TH	Office visits, Antepartum care 1-3 visits, w/obstetrical service modifier.	99211 – 99215 limited to 3 units total, per pregnancy, per provider. Must use modifier TH when billing.
99212	TH	Office/outpatient visit, est	
99213	TH	Office/outpatient visit, est	
99214	TH	Office/outpatient visit, est	
99215	TH	Office/outpatient visit, est	

Note: CPT codes 59425, 59426, or E&M codes 99211-99215 with normal pregnancy diagnoses may not be billed in combination during the entire pregnancy. **Do not bill the agency for prenatal care until all routine prenatal services are complete.**

Additional monitoring

CPT Code	Modifier	Short Description	Comments
99211	TH	Office/outpatient visit, est	
99212	TH	Office/outpatient visit, est	
99213	TH	Office/outpatient visit, est	
99214	TH	Office/outpatient visit, est	
99215	TH	Office/outpatient visit, est	

Note: Midwives who provide increased monitoring for routine prenatal care may bill using the appropriate E&M code with modifier TH.

Delivery (intrapartum)

CPT Code	Modifier	Short Description	Comments
59400		Obstetrical care (antepartum, delivery, and postpartum care)	
59409		Obstetrical care (delivery only)	
59410		Obstetrical care (delivery and postpartum only)	

Postpartum

HCPCS Code	Modifier	Short Description	Comments
59430		Care after delivery (postpartum only)	

Labor management

Bill these codes only when the client labors at the birth center or at home and is then transferred to a hospital, another provider delivers the baby, and a referral is made during active labor. The diagnoses must be related to complications during labor and delivery. The delivering physician may not bill for labor management. Prolonged services must be billed on the same claim as E&M codes along with modifier TH and one of the diagnoses listed above (all must be on each detail line of the claim).

CPT Code	Modifier	Short Description	Comments
Use when client labors at the birth center			
99211	TH	Office/outpatient visit, est (Use when client labors at birth center)	
99212	TH	Office/outpatient visit, est	
99213	TH	Office/outpatient visit, est	
99214	TH	Office/outpatient visit, est	
99215	TH	Office/outpatient visit, est	
Use when client labors at home			
99347	TH	Home visit, est patient	
99348	TH	Home visit, est patient	
99349	TH	Home visit, est patient	
99350	TH	Home visit, est patient	
And			
+ 99354 (Add-on code)	TH	Prolonged services, 1st hour. **Limited to 1 unit.**	
+ 99355 (Add-on code)	TH	Prolonged services, each add'l 30 minutes. **Limited to 4 units.**	

Other Codes

CPT Code	Modifier	Short Description	Comments
59020		Fetal contract stress test	
59020	TC	Fetal contract stress test	
59020	26	Fetal contract stress test	
59025		Fetal non-stress test	
59025	TC	Fetal non-stress test	
59025	26	Fetal non-stress test	
36415		Drawing blood	
84703		Chorionic gonadotropin assay	
85013		Hematocrit	
85014		Hematocrit	
A4266		Diaphragm	
A4261		Cervical cap for contraceptive use	
57170		Fitting of diaphragm/cap	
90371		Hep b ig, im	Not billable by a licensed midwife. For exception, see Authorization - Expedited Prior Authorization.
96372		Ther/Proph/Diag Inj, SC/IM	
J2790		Rh immune globulin	
J2540		Injection, penicillin G potassium, up to 600,000 units.	Not billable by a Licensed Midwife. For exception, see Authorization- Expedited Prior Authorization.

CPT Code	Modifier	Short Description	Comments
S0077		Injection, clindamycin phosphate, 300 mg.	Not billable by a Licensed Midwife. For exception, see Authorization- Expedited Prior Authorization.
J0290		Injection, ampicillin, sodium, up to 500mg. (use separate line for each 500 mg used)	Not billable by a Licensed Midwife. For exception, see Authorization- Expedited Prior Authorization.
J1364		Injection, erythromycin lactobionate, per 500 mg. (use separate line for each 500 mg used)	Not billable by a Licensed Midwife. For exception, see Authorization- Expedited Prior Authorization.
J7050		Infusion, normal saline solution, 250cc	
S5011		5% dextrose in lactated ringer, 1000 ml.	
J7120		Ringers lactate infusion, up to 1000cc	
96360		Hydration IV Infusion, Init	
96361		Hydrate IV Infusion, add On	
96365		Ther/proph/Diag IV Inf, Init	
96366		Ther/proph/Diag IV Inf add on	
J8499		Oral methergine 0.2 mg	Enter NDC on claim, see ProviderOne billing and resource guide for additional information
J2210		Injection methylergonovine maleate, up to 0.2mg	
J3475		Injection, magnesium sulfate, per 500 mg	
J2590		Injection, oxytocin	

CPT Code	Modifier	Short Description	Comments
J0170		Injection adrenalin, epinephrine, up to 1ml ampule	
J3430		Injection, phytonadione (Vitamin K) per 1 mg.	
90471		Immunization admin	
90472		Immunization admin, each add	List separately in addition to code for primary procedure.
S3620		Newborn metabolic screening panel, include test kit, postage and the laboratory tests specified by the state for inclusion in this panel.	Department of Health (DOH) newborn screening tests for metabolic disorders. Includes 2 tests on separate dates, one per newborn. DOH will bill the agency for this service.
92588		Newborn hearing screen	
99460		Init NB EM per day, Hosp	Newborn assessment for a baby born in a birth center that is admitted and discharged on the same day. Limited to one per newborn. Do not bill the agency if baby is born in a hospital.
99461		Init NB EM per day, Non-Fac	Newborn assessment for a home birth. Limited to (1) one per newborn.
99463		Same day NB discharge	Newborn assessment for a baby born in a birth center who is transferred to a hospital for care.
99465		NB Resuscitation	
92950		Cardiopulmonary resuscitation (e.g., in cardiac arrest)	

Facility Fee Payment

The agency reimburses for a facility fee only when services are performed in birth centers licensed by the Department of Health and have a current Core Provider Agreement with the agency.

CPT Code	Modifier	Short Description	Comments
59409	59 and SU	Delivery only code with use of provider's facility or equipment modifier.	Limited to one unit per client, per pregnancy. Facility fee includes all room charges, equipment, supplies, anesthesia administration, and pain medication.
S4005		Interim labor facility global (labor occurring but not resulting in delivery).	Limited to one per client, per pregnancy. May only be billed when client labors in the birth center and then transfers to a hospital for delivery.

Note: Payments for facility use are limited to only those providers who have been approved by the agency. When modifier SU is attached to the delivery code, it is used to report the use of the provider's facility or equipment only.

Home Birth Kit

HCPCS Code	Modifier	Short Description	Comments
S8415		Disposable supplies for home delivery of infant	Limited to one per client, per pregnancy.

What fees do I bill the agency?

See the agency's Planned Home Births and Births in Birth Centers Fee Schedule.

What does global (total) obstetrical care include?

Global obstetrical (OB) care (CPT code 59400) includes:

- Routine prenatal care in any trimester
- Delivery
- Postpartum care

If you provide all of the client's prenatal care, perform the delivery, and provide the postpartum care, you must bill using the global OB procedure code.

> **Note:** Bill the global obstetric procedure code if you performed all of the services and no other provider is billing for prenatal care, the delivery, or postpartum care. (See WAC 182-533-0400(5). If you provide all or part of the prenatal care and/or postpartum care but you do not perform the delivery, you must bill the agency for only those services provided using the appropriate prenatal and/or postpartum codes. In addition, if the client obtains other medical coverage or is transferred to an agency-contracted managed care organization (MCO) during pregnancy, you must bill for only those services provided while the client is enrolled with agency fee-for-service.

What does routine prenatal care include?

Prenatal care includes:

- Initial and subsequent history
- Physical examination
- Recording of weight and blood pressure
- Recording of fetal heart tones
- Routine chemical urinalysis
- Maternity counseling, such as risk factor assessment and referrals

Necessary prenatal laboratory tests may be billed in addition to prenatal care, **except for dipstick tests** (CPT codes 81000, 81002, 81003, and 81007).

In accordance with CPT guidelines, the agency considers routine prenatal care for a normal, uncomplicated pregnancy to consist of:

- Monthly visits up to 28 weeks gestation
- Biweekly visits to 36 weeks gestation
- Weekly visits until delivery
  (approximately 14 prenatal visits)

CPT Code	Modifier	Short Description	Comments
59426		Prenatal care, 7 or more visits	Limited to one unit per client, per pregnancy.
59425		Prenatal care, 4-6 visits	Limited to one unit per client, per provider per pregnancy.
99211-99215	TH	Office visits, prenatal care 1-3 visits only, w/obstetrical service modifier	

Note: Do not bill using CPT codes 59425, 59426, and E&M codes 99211-99215 with normal pregnancy diagnoses in combination with each other during the same pregnancy. **Do not bill the agency for prenatal care until all prenatal services are complete.**

What if an eligible client receives services from more than one provider?

When an eligible client receives services from more than one provider, the agency reimburses each provider for the services furnished. (WAC 182-533-0400(7))

Example: For a client being seen by both a midwife and a physician, the agency's reimbursement for the co-management of the client would be as follows:

- The physician would be paid for the consult office visits.
- The midwife would be paid for the prenatal visits.

Is obstetrical care allowed to be unbundled?

In the situations described below, you may not be able to bill the agency for global OB care. In these cases, it may be necessary to **unbundle** the OB services and bill the prenatal, delivery, and postpartum care separately, as the agency may have paid another provider for some of the client's OB care, or another insurance carrier may have paid for some of the client's OB care.

When a client transfers to your practice late in the pregnancy

- Do not bill the global OB package. Bill the prenatal care, delivery, and postpartum care separately if the client has had prenatal care elsewhere. The provider who had been providing the prenatal care prior to the transfer bills for the services performed. Therefore, if you bill the global OB package, you would be billing for some prenatal care that another provider has claimed.

- If the client did not receive any prenatal care prior to coming to your office, bill the global OB package. In this case, you may actually perform all of the components of the global OB package in a short time. The agency does not require you to perform a specific number of prenatal visits in order to bill for the global OB package.

If the client moves to another provider (not associated with your practice), moves out of your area prior to delivery, or loses the pregnancy

Bill only those services you actually provide to the client.

If the client changes insurance during pregnancy

When a client changes from one agency-contracted MCO to another, bill those services that were provided while the client was enrolled with the original MCO to the original carrier, and those services that were provided under the new coverage to the new MCO. You must unbundle the services and bill the prenatal, delivery, and postpartum care separately.

Often, a client will be eligible for fee-for-service at the beginning of pregnancy, and then be enrolled in an agency-contracted MCO for the remainder of pregnancy. The agency is responsible for reimbursing only those services provided to the client while the client is on fee-for-service. The MCO reimburses for services provided after the client is enrolled with the MCO.

Coding for prenatal care only

If it is necessary to unbundle the global package and bill separately for prenatal care, bill **one** of the following:

- If the client had a **total** of one to three prenatal visits, bill the appropriate level of **E&M service with modifier TH** for each visit with the date of service the visit occurred and the appropriate diagnosis.

  Modifier TH: Obstetrical treatment/service, prenatal or postpartum

- If the client had a total of four to six prenatal visits, bill using CPT code 59425 with a one (1) in the units box. Bill the agency using the date of the last prenatal visit in the *to* and *from* fields.

- If the client had a total of seven or more visits, bill using CPT code 59426 with a *one (1)* in the units box. Bill the agency using the date of the last prenatal visit in the *to* and *from* fields of the form.

Do not bill prenatal care only codes in addition to any other procedure codes that include prenatal care (i.e. global OB codes).

When billing for prenatal care, do not bill using CPT E/M codes for the first three visits, then CPT code 59425 for visits four through six, and then CPT code 59426 for visits seven and on. These CPT codes are used to bill only the total number of times you saw the client for all prenatal care during pregnancy, and may not be billed in combination with each other during the entire pregnancy period.

Note: Do not bill the agency until all prenatal services are complete.

Coding for deliveries

If it is necessary to unbundle the OB package and bill for the delivery only, bill the agency using one of the following CPT® codes:

- 59409 (vaginal delivery only)
- 59514 (cesarean delivery only)
- 59612 (vaginal delivery only, after previous cesarean delivery [VBAC])
- 59620 (cesarean delivery only, after attempted vaginal delivery after previous cesarean delivery [attempted VBAC])

If a provider does not furnish prenatal care, but performs the delivery and provides postpartum care, bill the agency one of the following CPT codes:

- 59410 (vaginal delivery, including postpartum care)
- 59515 (cesarean delivery, including postpartum care)
- 59614 (VBAC, including postpartum care)
- 59622 (attempted VBAC, including postpartum care)

Natural deliveries

For all natural deliveries for a client equal to or over 39 weeks gestation, bill using EPA #870001378. For a natural delivery before 39 weeks, use EPA #870001375.

CPTCode	Short Description	EPA Number
CPT: 59400, 59409, 59410	Elective delivery or natural delivery at or over 39 weeks gestation	870001378
CPT: 59400, 59409, 59410	Natural delivery before 39 weeks	870001375

Coding for postpartum care only

If it is necessary to unbundle the global OB package and bill for postpartum care only, you must bill the agency using CPT code 59430 (postpartum care only).

If you provide all of the prenatal and postpartum care, but do not perform the delivery, bill the agency for the prenatal care using the appropriate coding for prenatal care (see Authorization), along with CPT code 59430 (postpartum care only).

Do not bill CPT code 59430 (postpartum care only) in addition to any procedure codes that include postpartum care.

> **Note:** Postpartum care includes office visits for the six-week period after the delivery and includes family planning counseling.

Additional monitoring for high-risk conditions

When providing increased monitoring for the conditions listed below in excess of the CPT guidelines for normal prenatal visits, bill using E&M codes 99211-99215 with modifier TH. The office visits may be billed in addition to the global fee only after exceeding the CPT guidelines for normal prenatal care (i.e., monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery).

CPT Code	Modifier	Short Description	Comments
99211-99215	TH	Office visits; use for increased monitoring prenatal management for high-risk conditions.	See the Prenatal management/consultation & referral

If the client has one of the conditions listed above, the provider is not automatically entitled to additional payment. In accordance with CPT guidelines, it must be medically necessary to see the client **more often** than what is considered routine prenatal care in order to qualify for additional payments. **The additional payments are intended to cover additional costs incurred by the provider as a result of more frequent visits.**

> **Note:** Licensed midwives are limited to billing for certain medical conditions (see Prenatal management/consultation & referral) that require additional monitoring under this program.

For example:

Client A is scheduled to see the client's provider for prenatal visits on January 4, February 5, March 3, and April 7.

The client attends the January and February visits as scheduled. However, during the scheduled February visit, the provider discovers the client's blood pressure is slightly high and wants the client to come in on February 12 to be checked again. At the February 12 visit, the provider discovers the client's blood pressure is still slightly high and asks to see the client again on February 18. The February 12 and February 18 visits are outside of the client's regularly scheduled prenatal visits, and outside of the CPT guidelines for routine prenatal care since the client is being seen more often than once per month.

The February 12 and February 18 visits may be billed separately from the global prenatal visits using the appropriate E&M codes with modifier TH, and the diagnosis must represent the medical necessity for billing additional visits. **A normal pregnancy diagnosis will be denied outside of the global prenatal care**. **It is not necessary to wait until all services included in the routine prenatal care are performed to bill the extra visits, as long as the extra visits are outside of the regularly scheduled visits**.

Labor management

Providers may bill for labor management **only** when another provider (outside of your group practice) performs the delivery. If you performed the entire prenatal care for the client, attended the client during labor, delivered the baby, and performed the postpartum care, **do not** bill the agency for labor management. These services are included in the global OB package.

However, if you performed all of the client's prenatal care and attended the client during labor, but transferred the client to another provider (outside of your group practice) for delivery, you must unbundle the global OB package and bill separately for prenatal care and the time spent managing the client's labor. The client must be in active labor when the referral to the delivering provider is made.

To bill for labor management in the situation described above, bill the agency for the time spent attending the client's labor using the appropriate CPT E&M codes 99211-99215 (for labor attended in the office) or 99347-99350 (for labor attended at the client's home). In addition, the agency will reimburse providers for up to three hours of labor management using prolonged services CPT codes 99354-99355 with modifier TH. Reimbursement for prolonged services is limited to three hours per client, per pregnancy, regardless of the number of calendar days a client is in labor, or the number of providers who provide labor management. Labor management may not be billed by the delivering provider, or by any provider within the delivering provider's group practice.

Note: The E&M code and the prolonged services code must be billed on the same claim.

CPT Code	Modifier	Short Description	Comments
99211–99215	TH	Office visits – labor at birth center	
99347-99350	TH	Home visits – labor at home	
+99354	TH	Prolonged services, First hour	Limited to one unit
+99355	TH	Prolonged services, each add'l 30 minutes	Limited to four units

Does the agency pay for newborn screening tests?

The midwife or physicians will collect the blood for the newborn screening and send it to DOH. DOH will bill the agency for payment of HCPCS code S3620. The newborn screening panel includes:

- Biotinidase deficiency
- Congenital adrenal hyperplasia (CAH)
- Congenital hypothyroidism
- Homocystinuria
- Phenylketonuria (PKU)
- Galactosemisa
- Hemoglobinopathies
- Homocystinuria
- Maple Syrup Urine Disease (MSUD)
- Medium chain acyl-CoA dehydrogenase deficiency (MCAD deficiency)
- Severe combined immunodeficiency (SCID)

Note: Payment includes two tests for two different dates of service, **allowed once per newborn**. Do not bill HCPCS code S3620 if the baby is born in the hospital. This code is only for outpatient services in birth centers, physician offices, and homes in which midwives provide home births.

How is the administration of immunizations billed?

Immunization administration CPT® codes 90471 and 90472 may be billed only when the materials are not received free of charge from DOH. For information on Immunizations, see the agency's Physician-related services/healthcare professional services billing guide or Early periodic screening, diagnosis & treatment (EPSDT) billing guide.

How are home-birth supplies billed?

Home-birth supplies are billed using HCPCS code S8415. Payment is limited to one per client, per pregnancy.

HCPCS Code	Description	Limits
S8415	Supplies for home delivery of infant	Limited to one per client, per pregnancy.

Are medications billed separately?

Certain medications can be billed separately and are listed on the fee schedule. Some of the medications listed in the agency's fee schedule are not billable by licensed midwives. By law, a licensed midwife may obtain and administer only certain medications. Drugs listed as **not billable by a licensed midwife** must be obtained at a pharmacy with a physician's order. **(See** EPA criteria for drugs not billable by licensed midwives).

Long Acting Reversible Contraception (LARC)

For information regarding family planning services including long acting reversible contraceptives (LARC), see the Family planning billing guide.

Note: Drugs must be billed using the procedure codes listed in the fee schedule and they are reimbursed at the agency's established maximum allowable fees. Name, strength, and dosage of the drug must be documented and retained in the client's file for review at the agency's request.

How are newborn assessments billed?

Home birth setting

To bill for a newborn assessment completed at the time of the home birth, providers must bill using CPT code 99461. Reimbursement is **limited to one per newborn.** Do not bill CPT code 99461 if the baby is born in a hospital. Bill on a separate claim . On the claim, answer "Yes" to the question, "Is the claim for a Baby on Mom's Client ID?" And enter SCI=B in the *Claim Note* section of the claim.

Birth center births

To bill for a newborn assessment completed at the time of a birth center birth for a baby that is admitted and discharged on the same day, use CPT code 99460. For a baby that is born in a birth center, when a newborn assessment is completed and the baby is transferred to a hospital for care, bill with CPT code 99463.

How do I bill for neonates/newborns?

For services provided to a newborn who has not yet received a Services Card, bill the agency using the parent's ProviderOne Client ID in the appropriate fields on the claim. For more information on how to bill for neonates, including infants who will be placed in foster care, see Inpatient hospital services billing guide.

When billing electronically for twins using the mother's ProviderOne number, enter each twin's identifying information in the *Billing Note* section of the claim. Use the following claim indicators to identify the infant being serviced: SCI=BA for twin A, SCI=BB for twin B, and SCI=BC for a third infant, in the case of triplets. The agency will deny the claim if there is no identifying information for the twin.

Note: Bill services for mothers on separate claims.

How is the facility fee billed in birth centers?

Note: The midwife may bill the agency for the facility fee or facility transfer fee payment. The agency pays the midwife, who then reimburses the approved birth center. See Resources Available for a list of approved birth centers.

Facility Fee – When billing for the facility fee, use CPT code 59409 with modifiers SU and 59. Only a facility licensed as a childbirth center by DOH and approved by the agency is eligible for a facility fee. Bill this fee only when the baby is born in the facility. The facility fee includes all room charges for client and baby, equipment, supplies, anesthesia administration, and pain medication. The facility fee does not include other drugs, professional services, newborn hearing screens, lab charges, ultrasounds, other x-rays, blood draws, or injections.

Facility Transfer Fee – The facility transfer fee may be billed when the mother is transferred in active labor to a hospital for delivery there. Use CPT code S4005 when billing for the facility transfer fee.

Procedure Code	Modifier	Description	Limits
59409	59 SU	Delivery only code with use of provider's facility or equipment modifier.	Limited to one per client, per pregnancy.
S4005		Interim labor facility global (labor occurring but not resulting in delivery)	Limited to one per client, per pregnancy may only be billed when client labors in the birth center and then transfers to a hospital for delivery.

Note: Payments to midwives for facility use are limited to only those birth centers that have been approved by the agency. When modifier SU is attached to the delivery code, it is used to report the use of the provider's facility or equipment only. The name of the birth center must be entered in the *Service Facility* section under the Other Claim Info tab.

What additional documentation must be kept in the client's record?

WAC 182-533-0600, WAC 182-502-0020

Prenatal care records

- Initial general (Gen) history, physical examination, and prenatal lab tests
- Gynecological (Gyn) history, including obstetrical history, physical examination, and standard lab tests. Ultrasound, if indicated
- Subsequent Gen/Gyn history, physical and lab tests
- Client's weight, blood pressure, fetal heart tones, fundal height, and fetal position at appropriate gestational age
- Consultation, referrals, and reason for transferring care, if necessary
- Health education and counseling
- Consultation or actual evaluation by the consulting physician for any high-risk condition
- Risk screening evaluation

Intrapartum/postpartum care records

- Labor, delivery, and postpartum periods
- Maternal, fetal, and newborn well-being, including monitoring of vital signs, procedures, and lab tests
- Any consultation referrals and reason for transferring care, if necessary
- Initial pediatric care for newborn, including the name of the pediatric care provider, if known
- Postpartum follow-up, including family planning

Informed consent materials

Copy of informed consent, including all of the following:

- Scope of maternal and infant care
- Description of services provided, including newborn screening, prophylaxis eye treatment, and screening for genetic heart defects

> **Note:** Parents may refuse. Documentation must include a signed waiver for each service that is declined.

- Limitations of technology and equipment in the home birth setting
- Authority to treat
- Plan for physician consultation or referral
- Emergency plan
- Informed assumption of risks
- Client responsibilities and requirements

Billing

All claims must be submitted electronically to the agency, except under limited circumstances.
For more information about this policy change, see Paperless billing at HCA.
For providers approved to bill paper claims, see the agency's Paper claim billing resource.

What are the general billing requirements?

Providers must follow the agency's ProviderOne billing and resource guide. These billing requirements include:

- What time limits exist for submitting and resubmitting claims and adjustments
- When providers may bill a client
- How to bill for services provided to primary care case management (PCCM) clients
- How to bill for clients eligible for both Medicare and Medicaid
- How to handle third-party liability claims
- What standards to use for record keeping

Can more than one EPA number be submitted on the same claim?

Yes. Expedited prior authorization (EPA) numbers for drugs billed by a licensed midwife and the EPA number for a natural delivery may be billed on the same claim.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency's Billers, providers, and partners webpage.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the HIPAA electronic data interchange (EDI) webpage.

The following claim instructions relate specifically to planned home births and births in birth centers:

Name	Entry
Claim Note	When billing for baby using the parent's ProviderOne Client ID, answer "Yes" to the question, "Is the claim for a Baby on Mom's Client ID?" and **enter** *SCI=B*
Prior Authorization Number	To be reimbursed for drugs listed in fee schedule as *Not billable by a Licensed Midwife*, enter the EPA number 870000690. (See Coverage Table)
Place of Service	Enter the appropriate two digit code as follow: Use code 11 for "Office" Use code 12 for "Home" Use code 25 "Birth Center"
Service Facility (under the Other Claim Info tab)	Enter the name of the birth center.