Washington State Health Care Authority

Medicaid Provider Guide

Planned Home Births and Births in Birthing Centers

(WAC 182-533-0400 & WAC 182-533-0600)

January 1, 2014

A Billing Instruction

About this guide

This publication, by the Health Care Authority (agency), supersedes all previous *Planned Home Births and Births in Birthing Centers Medicaid Provider Guides* published by the agency.

What has changed?

Reason for Change	Effective Date	Subject	Change
PN 13-102	1/1/2014	Definitions	Add the words "Kit contains disposable" to the definition of **Home birth kit**.
		Coverage Table-Medications	Add HCPCS code **J3490** for Eye ointment.
		Does the agency pay for newborn screening tests?	Add Biotinidase deficiency, Congenital hypothyroidism, Hemoglobinopathies, Homocystinuria, and Severe combined immunodeficiency (SCID)" to the bulleted list for newborn screening panels.
		What additional documentation must be kept in the client's record?	**Informed consent list** – To the second bullet in the list – Add the words: "including newborn screening and prophylaxis eye treatment". To the last bullet in the list - Add the words: "and requirements".

How can I get agency provider documents?

To download and print agency provider notices and Medicaid provider guides, go to the agency's Provider Publications website.

Table of Contents

Alert! The page numbers in this table of contents are now "clickable"—do a "control + click" on a page number to go directly to a spot. As an Adobe (.pdf) document, the guide also is easily navigated by using bookmarks on the left side of the document. If you don't immediately see the bookmarks, right click on the gray area next to the document and select Page Display Preferences. Click on the bookmark icon on the left.)

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Resources Available

Note: The table below contains resources and information relevant to Planned Home Births and Births in Birthing Centers. For more contact information, see the agency's Resources Available web page.

Topic	Contact Information
Policy questions or exception to Rule questions	Planned Home Births and Births in Birthing 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 web page Email: Contact Medicaid Phone: 360-725-1655
Which birthing centers are agency-approved birthing centers?	• Bellingham Birthing Center – Bellingham, WA • Best Beginnings Birth Center-Lynnwood, WA • Birthing Inn -Tacoma, WA • Birthright LLC-Spokane, WA • Cascade Birth Center-Everett, WA • Center for Birth LLC-Seattle, WA • Columbia Birth Center-Kennewick, WA • Community Birth and Family Center-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 • Seattle Home Maternity Services and Childbirth Center-Seattle, WA • Seattle Naturopathy Acupuncture, and Childbirth Center-Seattle, WA • Wenatchee Midwife and Childbirth Center-Wenatchee, WA

Definitions

This list defines terms and abbreviations, including acronyms, used in this Medicaid provider guide. See the agency's Medical Assistance Glossary for a more complete list of definitions.

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

Birthing Center Provider – Any of the following individuals, who have a Core Provider Agreement with the agency to deliver babies in a birthing 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 Birthing 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 woman'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 birthing 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 birthing center or home birth provider to the consulting physician.

Facility fee – The portion of the agency's payment for the hospital or birthing 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 antepartum 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 contains that disposable supplies that are used in a planned home birth (**see** list of supplies required).

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 who is licensed as an ARNP, or a physician.

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 submitted to the Washington Health and Recovery Services Administration for medical services provided in an office, nursing facility, hospital, outpatient, emergency room, or other place of service.

Planned Home Births and Births in Birthing Centers

What does Planned Home Births and Births in Birthing Centers Provide?

The Planned Home Births and Births in Birthing Centers 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 women to give birth in an out-of-hospital setting.

When does the agency cover Planned Home Births and Births in Birthing Centers?

(WAC 182-533-0600(1))

The agency covers planned home births and births in birthing centers 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 birthing 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 birthing 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 birthing center facility?

(WAC 182-533-0600(3))

An agency-approved birthing center facility must:

- Be licensed as a childbirth center by the Department of Health (DOH) as defined in chapter 246-329-010 WAC.
- Be specifically approved by the agency to provide birthing center services (see Resources Available for a list of approved centers).
- Have a valid core provider agreement (CPA) with the agency.
- Maintain standards of care required by DOH for licensure.

The agency suspends or terminates the core provider agreement of a birthing center if it fails to maintain DOH standards.

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

(WAC 182-533-0600(2),(5), and (6))

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

- Have a core provider agreement (CPA) with the agency.
- 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.
- Have current, written, and appropriate plans for consultation, emergency transfer, and transport of client and/or newborn to a hospital.

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

- Follow the agency's Risk Screening Guidelines (see Prenatal Management/Risk Screening Guidelines) and consult with and/or refer the client or newborn to a physician or hospital when medically appropriate.

- Make appropriate referral of the newborn for pediatric care and medically necessary follow-up care.

- Inform parents of the benefits of a newborn screening test and offer to send the newborn's blood sample to DOH for testing (the parent may refuse this service). The provider must pay DOH for the cost of the tests and then bill agency for reimbursement.

In addition, agency-approved home birth providers must send the following documentation to the Planned Home Birth and Birthing Center Program Manager (see Resources Available):

- Provide certificate of current license as midwife or licensed nurse midwife

- The names and NPI number of back up midwives that are current Medicaid providers and will provide 24 hour-per-day coverage

- Documentation of local area emergency medical services and emergency response capability in the area

- Professional consultation plan and referral

- Copy of midwifes informed consent that including newborn screening, prophylactic eye ointment, and vitamin K injection

- Documentation of participation in a formal, state sanctioned, quality assurance/improvement program or professional liability review process (e.g., programs offered by Joint Underwriting Association (JUA), Midwives' Association of Washington State (MAWS), etc.)

- Copy of the of the midwifery and birth center professional liability policy

What equipment, supplies, and medications are 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

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)
Neonatal ophthalmic ointment (or other approved eye prophylaxis)
IV fluids, one or more liters of LR

Disposable supplies home birth kit contains:

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

Client Eligibility

How can I verify a patient's eligibility?

Providers must verify that a patient has Washington 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.

Verifying eligibility is a two-step process:

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

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

Step 2. **Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's Health Care Coverage—Program Benefit Packages and Scope of Service Categories web page.

Note: Patients who are not Washington 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 managed care plan eligible?

(WAC 182-533-0400(2))

Yes! When verifying eligibility using ProviderOne, if the client is enrolled in an agency managed care plan, 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, women may go directly to a specialist in women's health without a referral from her PCP. However, the provider **must be within** her managed care plan's provider network.

The client must obtain all medical services covered under a managed care plan through designated facilities or providers. The managed care plan is responsible for:

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

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

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

> **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 plan. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

Are Primary Care Case Management (PCCM) clients covered?

For the client who chooses to obtain care with a PCCM provider, this information will be displayed on the client benefit inquiry screen in ProviderOne. These clients must obtain or be referred for services by a PCCM provider. The PCCM provider is responsible for coordination of care just as if the PCP would be in a plan setting. The Woman's Direct Access health care law does not apply to PCCM clients. The referral number is required on the CMS-1500 claim form.

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 PCCM provider. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

First Steps Program Services

All pregnant women receiving medical assistance qualify for First Steps. The First Steps program helps low-income pregnant women 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 she is pregnant. First Steps services are supplemental services that include Maternity Support Services (MSS), Childbirth Education, and Infant Case Management (ICM).

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 women 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 family situations that place infants at higher risk of having problems. Infant Case Management (ICM) that starts in the baby's third month (after MSS concludes) can help a client learn to use the resources in her community so that the baby and family can thrive. Infant case management may start at any time during the child's first year. It continues through the month of the infant's first birthday.

For further information on the MSS/ICM program, visit the First Steps web page.

Childbirth Education

Childbirth education classes are available to all Medicaid eligible women. Instruction takes place in a group setting and may be completed over several sessions. Childbirth education is intended to help the client and her support person(s) 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 web page.

Also, see the agency's Childbirth Education Medicaid Provider Guide.

For more information about First Steps services and/or to receive a list of contracted providers, contact the First Steps Program Manager at 360-725-1293 or the visit the First Steps web page.

Prenatal Management/ 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 required documentation as listed below.

The diagnoses listed below are suitable for management by the midwife, but do require more visits to monitor the client. Documentation of more visits is required in the client's chart.

Diagnosis Code	Condition
640.03	Threatened abortion **(first trimester).** **(May be managed by the midwife without consultation with a physician.)**
643.03	Mild hyperemesis gravidarum **(May be managed by the midwife and will require more visits to monitor the client.)**
648.83	Abnormal glucose tolerance in a gestational diabetic *(***If the condition is responsive to treatment (i.e., controlled by diet alone.)**

The diagnoses listed on the next page are suitable for prenatal co-management by a home birth or birthing center provider and a consulting physician. If a physician is the provider, that physician should consult with another physician as needed. These diagnoses require more frequent monitoring and the agency allows additional payment(s) to the provider (see Authorization).

The client's record must contain either documented consultation or actual evaluation by a consulting physician in order for the provider to be reimbursed for the following diagnosis codes:

Diagnosis Code	Condition
642.03	Benign essential hypertension complicating pregnancy, childbirth, puerperium (controlled without medication)
642.33	Transient hypertension of pregnancy
644.03	Threatened premature labor **(after consultation and/or referral to a physician, and the midwife and physician have determined the client is stable and appropriate for close monitoring by the midwife)**
648.23	Anemia **(Hct < 30 or Hgb < 10) – Unresponsive to treatment**

Risk screening criteria

(WAC 182-533-0600(7))

The following conditions are high-risk factors. The agency does not approve or cover planned home births or births in birthing centers for women with a history of or identified with any of these factors.

- 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 site of delivery
- Known multiple gestation
- Known 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(20))

For information about smoking cessation, see **Behavior change intervention – smoking cessation** in the **Physician-Related Services/Health Care Professional Services Mediciad Provider Guide.**

Prenatal Management/Consultation & Referral

Definitions below apply to the following tables labeled *Indications for Consultation & Referral antepartum.*

Consultation - The process whereby the provider, who maintains primary management responsibility for the woman'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:

- Telephone, 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 and/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 birthing 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 antepartum* table may require either a consultation or referral. Provider 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.

Indications for consultation and referral antepartum

(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 and/or hospital when emergency conditions in the following list arise intrapartum.

Note: In some intrapartum situations, due to time 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 Antepartum and/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 (3^{rd} or 4^{th} 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 ≤ 6 at five minutes of age • Birth weight < 2500 grams • Abnormal jaundice • 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 • *Neonatal seizure • Clinical evidence of prematurity (gestational age < 35 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

Note: See the agency's ProviderOne Billing and Resource Guide for more information on requesting 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, the you must create a 9-digit EPA number. The first six digits of the EPA number must 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".

EPA criteria for drugs not billable by licensed midwives

Procedure Codes: 90371, J2540, S0077, J0290, J1364

690 Licensed midwife has met all of the following:

- Obtained physician or standing orders for the administration of the drug(s) 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: Billing - Enter the EPA number (**870000690**) in field 23 (Prior Authorization) on the CMS-1500 claim form. **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 Birthing Center services:

Code Status Indicator	CPT Code	Modifier	Short Description	Policy/ Comments
Routine Antepartum Care				
Note: CPT codes 59425, 59426, or E&M codes 99211-99215 with normal pregnancy diagnoses V22.0-V22.2, **may not** be billed in combination during the entire pregnancy. **Do not bill the agency for antepartum care until all routine antepartum services are complete.**				
	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	
Additional Monitoring				
Note: Midwives who provide increased monitoring for the diagnoses listed on page C.1 and C.2 and are seen in excess of the CPT guidelines for routine antepartum care may bill using the appropriate E&M code with modifier TH.				
	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	

Code Status Indicator	CPT Code	Modifier	Short Description	Policy/ Comments
Delivery (Intrapartum)				
	59400		Obstetrical care (prenatal, delivery, and postpartum care)	
	59409		Obstetrical care (delivery only)	
	59410		Obstetrical care (delivery and postpartum only)	
Code Status Indicator	**HCPCS Code**	**Modifier**	**Short Description**	**Policy/ Comments**
Medications				
	J3490		Eye ointment	
Code Status Indicator	**CPT Code**	**Modifier**	**Short Description**	**Policy/ Comments**
Postpartum				
	59430		Care after delivery (postpartum only)	
Labor Management				
Note: Bill only when the client labors at the birthing 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 following diagnoses must be used 640–674.9, V22.0–V22.2, and V23–V23.9.				
Note: The delivering physician may not bill for labor management. Prolonged services must be billed on the same claim form 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 form).				
Code Status Indicator	**CPT Code**	**Modifier**	**Short Description**	**Policy/ Comments**
Use when client labors at birthing center				
	99211	TH	Office/outpatient visit, est (Use when client labors at birthing 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	
OR – 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	
Code Status Indicator	**CPT Code**	**Modifier**	**Short Description**	**Policy/ Comments**
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				
	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.
	S0077		Injection, clindamycin phosphate, 300 mg.	Not billable by a Licensed Midwife. For exception, see Authorization- Expedited Prior Authorization.

Code Status Indicator	CPT Code	Modifier	Short Description	Policy/ Comments
	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	
	J2210		Injection methylergonovine maleate, up to 0.2mg	
	J3475		Injection, magnesium sulfate, per 500 mg	
	J2590		Injection, oxytocin	
	J0170		Injection adrenalin, epinephrine, up to 1ml ampule	
	J3430		Injection, phytonadione (Vitamin K) per 1 mg.	
	90708		Measles-rubella vaccine, sc	
	90471		Immunization admin	
	90472		Immunization admin, each add	List separately in addition to code for primary procedure.

Code Status Indicator	CPT Code	Modifier	Short Description	Policy/ Comments
	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 newborn screening tests for metabolic disorders. Includes 2 tests on separate dates. one per newborn.
	99460		Init NB EM per day, Hosp	Newborn assessment for a baby born in a birthing 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 birthing 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 Birthing Centers licensed by the Department of Health, and have a Core Provider Agreement with the agency. The facility payments listed below will be billed by and paid to the midwife who must then reimburse the birthing center.				
Code Status Indicator	**CPT Code**	**Modifier**	**Short Description**	**Policy/ 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 birthing 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 Supplies				
Code Status Indicator	**HCPCS Code**	**Modifier**	**Short Description**	**Policy/ Comments**
Home Birth Kit				
	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 Birthing Centers Fee Schedule

Billing and Claim Forms

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.

What does global (total) obstetrical care include?

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

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

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

> Bill the global obstetric procedure code if you performed all of the services and no other provider is billing for antepartum care, the delivery, or postpartum care. (See WAC 182-533-0400(5). If you provide all or part of the antepartum 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 antepartum and/or postpartum codes. In addition, if the client obtains other medical coverage or is transferred to an agency managed care plan during her pregnancy, you must bill for only those services provided while the client is enrolled with agency fee-for-service.

What does routine antepartum care include?

Antepartum 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 antepartum care, **except for dipstick tests** (CPT codes 81000, 81002, 81003, and 81007).

In accordance with CPT guidelines, the agency considers routine antepartum 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 antepartum visits).

CPT Code	Modifier	Short Description	Policy/ Comments
59426		Antepartum care, 7 or more visits	Limited to one unit per client, per pregnancy.
59425		Antepartum care, 4-6 visits	Limited to one unit per client, per provider per pregnancy.
99211-99215	TH	Office visits, antepartum care 1-3 visits only, w/obstetrical service modifier	Diagnoses V22.0-V22.2 limited to 3 units, must use modifier TH with diagnoses to be reimbursed.

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 antepartum care until all antepartum services are complete.**

When an eligible client receives services from more than one provider, the agency reimburses each provider for the services furnished (see 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 antepartum 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 antepartum, 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 antepartum care, delivery, and postpartum care separately if the client has had antepartum care elsewhere. The provider who had been providing the antepartum care prior to the transfer bills for the services that he/she performed. Therefore, if you bill the global OB package, you would be billing for some antepartum care that another provider has claimed.

-OR-

- If the client did not receive any antepartum 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 antepartum 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 her pregnancy…

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

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

Coding for antepartum care only

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

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

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

When billing for antepartum 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 antepartum care during her pregnancy, and **may not** be billed in combination with each other during the entire pregnancy period.

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

Coding for deliveries

If it is necessary to unbundle the global OB package and bill for the delivery only, you must bill the agency using the vaginal delivery only code (CPT code 59409).

If you do not provide antepartum care, but perform the delivery and provide postpartum care, bill the agency using the vaginal delivery, including postpartum care code (CPT code 59410).

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 antepartum and postpartum care, but do not perform the delivery, bill the agency for the antepartum care using the appropriate coding for antepartum 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.

Increased monitoring

When providing **increased monitoring** for the conditions listed below in excess of the CPT guidelines for normal antepartum 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 antepartum 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	Policy/ Comments
99211-99215	TH	Office visits; use for increased monitoring prenatal management	Limited to diagnoses: 640.03, 642.03, 642.33, 643.03, 644.03, 648.23, 648.83. Must have –TH to pay midwives.

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 antepartum 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 and Referral) that require additional monitoring under this program.

For example:

Client A is scheduled to see her provider for her antepartum visits on January 4, February 5, March 3, and April 7.

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

The February 12 and February 18 visits may be billed separately from the global antepartum 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 (i.e. V22.0 – V22.2) will be denied outside of the global antepartum care**. **It is not necessary to wait until all services included in the routine antepartum 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 antepartum 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 antepartum 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 antepartum 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 with modifier TH** (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(s) **must** be billed on the same claim form.

CPT Code	Modifier	Short Description	Policy/ Comments
99211–99215	TH	Office visits – labor at birthing center	Diagnoses 640–674.9, V22.0–V22.2, and V23–V23.9 must have modifier TH to be reimbursed with these diagnoses, labor management may not be billed by delivering physician.
99347-99350	TH	Home visits – labor at home	
+99354 **Limited to one unit**	TH	Prolonged services, First hour	
+99355 **Limited to four units**	TH	Prolonged services, each add'l 30 minutes	

Does the agency pay for newborn screening tests?

A midwife or physician may bill the agency for payment of HCPCS code S3620 after paying the DOH for the cost of the newborn screening tests for metabolic disorders. 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 because the hospital has been charged for the tests.

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 Medicaid Provider Guide or Early Periodic Screening, Diagnosis & Treatment (EPSDT) Medicaid Provider Guide.

How are deposable supplies (home birth kit) billed?

When disposable items are used, bill the agency for a home birth kit using HCPCS code S8415. Payment is **limited to one per client, per pregnancy.**

HCPCS Code	Summary of 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**)**.

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 form and enter a ***B*** in field 19 of the form for baby under mother's Client ID.

Birthing center births

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

How is the facility fee billed in birthing centers?

Note: The midwife must bill the agency for the facility fee or facility transfer fee payment. The agency pays the midwife, who then reimburses the approved birthing center. See Resources Available for a list of approved birthing 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 mother and baby, equipment, supplies, anesthesia administration, and pain medication. The facility fee does not include other drugs, professional services, lab charges, ultrasound, 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	Summary of 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 birthing center and then transfers to a hospital for delivery.

Note: Payments to midwives for facility use are limited to only those birthing 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 birthing center must be entered in field 32 on the CMS-1500 claim form.

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

(WAC 182-533-0600)

Antepartum care

- 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

- 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

- Copy of informed consent, including all of the following:

  - ✓ Scope of maternal and infant care
  - ✓ Description of services provided, including newborn screening and prophylaxis eye treatment
  - ✓ 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

What is the National Correct Coding Initiative (NCCI)?

The National Correct Coding Initiative (NCCI) was created by the Centers for Medicare and Medicaid Services (CMS) to promote national correct coding methods. NCCI assists the agency to control improproper codeing that may lead to inappropriate payment.
NCCI coding policies do not supersede the agency's current Washington Administrative Code (WAC) regarding coverage and reimbursement policies or the agency's Medicaid provider guides and provider notices.

For more information, see the National Correct Coding Initiative.

How is the CMS-1500 claim form completed?

Note: See the agency's ProviderOne Billing and Resource Guide for general instructions on completing the CMS-1500 claim form.

The following CMS-1500 claim form instructions relate to planned home births and births in birthing centers:

Field No.	Name	Entry
19.	**Reserved for Local Use**	When billing for baby using the parent's ProviderOne Client ID, **enter** *B*
23.	**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)
24B.	**Place of Service**	Enter the appropriate two digit code as follow: **Code Number / To Be Used For** 11 Office 12 Home 25 Birthing Center
32.		Enter the name of the birthing center.