

Washington State Health Care Authority

Medicaid Provider Guide

Planned Home Births and Births in Birthing Centers
[WAC 182-533-0400 & WAC 182-533-0600]



Washington State
Health Care Authority

A Billing Instruction

About this Guide

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

What Has Changed?

Reason for Change	Effective Date	Section/ Page No.	Subject	Change
July Fee Schedule and Coverage Changes	July 1, 2011	E.5 and F.9	Facility Fee Payment	Add Modifier 59 for Procedure Code 59409 Facility Fee Payment

Copyright Disclosure

CPT is a registered trademark of the American Medical Association.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

CPT Copyright 2012 American Medical Association. All rights reserved.

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

Important Contacts	iii
Definitions & Abbreviations	1
Section A: About Planned Home Births and Births in Birthing Centers	
What Is Planned Home Births and Births in Birthing Centers?.....	A.1
When Does the Agency Cover Planned Home Births and Births in Birthing Centers?.....	A.1
What Are the Requirements to Be an Agency-Approved Birthing Center Facility?.....	A.1
What Are the Requirements to Be an Agency-Approved Planned Home Birth Provider or Birthing Center Provider?	A.2
What Equipment, Supplies, and Medications Are Required for a Planned Home Birth?.....	A.3
Section B: Client Eligibility	
Who Is Eligible for Full-Scope Maternity Care and Newborn Delivery Services?	B.1
Are Clients Enrolled in an Agency Managed Care Plan Eligible?	B.1
Primary Care Case Management (PCCM).....	B.2
First Steps Program Services	B.3
Section C: Prenatal Management/Risk Screening Guidelines	
Prenatal Management.....	C.1
Risk Screening Guidelines	C.2
Smoking Cessation for Pregnant Women	C.3
Prenatal Management/Consultation & Referral.....	C.4
Indications for Consultation and Referral.....	C.5
Antepartum	C.5
Intrapartum	C.6
Postpartum	C.7
Newborn	C.8
Section D: Authorization	
Expedited Prior Authorization (EPA).....	D.1
What is the EPA Process?.....	D.1
When do I need to create an EPA number?.....	D.1
How do I create an EPA number?	D.1
EPA Criteria for Drugs “Not Billable by Licensed Midwives”	D.2

Table of Contents (cont.)

Section E: Coverage Table

Routine Antepartum Care	E.1
Additional Monitoring	E.1
Delivery (Intrapartum)	E.2
Postpartum	E.2
Labor Management	E.2
Other	E.3
Facility Fee Payment.....	E.5
Home Birth Supplies.....	E.6
Home Birth Kit	E.6

Section F: Billing and Claim Forms

Global (Total) Obstetrical Care	F.1
Unbundling Obstetrical Care	F.1
Routine Antepartum Care	F.2
Coding for Antepartum Care Only	F.3
Coding for Deliveries	F.4
Coding for Postpartum Care Only	F.4
Increased Monitoring	F.5
Labor Management	F.6
Department of Health Newborn Screening Tests	F.7
Immunizations.....	F.7
Home Birth Kit	F.8
Medications.....	F.8
Newborn Assessment – Home Birth Setting	F.8
Billing - Specific to Birthing Centers (Facility Fees)	F.9
Billing - General to all Medical Assistance Programs.....	F.10
What Additional Documentation Must Be Kept in the Client’s Record?.....	F.10
National Correct Coding Initiative (CCI)	F.11
Completing the CMS-1500 Claim Form.....	F.12

Important Contacts

Note: This section contains important contact information relevant to Planned Home Births and Births in Birthing Centers. For more contact information, see the agency [Resources Available](#) web page

Topic	Contact Information
Policy questions or Exception to Rule questions	Planned Home Births and Births in Birthing Centers Program Manager MPA Program Mgmt & Authorization Section PO Box 45506 Olympia, WA 98504-5506 FAX 1-360-725-1966
Newborn screenings	Department of Health 1-206-361-2890 or 1-866-660-9050 Email: nbs.prog@doh.wa.gov
Medical Information	University of Washington Med Con Line 1-800-326-5300 (toll free)
Maternity Support Services/Infant Case Management	First Steps website: http://maa.dshs.wa.gov/firststeps/index.htm Email: Firststeps@dshs.wa.gov Phone: 1-360-725-1655
Which Birthing Centers are Agency-Approved Birthing Centers?	<ul style="list-style-type: none"> • 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 & Abbreviations

[Refer to [WAC 182-533-0400](#)]

This section defines terms and abbreviations, including acronyms, used in this Medicaid provider guide. Please refer to the Agency's online [Medical Assistance Glossary](#) for a more complete list of definitions.

Authorization Number – A 9-digit number assigned by the Agency that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pending, or denied.

Birthing Center – A specialized facility licensed as a childbirth center by the Department of Health (DOH) [Refer to [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](#); or
- 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; or
- 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.

Planned Home Births and Births in Birthing Centers

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

Home birth kit – Disposable supplies that are used in a planned home birth. (See [list of supplies required](#) on page A.3.)

Home Birth Provider -

- A midwife currently licensed in the State of Washington under [chapter 18.50 RCW](#); or
- Nurse-midwife currently licensed in the State of Washington under [chapter 18.79 RCW](#); or
- 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.

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.

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 provide a safe alternative delivery setting to pregnant medical assistance 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?

[Refer to [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 CN or MN scope of care (see *Client Eligibility* section);
- 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); and
- Passes Agency's risk screening criteria. (For risk screening criteria, see Section C).

What Are the Requirements to Be an Agency-Approved Birthing Center Facility? [Refer to [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 the Important Contacts section for a list of approved centers);
- Have a valid core provider agreement (CPA) with the Agency; and
- 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?

[Refer to [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](#); or
 - ✓ Nurse midwife under [chapter 18.79 RCW](#); or
 - ✓ Physician under chapters [18.57](#) or [18.71](#) RCW; and
- Have evidence of current cardiopulmonary resuscitation (CPR) training for:
 - ✓ Adult CPR; and
 - ✓ 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, including the criteria listed in Section D, in advance of the birth.
- Follow the Agency's Risk Screening Guidelines (see Section C) 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; and
- 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...

In addition, Agency-approved home birth providers must send the following documentation to the Planned Home Birth and Birthing Center Program Manager (see *Important Contacts* section):

- Provide medically necessary equipment, supplies, and medications for each client (see list next page for home birth supplies);
- Have arrangements for 24 hour-per-day coverage;
- Have documentation of contact with local area emergency medical services to determine the level of response capability in the area; and
- Participate 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.).

What Equipment, Supplies, and Medications Are Required for a Planned Home Birth?

Equipment:

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

Medications:

Pitocin, 10 U/ml
Methergine, 0.2 mg/ml
Epinephrine, 1:1000
MgSO₄, 50% solution, minimum 2-each of 5 gms 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

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
Time piece with second hand
Sterile cord clamps, binding equipment or umbilical tape

Supplies (cont.)

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

Who Is Eligible for Full-Scope Maternity Care and Newborn Delivery Services? [Refer to [WAC 182-533-0400\(2\)](#)]

The Agency covers full-scope maternity care and newborn delivery services for fee-for-service clients on a Benefit Service Package that covers these services.

Note: Refer to the *Scope of Healthcare Services Table* web page at: <http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html> for an up-to-date listing of Benefit Service Packages.

Note: If the client is pregnant but doesn't have a BSP that covers maternity care and newborn delivery costs, please refer the client to her local Community Services Office (CSO) to be evaluated for a possible change in her BSP that would enable her to receive full-scope maternity care.

Please see the Agency [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client's eligibility.

Are Clients Enrolled in an Agency Managed Care Plan Eligible? [Refer to [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.

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..

All medical services covered under a managed care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

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

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

If the client's obstetrical provider is not contracted with the client's managed care plan, the provider will not be paid for services unless a referral is obtained from the plan. The client needs to call her plan for assistance if she has questions

Note: To prevent billing denials, please 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.

Primary Care Case Management (PCCM)

For the client who has chosen 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 via a PCCM provider. The PCCM provider is responsible for coordination of care just like 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, please 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. Please 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. First Steps is a program that 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.

Planned Home Births and Births in Birthing Centers

Pregnant women with First Steps coverage can receive Maternity Support Services 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 that starts in the baby's third month (after Maternity Support Services conclude) 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 website](#).

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 website](#). The Childbirth Education Consultant can be reached by calling 1-360-236-3552.

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, please contact the First Steps Clearinghouse at 1-360-725-1666 or the visit the [First Steps website](#).

Prenatal Management/ Risk Screening Guidelines

Prenatal Management

[Refer to [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 Guidelines and Indications for Consultation and Referral.
- **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 (<i>first trimester</i>). (<i>May be managed by the midwife without consultation with a physician.</i>)
643.03	Mild hyperemesis gravidarum (<i>May be managed by the midwife and will require more visits to monitor the client.</i>)
648.83	Abnormal glucose tolerance in a gestational diabetic (<i>If the condition is responsive to treatment (i.e., controlled by diet alone.)</i>)

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 Section D for further information.)

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 (<i>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</i>)
648.23	Anemia (<i>Hct<30 or Hgb<10</i>) – Unresponsive to treatment

Risk Screening Guidelines

[Refer to [WAC 182-533-0600\(7\)](#)]

The Agency does not cover planned home births or births in birthing centers 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 site of delivery;
- ✓ Known multiple gestation;
- ✓ Known breech presentation in labor with delivery not imminent; or
- ✓ Other significant deviations from normal as assessed by the provider.

Smoking Cessation for Pregnant Women

[Refer to [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 Medicaid Provider Guide](#).

Prenatal Management/Consultation & Referral

These definitions apply to the following tables labeled “Indications for Consultation & Referral”:

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: The Agency expects the provider to screen out high-risk pregnancy by following Agency risk screening guidelines. The following conditions may require either a consultation or referral. The Agency expects the provider to use his or her professional judgment in assessing and determining appropriate consultation and the need for 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 12 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; or
- 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 6 hours with client at rest);
- Hydatidiform mole (molar pregnancy);
- Gestational diabetes not controlled by diet;
- Severe anemia unresponsive to treatment (Hgb<10, Hct<28);
- 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 3rd 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; or
- Development of any of the high-risk conditions that are listed in "Risk Screening Guidelines."

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); or
- 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 the following conditions 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; or
- *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; or
- 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; or
- *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; or
- 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; or
- Jaundice prior to 24 hours.

* **These conditions require emergency transport.**

Authorization

Note: Please see the Agency's [ProviderOne Billing and Resource Guide](#) for more information on requesting authorization.

Expedited Prior Authorization (EPA)

What is the 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?

Drugs that are listed as "Not billable by a Licensed Midwife" in the fee schedule can be administered by licensed midwives when ordered by a physician. 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 licensed midwife must create a 9-digit EPA number. The first six digits of the EPA number must be 870000. The last 3 digits must be **690**, which meets the EPA criteria listed below.

Note: Licensed midwives are reminded that 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;”
- The physician or standing orders are located in the client’s file; and
- The licensed midwife 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 onto the claim.**

Coverage Table

Due to its licensing agreement with the American Medical Association, the Agency publishes only the official, brief CPT procedure code descriptions. To view the entire description, please refer to your current CPT book.

Use the following procedure codes when billing for Birthing Center services:

Code Status Indicator	Procedure Code	Modifier	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	

**Planned Home Births and
Births in Birthing Centers**

Code Status Indicator	Procedure Code	Modifier	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]	
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: Labor management may not be billed by the delivering physician. 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).				
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	
And				
	+ 99354 (Add-on code)	TH	Prolonged services, 1 st hour. Limited to 1 unit.	

**Planned Home Births and
Births in Birthing Centers**

Code Status Indicator	Procedure Code	Modifier	Description	Policy/ Comments
	+ 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 Section E - 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 Section E - Expedited Prior Authorization.]
	S0077		Injection, clindamycin phosphate, 300 mg.	[Not billable by a Licensed Midwife. For exception, see Section E - 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 Section E - Expedited Prior Authorization.]

**Planned Home Births and
Births in Birthing Centers**

Code Status Indicator	Procedure Code	Modifier	Description	Policy/ Comments
	J1364		Injection, erythromycin lactobionate, per 500 mg. (use separate line for each 500 mg used)	[Not billable by a Licensed Midwife. For exception, see Section E - 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.]
	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.]

**Planned Home Births and
Births in Birthing Centers**

Code Status Indicator	Procedure Code	Modifier	Description	Policy/ Comments
	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.				
	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.				

Planned Home Births and Births in Birthing Centers

Code Status Indicator	Procedure Code	Modifier	Description	Policy/ Comments
Home Birth Supplies				
Home Birth Kit				
	S8415		Supplies for home delivery of infant	Limited to one per client, per pregnancy.

Fee Schedule

You may view the Agency 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.

Global (Total) Obstetrical Care

Global OB care (CPT codes 59400) includes:

- Routine antepartum care in any trimester;
- Delivery; and
- 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. [Refer to 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.

Unbundling Obstetrical Care

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 you may have been paid by another insurance carrier for some of the client's OB care.

When a client transfers to your practice late in the pregnancy...

- If the client has had antepartum care elsewhere, you will not be able to bill the global OB package. Bill the antepartum care, delivery, and postpartum care separately. 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 your 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 your client changes insurance during her pregnancy...

Often, a client will be fee-for-service at the beginning of her pregnancy, and then be enrolled in an Agency 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.

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.

Routine Antepartum Care

Antepartum care includes:

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

**Planned Home Births and
Births in Birthing Centers**

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

Per 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; and
- Weekly visits until delivery (approximately 14 antepartum visits). See chart on next page for billing.

Procedure Code/ Modifier	Description	Limitations
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 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. [Refer to 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; and
- The midwife would be paid for the antepartum visits.

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 "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 "1" in the units box. Bill the Agency using the date of the last antepartum visit in the "to and from" fields.

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 Section D), 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).

Procedure Code/ Modifier	Summary of Description	Limits
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. Per 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 pages C.1 – C.2) 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 all of the client’s antepartum care, 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.

Procedure Code/ Modifier	Summary of Description	Limits
99211-99215 TH or	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 TH Limited to 1 unit	Prolonged services, 1 st hour	
+99355 TH Limited to 4 units	Prolonged services, each add’l 30 minutes	

Department of Health (DOH) Newborn Screening Tests

A midwife or physician may bill the Agency for payment of procedure code S3620 after paying the Department of Health for the cost of the newborn screening tests for metabolic disorders. The newborn screening panel includes screens for:

- PKU;
- CAH;
- Congenital hypothyroidism;
- Hemoglobinopathies;
- Biotinidase deficiency;
- MSUD;
- MCAD deficiency;
- Homocystinuria; and,
- Galactosemisa.

Note: Payment includes two tests for two different dates of service, **allowed once per newborn**. Do not bill procedure code S3620 if the baby is born in the hospital because the hospital has been charged for the tests.

Immunizations

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, please refer to the Agency's [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#) or [Early Periodic Screening, Diagnosis & Treatment \(EPSDT\) Medicaid Provider Guide](#).

Home Birth Kit

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**.

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

Medications

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 order. If you are unable to obtain a medication from a pharmacy and are using from your own supply, **see Section E - Authorization** for further information on billing.

Note: Drugs must be billed using the procedure codes listed in the fee schedule and 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.

Newborn Assessment – 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 in field 19 enter "B" for baby under mother's Client ID.

Newborn Assessment - 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 procedure 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 procedure code 99460.

Billing - Specific to Birthing Centers (Facility Fees)

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 *Important Contacts* 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? [Refer to 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;
 - ✓ 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; and
 - ✓ Client responsibilities.

National Correct Coding Initiative (CCI)

The Health Care Authority (the Agency) is evaluating and implementing Medicare's National Correct Coding Initiative (CCI). CCI changes could affect reimbursements to providers for CPT and HCPCS procedure codes.

CCI was created by the Centers for Medicare and Medicaid Services (CMS) to promote correct coding by physicians and providers and to ensure that appropriate payments are made for provider services. CCI coding policies are based on the following:

- The American Medical Association's (AMA) Current Procedural Terminology (CPT) manual;
- National and local policies and edits;

CPT® codes and descriptions only are copyright 2012 American Medical Association.

Planned Home Births and Births in Birthing Centers

- Coding guidelines developed by national professional societies;
- Analysis and review of standard medical and surgical practices; and
- Review of current coding practices.

CCI coding policies do not supercede 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, please see the National Correct Coding Initiative web site:

<http://www.cms.hhs.gov/physicians>

Completing the CMS-1500 Claim Form

Note: Refer to 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 Section E for further information.)										
24B.	Place of Service	Enter the appropriate two digit code as follow: <div style="text-align: center;"> <table> <tr> <td>Code</td> <td>To Be</td> </tr> <tr> <td><u>Number</u></td> <td><u>Used For</u></td> </tr> <tr> <td>11</td> <td>Office</td> </tr> <tr> <td>12</td> <td>Home</td> </tr> <tr> <td>25</td> <td>Birthing Center</td> </tr> </table> </div>	Code	To Be	<u>Number</u>	<u>Used For</u>	11	Office	12	Home	25	Birthing Center
Code	To Be											
<u>Number</u>	<u>Used For</u>											
11	Office											
12	Home											
25	Birthing Center											
32.		Enter the name of the birthing center.										