Washington State Health Care Authority

**Washington Apple Health (Medicaid)**

# Planned Home Births & Births in Birth Centers Billing Guide

**January 1, 2024**

Washington State Health Care Authority

## Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and a governing statute or HCA rule arises, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please notify us at askmedicaid@hca.wa.gov.

## About this guide[1]

This publication takes effect **January 1, 2024**, and supersedes earlier billing guides to this program.

The Health Care Authority is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

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

Refer also to HCA's ProviderOne Billing and Resource Guide for valuable information to help you conduct business with the Health Care Authority.

## How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's provider alerts webpage.

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

## Confidentiality toolkit for providers

The Washington State Confidentiality Toolkit for Providers is a resource for providers required to comply with health care privacy laws. To learn more about the toolkit, visit the HCA website.

[1] This publication is a billing instruction.

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## Where can I download HCA forms?

To download an HCA form, see HCA's Forms & Publications webpage. Type only the form number into the Search box (Example: 13-835).

## Copyright disclosure



## What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

| Subject | Change | Reason for Change |
|---|---|---|
| What newborn practices must birth centers follow to promote breastfeeding/chestfeeding | Deleted reference to the Department of Health's Breastfeeding Friendly Washington website | This program is no longer available |
| Screening of Mental Health Conditions During Pregnancy and Postpartum | Added new section | Policy change. HCA now covers American College of Obstetricians and Gynecologists' recommended screenings for depression and anxiety. |

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# Resources Available

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|---|---|
| **Policy questions or exception to rule questions** | HCA Planned Home Births and Births in Birth Centers Program Manager<br>(800) 562-3022 (toll free) |
| **Newborn screenings** | Department of Health<br>(206) 418-5410 or (866) 660-9050<br>Email: nbs.prog@doh.wa.gov |
| **Medical information** | University of Washington Med Consultation Line<br>(800) 326-5300 (toll free) |
| **Maternity Support Services/Infant Case Management** | See First Steps webpage<br>Email: FirstSteps@hca.wa.gov |

| Topic | Contact |
|---|---|
| **Which birth centers are HCA-approved birth centers?** | • Astoria Birth Center LLC – Astoria, OR<br>• Bellingham Birth Center - Bellingham, WA<br>• Birthroot Midwives & Birth Center - Bellingham, WA<br>• Center for Birth LLC - Seattle, WA<br>• Columbia Birth Center LLC – Richland, WA<br>• Community Birth Center – Lacey, WA<br>• Eastside Birth Center - Bellevue, WA<br>• Lakeside Birth Center - Sumner, WA<br>• Lynden Birth Center – Lynden, WA<br>• Moonrise Wellness & Birth Center – Mountlake Terrace, WA<br>• Mount Vernon Birth Center - Mount Vernon, WA<br>• Puget Sound Birth Center - Kirkland, WA<br>• Rainier Valley Birth & Health Center – Renton, WA<br>• Rolling Hills Birth Center – Pullman, WA<br>• Salmonberry Community Birth Center – Poulsbo, WA<br>• Seattle Home Maternity Services and Childbirth Center-Seattle, WA<br>• Spokane Midwives Home & Birth Center, PLLC – Spokane<br>• Sprout Birth Center - Mountlake Terrace, WA<br>• The Birth Cottage LLC – Enumclaw, WA<br>• The Birth House - Olympia, WA<br>• The Birthing Inn – Tacoma, WA<br>• The Bridge Birth Center – Vancouver, WA<br>• The Special Delivery Birth Center – Arlington, WA<br>• Wenatchee Midwife and Childbirth Center - Wenatchee |

# Definitions

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

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

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

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

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

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

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

A consulting relationship may result in:

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

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

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

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

**Home birth kit** – A kit that contains disposable supplies that are used in a planned home birth.

**Home Birth Provider** –

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

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

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

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

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

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# Program Overview and Provider Requirements

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

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

## When does the Health Care Authority (HCA) cover planned home births and births in a birth center?

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

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

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

An HCA-approved birth center facility must:

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

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

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

- Have a core provider agreement (CPA) with HCA.
- Follow WAC 182-533-0400 and WAC 182-533-0600.
- Have a signed HCA midwife attestation form.
- Be licensed in the State of Washington as a:
  - Midwife under chapter 18.50 RCW
  - Nurse midwife under chapter 18.79 RCW
  - Physician under chapters 18.57 or 18.71 RCW
- Have evidence of current cardiopulmonary resuscitation (CPR) training for:
  - Adult CPR
  - Neonatal resuscitation
- Obtain from the client a signed informed consent form, including the criteria listed in Authorization, in advance of the birth.
- Make appropriate referral of the newborn for pediatric care and medically necessary follow-up care. (WAC 246-834-255)
- Inform parents of the benefits of a newborn screening test for heritable or metabolic disorders and offer to send the newborn's blood sample to DOH for testing (the parent may refuse this service). DOH will bill HCA for payments of HCPCS code S3620. (WAC 246-650-020 and RCW 70.83.020)
- Inform parents of and provide newborn screening for congenital heart defects. (RCW 70.83.090)
- Inform parents of the benefits and risks of vitamin K injections and required prophylactic eye ointment for newborns. (WAC 246-100-202).

## What newborn practices must birth centers follow to promote breastfeeding/chestfeeding?

Birth centers must implement policies and procedures to promote the following practices, which positively impact the initiation of breastfeeding/chestfeeding:

- Skin-to-skin placement of the newborn on the birthing parent's chest immediately following birth
- Rooming-in practices in which the newborn and the birthing parent share the same room for the duration of their post-delivery stay at the birth center

HCA provides for exceptions to these requirements when skin-to-skin placement or rooming-in are contraindicated for the health and well-being of either birthing parent or newborn.

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

Planned home birth providers must provide medically necessary equipment, supplies, and medications for each client.

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

### Prenatal care records

Keep the following prenatal care records in the client's record:

- 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
- Name, strength, and dosage of medications administered

### Intrapartum/postpartum care records

Keep the following intrapartum/postpartum care records in the client's record:

- Labor, delivery, and postpartum periods
- Pregnant client, 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
- Name, strength, and dosage of medications administered

### Informed consent materials

Keep a copy of the informed consent in the client's record, including all the following:

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

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

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

## Related programs

### First Steps program services

The First Steps program helps pregnant clients get the health and social services they may need and covers a variety of services for pregnant individuals and their infants. First Steps is available as soon as an individual knows they are pregnant and is covered by Apple Health (Medicaid). First Steps services are supplemental services that include Maternity Support Services (MSS), Childbirth Education, and Infant Case Management (ICM). Eligible pregnant clients may receive Maternity Support Services (MSS) during pregnancy and through the post pregnancy period (the last day of the month from the 60th day after the pregnancy ends).

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

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

Pregnant clients with First Steps coverage can receive MSS during pregnancy and 60 days postpartum. MSS can begin during the prenatal, delivery, or postpartum period.

Sometimes there are situations that may place infants at a higher risk of having problems. Infant Case Management (ICM) can help an infant's family learn to use the resources in the community so that the baby and family can thrive. ICM may start at any time after MSS ends and continues through the month of the infant's first birthday.

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

## Childbirth education

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

Also, see HCA's **Childbirth education billing guide**.

For more information about First Steps services or to receive a list of contracted providers, contact the First Steps Program Manager at HCAFirstSteps@hca.wa.gov or visit the **First Steps webpage**.

# Client Eligibility

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

> **Note**: It is important to always check a client's eligibility prior to providing any services because if affects who will pay for the services.

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

## How do I verify a client's eligibility?

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

### Verifying eligibility is a two-step process:

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

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

**Step 2.** **Verify service coverage under the Apple Health client's benefit package**. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's **Program Benefit Packages and Scope of Services** webpage.

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

- **Online**: Go to **Washington Healthplanfinder** - select the "Apply Now" button. For patients age 65 and older or on Medicare, go to **Washington Connections** select the "Apply Now" button.
- **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form.
  To download an HCA form, see HCA's Free or Low Cost Health Care, **Forms & Publications** webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older or on Medicare, complete the *Washington Apple Health Application for Aged, Blind, Disabled/Long-Term Services and Support (HCA 18-005)* form.
- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the **Health Benefit Exchange Navigator**.

## Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

**Yes**. Most Apple Health (Medicaid) clients are enrolled in one of HCA's contracted managed care organizations (MCOs). For these clients, managed care enrollment is displayed on the client benefit inquiry screen in ProviderOne.

All medical services covered under an HCA-contracted MCO must be obtained through the MCO's contracted network. The MCO is responsible for:

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

**Note**: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

**Send claims to the client's MCO for payment**. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 182-502-0160.

## Managed care enrollment

Most Apple Health (Medicaid) clients are enrolled in HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination. Providers must check eligibility to determine enrollment for the month of service.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care.

### Checking eligibility

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's **Get Help Enrolling** page.
- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's policies.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:

  Go to **Washington Healthplanfinder website**.
- **Available to all Apple Health clients:**
  - Visit the **ProviderOne Client Portal website**:
  - Request a change online at **ProviderOne Contact Us** (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

For online information, direct clients to HCA's **Apple Health Managed Care** webpage.

## Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an HCA-contracted managed care plan are automatically enrolled in a BHSO except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS Medicaid program will

reimburse providers for the covered services. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

## Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

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

## Integrated Apple Health Foster Care (AHFC)

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

Clients under this program are:

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

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

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support Team at 1-800-562-3022, Ext. 15480.

## Fee-for-service Apple Health Foster Care

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

## American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's **American Indian/Alaska Native webpage**.

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# Prenatal Management and Risk Screening Guidelines

## What are the risk screening criteria?

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

To be reimbursed for CPT® codes 99212 through 99215 with HCPCS modifier TH (Increased Monitoring Prenatal Management), the client's record must contain the appropriate ICD diagnosis code.

### Risk screening criteria

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

- Previous cesarean section
- Current substance use disorder
- Significant hematological disorders/coagulopathies
- History of deep venous thrombosis or pulmonary embolism
- Cardiovascular disease-causing functional impairment
- Chronic hypertension
- Significant endocrine disorders including pre-existing diabetes (type I or type II)
- Hepatic disorders including uncontrolled intrahepatic cholestasis of pregnancy and/or abnormal liver function tests
- Isoimmunization, including evidence of Rh sensitization/platelet sensitization
- Neurologic disorders or active seizure disorders
- Pulmonary disease
- Renal disease
- Collagen-vascular diseases
- Current severe psychiatric illness
- Cancer affecting the reproductive system
- Multiple gestation
- Breech presentation in labor with delivery not imminent
- Other significant deviations from normal as assessed by the provider

## Tobacco/nicotine cessation for pregnant clients

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

## Prenatal management/consultation & referral

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

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

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

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

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

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

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

## Prenatal indications for consultation and referral

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

**Conditions requiring consultation**

HCA 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 (nonstress 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**

HCA 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 <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 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 pregnant client's care any time after the onset of labor, up to and including the delivery of the placenta)

**Conditions requiring consultation**

HCA requires physician consultation and the client MAY require referral to a physician and/or hospital when the following 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**

HCA requires physician consultation and referral to a physician or hospital when emergency conditions in the following list arise intrapartum. In some intrapartum situations, due to urgency, it may not be prudent to pause medical treatment long enough to seek physician consultation or initiate transport.

- Labor before the completion of 37 weeks gestation, with known dates
- Abnormal presentation or lie at time of delivery, including breech
- Birthing parent 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 fever in birthing parent
- *Birthing parent 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 birthing parent vital sign instability and/or shock

***These conditions require emergency transport**.

## Postpartum

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

**Conditions requiring consultation**

HCA requires physician consultation and the client MAY require referral to a physician when the following birthing parent conditions arise postpartum:

- Development of any of the applicable conditions listed under Prenatal or Intrapartum
- Significant birthing parent confusion or disorientation
- Other significant deviations from normal as assessed by the provider

**Conditions requiring referral**

HCA 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
- *Birthing parent seizure
- Lacerations, if repair is beyond provider's level of expertise (3rd or 4th degree)
- *Sustained birthing parent vital sign instability and/or shock
- Development of birthing parent 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**

HCA 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
- Other significant deviations from normal as assessed by the provider

**Conditions requiring referral**

HCA requires that a pediatric physician be consulted, and a referral made when the following conditions arise in a neonate:

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

*__These conditions require emergency transport__.

## Screening of Mental Health Conditions During Pregnancy and Postpartum

HCA covers screening for depression and anxiety during pregnancy and the postpartum period. Providers must screen pregnant and postpartum clients for depression and anxiety using a standardized, validated screening tool. Screening results are not equivalent to a diagnosis. Screening for perinatal depression and anxiety must occur at the initial prenatal/OB visit, at least once during the 2nd or 3rd trimester, and once in the postpartum period, per American College of Obstetricians and Gynecologists recommendation.

When billing HCA for perinatal depression and anxiety screening, use **CPT® code 96127 or 96160**. If the provider conducts a depression screening and anxiety screening on the same date of service using two different screening tools, the provider may bill separately for each screening using the appropriate CPT® code. Submit the claim for the screening with the date the screening occurred. Perinatal mental health screening may be billed in addition to bundled or unbundled obstetric codes. If more frequent screening is needed, providers may submit a limitation extension request to HCA.

To be paid for **CPT® codes 96160 and 96127**, providers must indicate the screening outcome by including one of the modifiers listed below. Providers must document in the client's record the name of the screening tool, the score, and what referrals were made.

| Modifier | Description |
|---|---|
| **U1** | No need identified (negative screen). Indicates screening score within a normal range. |
| **U2** | Need identified (positive screen). Indicates risk, concern, impairment, or identification of a developmental and/or behavioral disorder. |

**Note**: Providers may use the Perinatal Psychiatry Consultation Line (PPCL) for recommendations and referrals related to perinatal mental and behavioral health. Providers may refer the client to Perinatal Support Washington Warmline for telephone support, professional referrals, and information about other resources.

# Authorization

## What is expedited prior authorization (EPA)?

Expedited prior authorization (EPA) is designed to eliminate the need for written authorization. HCA establishes authorization criteria and identifies the criteria with specific codes, enabling providers to use an EPA number when appropriate.

## What are the EPA criteria for drugs listed as "not billable by a licensed midwife?"

HCA allows licensed midwives to use EPA when administering drugs listed as "not billable by a licensed midwife" in the fee schedule. When billing for drugs listed as "not billable by a licensed midwife," use EPA# 870000690. The licensed midwife must meet all the following EPA criteria:

- Obtained physician or standing orders for the administration of the drug listed as "not billable by a licensed midwife"
- Placed the physician or standing orders in the client's file
- Upon request, provides a copy of the physician or standing orders to HCA

This EPA number is **only** for the procedure codes listed in the fee schedule as "not billable by a licensed midwife."

## Natural deliveries

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

| CPT® Code | Short Description | EPA Number |
|---|---|---|
| **59400, 59409, 59410** | Elective delivery or natural delivery at or over 39 weeks gestation | 870001378 |
| **59400, 59409, 59410** | Natural delivery before 39 weeks | 870001375 |

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

**Yes**. EPA numbers for drugs billed by a licensed midwife and the EPA number for a natural delivery may be billed on the same claim.

Washington State Health Care Authority

# Coverage and Billing

## What are the general billing requirements?

Providers must follow HCA'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

## How do I bill claims electronically?

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

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

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

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

## What fees do I bill to HCA?

Bill your usual and customary fee. For HCA's current maximum allowable fees, see HCA's Planned Home Births and Births in Birth Centers Fee Schedule.

## What does global (total) obstetrical (OB) care include?

### Coverage

Global obstetrical (OB) care (CPT® code 59400) includes **all** the following:

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

### Coverage table

| CPT® Code | Modifier | Short Description | Comments |
|---|---|---|---|
| **59400** | | Obstetrical care | Antepartum, delivery, and postpartum care |

### Billing

Note the following when billing for global OB care:

- If you provide all the client's prenatal 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 the services and no other provider is billing for prenatal care, the delivery, or postpartum care.
- If you provide all or part of the prenatal care and/or postpartum care but you do not perform the delivery, you must bill HCA for only those services provided using the appropriate prenatal and/or postpartum codes. In addition, if the client obtains other medical coverage or is transferred to an HCA-contracted managed care organization (MCO) during pregnancy, you must bill for only those services provided while the client is enrolled with HCA fee-for-service.
- Use HCPCS code 0500F along with the appropriate diagnosis code on the first prenatal visit. HCA is tracking the date a client begins receiving obstetrical care (date the OB record is initiated). Note this date by entering HCPCS code 0500F with the appropriate ICD diagnosis codes Z33.1, Z34.00, Z34.80, or Z34.90 on the claim. Use a billed amount of $0.01 (one cent) when submitting the HCPCS code 0500F claim; the claim will pay at zero. HCA collects this code for quality measurement, tracking, and care coordination.

# Audio-only visits as part of global OB care

## Global OB care (CPT® code 59400)

When billing for global OB care (CPT® code 59400), note the following:

- HCA pays for a total of three audio-only visits as follows:
  - Up to two antepartum visits to be provided via audio-only telemedicine
  - One early postpartum visit to be provided via audio-only telemedicine. An early postpartum visit is a postpartum visit up to two weeks after delivery.
- You may not provide the comprehensive postpartum visit typically scheduled at around six weeks after delivery via audio-only telemedicine.
- When you have used two or three audio-only telemedicine visits during global OB care, bill the global OB code with modifier 93.
- When you have used only one audio-only telemedicine visit during global OB care, no additional modifier is required.

# Audio-only visits when global OB care is unbundled

(Refer to Unbundling OB care)

## Antepartum care only (CPT® codes 59425 and 59426)

When billing for antepartum care only, HCA pays for up to two antepartum visits via audio-only telemedicine.

- When you use two audio-only telemedicine visits during the antepartum period, bill either CPT® code 59425 or 59426 with modifier 93.
- When you use only one audio-only telemedicine visit during the antepartum period, no additional modifier is required.

## Postpartum care only (CPT® code 59430)

When billing for postpartum care only:

- HCA pays for one early postpartum visit via audio-only telemedicine. An early postpartum visit is a postpartum visit up to two weeks after delivery.
- HCA does not allow the postpartum visit typically scheduled at around six weeks after delivery to be provided via audio-only telemedicine.
- When you use an audio-only telemedicine visit during the early postpartum period, no additional modifier is required.

## Delivery only (CPT® code 59409) or delivery with postpartum care (CPT® code 59410)

These services require in-person care. HCA does not pay for these services to be provided via audio-only or audio/visual telemedicine.

Washington State Health Care Authority

## What does routine prenatal care include?

### Coverage

According to CPT® guidelines, HCA considers routine prenatal care for a normal, uncomplicated pregnancy to consist of all the following:

- Visits
  - Monthly visits up to 28 weeks gestation
  - Biweekly visits to 36 weeks gestation
  - Weekly visits until delivery (approximately 14 prenatal visits)
- Care:
  - Initial and subsequent history
  - Physical examination
  - Recording of weight and blood pressure
  - Recording of fetal heart tones
  - Routine chemical urinalysis
  - Birthing parent counseling, such as risk factor assessment and referrals

### Billing

You may bill medically necessary prenatal laboratory tests in addition to prenatal care, **except for dipstick tests** (CPT® codes 81000, 81002, 81003, and 81007). Refer to the prenatal care coverage table for more information.

You may bill limited ultrasounds in addition to prenatal care. Refer to Limited obstetrical ultrasounds for more information.

## What does postpartum care include?

For billing purposes, postpartum care includes routine office visits for the 6-week period after the delivery. Services provided after the 6-week postpartum visit are eligible for separate reimbursement.

> **Note:** After Pregnancy Coverage (APC) is a 12-month Medicaid extension for clients who have been recently pregnant. Visit HCA's APC webpage for more information on APC coverage.

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

When an eligible client receives services from more than one provider, HCA reimburses each provider for the services furnished.

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

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

## Unbundling OB care

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

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

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

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

### If the client changes insurance during pregnancy

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

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

while the client is on fee-for-service. The MCO reimburses for services provided after the client is enrolled with the MCO.

## Coding for prenatal care only

### Billing

Do not bill HCA for obstetrical services until all care (prenatal, delivery, and postpartum) is completed. **Do not bill prenatal care only codes in addition to any other procedure codes that include prenatal care (i.e., global OB codes).**

CPT® codes 59425, 59426, or E&M CPT® codes 99212-99215 with normal pregnancy diagnoses may not be billed in combination during the entire pregnancy.

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

- If the client had a total of one to three prenatal visits, bill the appropriate level of E&M service (CPT® codes 99212-99215) with modifier TH for each visit with the date of service the visit occurred and the appropriate diagnosis.
- If the client had a total of four to six prenatal visits, bill using CPT® code 59425 with a one (1) in the *units* box. Bill HCA using the date of the last prenatal visit in the *to* and *from* fields.
- If the client had a total of seven or more visits, bill using CPT® code 59426 with a one (1) in the *units* box. Bill HCA using the date of the last prenatal visit in the *to* and *from* fields of the form.

### Coverage table

Using the following CPT® codes, bill only the total number of times you saw the client for all prenatal care during pregnancy. You may not bill these in combination with each other during the entire pregnancy period.

| CPT® Code | Modifier | Short Description | Comments |
|---|---|---|---|
| **99212** | TH | Office o/p est sf 10-19 min | Prenatal care, 1-3 visits only. Must use modifier TH when billing. Limited to 3 units total of CPT® codes 99212-99215 with modifier TH per pregnancy, per provider. |
| **99213** | TH | Office o/p est low 20-29 min | Prenatal care, 1-3 visits only. Must use modifier TH when billing. Limited to 3 units total of CPT® codes 99212-99215 with modifier TH per pregnancy, per provider. |

| CPT® Code | Modifier | Short Description | Comments |
|---|---|---|---|
| **99214** | TH | Office o/p est mod 30-39 min | Prenatal care, 1-3 visits only. Must use modifier TH when billing. Limited to 3 units total of CPT® codes 99212-99215 with modifier TH per pregnancy, per provider. |
| **99215** | TH | Office o/p est hi 40-54 min | Prenatal care, 1-3 visits only. Must use modifier TH when billing. Limited to 3 units total of CPT® codes 99212-99215 with modifier TH per pregnancy, per provider. |
| **59425** | | Prenatal care, 4-6 visits | Limited to one unit per client, per provider, per pregnancy. |
| **59426** | | Prenatal care, 7 or more visits | Limited to one unit per client, per pregnancy. |

## Coding for delivery only or delivery with postpartum care

### Billing

If it is necessary to unbundle the OB package and bill for the delivery only, bill HCA using CPT® code 59409 (vaginal delivery only).

If a provider does not furnish prenatal care, but performs the delivery and provides postpartum care, bill HCA using CPT® code 59410 (vaginal delivery, including postpartum care).

Do not bill for obstetrical services until all care (prenatal, delivery, and postpartum) is completed. Do not bill CPT® code 59409 or 59410 in addition to any other procedure codes that include delivery (e.g., global OB codes).

### Coverage table

| CPT® Code | Modifier | Short Description | Comments |
|---|---|---|---|
| **59409** | | Obstetrical care | Delivery only |
| **59410** | | Obstetrical care | Delivery and postpartum only |

## Coding for postpartum care only

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

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

Do not bill HCA for obstetrical services until all care (prenatal, delivery, and postpartum) is completed. Do not bill CPT® code 59430 (postpartum care only) in addition to any procedure codes that include postpartum care (e.g., global OB codes).

### Coverage table

| CPT® Code | Modifier | Short Description | Comments |
|---|---|---|---|
| **59430** | | Care after delivery | Postpartum only |

## Additional monitoring for high-risk conditions

### Billing

When providing additional monitoring for high-risk conditions more than the CPT® guidelines for normal prenatal visits, bill using E&M CPT® codes 99212-99215 with modifier TH. The office visits may be billed in addition to the global fee only after exceeding the CPT® guidelines for normal prenatal care. Providers must bill with a primary diagnosis that identifies that the high-risk conditions are pregnancy related.

A condition that is classifiable as high-risk alone does not entitle the provider to additional payment. Per CPT® guidelines, it must be medically necessary to see the client **more often** than what is considered routine prenatal care to qualify for additional payments. **The additional payments are intended to cover additional costs incurred by the provider because of more frequent visits.**

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

### Coverage table

| CPT® Code | Modifier | Short Description | Comments |
|---|---|---|---|
| **99212** | TH | Office o/p est sf 10-19 min | See the Prenatal management/consultation & referral |

| CPT® Code | Modifier | Short Description | Comments |
|---|---|---|---|
| **99213** | TH | Office o/p est low 20-29 min | See the Prenatal management/consultation & referral |
| **99214** | TH | Office o/p est mod 30-39 min | See the Prenatal management/consultation & referral |
| **99215** | TH | Office o/p est hi 40-54 min | See the Prenatal management/consultation & referral |

**For example**:

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

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

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

## Labor management for clients who transfer to a hospital for delivery

### Billing

If you performed the entire prenatal care for the client, attended the client during labor, delivered the baby, and performed the postpartum care, do not bill HCA for labor management. These services are included in the global OB package.

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

Bill these labor management codes only when the client labors at the birth center or at home and is then transferred to a hospital during labor and another provider delivers the baby. The diagnoses on the claim must be related to complications during labor and delivery. The delivering hospital provider may not bill for labor management.

To bill for labor management in this situation, bill HCA for the time spent attending the client's labor using one of the appropriate CPT® E&M codes 99212-99215 (for labor attended in the office) or CPT® codes 99347-99350 (for labor attended at the client's home). In addition, HCA reimburses providers for up to 90 minutes of labor management using prolonged services (HCPCS code G2212) with modifier TH. Prolonged services must be billed on the same claim as E&M codes along with modifier TH and the appropriate diagnosis code (all must be on each detail line of the claim).

## Coverage table

| Procedure code | Modifier | Short Description | Comments |
|---|---|---|---|
| **CPT® 99212** | TH | Office o/p est sf 10-19 min | Use when client labors at the birth center then transfers to hospital for delivery. Diagnoses on claim must be related to complications of labor and delivery. |
| **CPT® 99213** | TH | Office o/p est low 20-29 min | Use when client labors at the birth center then transfers to hospital for delivery. Diagnoses on claim must be related to complications of labor and delivery. |
| **CPT® 99214** | TH | Office o/p est mod 30-39 min | Use when client labors at the birth center then transfers to hospital for delivery. Diagnoses on claim must be related to complications of labor and delivery. |
| **CPT® 99215** | TH | Office o/p est hi 40-54 min | Use when client labors at the birth center then transfers to hospital for delivery. Diagnoses on claim must be related to complications of labor and delivery. |
| **CPT® 99347** | TH | Home visit, est patient | Use when client labors at home then transfers to hospital for delivery. Diagnoses on claim must be related to complications of labor and delivery. |
| **CPT® 99348** | TH | Home visit, est patient | Use when client labors at home then transfers to hospital for delivery. Diagnoses on claim must be related to complications of labor and delivery. |

| Procedure code | Modifier | Short Description | Comments |
|---|---|---|---|
| **CPT® 99349** | TH | Home visit, est patient | Use when client labors at home then transfers to hospital for delivery. Diagnoses on claim must be related to complications of labor and delivery. |
| **CPT® 99350** | TH | Home visit, est patient | Use when client labors at home then transfers to hospital for delivery. Diagnoses on claim must be related to complications of labor and delivery. |
| **HCPCS +G2212** | TH | Prolong outpt/office vis | Use when client labors at home or at the birth center then transfers to hospital for delivery. **Limited to six 15-minute units** |

## Are medications billed separately?

Certain medications can be billed separately and are listed on HCA's Planned Home Births and Births in Birthing Centers Fee Schedule and the Coverage Table for Other Codes. Some of the medications listed on HCA's Planned Home Births and Births in Birthing Centers 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 What are the EPA criteria for drugs listed as "not billable by a licensed midwife?").

## Limited obstetrical ultrasounds

### Coverage

HCA considers limited ultrasounds of a client's pregnant uterus to be medically necessary when performed by an HCA-approved planned home birth provider for the following purposes only:

- Confirmation of viability
- First trimester dating
- Third trimester presentation
- Placental location
- Amniotic fluid assessment

HCA does not pay for ultrasounds when provided solely for the determination of gender.

For more information about routine obstetrical ultrasounds, refer to HCA's Physician-related services/health care professional services billing guide.

### Coverage table

| CPT® Code | Short Description |
|---|---|
| **76815** | Ob us limited fetus(s) |
| **76817** | Transvaginal us obstetric |

## Long-Acting Reversible Contraception (LARC)

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

## How are newborn assessments billed?

### Newborn assessment at home birth

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

### Newborn assessment in birth center

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

### Coverage table

| CPT® Code | Short Description | Comments |
|---|---|---|
| **99460** | Init nb em per day hosp | Newborn assessment for a baby born in a birth center that is admitted and discharged on the same day. Limited to one per newborn. Do not bill HCA if baby is born in a hospital. |
| **99461** | Init nb em per day non-fac | Newborn assessment for a home birth. Limited to 1 per newborn. |
| **99463** | Same day nb discharge | Newborn assessment for a baby born in a birth center who is transferred to a hospital for care. |

## How do I bill for neonates/newborns?

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

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

**Note**: Bill services for birthing parents on separate claims.

## Does HCA pay for newborn screening tests?

**Yes**. The midwife or physician collects the blood for the newborn screening and sends it to the Washington State Department of Health (DOH). The midwife or physician may bill for the blood collection using the appropriate CPT® code. DOH bills HCA for the newborn screening tests using HCPCS code S3620. HCA reimburses only DOH for this service.

The newborn screening panel includes tests for treatable disorders as determined by DOH. For the most current list of tests included in the screening panel, visit the What Disorders are Screened for in Washington State? webpage.

Newborn screening panels are covered in accordance with the Department of Health's recommendations. For most infants, newborn screening requires two tests on two different dates of service. For some infants, a third newborn screen is recommended. Please refer to the DOH Newborn Screening Program Health Care Provider Manual for guidance on the timing and frequency of newborn screening tests.

## How is the administration of immunizations billed?

### Billing

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 HCA's Physician-Related Services/Healthcare Professional Services Billing Guide or Early Periodic Screening, Diagnosis & Treatment (EPSDT) Billing Guide.

### Coverage table

| CPT® Code | Short Description | Comments |
|---|---|---|
| **90471** | Immunization admin | |

| CPT® Code | Short Description | Comments |
|---|---|---|
| **90472** | Immunization admin each add | List separately in addition to code for primary procedure |

## How are home-birth supplies billed?

### Billing

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

### Coverage table

| HCPC Code | Description | Limits |
|---|---|---|
| **S8415** | Supplies for home delivery | Limited to one per client, per pregnancy. |

## Birth center facility fee

### Reimbursement

HCA reimburses for a facility fee only when services are performed in a birth center that:

- Is licensed by the Department of Health
- Has a current Core Provider Agreement with HCA.

The facility fee does not include other drugs, professional services, newborn hearing screens, lab charges, ultrasounds, other x-rays, blood draws, or injections.

### Coverage table

| CPT® / HCPCS Code | Modifier | Short Description | Comments |
|---|---|---|---|
| **59409** | 59 and SU | Obstetrical care | Limited to one unit per client, per pregnancy. Facility fee includes all room charges, equipment, supplies, anesthesia administration, and pain medication. |

| CPT® / HCPCS Code | Modifier | Short Description | Comments |
|---|---|---|---|
| **S4005** | | Interim labor facility globa | Limited to one per client, per pregnancy. May only be billed when client labors in the birth center and then transfers to a hospital for delivery. |

# Coverage Table for Other Codes

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

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

| CPT®/HCPCS Code | Modifier | Short Description | Comments |
|---|---|---|---|
| **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. |
| **J0290** | | Injection, ampicillin, sodium, up to 500 mg (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 | |
| **J7121** | | 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 | |
| **J3105** | | Terbutaline sulfate inj | To temporarily decrease contractions pending emergency intrapartal transport |

| CPT®/HCPCS Code | Modifier | Short Description | Comments |
|---|---|---|---|
| **J8499** | | Oral methergine 0.2 mg | Limited to treatment of postpartum hemorrhage only. Must be billed with one of the following diagnosis codes: O72.0, O72.1, or O72.2.<br>Enter NDC on claim, see ProviderOne Billing and Resource Guide for additional information. |
| **J2210** | | Injection methylergonovine maleate, up to 0.2 mg | Limited to treatment of postpartum hemorrhage only. Must be billed with one of the following diagnosis codes: O72.0, O72.1, or O72.2. |
| **S0191** | | Misoprostol, oral, 200 mcg | Limited to treatment of postpartum hemorrhage only. Must be billed with one of the following diagnosis codes: O72.0, O72.1, or O72.2. |
| **J3490** | | Drugs unclassified injection | Use to bill for IV TXA.<br>Limited to treatment of postpartum hemorrhage only. Must be billed with one of the following diagnosis codes: O72.0, O72.1, or O72.2. |
| **J2590** | | Injection, oxytocin | Limited to treatment of postpartum hemorrhage only. Must be billed with one of the following diagnosis codes: O72.0, O72.1, or O72.2. |
| **J3475** | | Injection, magnesium sulfate, per 500 mg | |
| **J0170** | | Injection adrenalin, epinephrine, up to 1ml ampule | |
| **J3430** | | Injection, phytonadione (Vitamin K) per 1 mg | |
| **92588** | | Newborn hearing screen | |

| CPT®/HCPCS Code | Modifier | Short Description | Comments |
|---|---|---|---|
| **99465** | | NB Resuscitation | |
| **92950** | | Cardiopulmonary resuscitation (e.g., in cardiac arrest) | |