Planned Community Births
(Out-of-Hospital Births)
Prior Authorization and Billing Guide

Oregon Health Authority

HEALTH SYSTEMS DIVISION

Provider guide for prior
authorization and billing for
community birth services

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Oregon HEALTH PLAN

Contents

Introduction

The Oregon Health Authority (OHA) will reimburse licensed community birth providers practicing within the scope of their license for prenatal, labor and delivery, and postpartum care provided to eligible Oregon Health Plan (OHP) members when:

- OHA determines the member is experiencing a low-risk pregnancy which makes a planned community birth medically appropriate;
- The provider submits a timely, complete request for prior authorization of community birth services;
- OHA approves the prior authorization request; and
- The provider meets all other applicable state and federal legal requirements, including but not limited to the Chapter 410 Oregon Administrative Rules (OAR) and Guideline Note 153 of the Health Evidence Review Commission's (HERC) Prioritized List of Health Services.

About this guide

This guide provides detailed information to help community birth providers request prior authorization and reimbursement from OHA for planned community birth services provided to OHP members.

It gives instructions on how to:

- Enroll as an Oregon Medicaid provider.
- Request prior authorization from OHA.
- Document that your patient meets low-risk criteria.
- Document care that is medically appropriate.
- Bill OHA for approved services.

Provider enrollment

Community birth provider types

The following provider types enrolled with OHA may seek prior authorization and reimbursement for planned community birth services to OHP members:

- Licensed Direct entry Midwife (LDM)
- Certified Nurse Midwife (CNM)
- Doctor of Chiropractic medicine (DC)
- Naturopathic medicine Doctor (ND)
- Nurse Practitioners (NP)
- Doctor of Osteopathic Medicine (DO)
- Medical Doctor (MD)

Hereafter, the above will be referred to as "licensed providers."

These licensed providers must:

- Have a valid license or certification to provide community birth services in Oregon;
- Meet all applicable provider enrollment requirements in state and federal statutes and regulations, including but not limited to OARs 410-120-1260, 943-120-0310 and 943-120-0320;
- Have no patient safety-related disciplinary investigation or action pending or in process. (OHA will consider providers with past investigations or actions for enrollment on a case-by-case basis.)

In order to receive reimbursement through OHP, licensed providers must personally provide the community birth services to the OHP member, except in situations where a non-licensed or certified provider (i.e., a student) is permitted under applicable state licensing laws to provide those services under the direct supervision of a licensed provider.

Direct supervision means the licensed provider is present at all times while the services are being provided to the OHP member and the provider is actually able to intervene for the student if necessary.

Assistants for labor and delivery must also be enrolled with OHA.

How to enroll with OHA

Visit the Provider Enrollment page at www.oregon.gov/OHA/healthplan/pages/providerenroll.aspx. Click on the Provider Description that describes you (*e.g.,* Direct Entry Midwife, Billing Provider, Birthing Center, Naturopath) to find the required forms and documents.

You must have written confirmation of enrollment with OHA prior to seeking prior authorization or reimbursement for planned community birth services provided to OHP members.

If you have questions about enrolling with OHA

If you have questions about how to enroll, contact Provider Enrollment at 1-800-422-5047 or email provider.enrollment@state.or.us.

Covered services and coverage criteria

OHA will reimburse for covered community birth services when they are:

- Authorized by OHA as medically appropriate based on clinical criteria demonstrating a low risk pregnancy and
- Provider submits a timely, complete request for prior authorization of community birth services and receives approval from OHA; and
- Meets all other applicable state and federal legal requirements including but not limited to OAR Chapter 410 and Guideline Note 153 of the Prioritized List of Health Services.

Covered services

- Risk assessment (at initiation of care and throughout pregnancy and delivery)
- Antepartum care, vaginal delivery, and postpartum care through 60 days post-Estimated Date of Delivery (EDD)
- Tests performed and interpreted by the community provider
- Provider-administered medications
- Labor support prior to transfer if the pregnant person must be transferred to a hospital for delivery.
- Services for one OHP-enrolled assistant acting as a second birth attendant, provided primary attendant is present at all times
- Initial evaluation and care of the newborn on the day of delivery
- Supplies (packaged rate, for home births only)

OHP will reimburse birthing centers directly for a global rate facility payment, including supplies.

OHP will reimburse services referred out to a lab or another provider. Reimbursement is to the referred provider, not the OOHB provider. Pass-through billing is not allowed. Referrals include but are not limited to labs, pharmacy, imaging centers, and consulting specialists.

Clinical coverage criteria

Pregnancy risk criteria

Planned community births are covered for pregnant women who OHA has determined are low risk for adverse obstetric or birth outcomes based on Guideline Note 153 of the current Prioritized List. OHA requires initial (at the onset of care) and ongoing risk assessment to check for the presence or the development of the high-risk conditions listed in Guideline Note 153. For additional information about Guideline Note 153, see the Out of

Hospital Birth Coverage Guidance (approved August 13, 2020). Providers must perform and provide documentation of the risk assessments required by OHA. Alternatives to the OHA-required risk assessments will not be accepted.

Notwithstanding the requirement for providers to conduct initial and ongoing risk assessments, OHA determines whether the OHP member's pregnancy is low-risk such that community birth services are medically appropriate and the services are reimbursable based on Guideline Note 153 of the Prioritized List and OAR Chapter 410.

If high-risk conditions are present:

Certain conditions, if present or when they develop, are designated in Guideline Note 153 to require planned hospital birth or transfer of the pregnant person or infant to hospital-based care. Community birth is not covered when any of these conditions are present.

If potentially risky conditions are present:

Certain conditions, if present or when they develop, are designated in Guideline Note 153 to require consultation. Community birth is only covered when one of these conditions is present where the community birth provider obtains recommendations from an appropriate consultant and the recommendations are then appropriately managed in the planned community birth setting. Consultations must be with a provider, who within the scope of their license is appropriate to diagnose and treat the high-risk or potentially risky condition and is one of the following:

- A provider (MD/DO or CNM) who has active admitting privileges to manage pregnancy in a hospital, and/or
- An appropriate specialty consultation (e.g., maternal-fetal medicine, hepatologist, hematologist, psychiatrist).

If there are multiple potentially risky conditions or other high-risk conditions:

The list of high-risk conditions specified in Guideline Note 153 is not exhaustive. Other physical health, behavioral health, obstetric, or fetal high-risk conditions may arise that require consultation and/or transfer to hospital-based care. Additionally, having multiple risk conditions requiring consultation may increase the risk sufficiently to indicate the need for transfer of care as set out in OAR 410-130-0240(4)(l).

OHA will apply medically appropriate criteria as defined in Oregon Administrative Rule (OAR) 410-120-0000 (145) to determine if a high-risk condition that was not specified in Guideline Note 153 exists and to determining if the presence of multiple risk conditions requiring consultation creates a high-risk condition. Community birth is not covered when OHA determines that a high-risk condition exists by applying medically appropriate criteria.

Documentation requirements

OHA uses concurrent review to assess clinical coverage criteria. The documentation requirements and time frames are listed in Appendix A of this guide. These documentation requirements are the **minimum necessary** for OHA to evaluate our clinical coverage criteria and make an authorization determination. Community birth is not covered if these documentation requirements are not met.

Oregon Administrative Rules

Providers must follow all rules that govern their licensure or certification. This includes, if applicable:

- Chapter 332, Health Licensing Office, Board of Direct Entry Midwifery, Division 25 – Practice

Standards OHA Chapter 332, Division 25 Practice Standards
- Ambulatory Surgical Centers – Service Restrictions 333-076-0650

By enrolling with OHA as an Oregon Medicaid provider, providers agree to follow all pertinent state and federal regulations, including OHA administrative rules. The following list of Oregon Administrative Rules (OARs) is provided as a quick reference, and which may not be exhaustive depending on individual performing or billing provider types but which providers must review and follow prior to and for the purpose of seeking PA or reimbursement:

- 410-120-0000, General Rules – Acronyms and Definitions
- 410-120-1200, General Rules - Excluded Services and Limitations
- 410-120-1280, General Rules - Billing
- 410-120-1320, General Rules – Authorization of Payment
- 410-120-1360, General Rules - Requirements for Financial, Clinical and Other Records
- 410-120-1397, Recovery of Overpayments to Providers – Recoupment and Refunds
- 410-130-0200, Medical-Surgical Services – Prior Authorization
- 410-130-0240, Medical-Surgical Services – Medical Services
- 410-141-3830, Prioritized List of Health Services and Guideline Note 153

Prior authorization

All pregnancy related services for a planned community birth require prior authorization by the Oregon Health Authority (OHA) for fee-for-service reimbursement, **prior to billing**.

For all requests, request prior authorization for the appropriate delivery code:

- **59400:** Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care (Global code)
- **59409:** Vaginal delivery only (with or without episiotomy and/or forceps)
- **59410:** Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care

OHA's Health Systems Division (the "Division") is making the following changes to help reduce the burden on Oregon's hospitals and health systems as they respond to the current surge in COVID-19 hospitalizations:

- The requirement for a complete community birth PA request with documentation to be received by the Division at 34-weeks is **extended to no later than 38 weeks, 0 days gestation, through the COVID-19 health emergency or until rescinded or revised by the Division.**
- Documentation submitted when requesting authorization must support the medical justification for the service. A complete request is one that contains all necessary documentation and meets any other requirements as described in OAR chapter 410. OAR 410-120-1320(2). OHA will not authorize community birth services when the required documentation has not been submitted. OAR 410-120-1320(3).

Process overview

The Provider Clinical Support Unit will review each of your prior authorization requests and may ask for additional documentation to support your request. The unit will determine:

- Whether documentation is present and adequate; missing; or present but inadequate;
- Whether documentation meets low-risk pregnancy criteria per HERC Guideline Notes; and
- Whether documentation demonstrates that the requested services are medically appropriate, according to previously noted Oregon Administrative Rules.

OHA's prior authorizations will be provisional until the final concurrent review after delivery. All required documents must be submitted by 38 weeks, 0 days gestation, with the exception of ongoing narrative notes and assessments that occur after 38 weeks until birth. OHA will review these using concurrent review, with a final authorization after delivery.

If your request has missing or inadequate documentation:

OHA will inform you of the additional information we require. You need to provide complete documentation to OHA no later than 38 weeks, 0 days gestation. If a response is not received by 38 weeks, 0 days gestation, the request for prior authorization will be denied due to missing information.

If your request is complete, accurate and timely:

If the documentation demonstrates that a community birth is medically appropriate and meets low-risk criteria, OHA will notify you of a provisional approval in a letter of notification**.**

How to submit prior authorization requests

You can submit requests in three ways.

- Use the Provider Web Portal at https://www.or-medicaid.gov (select PA Assignment "Out of Hospital Births"). Complete the PA request form, and upload the supporting documentation;
- Fax the OHA Prior Authorization Request Form (MSC 3971) and supporting documentation to the Provider Clinical Support Unit at 503-378-5814 (Salem), or
- Send OHA Prior Authorization Request Form (MSC 3971) and supporting documentation via secure email to the unit at prior.authorization@dhsoha.state.or.us.

For all requests, fax clinical documentation to OHA as listed below.

Documentation required for initial request

1. **Completed Oregon Electronic Document Management System (EDMS) Coversheet** MSC 3971
2. **Completed OHA provider documentation checklist** (Appendix A) for Community Birth Services. Requests will not be reviewed without this completed checklist included in the PA request.
3. **Member-specific transfer plan signed and dated by the member.** This plan must list the hospital's name, address, and phone number; and how the member will get there. Please note whether hospitals have 24-hour OB and anesthesia availability in case an emergency C-section is needed.
4. **All medical documentation** to support your request, including ICD-10 diagnosis codes and CPT/HCPCS procedure codes. Providers are responsible to submit complete and accurate documentation that their members meet low-risk criteria. This includes documentation from any former providers in addition to the current provider. Please refer to the Documentation section of this guide for specific format and content of documentation.

Documentation required for concurrent review

OHA will conduct concurrent review of the documentation submitted with the prior authorization request to determine whether the pregnancy remains low-risk under the applicable rules and HERC Guideline Note 153.

Prior to delivery:

The following documentation is required to be submitted no later than 38 weeks, 0 days gestation, with the exception of flow sheet documentation for prenatal encounters after OHA provisional approval. If complete documentation is not submitted to support the request, OHA will deny the prior authorization request:

- Standardized gestational diabetes mellitus (GDM) screening between 24 weeks, 0 days – 28 weeks, 0 days gestation using either a 2-step (screening test followed by a diagnostic test) or 1-step (diagnostic test used for all pregnant persons) approach. Please note that Hemoglobin A1c and/or home glucose monitoring is not a substitute for the mandatory evidence-based testing and will not be accepted as supportive documentation of GDM screening and would result in a denial of coverage.

- A second trimester ultrasound for evaluation of placental, uterine, or fetal anomalies
- Routine prenatal labs
- Flow sheet documentation of all prenatal encounters that have occurred since OHA provisional approval notice, through the entire pregnancy including labor and delivery monitoring. This documentation must be submitted every 2 weeks from the time of provisional approval through delivery.

After delivery:

The following documentation is required to be submitted no later than 30 days after delivery for final authorization of coverage. Note that authorization of coverage is not a guarantee of payment, or that if payment is made, that an audit by the Provider Integrity Audit Unit of OHA may not conduct an audit:

- Flow sheet documentation of labor including Blood Pressure (BP) and Fetal Heart Rate (FHR) monitoring throughout labor, length of time between rupture of membranes and birth, total estimated blood loss (EBL), birth of placenta time and status (intact and normal or not)
- Birth data including date of birth, Estimated Gestational Age (EGA) at birth, birth weight, Apgar scores at 1 minute and 5 minutes
- Narrative documentation for the summary of the birth including any complications (e.g. post-partum hemorrhage requiring medication or transport, newborn concerns, etc.).

If you have questions or concerns about prior authorization

Please review this guide and PA notices you received from OHA. For status and updates to PA, check the portal.

If you still have questions or concerns, call the PA Line at 1-800-336-6016 option No. 3. The PA Line is staffed Monday through Friday, 8 a.m. to 5 p.m., to answer questions about the status of your PA request.

Documentation

Philosophy

The goal of documentation is to ensure the member's safety, and should not be regarded as a mere administrative requirement. OHP reimburses services which are consistent with community standards of quality, safety, and ethics, which depend on accurate documentation.

Accurate, verifiable, original documentation helps OHP ensures that pregnant persons planning a community birth have truly low-risk pregnancies, and that such a birth setting is medically appropriate. Documentation should show that the provider addressed potential risk factors thoughtfully and appropriately, according to community standards of care and HERC Guideline Note 153.

General requirements

OHP enrolled providers are responsible for ensuring that they maintain appropriate documentation and submit it to OHA upon request. OAR 410-120-1360(2)-(3). Failure to provide documentation requested by OHA may result in denial of the claim, recovery of payment or other authorized sanctions. OAR 410-120-1360(5).

Narrative requirements

All encounters between the provider and patient must have a narrative entry that:

- Clearly conveys the purpose of the visit;
- Relates the progress, problems, and questions that patient is experiencing;
- Relates and addresses objective findings, including results of any physical evaluation/examination performed and the actions planned and/or taken;
- Is legible; and
- Where possible, states findings in the form of actual numbers, not subjective judgments. For example, Fundal Height (FH) should be recorded as "35 cm," not "normal."

SOAP format: Subjective, Objective, Assessment, Plan – is recommended. Briefly:

- S (Subjective) is Something the patient tells you
- O (Objective) is Other than the patient's description (*e.g.*, physical exam, labs)
- A (Assessment) is Actual clinical interpretation by the provider of the visit and pregnancy
- P (Plan) is Proposed Plan of action based on assessment

Checklists and flow charts are not a replacement for adequate narrative documentation.

All notes must be signed by the provider responsible for the care delivered at the visit.

Documentation requirements

Documentation should be original documentation by the provider delivering care.

- If external records are referenced, they should be separately attached and attributed to source and original date, never cut and pasted.
- Lab and imaging results should be on **original letterhead from the laboratory or facility** which performed the testing. A text note that a lab result or ultrasound is normal is not sufficient.

Providers **must** include the following documentation with their prior authorization request as set out in Appendix A of this document:

- Narrative entry for every encounter, with the content described below.
- Comprehensive medical history, regardless of whether the pregnant person has had a previous prenatal care provider for the current pregnancy, including pre-pregnancy weight.
- OB history: Gravida, Para, Sab, Tab, Premature. For each previous pregnancy, outcome described as weeks' gestation, birth weight, with notes about any complications of pregnancy, labor and delivery, and postpartum period.
- Member's medical history, history of the current pregnancy so far; psychosocial history including presence or history of substance abuse, mental illness, or high-risk living situation; family history, medication list, allergies.
- All medications, herbs, and supplements the pregnant person is taking, with specific doses in appropriate units, frequency, and duration.
- Objective data for every visit: FH, presentation, FHR, fetal movement, preterm labor symptoms, blood pressure, edema, weight, UA glucose/protein.
- Flow charts for visit week of gestation, including at minimum: weight, FH, BP, UA results, etc..
- Original laboratory results for syphilis, HIV, hep B, CBC with diff, ABO typing, Rh factor, blood typing, rubella status, antibody screen, urine cultures, other. Provider should also include the results for any other laboratory tests performed during prenatal care.
- All risk conditions and abnormal lab or imaging results at the time they are known, and provider's follow-up, and treatment plan, at that time. For example, "UA shows 1+ proteinuria today: will obtain first a.m. void to rule out non-orthostatic proteinuria," would be appropriate but "UA not indicated" at the next visit would not.
- Results for the standardized gestational diabetes (GDM) screen using a 1 and/or 3-hour screen. These results may not be available at the time the PA request is initially submitted if it is before 24 weeks gestation. However, it must be submitted on or before 38 weeks (zero days) gestation. Alternative tests or self-reports will not be accepted by OHA
- Ultrasound showing complete fetal anatomy and placentation (and a follow-up ultrasound if indicated).
- A completed Provider Documentation Checklist for Community Birth Services (see Appendix A).

Documentation should support the following:

- Provider has evaluated for the presence of high risk and potentially high risk conditions referenced in the HERC's Prioritized List Guideline Note 153, and other Guidelines as clinically relevant to the individual patient.
- Provider is continually monitoring for the possible development of high risk and potentially high-risk conditions.
- Provider sought appropriate consultation(s) regarding any potentially high-risk conditions as defined by Guideline note 153 and provider is appropriately managing consultant's recommendations.

Special circumstances

Some circumstances require more documentation, as listed below.

Member refuses an indicated test

Always document a patient's decision to refuse testing that is clinically appropriate and necessary for risk assessment.

If the member refuses a required clinical or diagnostic assessment (e.g., syphilis, HIV, Hep B, CBC, blood typing, rubella status, antibody screen, ultrasound, GDM testing) as described in this guide and applicable rules and tables:

- Risk status of the pregnancy cannot be assessed.
- Criteria for coverage of community birth will not be met.
- OHA will not be able to approve the PA request for community birth services.

Member's condition meets consultation criteria as defined in Guideline Note 153 of the Prioritized List

If any conditions are present which require consultation from a licensed provider who has active admitting privileges to manage pregnancy in a hospital and/or an appropriate specialty consultation, documentation must include:

- Date of consultation.
- Credentials and name of consulting provider.
- Documentation from the consulting provider as a result of the encounter including assessment and recommendation(s) related to the condition which prompted the consult.
- The name of the hospital where the consulting provider has admitting privileges; and
- After the consultation, community birth provider's written assessment and plan for the condition that triggered the consult, considering the consultant's recommendations.

In-person consultation is always preferred, so that the consultant has full access to medical records and the patient. If consultation is obtained using a telehealth modality, it must be medically and clinically appropriate for the nature of the condition. In other words, if a physical exam or direct patient interview is needed to evaluate the condition, a telephone consult is not acceptable.

Gestational diabetes mellitus (GDM) screen

Documentation must include the following:

- Date and times of collection
- Method (*e.g.,* 1- or 2-3 hour oral glucose tolerance test)
- Actual numerical results. For example, "One-hour GTT using a solution containing 50 grams of glucose on 9-1-15 = 111" would be acceptable, but "GDM testing normal" is not acceptable documentation.

GDM screening and testing must be conducted utilizing standardized method(s). Hemoglobin A1c and/or home glucose monitoring is not a substitute for the required standardized Oral Glucose Challenge Test (OGCT) or Oral Glucose Tolerance Test (OGTT). GDM testing utilizing non-standardized methods are not acceptable and will result in denial of coverage for community birth services.

Member has received previous prenatal care for current pregnancy

Providers must submit copies of original records including risk factor documentation, attached separately with

attribution to source. Text notes such as “Previous care normal,” “No concerns” or “Low risk” are not sufficient.

Providers should obtain previous records **on or before** the first visit and review them as early in the pregnancy as possible. Providers should include a dated narrative note indicating when the provider reviewed records and conducted an assessment of risk based on the record review. Providers should address all risk factors regardless of whether the previous provider noted them. See Guideline Note 153 of the Prioritized List of Health Services for more information.

Member has anemia

A hemoglobin (HGB) of < 8.5 is a high risk condition and requires transfer of care. A HGB < 10.5 requires a consultation. Please see Guideline Note 153. Providers should:

- Obtain ferritin levels as soon as anemia is detected, to verify whether deficient iron stores are present, in addition to hemodilution.
- Calculate dosing of iron based on degree of iron deficiency and anemia,
- Specify product name and exact dosage of iron used to treat anemia, as for all medications and supplements;
- Re-check hemoglobin every 4 weeks in anemic women to verify that dosing is adequate and tolerated. An improvement in hemoglobin of 1.0 or more is considered evidence of clinical improvement; smaller changes may be within the margin of error for measurement; and
- If improvement is lacking, adjust iron dose upward accordingly.

Correcting documentation

Corrections must be entered into the OHP member’s record in chronological order at the time they are made. For example, if an item in history is discovered to be in error, do not redact or amend the original note; place a signed addendum in chronological order with the current date with new information.

Billing

Eligibility and enrollment

Verify the member's OHP eligibility and enrollment prior to rendering service or billing. Prior authorization is based on a member's eligibility status at the time of OHA's authorization. It does not guarantee future OHP eligibility or payment for services rendered to an ineligible individual.

Go to the OHP Eligibility Verification page to learn more about how to verify eligibility and enrollment.

For services to the pregnant person

Once OHA provisionally approves community birth services for an OHP member, prenatal, antepartum, delivery and post-partum care will be carved out of coordinated care organization (CCO) coverage and will be covered as fee-for-service.

- Providers may bill OHP for initial risk assessment visits and for services rendered under provisional authorization only.
- Initial visits to evaluate OHA's risk criteria are carved out with or without prior authorization. CCO enrollment will not change such that other care (physical and behaclienvioral health) will remain through the CCO.

If OHA later issues a denial of the PA request upon concurrent review:

- OHP is responsible to pay only for services rendered before the denial was issued.
- The provider must discuss payment with the member before rendering additional services. The provider's discussion with the member is about future services and whether the member agrees to pay for them.
- Providers may need to use billing codes that separate out antepartum care from the global so OHP can pay our portion and the member can pay hers.

If OHA continues to approve the PA request upon concurrent review, pregnancy-related care continues for up to 60 days following the end of pregnancy for the pregnant person.

For services to the newborn

Newborns must be reported to OHP on the Newborn Notification form (OHP 2410) as soon as possible after delivery. Once reported, all newborns of current OHP members are enrolled with OHP Plus benefits in a CCO. CCO enrollment is retroactive to their date of birth. Depending on when the birth is reported to OHP, this process may take up to a month to complete.

Providers can submit the Newborn Notification form in three ways:

- Mail to OHP Customer Service: P.O. Box 14520 Salem, OR 97309-5044
- Fax to 503-378-4138
- Send via secure email to OHP.Newborns@dhsoha.state.or.us. This mailbox will only be available for the duration of the COVID-19 emergency

Do not bill OHA for delivery before submission of the Newborn Notification form. The Office of Payment Accuracy and Recovery (OPAR) within the Oregon Department of Human Services may retract payment in such cases.

The CCO is responsible for paying for all newborn care unless the care is provided by a non-contracted provider. Providers who are not contracted with a CCO may bill OHA (not the CCO) for newborn care provided on the first day of life only. Subsequent newborn care is the CCO's responsibility.

Billing and coding

Refer to Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code descriptions and standards for more information. **Appendix B** lists the most common services provided and procedure codes for prenatal care, labor and delivery, and postpartum care.

Billing OHP members for non-covered services

Because they receive Medicaid benefits, OHP members have special rights under federal and state law. It is against the law for you to require them to pay for any services covered by Medicaid, except when **all** of the following occurs:

1. OHA denies your PA request because the pregnant person does not meet low-risk pregnancy criteria.
2. OHA's denial is **not** due to inaccurate, incomplete, or late documentation submission for the PA request.
3. The member signs informed consent that she is aware of the risks of proceeding with community birth services despite not meeting low-risk pregnancy criteria.
4. The member signed a Medicaid-specific Agreement to Pay Form (OHP 3165) that lists the planned community birth services, shows she understands these services are not covered, and she agrees to pay for them.
5. You bill only for services provided after the date the member signed the OHP 3165 form.

Providers may not bill the member for more than OHP's usual reimbursement rate for the services. Providers may not collect a deposit or advance payment from an OHP client. Billing a client in any other circumstance constitutes fraud and may be prosecuted. OAR 410-120-1280(1)(b)

In addition, providers may not bill the member:

- For any services OHP would not reimburse if the PA request had been approved.
- If OHA denies the PA request due to lack of complete, accurate, and timely documentation. OAR 410 120 1280(1)(b) requires that a member "may not be billed for services or treatments that have been denied due to provider error (*e.g.,* required documentation not submitted, prior authorization not obtained).

If you have billing questions or concerns

Please review this guide, notices received from OHA, and the OHP Billing Tips page. If you still have questions or concerns, call the Provider Services Unit at 1-800-336-6016 (Option 5). Provider Services staff can answer questions about billing, appeals and requests for claim reconsideration.

Appendix

Appendix A: OHA Provider Documentation Checklist for Community Birth Services

Providers must use this form to record all required documentation that is submitted to OHA. All required documentation is indicated below in the "Minimum required" column and set out in Table 1 of OAR 410-130-0240. To expedite review:

- Please note date(s) for all items listed below. Enter the date the item was obtained unless otherwise specified.
- Attach all documentation in chronological order of the chart. Records must be legible.
- For items that are not applicable, please enter "N/A." Note that for items that are required, providers may not enter "N/A."
- Please refer to the Documentation section of this guide for specific format and content of documentation.

Request information

Prior authorization number: _____ **Member name:** _____ **Expected due date:** _____

Required documentation due no later than 38 weeks, 0 days gestation:

Minimum required	Additional guidance	Date(s)
1. **Subjective information:** Narrative entry containing content of subjective, objective, assessment, and plan (SOAP), **for every encounter** with the requesting community birth provider based upon clinical data	Enter date(s) so far, from first to most recent visit. • Assessment and Plan for each individual risk factor, if any • Assessment and Plan for each abnormal lab finding, if any	
2. Complete maternal obstetrics history, including from all prior providers.	Refer to HERC Guideline Note 153 for obstetric history needed to evaluate risk of adverse obstetrical or birth outcomes	
3. Complete medical/surgical history	Refer to HERC Guideline Note 153 for medical and surgical history needed to evaluate risk of adverse obstetrical or birth outcomes	
4. Complete psychosocial history	Refer to HERC Guideline Note 153 for psychosocial history needed to evaluate risk of adverse obstetrical or birth outcomes	
5. Medication list	Include all over the counter medications, nutritional supplements, and herbal products with dosing information	
6. Complete physical exam	Refer to HERC Guideline Note 153 for clinical information needed to evaluate risk of adverse obstetrical or birth outcomes	
7. **Objective data:** Required testing. Includes copies of the original lab reports for the following tests. Include date(s) collected or performed. These include any records for services performed prior to current provider: • Syphilis, HIV, Hep B, CBC, blood type with antibody screen	If any listed tests are not performed or the member declines, the Division will not authorize PA or payment.	

Minimum required	Additional guidance	Date(s)
• Copy of original lab report for standardized glucose tolerance test (GTT) 1 &/or 3-hour screen for gestational diabetes mellitus (GDM).(Generally performed at **24-28** weeks gestation) • Copy of ultrasound report showing fetal anatomy and placentation. (Generally performed at **18-22 weeks** gestation). The Division may request additional ultrasound records if a provider, consulting provider or radiologist indicated additional ultrasound is recommended		
8. Informed consent for declined care or testing	If any listed tests are not performed or the member declines, the Division will not authorize PA or payment.	
9. **Objective data:** Provider's documentation for each encounter with the member from initiation of care with the provider to time of submission, to include the following clinical data elements: gestational age, fundal height (FH), presentation, fetal heart rate (FHR), blood pressure (BP), edema, weight, and urine glucose/protein	May be submitted in flowchart format provided that sufficient clinical detail is included.	
10. All records of previous prenatal care from other providers for **current pregnancy**	Note that the submitting provider is responsible for obtaining and submitting all prior maternal obstetrics history and documents by 38 weeks, 0 days gestation.	
11. Dated narrative note of provider review of all previous prenatal care records including the community birth provider's assessment of risk based upon this review	While the provider must conduct a risk review, the Division determines risk for purposes of PA and payment	
12. Consult documentation from provider performing consult.	Refer to HERC Guideline Note 153 for conditions that require consultation by an appropriate provider	
13. Transfer plan, signed and dated by member naming the hospital(s) chosen as a contingency plan in the event that the planned community birth requires a different level of care for the pregnant person and/or the newborn	Transfer plan must include: • Identification of hospital(s) with 24/7 obstetric services • Identification of hospital(s) with a neonatal intensive care unit (NICU) • Preferred method for transportation to hospital	

Final documentation required to OHA prior to or at the time of claim submission

Minimum required	Additional guidance	Date(s)
14. Flow sheet or other documentation of labor, including Blood Pressure (BP) and Fetal Heart Rate (FHR) monitoring throughout labor, length of time between rupture of membranes and birth, total estimated blood loss (EBL), birth of placenta time and status (intact and normal or not)		
15. Birth data including date of birth, location of delivery, Estimated Gestational Age (EGA) at birth, birth weight, Apgar scores at 1 minute and 5 minutes		
16. Narrative documentation for the summary of the birth including any complications (e.g. post-partum hemorrhage requiring medication or transport, newborn concerns, etc.)		

Appendix B: Billing Code Tables

Billing pathways (prenatal, delivery, and postpartum care):

Global

Bill the global when the same provider:

- Completed at least 7 prenatal care visits, delivered the baby, and provided the postpartum care.
- Provided all the elements (7 prenatal, delivery, and postpartum).

Code	Description
59400	Obstetrical care (antepartum, delivery, and postpartum care)

Not global: Delivery and care

Bill this pathway when the provider who delivers the baby did not provide all the prenatal and/or postpartum care required to bill the global.

- Including situation where the visits were split between more than one provider or pregnant person entered care at a point where 7 prenatal visits was not feasible.
- You must use the codes with the highest level of bundling for your situation. For example, you may not bill E&M codes if you provided 4-6 antepartum visits.

Code	Description
E&M codes*	Antepartum care, 3 or fewer visits
59425	Antepartum care, 4-6 visits
59426	Antepartum care, 7 or more visits
59409	Obstetrical care (delivery only)
59410	Obstetrical care (delivery and postpartum only)
59430	Care after delivery (postpartum only)

* **E&M codes** are 99202-99205 for new patients and 99211-99215 for established patients. Directions for selecting the correct E&M code are beyond the scope of this guide.

Not global: Care but not delivery

Bill this pathway when you provided some service but did not deliver the baby or when OHP will not be paying for the delivery.

- Including risk assessment visits for a pregnant person determined not to be eligible for OHP payment,
- Services rendered under preliminary approval before a PA denial, and/or
- Services rendered under preliminary approval before transfer of care.
- You must use the codes with the highest level of bundling for your situation.

Code	Description
E&M codes*	Antepartum care, 3 or fewer visits
59425	Antepartum care, 4-6 visits
59426	Antepartum care, 7 or more visits
59899	Labor support
59430	Care after delivery (postpartum only)

* **E&M codes** are 99202-99205 for new patients and 99211-99215 for established patients. Directions for selecting the correct E&M code are beyond the scope of this guide.

Global or not global: Codes billable in addition to the routine obstetric care

Code	Description	Comments
57170	Fitting of diaphragm/cap	• One (1) per date of service.

Code	Description	Comments
90371	HepB ig IN	• One (1) unit per date of service. • Must include NDC code on the claim. • Provider bills unless the place of service is a Birth Center or hospital. **See Birth Center billing below.**
90471	Immunization admin	• One (1) unit per date of service.
90472	Immunization admin, each add	• Bill one (1) for each administration after the first. Up to 5 per date of service.
92950	Cardiopulmonary resuscitation (e.g., in cardiac arrest)	• UP to three (3) per date of service.
96360	Hydration IV Infusion, Init	• One (1) per date of service.
96361	Hydrate IV Infusion, add On	• Up to eight (8) per date of service.
96372	Ther/Proph/Diag Inj, SC/IM	• Up to four (4) per date of service.
A4261	Cervical cap for contraceptive use	• One (1) per date of service. • Must include NDC code on the claim.
A4266	Diaphragm	• One (1) per date of service. • Must include NDC code on the claim.
J0171	Injection adrenalin, epinephrine, 0.1 mg	• Up to one hundred twenty (120) units per date of service. • Must include NDC code on the claim. • Provider bills unless the place of service is a Birth Center or hospital. **See Birth Center billing below.**
J0290	Injection, ampicillin, sodium, up to 500 mg (use separate line for each 500 mg used)	• Up to twenty-four (24) units per date of service. • Must include NDC code on the claim. • Provider bills unless the place of service is a Birth Center or hospital. **See Birth Center billing below.**
J1364	Injection, erythromycin lactobionate, per 500 mg (use separate line for each 500 mg used)	• Up to two (2) units per date of service. • Must include NDC code on the claim. • Provider bills unless the place of service is a Birth Center or hospital. **See Birth Center billing below.**
J2210	Injection methylergonovine maleate, up to 0.2 mg	• One (1) unit per date of service. • Must include NDC code on the claim. • Provider bills unless the place of service is a Birth Center or hospital. **See Birth Center billing below.**
J2540	Injection, penicillin G potassium, up to 600,000 units	• Up to seventy-five (75) units per date of service. • Must include NDC code on the claim. • Provider bills unless the place of service is a Birth Center or hospital. **See Birth Center billing below.**
J2790	Rh Immune globulin	• One (1) unit per date of service. • Must include NDC code on the claim. • Provider bills unless the place of service is a Birth Center or hospital. **See Birth Center billing below.**
J3875	Injection, magnesium sulfate, per 500 mg	• Up to twenty (20) units per date of service. • Must include NDC code on the claim. • Provider bills unless the place of service is a Birth Center or hospital. **See Birth Center billing below.**

Code	Description	Comments
J7050	Infusion, normal saline solution, 250cc	• Up to ten (10) units per date of service. • Must include NDC code on the claim. • Provider bills unless the place of service is a Birth Center or hospital. **See Birth Center billing below.**
J7120	Ringers lactate infusion, up to 1000cc	• Up to four (4) units per date of service. • Must include NDC code on the claim. • Provider bills unless the place of service is a Birth Center or hospital. **See Birth Center billing below.**
J7121	5% dextrose in lactated ringers infusion, up to 1000cc	• Up to four (4) units per date of service. • Must include NDC code on the claim. • Provider bills unless the place of service is a Birth Center or hospital. **See Birth Center billing below**
J8499	Oral methergine 0.2 mg	• One (1) units per date of service. • Must include NDC code on the claim. • Must include dosage amount. OHP uses dosage listed for pricing this code. • Provider bills unless the place of service is a Birth Center or hospital. **See Birth Center billing below**
S0077	Injection, clindamycin phosphate, 300 mg	• One (1) unit per date of service. • Must include NDC code on the claim. • Provider bills unless the place of service is a Birth Center or hospital. **See Birth Center billing below**
S8415	Disposable supplies for home delivery of infant	• One (1) unit per date of service.

Codes billable for the infant on the first day of life

Code	Description	Comments
92588	Newborn hearing screen	• One (1) unit per date of service. • May be billed by either the professional or the Birth Center but not both for the same date of service. • Report results to Oregon Early Hearing Detection and Intervention (EHDI) if required.
99460	Init NB evaluation and management per day, Facility (i.e. Birth Center)	• One (1) unit per date of service. • This code may not be billed with 99463. Discharge to home is included in this code.
99461	Init NB evaluation and management per day, Non-Facility (i.e. Home)	• One (1) unit per date of service. • This code may not be billed with 99463.
99463	Same day NB discharge (i.e. BC to hospital)	• One (1) unit per date of service. • This code is for NB care needed to transfer the infant to a hospital. Do not bill 99460 or 99461 with this code.
99465	NB Resuscitation	• One (1) unit per date of service.
J3830	Injection, phytonadione (Vitamin K) per 1 mg	• Typically, one (1) unit per date of service. • Must include NDC code on the claim. • Provider bills unless the place of service is a Birth Center or hospital. **See Birth Center billing below.**

Code	Description	Comments
S3620	Newborn metabolic screening panel, include test kit, postage and the laboratory tests specified by the state for inclusion in this panel	• One (1) unit per date of service. • Newborn screening double kit. • Route the "2nd specimen" in the double kit to the provider who will collect this specimen. You may send it with the parent to give to the follow up provider. • May be billed by either the professional or the Birth Center but not both for the same date of service.

Codes for birth center facilities

Codes listed as "bundled" are bundled into the Birth Center facility payment can cannot be billed separately.

Code	Description	Comments
59409	Obstetrical care (delivery only)	• Birthing Center Facility payment. • Some supplies are bundled into this payment. See individual items below.
90371	Hep b ig im	• One (1) unit per date of service. • Birth center is responsible for this supply. • Pays separately (outside of the facility bundle)
92588	Newborn hearing screen	• One (1) unit per date of service. • May be billed by either the professional or the Birth Center but not both for the same date of service. • Report results to Oregon Early Hearing Detection and Intervention (EHDI) if required. • Pays separately (outside of the facility bundle)
J0171 (Bundled)	Injection adrenalin, epinephrine, 0.1 mg	• Birth center is responsible for this supply.
J0290	Ampicillin 500 mg inj	• Birth center is responsible for this supply. • Payment is **bundled** into the Birth Center facility payment.
J1364	Erythro lactobionate /500 mg	• Up to two (2) units per date of service. • Birth center is responsible for this supply. • Pays separately (outside of the facility bundle)
J2210 (Bundled)	Methylergonovin maleate inj	• Birth center is responsible for this supply. • Payment is **bundled** into the Birth Center facility payment.
J2540	Penicillin g potassium inj	• Birth center is responsible for this supply.
J2790 (Bundled)	Rho d immune globulin inj	• Birth center is responsible for this supply.
J3830 (Bundled)	Vitamin k phytonadione inj	• Birth center is responsible for this supply.
J3875 (Bundled)	Inj magnesium sulfate	• Birth center is responsible for this supply.
J7050 (Bundled)	Normal saline solution infus	• Birth center is responsible for this supply.
J7120 (Bundled)	Ringers lactate infusion	• Birth center is responsible for this supply.
J7121 (Bundled)	5% dextrose in lactated ringers infusion, up to 1000cc	• Birth center is responsible for this supply.
J8499 (Bundled)	Oral methergine 0.2 mg	• Birth center is responsible for this supply.

Code	Description	Comments
S0077 (Bundled)	Injection, clindamycin phosphate, 300 mg	• Birth center is responsible for this supply.
S4005	Interim labor facility global (labor occurring but not resulting in delivery)	• Birth Center Facility payment for labor support. Use this code in transfer situations when no delivery occurred.
S3620	Newborn metabolic screening panel, include test kit, postage and the laboratory tests specified by the state for inclusion in this panel	• One (1) unit per date of service. • Newborn screening double kit. • Route the “2nd specimen” in the double kit to the provider who will collect this specimen. You may send it with the parent to give to the follow up provider. • May be billed by either the professional or the Birth Center but not both for the same date of service.