HERC Coverage Guidance: Planned Out-of-Hospital Birth

High-Risk Condition Response Table (Updated with EbGS February and June 2020 Decisions)

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Table 1. Medical History or Obstetric History

Risk Factor (Medical or Obstetric History)	Comment ID/ Summary	Evidence/ Guidelines/ Standards	Options considered for EbGS February 2020 meeting	EbGS February 2020 Decision (June 2020 Revisions *Italicized*)
Cancer • Cancer affecting site of delivery	I7 Proposed modification – clarification, commenter says criterion is unclear.	This phrasing arises from the WA Billing Guide (2017). Available studies do not mention cancer in exclusion criteria. LDEM proposed (2019) uses "active cancer" phrasing.	Consider modification: Active gynecologic cancer	Change to: • Active gynecologic cancer
Cardiovascular disease • Cardiovascular disease causing functional impairment	I8 Proposed modification – expansion, commenter says functional	Birthplace (2011) excludes confirmed cardiac disease. Language regarding severity of cardiac disease varies by guideline. The phrasing here is from WA Billing Guide (2017). NICE (2017) has individual planning when cardiac disease will not have	Consider modification: Significant cardiovascular disease (e.g., functional impairment).	No change.

	impairment too restrictive, functional impairment unclear as well.	intrapartum implications. ACNM (2015) states "substantial medical conditions that have required acute medical supervisions during the pregnancy and could impact the birth such as cardiac disease."		
Collagen vascular disease • Any	P2, AB2 Proposed modification – allow for consultation for rheumatoid arthritis based on variable disease severity.	This phrasing arises from the WA Billing Guide (2017) in which it is a transfer criterion. Birthplace (2011) excludes women with systemic lupus erythematosus, scleroderma but does not specifically address rheumatoid arthritis.	No change or consider changing collagen vascular disease from a transfer (3) to a consult criterion (2). (Note: Meeting materials correct a comment in Appendix I that incorrectly listed this as a consultation criterion.)	Change to consult criteria and combine with connective tissue disorders – Rename Connective Tissue Disorders. • Systemic lupus erythematous • Scleroderma • Rheumatoid arthritis • Any collagen-vascular disease
Delivery history • Prior cesarean section	F1, F2, L3, P3, Q3, U2, V2 W1, AB3 Conflicting comments, delete entire category based on good VBAC outcomes for OOHB, modify to coverage	While a successful VBAC is an optimal outcome, this issue at hand regards outcomes for all women attempting a TOLAC. The exclusion of prior cesarean section is in keeping with findings from a comparative U.S. study (Grunebaum, McCullough, Spara et	Make no change. This is based on evidence of worse neonatal outcomes and in keeping with ACNM (2015), ACOG (2017), NICE (2017), and the WA Billing	No change.

	when there is a prior vaginal delivery as well (F2, Q3). Commenters cite unspecified data, or from the Oregon Association of Birth Centers, American Association of Birth Centers or CMS showing good outcomes for women with prior cesarean and prior vaginal deliveries. Some suggest coverage with informed consent in this population.	al., 2017) that found an 8-fold increase in neonatal mortality. A separate U.S. study (Tilden et al., 2017) observed a non-statistically significant increase in neonatal death for women completing a vaginal birth after cesarean in home or birth center settings compared to hospitals. Findings from non-comparative studies (Bachilova et al., 2018; Cox et al., 2015) also observe rare but higher rates of neonatal harm or death in women undergoing TOLAC. Cheney et al., 2014 observed higher rates of intrapartum neonatal death but the results were not statistically significantly different. The question of outcomes for women attempting a TOLAC with a prior vaginal delivery are not addressed by comparative studies. For neonates, TOLAC increased odds of low 5-minute Apgars, hospitalization and NICU admission (Bovjberg et al., 2017). This exclusion condition is also aligned with guidelines from AABC	Guide (2017) and exclusion of prior cesarean section as low risk in multiple studies. EbGS previously discussed expert testimony indicating TOLAC is safe for women with a prior vaginal birth with a lower threshold for transfer. However, the subcommittee did not recommend coverage because TOLAC is not even available at many rural hospitals because of a lack of availability of emergency delivery services (lack of in-house anesthesia and/or in-house maternity provider).	

		(2017), ACNM (2015), ACOG (2017), NICE (2017), and the WA Billing Guide (2017). In many rural parts of Oregon, TOLAC is unavailable in hospitals because of a requirement that the hospital have an anesthesiologist available at all times.		
Endocrine conditions • Significant endocrine conditions other than diabetes (e.g., hyperthyroidism)	P4, U3, AB4 Proposed modification – clarification for CNM or ND (e.g., hypothyroidism).	Washington has "Significant endocrine disorders" as a transfer criteria (3). LDM Board has hyperthyroidism as a consultation criteria (2).	Make no change to the current recommendation for consultation for significant endocrine conditions other than diabetes (e.g., hyperthyroidism). Fix the error in Appendix I to omit an incorrect reference to hypothyroidism which may have resulted in confusion.	No change.
Fetal demise or stillbirth • History of unexplained fetal demise or stillbirth or	F3, P5, Q4, U4, V3, AB5	This phrasing arises from Birthplace (2011), continues to be a high-risk condition in NICE (2017). NICE (2017) allows for individual planning when a	Consider changing to: • Prior unexplained fetal demise, ~~or~~	Simplify to the following consult criteria:

previous death related to intrapartum difficulty	F3 Questions evidence for both transfer and consult. P5 and AB5 suggest changing transfer requirement to a consultation. Q4 asks for clarification of intrapartum difficulty and removal of transfer requirement (e.g., death related to intrapartum breech is not a risk for future pregnancies). U4 requests removal of transfer requirement. V3 proposes dropping transfer criteria based on informed decision of patient.	history of stillbirth/neonatal death from a non-recurrent cause. CMBC (2018) has consultation for previous neonatal mortality or stillbirth (no specific comment regarding intrapartum difficulty).	stillbirth, or previous death related to intrapartum difficulty	• Prior stillbirth/neonatal death

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Fetal demise or stillbirth • Prior unexplained stillbirth/neonatal death or death unrelated to intrapartum difficulty (consult)	F3 Questions evidence for transfer and consult.	See line above for response.	• Prior unexplained stillbirth, neonatal death, or death unrelated to intrapartum difficulty (consult) • Prior explained fetal demise, stillbirth, or previous death with potential for recurrence (consult)	Simplify to the following consult criteria: • Prior stillbirth/neonatal death
Fetal growth • History of intrauterine growth restriction (IUGR) • Prior small for gestational age infant • Prior baby > 4.5 kg or 9 lbs 14 oz	F6, F14, Q5 Proposed deletion all three consult criteria based on lack of evidence.	Phrasing arises from prior CG (2015) and CMBC (2018).	Consider deletion.	Delete category.
Hematologic disorders • History of thrombosis or thromboembolism	Q6 Proposed deletion of this category.	Birthplace (2011) excluded women with hemoglobinopathies, thromboembolic or bleeding	No change. Or consider:	Change to consultation criteria

• Maternal bleeding disorder	Commenter reports provider medical judgment should suffice.	disorders, platelet disorders given their higher risk for adverse events in pregnancy. Guidelines concur with these consultation and exclusion criteria ACNM (2015), NICE (2017), LDEM proposed (2019).	• History of unprovoked thrombosis or thromboembolism • Maternal bleeding disorder	• History of thrombosis or thromboembolism Maternal bleeding disorder remains a transfer criterion.
Hematologic disorders • Anemia with hemoglobin < 8.5 in prior pregnancy • Hemoglobinopathies • History of postpartum hemorrhage requiring intervention	F4 Proposed deletion- anemia with hemoglobin < 8.5 in prior pregnancy. Proposed modification – clarification on intent of history of postpartum hemorrhage requiring interventions.	Phrasing for history of postpartum hemorrhage requiring intervention arises from WA billing guide (2017) and is consistent with ACNM (2015), NICE (2017). Postpartum hemorrhage requiring interventions includes but not limited to Bakri balloon, blood transfusion, uterine aspiration or curettage, manual removal of placenta.	Thank you for bringing this to our attention. This was an error in the coverage guidance as posted for comment; the error has now been corrected by removing this criterion and the erroneous row in Appendix I.	Delete • Anemia with hemoglobin < 8.5 in prior pregnancy
Hypertensive disorders • Eclampsia • Pre-eclampsia requiring preterm birth	P6, U5, V4, AB6 P6, V4, AB6 - Proposed modification of the	Birthplace (2011) excluded women a history of pre-eclampsia requiring pre-term birth as high risk of adverse outcomes. Unable to identify unspecified evidence referenced by P6 on	No change.	No change.

• HELLP syndrome (hemolysis, elevated liver enzymes, low platelets) • Pre-existing or chronic hypertension	category to consult only. Proposed deletion (U5) of the history of pre-eclampsia requiring pre-term birth and HELLP components as these conditions not guaranteed to return in future pregnancies	improvement of outcomes for women with this history in the care of midwives. Guidelines concur with this exclusion condition NICE (2017).		
Infectious diseases • HIV positive	F5 Proposed deletion of this component based on provider capability to assess risk and lack of evidence.	Women with HIV are excluded from comparative studies (Birthplace, 2011; Hutton et al., 2016.) given their higher than average risk. Viral load influences delivery planning for mother and management of the neonate for post-exposure prophylaxis. Guidelines concur with this exclusion condition ACNM (2015), NICE (2017), WA Billing Guide (2017).	Make no change. This was discussed during EbGS and was agreed to require hospital level care. ACOG recommends cesarean section at 38 weeks for elevated viral load. Infant requires immediate antiretroviral therapy. Some recommend intrapartum antiretrovirals.	No change.

Miscarriage/nonviable pregnancy • 3 or more 1st trimester spontaneous miscarriages • 1 or more 2nd trimester spontaneous miscarriages	Q7 Proposed deletion of this category based on lack of evidence.	Phrasing from CMBC (2018) only and no mention of this condition across included studies.	Consider deletion.	Delete category.
Neonatal encephalopathy in prior pregnancy	Q8 Proposed deletion of this category based on lack of evidence.	Birthplace (2011) excluded women with a previous child with neonatal encephalopathy. NICE (2017) has this as an exclusion for planned out-of-hospital birth.	No change.	Change to consult criteria.
Neurological disorders • History of maternal seizure disorder	I9 Proposed modification that any maternal seizure disorder should be a transfer.		No change. EbGS previously discussed that active seizure disorders would be a transfer criteria and history of maternal seizure disorder that was not active (e.g., no seizure in 20 years) was	Delete history of maternal seizure disorder. Neurological disorders or active seizure disorders that would impact maternal or neonatal health (e.g. epilepsy, myasthenia gravis, previous cerebrovascular

			appropriate for consult.	accident) remains a transfer criterion.
Obesity or overweight (pre-pregnancy) • Class 2 or 3: BMI ≥ 35.0	F7, P7, Q9, U6, V5, AB7 Proposed deletion of this category – Evidence for consult lacking (F7, Q9). Lack of value in consult (F7, P7, Q9, V5, AB7). Discrimination and lack of evidence of harm for this population (U6). Request for informed refusal form (V5, AB7).	Absence of evidence on women from comparative studies as Birthplace (2011) women with BMI over 35 at booking excluded. Also excluded in the Dutch Perinatal Registry analysis (van der Kooy et al., 2017). Other comparative international studies of higher risk individuals did not isolate outcomes for this specific risk factor (Davis-Tuck et al., 2018; Li et al., 2015). Non-comparative U.S. studies observed increased neonatal harms with pre-pregnancy obesity (BMI ≥ 35 compared to < 25) (Bovbjerg et al., 2017). OHA review of neonatal deaths (2013) observed morbid obesity (BMI > 40) as one of several high-risk factors present.	Consider whether to make no change or delete. Evidence suggests increased harms, aligns with CMBC.	Delete category.
Perineal lacerations or obstetric anal sphincter injury	F8, Q10 Proposed deletion of these components	No included studies address prior perineal lacerations or obstetric anal sphincter injuries.	Consider deletion. Erroneous classifications in	Delete category.

• 4th degree prior pregnancy without satisfactory functional recovery • 3rd degree prior pregnancy • 4th degree prior pregnancy with satisfactory functional recovery	based on provider ability to determine.	Current phrasing consistent with prior CG (2015), CMBC (2018).	Appendix I for WA and LDEM (should be for current pregnancy, not historical).	
Psychiatric conditions • History of postpartum mood disorder with high risk to the infant (e.g., psychosis) • Schizophrenia, other psychotic disorders, bipolar I disorder or schizotypal disorders	F9, P8, P9, Q11, U7, U8, V6, AB8, AB9 Proposed deletion of this category based several concerns by commenters: Postpartum psychosis history, when well-supported and controlled in current pregnancy shouldn't impact place of birth (F9, P9). OOHB allows for greater control, closer follow-up, and	Birthplace excluded women requiring current inpatient care, consistent in NICE (2017). No additional evidence from comparative or non-comparative studies for this category. WA Billing Guide (2017) lists current severe psychiatric illness as a high-risk exclusion criteria. ACNM – psychiatric conditions that may affect intrapartum care management or maternal or neonatal transition following birth. CMBC – "history of serious psychological problems," requires consult.	Discuss whether to make no change or change to consult. Extensive EbGS discussion about this and variable recommendations from others on transfer versus consult.	Change to consult criteria. • History of postpartum mood disorder with high risk to the infant (e.g. psychosis) • Schizophrenia, other psychotic disorders, bipolar I disorder or schizotypal disorders

	may improve outcomes (F9, P8, Q11. V6, AB8, AB9). Absence of evidence (P8, U7, U8, AB8).	LDEM board – consult recommended for psychiatric disorders with concern for maternal and fetal safety, current treatment with prescription medication for any ongoing or chronic medical conditions." Extensive committee discussion weighing risks and benefits of the language for this condition and discussed concerns regarding involuntary transfers and potential for hospitals to exacerbation psychiatric conditions.		

Table 2. Conditions of Current Pregnancy

Risk Factor (Conditions of Current Pregnancy)	Comment ID/ Summary	Evidence/ Guidelines/ Standards	Options for consideration at EbGS February 2020 meeting	EbGS February 2020 Decision (June 2020 Revisions *Italicized*)
Age • < 17 years • > 40 years	F10, I2, L2, Q12, AA5 Proposed deletion of this category (F10, Q12) or the > 40 years component (L2).	Comparative studies of fetal or neonatal mortality from U.S. settings report greater risk for women over 35 years of life but did not adjust for other potential confounders or	Discuss options: 1) Make no change 2) Delete it altogether	Delete category.

	Proposed addition with language for consult if maternal age 35 to 39 years, and transfer for maternal age ≥ 40 years (I2). Proposed addition with language for transfer if maternal age > 35 years (AA5).	identify effect modifiers in older women (e.g., obesity, medical comorbidities). Comparative studies from non-U.S. settings that attempt to adjust for confounding observed the greatest risk of neonatal harm for nulliparous women over 40 (Li et al., 2014). NICE (2017) has age over 35 as indicating individual assessment. CMBC (2018) recommends consultation for young (< 17) or older (> 40) year old women.	3) Make more restrictive	
Amniotic membrane rupture • Pre-labor rupture > 24 hours	Q13, P10, U9, AB10 Proposed modification (Q13) – change to consult for pre-labor rupture of membranes (ROM) > 24 hours and transfer for ROM > 24 hours with signs or symptoms of infection. Request for deletion.	Included studies do not address this condition. Current phrasing arise from NICE (2017) and WA Billing Guide (2017).	Discuss whether to make no change or consider change to consult for pre-labor ROM > 24 hours and transfer for ROM > 24 hours with risk factors (e.g., GBS positive or unknown) or signs or symptoms of infection.	Change to consult criteria. Rupture before 37 weeks 0 days remains a transfer criterion.

Congenital or hereditary anomaly of the fetus • (Evidence of congenital anomalies requiring immediate assessment and/or management by a neonatal specialist)	F11 Proposed modification – requests clarification of who decides and right to refusal.		The decision would likely be based on a high-risk OB/Gyn consultant and/or pediatric consult. For coverage to occur, the transfer and consult criteria must be followed.	Change to consult criteria.
Congenital or hereditary anomaly of the fetus • Evidence of congenital anomalies requiring immediate assessment and/or management by a neonatal specialist	I5 Proposed addition with language requiring transfer for all fetal malformations based on increased risk. Specifically mentions *including < 3 vessel cord*.	Congenital anomalies constituted 29.5% of neonatal deaths among midwife-assisted home births (Grunebaum, McCullough, Arabin, et al., 2017). Many comparative studies specifically exclude known congenital anomalies from estimates (de Cock et al., 2015; Grunebaum, McCullough, Sapra, et al., 2017; Hutton et al., 2016; Snowden et al., 2015)	Discuss whether to make no change or consider whether < 3 vessel cord should be included as a transfer criterion. EbGS had an extensive discussion about the intent to enable coverage in the case of non-resuscitation, but otherwise any major congenital anomaly	Change to consult criteria. Do not mention 3 vessel cord.

		Phrasing arises from the ACNM (2015). Guideline language varies "affected by site of birth" (WA).	would likely require hospital delivery.	
Diabetes, gestational • Requiring medication or uncontrolled • Diet controlled	Proposed deletion for ND providers as medications within their scope of practice.		No change. Pregnant women who require pharmacotherapy for diabetes require more intensive monitoring and early induction of labor and increased infant monitoring. NICE and WA both consider pharmacotherapy for diabetes a transfer criterion.	No change to diabetes requiring medications or uncontrolled diabetes. Delete: Diet-controlled.
Diabetes, gestational • Requiring medication or uncontrolled • Diet controlled	U10 Proposed deletion of this category.	Birthplace (2011) excludes women with gestational diabetes. Phrasing aligns with ACNM (2015), NICE (2017) and WA (2017).	No change. Consultation for diet-controlled diabetes could be with a pregnancy dietician.	No change to diabetes requiring medications or uncontrolled diabetes. Delete: Diet-controlled.

Fetal demise or stillbirth • Fetal demise (after 12 weeks gestation)	F12, Q14 Proposed deletion of this category based on lack of evidence, unclear impact on safety or value.	Included studies do not address this condition. Phrasing arises from the WA billing guide (2017).	Discuss whether to make no change or consider deletion.	Delete category.
Fetal growth • IUGR (defined as fetal weight less than 5th percentile using ethnically-appropriate growth tables, or concerning reduced growth velocity on ultrasound)	I10 Proposed modification with language to require transfer for IUGR in current pregnancy.		This was an error, IUGR should have been red, not yellow, thank you for bringing this to our attention.	Clarified error. Keep as transfer criteria.
Fetal growth • Uteroplacental insufficiency • IUGR (defined as fetal weight less than 5th percentile using ethnically-	F14, Q15 Proposed deletion of the component suspected macrosomia (estimated weight > 4.5 kg or 9 lbs 14 oz) (F14) or category (Q15) as commenters request medical	Included studies do not address this condition. NICE (2017) recommend transfer for suspected growth restriction or macrosomia.	Discuss whether to make no change versus consider deletion of "suspected (estimated weight > 4.5 kg or 9 lbs, 14 oz)."	Delete: Suspected (estimated weight > 4.5 kg or 9 lbs, 14 oz)

appropriate growth tables, or concerning reduced growth velocity on ultrasound). • Inappropriate uterine growth (size-date discrepancy). (An ultrasound read by a qualified physician constitutes a consultation). • Suspected (estimated weight > 4.5 kg or 9 lbs, 14 oz)	judgment of individual case should suffice.			
Fetal monitoring • Abnormal fetal heart rate pattern	I15 Proposed modification – clarify definition as unclear.	Included studies do not address this condition. Topic of discussion by committee ultimately settled on current phrasing based on variety of language used by ACNM (2015), CMBC (2018), NICE (2017), proposed LDEM	No change. EbGS had an extensive discussion about this and was in favor of more broad compared to more detailed language.	Delete category.

		rules (2019) and WA billing guide (2017).		
Fetal monitoring or movement • Abnormally decreased fetal movement antepartum	I16 Proposed modification- to require transfer with any decreased fetal movements.	Included studies do no address this condition. Phrasing arises from NICE (2017). Topic of discussion by committee ultimately settled on current phrasing.	No change. EbGS had an extensive discussion about this and settled on this language.	Delete category.
Fetal presentation • Breech or noncephalic presentation	L3, AA8 Proposed modification to require transfer for only non-frank, non-complete breech presentations.	Included studies observed increased risk of neonatal death in non-cephalic presentations (Grunebaum, McCullough, Sapra et al., 2017). Phrasing aligns with AABC (2017), ACNM (2015), ACOG (2017), NICE (2017) and WA Billing Guide (2017).	No change.	No change.
Gestational age • < 37 weeks 0 days • ≥ 42 weeks 0 days	L3 Proposed modification to require transfer for gestational age < 36 weeks and 6 days and for > 42 weeks and 6 days based on scope of practice.	Included comparative studies on outcomes by gestational age reported increased risk of neonatal mortality ≥ 41 weeks (Grunebaum, McCullough, Sapra et al., 2017; Grunebaum, McCullough, Arabin et al., 2017). The included studies but	No change based on increased death rate at ≥ 41 weeks gestation. There is alignment with multiple sources ≥ 42. EbGS also discussed that planned OOHB	Change to "≥ 42 weeks 0 days (unless already in active labor at 41 weeks 6 days)."

		did not adjust for other potential confounders or identify effect modifiers (e.g., obesity, medical comorbidities, hypertensive disorders). Phrasing aligns with AABC (2017), ACNM (2015), NICE (2017).	may be more likely to be assigned to a later gestational age based on dating methodologies.	
	Q16 Proposed modification with language to require transfer for gestational age ≥ 42 weeks and 3 days or consideration of family history of post-dates births.	*See response above.* Family history consideration not addressed by included evidence nor guidelines.	No change. See above.	No change.
	I13, AA6 Proposed modification with language to require transfer for gestational age ≥ 41 weeks based on increased risk.	*See response above.* NICE (2017) covers women from 37 and 0 to 41 weeks and 6 days gestation.	Discuss whether to leave it at ≥ 42 weeks or change it to ≥ 41 weeks. Death rates increase at ≥ 41 weeks gestation. There is alignment with multiple sources ≥ 42.	No change.

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Hematologic conditions • Thrombocytopenia (platelets < 100,000)	P12, AB12 Proposed modification with requesting language to require transfer for thrombocytopenia (< 75,000).	Birthplace (2011) excluded women with history of thrombocytopenia < 100,000. Phrasing aligns with NICE (2017)	No change given lack of alignment with the new proposed platelet number.	No change.
Infectious conditions • Group B strep unknown	F13, L3, P13, Q17, U11, V7, AB13 Proposed deletion of this component based on patient right for informed refusal and lack of evidence.	Included studies and guidelines do not address this condition. OHA (2013) identified unknown or untreated group B streptococcal infection as a factor in neonatal deaths in the out of hospital birth setting.	Discuss whether to make no change or consider deletion.	Delete.
Infectious conditions • HIV, Hepatitis B or syphilis status unknown or positive	L4 Proposed modification for Unknown status for infections (i.e., HIV, Hep B, syphilis) – specific comment on low-risk individuals previously screened, necessity of repeating in current pregnancy and patient right to refuse unnecessary medical care.	Evidence nor guidelines comment on this issue.	Discuss whether to make no change or consider deletion of "unknown status."	Delete unknown status. Change to: • HIV, Hepatitis B or syphilis positive

Infectious disease • Genital herpes at time of labor	Q18 Proposed modification to change language to require transfer for genital herpes that is uncoverable [sic] at time of delivery.	Included studies do not address this suggested approach to managing active genital herpes. Included guidelines align with current phrasing ACNM (2017), NICE (2017), WA Billing Guide (2017).	No change.	No change.
Meconium	Proposed deletion of this category based on lack of evidence (F15) or when only risk factor should not require transfer (Q19). Proposed modification with language to change language to require transfer for any meconium staining (I12) based on increased risk.	Studies vary in their handling of meconium-stained fluids and consider meconium staining a complicating condition at the start of labor (e.g., Birthplace, 2011). Phrasing aligns with NICE (2017) and WA Billing guide (2017).	No change. Conflicting requests and currently aligns with others.	Delete category.
Multiple gestations	L3 Proposed deletion of this category based on scope of practice. I4 Affirmed that multiple gestations represent high risk	All included comparative studies report outcomes for singleton pregnancies and exclude multiple gestations. Findings from noncomparative studies (Bovbjerg et al., 2017) observed increased odd of maternal (cesarean delivery) and neonatal harms (low 5-	No change.	No change.

	of neonatal morbidity and mortality.	minute Apgar, NICU admission) for twin pregnancies. This condition also aligns with AABC (2017), ACNM (2015), ACOG (2017), CMBC (2018), NICE (2017), and WA Billing Guide (2017).		
Neurological disorders • Significant maternal confusion or disorientation	Q20 Proposed modification to change to consult based on a specific clinical example.	Phrasing arises from WA Billing Guide (2017).	Discuss whether to make no change or consider deletion.	Delete.
Parity • Grand multipara (5 or more previous births)	F16, L2, Q21 Proposed deletion of this category based on absence of evidence and lack of utility (F16), within scope (L2), unclear impact on outcomes (Q21).	Included studies do not address this condition. Phrasing arises from CMBC (2018).	Consider deletion.	Delete grand multipara.
	I3 Proposed addition of requiring transfer for nulliparity based on higher	Included comparative studies of neonatal mortality for nulliparous women observed increase risk (Grunebaum, McCullough, Sapra et al., 2017; Grunebaum, McCullough,	No change.	Do not add nulliparity to transfer criteria.

	neonatal mortality and high transfer rate.	Arabin et al., 2017). In studies with composite outcomes, neonatal harms are increased (Birthplace, 2011) or no different (Li et al., 2015) across settings for nulliparous women. Included guidelines do not address this suggestion addition. This was a topic of extensive discussion by the committee who ultimately prioritized the value women place on choice of birth setting for this category.		
Placental conditions • Low lying placenta within 2 cm or less of cervical os at 36 weeks or later	Q22 Proposed language clarification-low-lying placenta within 2 cm of OS at last documented ultrasound before onset of labor. Proposes if resolved on a 38 weeks scan, women should be eligible for OOHB.	The current phrasing arose from the proposed LDEM rules and 2015 coverage guidance. Evidence does not address this proposed clarification.	Discuss no change versus modifying to: Low lying placenta within 2 cm or less of cervical os at last documented ultrasound before the onset of labor ~~36 weeks or later~~.	Modify to: • Low lying placenta within 2 cm or less of cervical os at 38 weeks 0 days or later
Placental conditions	L4	Included studies do not address this condition.	No change.	No change.

• Placental delivery > 60 minutes	Proposed modification to a consult.	Included guidelines align with this condition ACNM 2015, NICE (2017), WA Billing guide (2017).	Others aligned with this.	
Prenatal care • Inadequate prenatal care defined as < 5 visits or care began in 3rd trimester	Q23, U13 Proposed deletion of this category citing patient autonomy (U13) and provider judgment (Q23).	Included studies do not address this condition. Phrasing varies from exclusion to consultation in WA Billing Guide (2017), CMBC (2018), and the 2015 CG depending on the timing of initiation, language around number of visits or compliance with the care plan.	Discuss no change or deletion.	Delete category.
Psychiatric conditions • Maternal mental illness requiring psychological or psychiatric intervention • Patient currently taking psychotropic medications	Q24 Request for deletion based on provider medical judgment should determine need for consult.	Included studies do not provide evidence on this specific condition. Included studies excluded individuals with maternal mental illness requiring inpatient admission (Birthplace, 2011). Included guidelines use a variety of language to address this condition (Appendix I) that broadly include wording regarding risk for potential harm to self or infant (ACNM,	No change. The language states the patient needs psychological or psychiatric intervention, therefore a consultation is necessary. The new consultation definition would clarify that a psychologist or psychiatrist would serve as the consultant.	No change.

		2015; CMBC, 2018; NICE, 2017; WA, 2017).		
Uterine condition • Uterine rupture, inversion or prolapse	P14, U12, V8, AB14 Proposed modification with addition of clarifying language: unless immediately reduces.	CMBC (2018), NICE (2017) and WA (2017) and DEM all have this as a transfer criterion. Included studies nor guidelines do not address this proposed modification.	No change. There is consistency across many sources that this should be a transfer requirement.	Change uterine prolapse to a consultation criterion; rupture and inversion remain transfer criteria.

Table 3. Neonatal Conditions

Risk Factor (Neonatal Conditions)	Comment ID/ Summary	Evidence/ Guidelines/ Standards	Options presented for consideration at February EbGS meeting	EbGS February 2020 Decision
Apgar score • < 5 at 5 minutes • < 7 at 10 minutes	I14 Proposed modification with language to require transfer if Apgar < 7 at 5 minutes based on increased risk.	Phrasing arises from CMBC (2018).	Discuss no change or change to Apgar < 7 at 5 minutes. Apgar Score • < ~~5~~7 at 5 minutes • < 7 at 10 minutes	Delete entire category of neonatal conditions.
Neonatal appearance • Persistent poor suck, poor feeding,	Q25 Proposed deletion of this criteria as clinical judgment should suffice.	Phrasing arises from CMBC (2018).	Consider deletion.	Delete entire category of neonatal conditions.

Risk Factor (Neonatal Conditions)	Comment ID/ Summary	Evidence/ Guidelines/ Standards	Options presented for consideration at February EbGS meeting	EbGS February 2020 Decision
lethargy, hypotonia or abnormal cry				
Neonatal weight • < 5th % for GA	Q26 Proposed deletion of this criteria unless other complications or issues.	Phrasing arises from the 2015 CG, proposed LDEM rules and CMBC (2018).	Discuss whether to make no change versus deletion.	Delete entire category of neonatal conditions.