

Out-of-Hospital Birth Reimbursement Guide



HEALTH SYSTEMS DIVISION

Provider guide for reimbursement of
out-of-hospital birth services

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Introduction

OHP will reimburse licensed out-of-hospital birth providers practicing within the scope of their license for prenatal, labor and delivery, and postpartum care that is:

- Medically appropriate for pregnancies that meet OHP's low-risk pregnancy criteria, and
- Authorized prior to billing OHP.

About this guide

This guide is for out-of-hospital birth providers to learn how to seek approval and reimbursement from the Oregon Health Authority (OHA) for medically appropriate out-of-hospital birth services provided to Oregon Health Plan (OHP) members.

It gives instructions on how to:

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

Provider enrollment

Out-of-hospital birth provider types

LDMs, CNMs, DCs, NDs, DOs, NPs, and MDs enrolled with OHA may seek authorization and reimbursement for planned out-of-hospital birth services to OHP members. All providers must:

- Have a current license to practice in Oregon;
- Be in good standing with their respective licensing boards; and
- 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.)

Licensed providers must personally perform all of the care provided, with the exception allowed for direct supervision of a student in the provider's area of licensure. *Direct supervision* means the licensed provider is present and 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 Web 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.

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

The Oregon Health Authority (OHA) will reimburse for covered out-of-hospital birth services when they are:

- Authorized by OHA as medically appropriate according to clinical criteria and
- Provided, documented and billed according to relevant Oregon Administrative Rules (OARs).

Covered services

- Some tests performed and interpreted by the out-of-hospital provider
- Provider-administered medications
- Antepartum care, vaginal delivery and postpartum care through 60 days post-EDD
- If the mother has to be transferred to a hospital for delivery, any labor support work done prior to the transfer
- 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 the lab (not the out-of-hospital birth provider) for labs and tests referred out to a lab. Pass-through billing is not allowed.

Clinical coverage criteria

Low-risk pregnancy criteria

[Guideline Note 153](#) of the [Prioritized List of Health Services](#) (effective January 1, 2016) defines OHA's clinical criteria for low-risk pregnancy. This guideline is based on the Health Evidence Review Commission (HERC)'s evidence-based [Coverage Guidance](#) (adopted November 12, 2015).

OHA is authorized to reimburse for care **only** for pregnancies which meet these low-risk criteria.

Consultation criteria

Certain high-risk conditions require you to consult with a provider having labor and delivery admitting privileges in a hospital. These conditions are listed in Guideline Note 153.

- The purpose of consultation is to evaluate, assess risk of, and advise management for the condition(s) that meet HERC’s consultation criteria.
- The purpose is **not** to obtain a “Go or No-Go” decision from the consultant about whether an out-of-hospital birth is appropriate.
- OHA determines medical appropriateness and whether the pregnancy continues to meet low-risk criteria based on review of the consultation documentation.

Other requirements

HERC guidance also requires that the provider:

- Perform appropriate risk assessments throughout pregnancy; and
- For certain intrapartum and postpartum complications, transfer the mother and/or newborn to a hospital.

Oregon Administrative Rules

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

- [332-025-0020 through 0110](#), Board of Direct Entry Midwifery – Practice Standards
- [332-025-0120](#), Board Of Direct Entry Midwifery – Informed Consent Practice Standards
- [333-076-0650](#), Ambulatory Surgical Centers – Service Restrictions

By enrolling with OHA as an Oregon Medicaid provider, you agree to follow all pertinent state and federal regulations, including OHA rules.

The Provider Clinical Support Unit must also determine whether services are “medically appropriate” as defined in OAR 410-120-0000(139), and meet general prior authorization and coverage requirements of OARs referenced below.

- [410-120-0000](#), General Rules – Acronyms and Definitions
- [410-120-1200](#), Excluded Services and Limitations
- [410-120-1320](#), General Rules – Authorization of Payment
- [410-130-0200](#), Medical-Surgical Services – Prior Authorization
- [410-130-0240](#), Medical-Surgical Services – Medical Services
- [410-141-0520](#), Prioritized List of Health Services

Prior authorization

All services for out-of-hospital births (with the exception of services from providers contracted with the member's CCO) require authorization by the Oregon Health Authority (OHA) for fee-for-service reimbursement, prior to billing. For all requests:

- Request prior authorization for codes 59400 (global pre, intra, and postnatal care) **and** 59899 (for services provided prior to hospital transfer, in case of complications requiring transfer).
- Submit as early in the pregnancy as possible, and no later than 27 weeks', 6 days' gestation. You can minimize the number of submissions by ensuring all items in the checklist are included, appropriate to the stage of pregnancy, just after fetal anatomy ultrasound results are obtained (18-22 weeks gestation).

If you do not send OHA all requested documentation prior to billing for delivery, OAR 410-120-1320(4)(b) and (18) permit the DHS/OHA Office of Payment Accuracy and Recovery to withdraw payment and assess a penalty.

OHA will review requests received after 27 weeks', 6 days' gestation for exceptional reasons only. If possible, please submit late requests within two weeks of learning of the situation requiring a late request.

Process overview

After review of your request, the Provider Clinical Support Unit 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](#); and
- Whether documentation demonstrates that the requested services are medically appropriate, according to Oregon Administrative Rules [333-076-0650](#), [410-130-0240](#), [410-120-1320](#), [410-130-0200](#), and [410-120-0000](#).

If your request has missing or inadequate documentation:

You need to provide OHA complete documentation within 30 days of OHA's response. After that, OHA will automatically deny the request due to missing information.

If your request is complete, accurate and timely:

If it demonstrates that an out-of-hospital birth is medically appropriate and meets low-risk criteria, OHA will notify you of provisional approval as soon as possible.

How to submit prior authorization requests

You can submit requests in two ways.

- Fax the DHS/OHA Prior Authorization Request Form ([MSC 3971](#)) to the Provider Clinical Support Unit at 503-378-5814 (Salem), or
- Use the Provider Web Portal at <https://www.or-medicaid.gov> (select PA Assignment “10 – Out of Hospital Births”).

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

Documentation required for initial request

As early in the pregnancy as possible send the following documents under the EDMS Cover Sheet ([MSC 3970](#)):

1. **OHA provider documentation checklist** for Out-of-Hospital Birth Services (see next page). Requests will no longer be reviewed without this checklist.
2. **Informed consent for Out-of-Hospital Birth Services, signed by client.**
3. Client-specific **transfer plan**, signed by the client. This plan must list the hospital’s name, address, and phone number; and how the client 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 clients meet low-risk criteria.

For requests submitted after 27 weeks, 6 days’ gestation:

Also include the reason your request is late, all previous prenatal records, and your review and assessment of previous records.

Information needed for follow-up assessments

The provisional approval from OHA will list the documentation needed for follow-up assessments. At a minimum, this will include:

- Standardized GTT screen for GDM at 24-28 weeks gestation;
- GBS test at 35-37 weeks’ gestation; and
- Documentation of all prenatal visits that have occurred since OHA approval.

If you have questions or concerns about prior authorization

Please review this guide and PA notices you received from OHA.

If you still have questions or concerns, call the PA Line at 1-800-642-8635 or 503-945-6821. The PA Line is staffed to answer questions about requesting authorization, or to update a request you submitted to OHA.

Due to the volume of PA requests, Provider Clinical Support staff can no longer accept personal phone calls or emails.

OHA Provider Documentation Checklist for Out-of-Hospital Birth Services

Use this form to record all required documentation you are submitting to OHA. 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 your chart. Records must be legible.
- For items that are not applicable, please enter "N/A." For example, items 5, 6, 7, 15 and 16 may not apply.
- 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

Documentation due for initial request	Date(s)
1. Transfer plan, signed. <i>Enter the date the client signed the plan.</i>	_____
2. Informed consent for out-of-hospital birth services, signed.	_____
3. Flow chart showing all visits so far by week, FH, presentation, FHR, fetal movement, BP, edema, weight, UAs, PTL symptoms	_____
4. Narrative entry containing content of subjective, objective, assessment, and plan, for every visit. <i>Enter date(s) so far, from first to last visit.</i>	_____
5. Informed consent for individual risk factors	_____
6. Informed consent for declined care or testing	_____
7. Plan for individual risk factors, if any, each	_____
8. Plan for abnormal lab findings, each	_____
9. Complete maternal OB history.	_____
10. Complete medical/surgical history	_____
11. Complete psychosocial history	_____
12. Thorough physical exam at first visit, including pre-pregnancy BMI	_____
13. Medication list with detailed dosing information	_____
14. Allergies	_____
15. All records of previous prenatal care (<i>obtained ASAP from first visit</i>)	_____
16. Dated narrative note reviewing all previous prenatal care records, including assessment of risk based on review.	_____
17. Original lab reports (e.g., syphilis, HIV, Hep B, gonorrhea/chlamydia, CBC with diff, ABO typing, Rh factor, Rubella, Antibody screen, urine cultures, other). <i>Enter date(s) collected or performed.</i>	_____
18. Ultrasound showing fetal anatomy (<i>generally 18-22 weeks</i>)	_____
Documentation due after 24 weeks:	Date(s)
19. Standardized GDM screen (<i>24-28 weeks</i>)	_____
20. GBS culture (<i>35-37 weeks</i>)	_____
21. All subsequent prenatal visit narratives and flow chart (<i>from approval through delivery</i>)	_____
Documentation due if consult is indicated:	Date(s)
22. Date and consult documentation from person performing consult	_____
23. Credentials and admitting hospital of consultant	_____
24. Narrative note by provider discussing assessment of risk and plan for monitoring and/or treatment, based on consult	_____

Billing

Eligibility and enrollment

Please verify the mother's OHP eligibility and enrollment prior to rendering service or billing. Prior authorization is not a guarantee of OHP eligibility or payment.

Go to the [OHP Eligibility Verification page](#) to learn more about how to verify eligibility and enrollment.

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 to current OHP members are enrolled with OHP Plus (BMH) benefits in a coordinated care organization (CCO), 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.

Do not bill OHA for delivery before submission of the Newborn Notification form. OPAR may retract payment in such cases.

The CCO is responsible to pay for all newborn care unless the care is provided by a non-contracted provider. Midwives should bill OHA (not the CCO) for newborn care on the first day of life.

For services to the mother

Once OHA approves out-of-hospital services for an OHP member, OHA will end the mother's CCO enrollment so that the services may be billed directly to OHA on a fee-for-service basis.

Billing and coding

Refer to Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code descriptions and standards for more information.

Service	How to bill
Obstetric care including antepartum and postpartum	Use global code 59400 to bill when antepartum care, vaginal delivery and postpartum care are all provided by the same provider.
	Refer to CPT/HCPCS standards for how and when it is permissible to bill antepartum care separate from vaginal delivery.

Service	How to bill
Transfer care	<p>If the mother meets transfer-to-hospital based care criteria after OHA approval of out-of-hospital birth services, OHA will reimburse services provided up until the time transfer to hospital care becomes indicated, provided complete, accurate and timely documentation of pregnancy care after approval, is received.</p> <p>To bill for labor support work done before transfer to a hospital, use code 59899 (unlisted maternity care procedure).</p>
Assistant services	Use modifier 80 or 81 to designate assistant services.
Newborn evaluation	<p>Newborn care on the first day of life may be billed with one of these codes once per provider per child:</p> <ul style="list-style-type: none"> ■ Use code 99461 for evaluation and care of newborns in a home setting. ■ Use code 99460 for evaluation and care in the birthing center setting.
Tests, medications and supplies	<p>Refer to CPT/HCPCS standards for how and when it is permissible to bill for tests and medications administered by the out-of-hospital birth provider.</p> <p>Use code S8415 to bill for supplies (packaged rate, for home births only).</p>

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 mother does not meet low-risk pregnancy criteria
2. The mother signs informed consent that she is aware of the risks of proceeding with out-of-hospital birth services despite not meeting low-risk pregnancy criteria
3. You submitted accurate, timely and complete documentation for the prior authorization request
4. The member signed a Medicaid-specific Agreement to Pay Form ([OHP 3165](#)) that shows she understands the 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

You may not bill the member for more than OHP's usual reimbursement rate for the services. You may not collect a deposit or advance payment from an OHP member.

Billing a member in any other circumstance constitutes fraud and may be prosecuted. OAR 410-120-1280(1)(b)

In addition, you may not bill the member:

- For any services OHP would not reimburse if the pregnancy had continued to meet low-risk criteria.
- If OHA denies your 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, etc”).

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. Provider Services staff can answer questions about billing, appeals and requests for claim reconsideration.

Documentation

Philosophy

The goal of documentation is to ensure the patient'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 ensure that women planning an out-of-hospital 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.

General requirements

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 (handwritten or typed); and
- Where possible, states findings in the form of actual numbers, not subjective judgments. For example, 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.

Documentation should include:

- Informed consent for out-of-hospital birth, and specific informed consent as applicable. Midwives must at a minimum meet the informed consent standards in [Oregon Administrative Rule 332-025-0120](#).
- First visit: Thorough physical examination, regardless of whether the mother has had a previous prenatal care provider, including height and BMI (based on pre-pregnancy weight).
- Objective data for every visit: Fundal Height, presentation, FHR, Fetal movement, preterm labor, blood pressure, edema, weight, UA glucose/protein
- Flow charts for visit week of gestation, including at minimum: weight, fundal height , BP, UA results, etc., so that trends become evident.
- Narrative entry for every visit, with content described above.
- All risk conditions and abnormal lab or imaging results at the time they are known, and provider’s follow-up 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 be.
- 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.
- Mother’s medical history, history of the 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 and supplements the mother is taking, with specific doses in appropriate units, frequency and duration, whether they have been prescribed by a maternity care provider, another provider, or self-prescribed; and whether they are prescription or over-the-counter.
- Original laboratory results for syphilis, HIV, Hepatitis B, and gonorrhea/chlamydia screening; CBC with Differential; ABO typing, Rh factor; rubella immunity; standard gestational diabetes testing (GDM screen); GBS and urine cultures, as obtained.
- Objective data for every visit: Weight, BP, pulse, fundal height, fetal heart rate, fetal movement, UA results.
- Ultrasound showing fetal anatomy.

Documentation should support the following:

- Provider addressed all absolute and non-absolute risk factors referred to in [Guideline Note 153](#), and others as clinically relevant to the individual client.
- Prenatal care meets community standards of prenatal care (see also the [United States Preventive Services Task Force](#) prenatal care guidelines).

Special circumstances

Some circumstances require more documentation, as listed below.

Mother refuses an indicated test

Always document a patient's decision to refuse testing that is clinically appropriate and necessary for risk assessment. Please include an Informed Consent that has been signed by the mother and states that the mother was informed what could happen if the test is not completed.

Fully discuss with the mother:

- How not having these test results presents health risks to both mother and baby, and possible psychosocial or emotional risk to the mother; and
- As applicable, that without these test results, OHA cannot determine whether the pregnancy is low-risk and cannot authorize reimbursement for any future services related to an out-of-hospital birth.

Mother's condition meets HERC consultation criteria

If any conditions are present which require consultation from a licensed provider who has admitting privileges in a hospital, your documentation must include:

- Date of consultation;
- Credentials and name of consulting provider;
- Original visit or call note documentation received from the consulting provider;
- The name of the hospital where the consulting provider has admitting privileges; and
- After the consultation, your written assessment and plan for the condition that triggered the consult, taking into account the consultation received.

In-person consultation is always preferred, so that the consultant has full access to medical records and the patient. If only telephone consult is obtained, it must be clinically reasonable 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.

OHA is working to increase the availability of consulting providers. OHA appreciates hearing of consultant availability or lack of availability in specific geographic areas.

GDM screen or urinalysis is performed in-house

Please submit the following:

- Date and times of collection
- Method (*e.g.*, 1- or 2- hour GTT)
- Actual numerical results. For example, "One hour GTT using 50 g glucola on 9-1-15 = 111" would be acceptable, but "GDM testing normal" would not be.

One-, two-, or three-hour GTTs performed between 24 and 28 weeks using standard 50g, 75g or 100g glucola, respectively, are considered adequate testing for GDM. Meals or candy, etc. are not acceptable. Random or fasting BGs or HgbA1C are not sufficient.

If at all possible, GDM testing is best performed by an accredited outside laboratory. GDM testing utilizing non-standardized methods are not acceptable.

Mother has had previous prenatal care

Please 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.

You should obtain previous records before or on the first visit and review them as early in the pregnancy as possible. Please include a dated narrative note indicating when you reviewed records and your assessment of risk based on the record review. Please address absolute and non-absolute risk factors regardless of whether the previous provider noted them.

Mother has anemia

Please specify product name and exact dosage of iron used to treat anemia, as for all medications and supplements.

- 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, keeping in mind that fetal and infant iron deficiency can lead to irreversible damage to cognitive and learning ability if not treated promptly and adequately. Maternal risks include failure to progress in labor, increased risk of transfusion and C-section, and preterm delivery.
- 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.
- If improvement is lacking, adjust iron dose upward accordingly. Iron should be given with Vitamin C or orange juice and at least one hour away from dairy to prevent calcium blocking absorption.

Correcting documentation

Corrections must be entered into the prenatal 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 chronologic order with the current date with new information.

Corrected, altered, or redacted records are not acceptable.

Examples of acceptable documentation

Antepartum Record (Form A through F), [American Congress of Obstetricians and Gynecologists \(ACOG\)](#). This is an example of excellent documentation format. See sample forms at www.healthdepartment.org/PHPRFTS5.htm.

Informed Consent Sample: Appendix 5, “Home Birth Informed Consent,” [Home Birth Handbook for Midwifery Clients](#) (Dec. 9, 2008), [College of Midwives of British Columbia](#)