

March 8, 2016

«AddressBlock»

To: Out-of-hospital birth providers Provider NPI: «Performing_Provider_NPI»

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Kim Wentz, M.D., M.P.H., Medicaid Medical Director

Subject: Requirements for out-of-hospital births effective December 1, 2015

As of December 1, 2015, the Oregon Health Plan (OHP) requires prior authorization for reimbursement of all out-of-hospital birth services. Required documentation must be submitted before the 28th week of gestation. Oregon Administrative Rule (OAR) 410-130-0200 was amended to allow the Oregon Health Authority (OHA) time to obtain documentation needed to review risk assessment of the pregnancy, and to ensure continuity of care with a hospital-based provider in cases where the pregnancy is not assessed to be low-risk.

This letter is to address concerns you have shared with us about this new requirement. Because we understand that many providers were not aware of the new requirement, OHA will accept requests for reconsideration if the denial was only because the submission was later than 27 weeks and 6 days gestation. OHA will accept these requests for reconsideration through March 31, 2016.

As of April 1, 2016, OHA will deny submissions received later than 27 weeks and 6 days gestation. You may request exceptions, and OHA will review them on a case-by-case basis.

We are enclosing the *Out-of-Hospital Birth Reimbursement Guide* (posted December 28, 2015), which includes the current requirements for prior authorization, documentation of risk assessment, and other guidance that pertains to out-of-hospital births.

Below are answers to frequently asked questions on this topic.

What should I do to ensure I have the latest information?

OHA posted this rule change to the OHP website, with email alerts sent to subscribers on November 16, 2015. Please sign up for OHA email updates to keep informed of changes to rules and guidelines that may affect how you do business with OHA:

1. OHP Provider Announcements at www.oregon.gov/OHA/healthplan/pages/announcements.aspx – For updates specific to your provider type, and the Health Systems Division’s monthly provider newsletter, *Provider Matters*.

2. Rules and guidelines for General Rules, Oregon Health Plan Rules, Medical-Surgical Services, and Temporary Rules at www.oregon.gov/OHA/healthplan/pages/policies.aspx. Rules specific to out-of-hospital birth are in the Medical-Surgical Services section at www.oregon.gov/OHA/healthplan/pages/medical-surgical.aspx.

Any necessary revisions to the *Out-of-Hospital Birth Reimbursement Guide* will be sent to the Medical-Surgical rules and guidelines subscribers.

How do I request reconsideration of a denial for out-of-hospital birth?

If OHA denied your prior authorization request on or after January 1, 2016, solely because the submission was later than 27 weeks and 6 days gestation, please resubmit your request no later than March 31, 2016. Please include the prior authorization number from the original decision notice OHA sent you. You do not need to resubmit previous documentation, only documentation of care delivered after the previous date of submission. Requests will be considered on a case-by-case basis to review whether risk assessment has been documented and shows the pregnancy is low-risk.

For all other requests for authorization of out-of-hospital birth reimbursement, please follow the timelines and documentation requirements effective December 1, 2015. These are outlined in the enclosed *Out-of-Hospital Birth Reimbursement Guide* and the Health Evidence Review Commission's Coverage Guidance for low-risk criteria at www.oregon.gov/OHA/herc/Pages/blog-home-birth.aspx.

For all out-of-hospital births, please submit complete documentation of care and risk assessment as early in the pregnancy as possible. To confirm the pregnancy's continued low-risk status, we will let you know when we need more information, and what kind of information to send, such as visit notes and screening results.

Questions?

If you have any questions about this announcement, contact the Provider Clinical Support Unit at 1-800-642-8635. We are available Monday through Friday, anytime between 8 a.m. and 5 p.m.

Thank you for your continued support of the Oregon Health Plan and the services you provide to our members.

Oregon Medicaid enrolled provider responsibilities

As an Oregon Medicaid enrolled provider, you are responsible for following the rules and guidelines that pertain to the care you provide. This includes signing up for email updates so that you know when rules and guidelines are updated. By submitting a claim to OHA, you are confirming that you have complied with all rules that apply to the service you are billing. See OAR 410-120-1280(5) and part 3 of your Provider Enrollment Agreement (OHA 3975) to learn more.

For all provider types and all services, prior authorization requirements are meant to ensure that the requested service is medically appropriate for the patient, before the service is actually delivered. (See OAR 410-120-1320 – Payment Authorization to learn more.)

OHA is committed to working with our partners to achieve positive birth outcomes. We use the Health Evidence Review Commission's Coverage Guidance and other guidelines to make sure that the services we approve are medically appropriate and safe for both mother and baby.

Guide to OHP reimbursement for out-of-hospital births

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Introduction

The Oregon Health Plan (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:

- Appropriate for pregnancies that meet OHP’s low-risk pregnancy criteria, and
- Authorized prior to billing OHP.

Also see Oregon Administrative Rule [410-130-0240\(4\)](#) for payment criteria and limitations.

Out-of-hospital birth provider types

LDMs, CNMs, NDs, DOs, NPs, and MDs enrolled with the Oregon Health Authority (OHA) may seek authorization and reimbursement for planned out-of-hospital birth services to OHP clients.

All providers must have a current license to practice in Oregon, and be in good standing with their respective licensing boards.

Licensed providers must personally perform all of the care provided, with the exception allowed for direct supervision¹ of a student in the provider's area of licensure.

Assistants for labor and delivery must also be enrolled with OHA. To learn how to enroll, visit the Provider Enrollment Web page at www.oregon.gov/OHA/healthplan/pages/providerenroll.aspx.

Covered services

OHP will reimburse out-of-hospital birth providers for the following services, if authorized by the Medical Management Unit as medically appropriate:

- 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.

Prior authorization

All services for out-of-hospital births require authorization, regardless of FFS or CCO enrollment, prior to billing. Authorization includes:

- An initial request no later than 27 weeks, 6 days' gestation to ensure that the OHP member meets [low-risk pregnancy criteria](#); and
- Follow-up assessments to demonstrate that the OHP member continues to [meet low-risk pregnancy criteria](#).

¹ *Direct supervision* means the licensed provider is present and actually able to intervene for the student if necessary.

Fax each request to the OHA Medical Management Unit at 503-378-5814 (Salem).

Information needed for initial request

Send the following documents under the EDMS Cover Sheet (MSC 3970 – [Word](#) or [PDF](#)):

- DHS/OHA Prior Authorization Request Form (MSC 3971 – [Word](#) or [PDF](#)).
- All medical documentation to support your request, including ICD-10 diagnosis codes and CPT/HCPCS procedure codes. Providers are responsible to submit adequate documentation that their clients meet low-risk criteria.

You can also find these forms at www.oregon.gov/OHA/healthplan/pages/forms.aspx or on the [Medical-Surgical policy page](#) under “Forms.”

You can also submit the request form through the Provider Web Portal at <https://www.or-medicaid.gov>. Select PA Assignment “10 – Out of Hospital Births.” If you do this, you still need to fax clinical documentation to 503-378-5814 as described above.

After review of your request, the Medical Management Unit may ask for additional documentation to support your request. The unit will determine:

- Whether documentation meets [low-risk pregnancy criteria](#) or not, and
- The medical appropriateness of requested services, according to Oregon Administrative Rules [333-076-0650](#), [410-130-0240](#), [410-120-1320](#), [410-130-0200](#), and [410-120-0000](#).

Information needed for follow-up assessments

If the Medical Management Unit approves the initial request, the approval will list the documentation needed for follow-up assessments, and how often.

Low-risk pregnancy criteria

At the request of the OHA [Licensed Direct Entry Midwife Staff Advisory Workgroup](#), the Health Evidence Review Commission (HERC) developed [evidence-based coverage guidance](#) that establishes low-risk pregnancy criteria for planned out-of-hospital births.

The guidance requires that the provider:

- Perform appropriate risk assessments throughout pregnancy;
- For certain high-risk conditions, consult with a provider having labor and delivery admitting privileges in a hospital; and
- For certain intrapartum and postpartum complications, transfer the mother and/or newborn to a hospital.

HERC’s coverage guidance was finalized and adopted on November 12, 2015.

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

Once reported to OHP on the Newborn Notification form ([Word](#)) ([PDF](#)), all newborns to current OHP members are enrolled with OHP Plus (BMH) benefits, and enrolled 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 three or more weeks to complete.

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 the Medical Management Unit 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.

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.

Transfer

To bill for labor support work done before transfer to a hospital, submit a request to adjust the existing out-of-hospital services authorization to add code 59899 (unlisted maternity care procedure) to the authorization. Include clinical documentation of the services rendered.

Once the request is approved, you may bill using code 59899.

Assistants

Use modifier 80 or 81 to designate assistant services.

Newborn evaluation

Newborn care on the first day of life may be billed with one of these codes once per provider per child:

- Use code 99461 for evaluation and care of newborns in a home setting.
- Use code 99460 or 99463 for evaluation and care in the birthing center setting.

Tests, medications and supplies

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.

Use code S8415 to bill for supplies (packaged rate, for home births only).

Documentation of care

Philosophy

The goal of documentation is to ensure the patient's safety, and should not be regarded as a mere checklist 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 is medically appropriate. Documentation should show that the provider addressed potential risk factors thoughtfully and appropriately to community standards of care.

General requirements

The Antenatal Record referenced below is an example of excellent documentation format.

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.

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

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

Documentation should include:

- Flow charts for visit week of gestation, fundal height, presentation, FHR, fetal movement, BP, edema, weight, signs of preterm labor, UAs, etc., so that trends become evident;
- Entries in the form of actual numbers, not subjective judgments. For example, FH should be recorded as “35 cm,” not “normal” or “near umbilicus,” etc;
- 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.
- Original documentation by the provider delivering care. If external records are referenced, they should be separately attached and attributed to source, never cut and pasted.
- Legible writing (handwritten or typed).
- Lab and imaging results 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 that addresses all risk factors referred to in Oregon Birthing Centers Tables [1](#), [2](#), and [3](#); and the [HERC coverage guidance](#). Content of prenatal care should

meet community standards of prenatal care (see also the [United States Preventive Services Task Force](#) prenatal care guidelines).

- 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.
- Thorough physical exam, mother's medical history, history of the pregnancy so far, social history, family history, medication list, allergies.
- Original laboratory results for syphilis, HIV, Hepatitis B, and gonorrhea/chlamydia screening; CBC with Differential; ABO typing, Rh factor; rubella immunity; gestational diabetes testing (GDM screen); and urinalysis.
- 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](#).
- Vitals for every visit: Weight, BP, fundal height in cm, fetal heart rate.
- First visit: Physical examination including height and BMI (based on pre-pregnancy weight).
- Ultrasound showing fetal anatomy.

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

If mother refuses an indicated test

It is also necessary to document a patient's decision to not engage in testing that is clinically appropriate and necessary for assessment. Please document that mother was informed what could happen if the test is not completed:

- The risk to herself and/or her baby; and
- If applicable, that OHP may not be able to authorize continued care for a planned out-of-hospital birth without this information.

FAQ 105 referenced below is an excellent example of the patient information component which could be used as part of informed consent for a woman refusing group B streptococcus (GBS) testing.

If conditions meet HERC consultation criteria

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

- Consult date
- Credentials and name of consulting provider
- Original visit notes from that provider, and
- The name of the hospital where the consulting provider has admitting privileges.

If only telephone consult was available, also provide consulting provider's telephone notes, if possible.

If GDM screen or urinalysis are performed in-house

Please submit the date of collection, method (*e.g.*, 1- or 2- hour GTT), and 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 hour or 2 hour GTTs performed between 24 and 28 weeks using standard 50g 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.

As with other lab testing, GDM testing is best performed by an accredited outside laboratory. GDM testing utilizing non-standardized methods will not be acceptable.

If the 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. Previous records should be obtained and reviewed as early in the pregnancy as possible.

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.

References

Antepartum Record (Form A), [American Congress of Obstetricians and Gynecologists \(ACOG\)](#)

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

Informed Consent Sample: Sample of patient information appropriate to include in informed consent for refusing GBS testing: [FAQ105: Group B Strep and Pregnancy, ACOG](#)

Oregon Administrative Rules:

- [332-025-0120](#), Board Of Direct Entry Midwifery – Informed Consent Practice Standards
- [333-076-0650](#), Ambulatory Surgical Centers – Service Restrictions
- [410-120-0000](#), General Rules – Acronyms and Definitions
- [410-120-1320](#), General Rules – Authorization of Payment
- [410-130-0200](#), Medical-Surgical Services – Prior Authorization
- [410-130-0240](#), Medical-Surgical Services – Medical Services
- [410-141-0060](#), Oregon Health Plan Managed Care Enrollment Requirements
- [410-141-3060](#), Enrollment Requirements in a CCO

Oregon Birthing Centers High Risk Factors for [Admission – Table 1](#); [Intrapartum – Table 2](#); [Postpartum Mother and Infant – Table 3](#)

[Oregon Health Evidence Review Commission Coverage Guidance: Planned Out-of-Hospital Birth](#), approved 11/12/15

[United States Preventive Services Task Force Published Recommendations](#) for screening, medication, and counseling during pregnancy