

Washington Apple Health (Medicaid)

Planned Home Births & Births in Birth Centers Billing Guide

June 11, 2022

Disclaimer

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

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

About this guide¹

This publication takes effect **June 11, 2022**, and supersedes earlier billing guides to this program.

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

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

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

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's [provider alerts webpage](#).

To access provider documents, go to HCA's [provider billing guides and fee schedules webpage](#).

Where can I download HCA forms?

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

¹ This publication is a billing instruction.

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What has changed?

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

Subject	Change	Reason for Change
Coding for postpartum care only	Replaced information in the note box with billing information for office visits during the 6-week postpartum period, including the comprehensive postpartum visit usually done at 6 weeks postpartum, and information regarding the new After Pregnancy Coverage (APC) 12-month Medicaid extension for clients who have been recently pregnant.	APC program goes into effect on June 11, 2022. Visit HCA's APC webpage for more information on APC coverage.

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Resources Available

Topic	Contact
Policy questions or exception to rule questions	Planned Home Births and Births in Birth Centers Program Manager Health Care Authority Program Mgmt. & Authorization Section PO Box 45506 Olympia, WA 98504-5506 Phone: 1-800-562-3022
Newborn screenings	Department of Health (206) 418-5410 or (866) 660-9050 Email: nbs.prog@doh.wa.gov
Medical information	University of Washington Med Consultation Line (800) 326-5300 (toll free)
Maternity Support Services/Infant Case Management	See First Steps webpage Email: FirstSteps@hca.wa.gov

Topic	Contact
<p>Which birth centers are HCA-approved birth centers?</p>	<ul style="list-style-type: none"> • Bellingham Birth Center - Bellingham, WA • Birth Inn - Tacoma, WA • Birthroot Midwives & Birth Center - Bellingham, WA • Cascade Birth Center - Everett, WA • Center for Birth LLC - Seattle, WA • Community Birth Center – Lacey, WA • Eastside Birth Center - Bellevue, WA • Greenbank Women’s Clinic and Childbirth Center- Greenbank, WA • Lakeside Birth Center - Sumner, WA • Moonrise Wellness & Birth Center – Mountlake Terrace, WA • Mount Vernon Birth Center - Mount Vernon, WA • Puget Sound Birth Center - Kirkland, WA • Rolling Hills Birth Center – Pullman, WA • Salmonberry Community Birth Center – Poulsbo, WA • Seattle Home Maternity Services and Childbirth Center-Seattle, WA • Spokane Midwives Home & Birth Center, PLLC – Spokane • Sprout Birth Center - Mountlake Terrace, WA • The Birth Cottage LLC – Enumclaw, WA • The Birth House - Olympia, WA • The Special Delivery Birth Center – Arlington, WA • Watershed Birth Center – Yakima, WA • Wenatchee Midwife and Childbirth Center - Wenatchee

Definitions

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

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

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

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

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

Chart – A compilation of medical records on an individual patient.

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

A consulting relationship may result in:

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

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

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

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

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

Home Birth Provider –

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

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

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

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

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

Program Overview

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

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

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

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

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

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

An HCA-approved birth center facility must:

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

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

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

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

What newborn practices must birth centers follow to promote breastfeeding?

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

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

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

For more information, visit the Department of Health's (DOH) [Breastfeeding Friendly Washington](#) website.

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

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

Client Eligibility

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

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

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

How do I verify a client's eligibility?

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

Verifying eligibility is a two-step process:

- Step 1. Verify the patient's eligibility for Apple Health.** For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in HCA's [ProviderOne Billing and Resource Guide](#).
If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

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

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

1. By visiting the [Washington Healthplanfinder's website](#).
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to: Washington Healthplanfinder, PO Box 946, Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit the [Washington Healthplanfinder's website](#) or call the Customer Support Center.

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

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

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

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

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

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

Managed care enrollment

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

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

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Checking eligibility

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

Clients have a variety of options to change their plan:

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

For online information, direct clients to HCA's [Apple Health Managed Care](#) webpage.

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

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an HCA-contracted managed care plan are automatically enrolled in a BHSO except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the FFS Medicaid program will reimburse providers for the covered services. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO). For full details on integrated managed care, see HCA's [Apple Health managed care webpage](#) and scroll down to "Changes to Apple Health managed care."

Integrated Apple Health Foster Care (AHFC)

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

Clients under this program are:

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

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

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

Fee-for-service Apple Health Foster Care

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

American Indian/Alaska Native (AI/AN) Clients

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

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

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

First Steps Program Services

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

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

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

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

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

For further information on the MSS/ICM program, visit the [First Steps webpage](#) and see HCA's [MSS/ICM billing guide](#).

Childbirth Education

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

Also, see HCA's [Childbirth education billing guide](#).

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

Prenatal Management and Risk Screening Guidelines

What are the risk screening criteria?

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

To be reimbursed for CPT® codes 99211 through 99215 with HCPCS modifier TH (Increased Monitoring Prenatal Management), the client's record must contain the appropriate ICD diagnosis code.

Risk screening criteria

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

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

Tobacco/nicotine cessation for pregnant clients

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

Prenatal management/consultation & referral

The definitions below apply to the following tables labeled [Prenatal indications for consultation and referral](#).

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

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

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

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

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

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

Prenatal indications for consultation and referral

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

Conditions requiring consultation

HCA requires physician (MD/DO) consultation and the client MAY require referral to a physician when the following conditions arise during the current pregnancy:

- Breech at 37 weeks
- Polyhydramnios/Oligohydramnios
- Significant vaginal bleeding
- Persistent nausea and vomiting causing a weight loss of > 15 lbs.
- Post-dates pregnancy (> 42 completed weeks)
- Fetal demise after twelve completed weeks gestation

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- Significant size/dates discrepancies
- Abnormal fetal NST (nonstress test)
- Abnormal ultrasound findings
- Acute pyelonephritis
- Infections, whose treatment is beyond the scope of the provider
- Evidence of large uterine fibroid that may obstruct delivery or significant structural uterine abnormality
- No prenatal care prior to the third trimester
- Other significant deviations from normal, as assessed by the provider

Conditions requiring referral

HCA requires physician (MD/DO) consultation and referral when the following conditions arise during current pregnancy:

- Evidence of pregnancy induced hypertension (BP > 140/90 for more than six hours with client at rest)
- Hydatidiform mole (molar pregnancy)
- Gestational diabetes not controlled by diet
- Severe anemia unresponsive to treatment (Hgb < 10, Hct < 28)
- Known fetal anomalies or conditions affected by site of birth
- Noncompliance with the plan of care (e.g., frequent missed prenatal visits)
- Documented placental abnormalities, significant abruption past the 1st trimester, or any evidence of previa in the third trimester
- Rupture of membranes before the completion of 37 weeks gestation
- Positive HIV antibody test
- Documented IUGR (intrauterine growth retardation)
- Primary genital herpes past the 1st trimester
- Development of any of the high-risk conditions that are listed in Risk screening criteria

Intrapartum

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

Conditions requiring consultation

HCA requires physician consultation and the client MAY require referral to a physician and/or hospital when the following conditions arise intrapartum:

- Prolonged rupture of membranes (>24 hours and not in active labor)
- Other significant deviations from normal as assessed by the provider

Conditions requiring referral

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

- Labor before the completion of 37 weeks gestation, with known dates
- Abnormal presentation or lie at time of delivery, including breech
- Birthing parent desire for pain medication, consultation, or referral
- *Persistent non-reassuring fetal heart rate
- Active genital herpes at the onset of labor
- Thick meconium-stained fluid with delivery not imminent
- *Prolapse of the umbilical cord
- Sustained fever in birthing parent
- *Birthing parent seizure
- Abnormal bleeding (*hemorrhage requires emergent transfer)
- Hypertension with or without additional signs or symptoms of pre-eclampsia
- Prolonged failure to progress in active labor
- *Sustained birthing parent vital sign instability and/or shock

***These conditions require emergency transport.**

Postpartum

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

Conditions requiring consultation

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

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

Conditions requiring referral

HCA requires physician consultation and referral when the following conditions arise postpartum:

- *Anaphylaxis or shock
- Undelivered adhered or retained placenta with or without bleeding
- *Significant hemorrhage not responsive to treatment
- *Birthing parent seizure
- Lacerations, if repair is beyond provider's level of expertise (3rd or 4th degree)
- *Sustained birthing parent vital sign instability and/or shock
- Development of birthing parent fever, signs/symptoms of infection or sepsis
- *Acute respiratory distress
- *Uterine prolapse or inversion

***These conditions require emergency transport.**

Newborn

(Refers to the infant's care during the first 24 hours following birth)

Conditions requiring consultation

HCA requires a pediatric physician be consulted. The client MAY require a referral to an appropriate pediatric physician when the following conditions arise in a neonate:

- Apgar score \leq 6 at five minutes of age
- Birth weight < 2500 grams
- Other significant deviations from normal as assessed by the provider

Conditions requiring referral

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

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

***These conditions require emergency transport.**

Authorization

What is the expedited prior authorization (EPA) process?

HCA's EPA process is designed to eliminate the need to request authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an EPA number when appropriate.

When do I need to create an EPA number?

You need to create an EPA number when administering drugs that are listed as "Not billable by a Licensed Midwife" in the fee schedule. For licensed midwives to be reimbursed by HCA for the administration of these drugs, the licensed midwife must meet the EPA criteria listed below.

How do I create an EPA number?

Once the EPA criteria are met, you must create a 9-digit EPA number. The first six digits of the EPA number will be 870000. The last three digits must be **690**, which meets the EPA criteria listed below.

Note: This EPA number is ONLY for the procedure codes listed in the fee schedule as "Not billable by a Licensed Midwife." See HCA's [ProviderOne Billing and Resource Guide](#) for more information on requesting authorization.

EPA criteria for drugs not billable by licensed midwives.

To use an EPA to bill CPT® codes 90371, J2540, S0077, J0290, J1364, the licensed midwife must meet all the following:

- Obtained physician or standing orders for the administration of the drug listed as **not billable by a licensed midwife**
- Placed the physician or standing orders in the client's file
- Will provide a copy of the physician or standing orders to HCA upon request

Note: Enter the EPA number (870000690) in the *Prior Authorization* section of the electronic professional claim.

Coverage Table

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

Use the following CPT® codes when billing for Birth Center services:

Routine Prenatal Care

CPT® Code	Modifier	Short Description	Comments
59425		Antepartum care, 4-6 visits	Limited to 1 unit per client, per pregnancy, per provider.
59426		Antepartum care, 7 or more visits	Limited to 1 unit per client, per pregnancy, per provider
99211	TH	Office visits, Antepartum care 1-3 visits, w/obstetrical service modifier	Limited to 3 units total, per pregnancy, per provider. Must use modifier TH when billing.
99212	TH	Office/outpatient visit, est	Limited to 3 units total, per pregnancy, per provider. Must use modifier TH when billing.
99213	TH	Office/outpatient visit, est	Limited to 3 units total, per pregnancy, per provider. Must use modifier TH when billing.
99214	TH	Office/outpatient visit, est	Limited to 3 units total, per pregnancy, per provider. Must use modifier TH when billing.
99215	TH	Office/outpatient visit, est	Limited to 3 units total, per pregnancy, per provider. Must use modifier TH when billing.

Note: CPT® codes 59425, 59426, or E&M codes 99211-99215 with normal pregnancy diagnoses may not be billed in combination during the entire pregnancy. **Do not bill HCA for prenatal care until all routine prenatal services are complete.**

Additional monitoring

CPT® Code	Modifier	Short Description	Comments
99211	TH	Office/outpatient visit, est	
99212	TH	Office/outpatient visit, est	
99213	TH	Office/outpatient visit, est	
99214	TH	Office/outpatient visit, est	
99215	TH	Office/outpatient visit, est	

Note: Midwives who provide increased monitoring for routine prenatal care may bill using the appropriate E&M code with modifier TH.

Delivery (intrapartum)

CPT® Code	Modifier	Short Description	Comments
59400		Obstetrical care (antepartum, delivery, and postpartum care)	
59409		Obstetrical care (delivery only)	
59410		Obstetrical care (delivery and postpartum only)	

Postpartum

CPT® Code	Modifier	Short Description	Comments
59430		Care after delivery (postpartum only)	

Labor management

Bill these codes only when the client labors at the birth center or at home and is then transferred to a hospital, another provider delivers the baby, and a referral is made during active labor. The diagnoses must be related to complications during labor and delivery. The delivering physician may not bill for labor management. Prolonged services must be billed on the same claim as E&M codes along with modifier TH and one of the diagnoses listed above (all must be on each detail line of the claim).

CPT® Code	Modifier	Short Description	Comments
99211	TH	Office/outpatient visit, est (Use when client labors at birth center)	Use when client labors at the birth center
99212	TH	Office/outpatient visit, est	Use when client labors at the birth center
99213	TH	Office/outpatient visit, est	Use when client labors at the birth center
99214	TH	Office/outpatient visit, est	Use when client labors at the birth center
99215	TH	Office/outpatient visit, est	Use when client labors at the birth center
99347	TH	Home visit, est patient	Use when client labors at home
99348	TH	Home visit, est patient	Use when client labors at home
99349	TH	Home visit, est patient	Use when client labors at home
99350	TH	Home visit, est patient	Use when client labors at home
+99354 (Add-on code)	TH	Prolonged services, 1 st hour. Limited to 1 unit.	
+99355	TH	Prolonged services, each add'l 30 minutes. Limited to 4 units.	

Other codes

CPT®/HCPCS Code	Modifier	Short Description	Comments
59020		Fetal contract stress test	
59020	TC	Fetal contract stress test	
59020	26	Fetal contract stress test	
59025		Fetal non-stress test	
59025	TC	Fetal non-stress test	
59025	26	Fetal non-stress test	
36415		Drawing blood	
84703		Chorionic gonadotropin assay	
85013		Hematocrit	
85014		Hematocrit	
A4266		Diaphragm	
A4261		Cervical cap for contraceptive use	
57170		Fitting of diaphragm/cap	
90371		Hep b ig, im	Not billable by a licensed midwife. For exception, see Authorization -Expedited Prior Authorization.
96372		Ther/Proph/Diag Inj, SC/IM	
J2790		Rh immune globulin	
J2540		Injection, penicillin G potassium, up to 600,000 units	Not billable by a licensed midwife. For exception, see Authorization -Expedited Prior Authorization.
S0077		Injection, clindamycin phosphate, 300 mg	Not billable by a licensed midwife. For exception, see Authorization -Expedited Prior Authorization.

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CPT®/HCPCS Code	Modifier	Short Description	Comments
J0290		Injection, ampicillin, sodium, up to 500 mg (use separate line for each 500 mg used)	Not billable by a licensed midwife. For exception, see Authorization -Expedited Prior Authorization.
J1364		Injection, erythromycin lactobionate, per 500 mg (use separate line for each 500 mg used)	Not billable by a licensed midwife. For exception, see Authorization -Expedited Prior Authorization.
J7050		Infusion, normal saline solution, 250cc	
S5011		5% dextrose in lactated ringer, 1000 ml	
J7120		Ringers lactate infusion, up to 1000cc	
96360		Hydration IV Infusion, Init	
96361		Hydrate IV Infusion, add On	
96365		Ther/proph/Diag IV Inf, Init	
96366		Ther/proph/Diag IV Inf add on	
J8499		Oral methergine 0.2 mg	Enter NDC on claim, see ProviderOne Billing and Resource Guide for additional information.
J2210		Injection methylergonovine maleate, up to 0.2 mg	
J3475		Injection, magnesium sulfate, per 500 mg	
J2590		Injection, oxytocin	
J0170		Injection adrenalin, epinephrine, up to 1ml ampule	
J3430		Injection, phytonadione (Vitamin K) per 1 mg	
90471		Immunization admin	

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CPT®/HCPCS Code	Modifier	Short Description	Comments
90472		Immunization admin, each add	List separately in addition to code for primary procedure
S3620		Newborn metabolic screening panel, include test kit, postage and the laboratory tests specified by the state for inclusion in this panel	Department of Health (DOH) newborn screening tests for metabolic disorders. Includes 2 tests on separate dates, one per newborn. DOH will bill HCA for this service.
92588		Newborn hearing screen	
99460		Init NB EM per day, Hosp	Newborn assessment for a baby born in a birth center that is admitted and discharged on the same day. Limited to one per newborn. Do not bill HCA if baby is born in a hospital.
99461		Init NB EM per day, Non-Fac	Newborn assessment for a home birth. Limited to 1 per newborn.
99463		Same day NB discharge	Newborn assessment for a baby born in a birth center who is transferred to a hospital for care.
99465		NB Resuscitation	
92950		Cardiopulmonary resuscitation (e.g., in cardiac arrest)	

Facility Fee Payment

HCA reimburses for a facility fee only when services are performed in birth centers licensed by the Department of Health and have a current Core Provider Agreement with HCA.

CPT®/HCPCS Code	Modifier	Short Description	Comments
59409	59 and SU	Delivery only code with use of provider's facility or equipment modifier	Limited to one unit per client, per pregnancy. Facility fee includes all room charges, equipment, supplies, anesthesia administration, and pain medication.
S4005		Interim labor facility global (labor occurring but not resulting in delivery)	Limited to one per client, per pregnancy. May only be billed when client labors in the birth center and then transfers to a hospital for delivery.

Note: Payments for facility use are limited to only those providers who have been approved by HCA. When modifier SU is attached to the delivery code, it is used to report the use of the provider's facility or equipment only.

Home Birth Kit

HCPC Code	Modifier	Short Description	Comments
S8415		Disposable supplies for home delivery of infant	Limited to one per client, per pregnancy.

What fees do I bill to the Health Care Authority (HCA)?

See HCA's Planned Home Births and Births in Birth Centers [Fee Schedule](#).

What does global (total) obstetrical care include?

Global obstetrical (OB) care (CPT® code 59400) includes:

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

If you provide all the client's prenatal care, perform the delivery, and provide the postpartum care, you must bill using the global OB procedure code.

Use HCPCS code 0500F along with the appropriate diagnosis code on the first prenatal visit. HCA is tracking the date a client begins receiving obstetrical care (date the OB record is initiated). Note this date by entering HCPCS code 0500F with the appropriate ICD diagnosis codes Z33.1, Z34.00, Z34.80, or Z34.90 on the claim. HCA collects this code for quality measurement, tracking, and care coordination.

Note: Bill the global obstetric procedure code if you performed all the services and no other provider is billing for prenatal care, the delivery, or postpartum care. If you provide all or part of the prenatal care and/or postpartum care but you do not perform the delivery, you must bill HCA for only those services provided using the appropriate prenatal and/or postpartum codes. In addition, if the client obtains other medical coverage or is transferred to an HCA-contracted managed care organization (MCO) during pregnancy, you must bill for only those services provided while the client is enrolled with HCA fee-for-service.

What does routine prenatal care include?

Prenatal care includes:

- Initial and subsequent history
- Physical examination
- Recording of weight and blood pressure
- Recording of fetal heart tones
- Routine chemical urinalysis
- Birthing parent counseling, such as risk factor assessment and referrals

Necessary prenatal laboratory tests may be billed in addition to prenatal care, **except for dipstick tests** (CPT® codes 81000, 81002, 81003, and 81007).

In accordance with CPT® guidelines, HCA considers routine prenatal care for a normal, uncomplicated pregnancy to consist of:

- Monthly visits up to 28 weeks gestation
- Biweekly visits to 36 weeks gestation
- Weekly visits until delivery (approximately 14 prenatal visits)

CPT® Code	Modifier	Short Description	Comments
59426		Prenatal care, 7 or more visits	Limited to one unit per client, per pregnancy.
59425		Prenatal care, 4-6 visits	Limited to one unit per client, per provider, per pregnancy.
99211-99215	TH	Office visits, prenatal care 1-3 visits only, w/obstetrical service modifier	

Note: Do not bill using CPT® codes 59425, 59426, and E&M codes 99211-99215 with normal pregnancy diagnoses in combination with each other during the same pregnancy. **Do not bill HCA for prenatal care until all prenatal services are complete.**

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

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

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

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

Is obstetrical care allowed to be unbundled?

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

When a client transfers to your practice late in the pregnancy

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

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

If the client moves to another provider (not associated with your practice), moves out of your area prior to delivery, or loses the pregnancy

Bill only those services you provide to the client.

If the client changes insurance during pregnancy

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

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

Coding for prenatal care only

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

- If the client had a total of one to three prenatal visits, bill the appropriate level of **E&M service with modifier TH** for each visit with the date of service the visit occurred and the appropriate diagnosis.

Modifier TH: Obstetrical treatment/service, prenatal or postpartum

- If the client had a total of four to six prenatal visits, bill using CPT® code 59425 with a one (1) in the *units* box. Bill HCA using the date of the last prenatal visit in the to and from fields.
- If the client had a total of seven or more visits, bill using CPT® code 59426 with a one (1) in the *units* box. Bill HCA using the date of the last prenatal visit in the to and from fields of the form.

Do not bill prenatal care only codes in addition to any other procedure codes that include prenatal care (i.e., global OB codes).

When billing for prenatal care, do not bill using CPT® E/M codes for the first three visits, then CPT® code 59425 for visits four through six, and then CPT® code 59426 for visits seven and on. These CPT® codes are used to bill only the total number of times you saw the client for all prenatal care during pregnancy and may not be billed in combination with each other during the entire pregnancy period.

Note: Do not bill HCA until all prenatal services are complete.

Coding for deliveries

If it is necessary to unbundle the OB package and bill for the delivery only, bill HCA using one of the following CPT® codes:

- 59409 (vaginal delivery only)
- 59514 (cesarean delivery only)
- 59612 (vaginal delivery only, after previous cesarean delivery [VBAC])
- 59620 (cesarean delivery only, after attempted vaginal delivery after previous cesarean delivery [attempted VBAC])

If a provider does not furnish prenatal care, but performs the delivery and provides postpartum care, bill HCA one of the following CPT codes:

- 59410 (vaginal delivery, including postpartum care)
- 59515 (cesarean delivery, including postpartum care)
- 59614 (VBAC, including postpartum care)
- 59622 (attempted VBAC, including postpartum care)

Natural deliveries

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

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

Coding for postpartum care only

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

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

Do not bill CPT® code 59430 (postpartum care only) in addition to any procedure codes that include postpartum care.

Note: For billing purposes, postpartum care includes routine office visits for the 6-week period after the delivery. The codes for obstetric care (global payment or unbundled) apply only to the period up to and including the comprehensive postpartum visit, usually done at 6 weeks postpartum. Services provided after the 6-week postpartum visit are eligible for separate reimbursement. After Pregnancy Coverage (APC) is a 12-month Medicaid extension for clients who have been recently pregnant. Visit HCA's APC [webpage](#) for more information on APC coverage.

Additional monitoring for high-risk conditions

When providing increased monitoring for the conditions listed below more than the CPT® guidelines for normal prenatal visits, bill using E&M codes 99211-99215 with modifier TH. The office visits may be billed in addition to the global fee only after exceeding the CPT guidelines for normal prenatal care (i.e., monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery).

CPT® Code	Modifier	Short Description	Comments
99211-99215	TH	Office visits; use for increased monitoring prenatal management for high-risk conditions	See the Prenatal management/consultation & referral

If the client has one of the conditions listed above, the provider is not automatically entitled to additional payment. In accordance with CPT guidelines, it must be medically necessary to see the client **more often** than what is considered routine prenatal care to qualify for additional payments. **The additional payments are intended to cover additional costs incurred by the provider because of more frequent visits.**

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

For example:

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

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

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

Labor management

Providers may bill for labor management **only** when another provider (outside of your group practice) performs the delivery. If you performed the entire prenatal care for the client, attended the client during labor, delivered the baby, and performed the postpartum care, **do not** bill HCA for labor management. These services are included in the global OB package.

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

To bill for labor management in the situation described above, bill HCA for the time spent attending the client's labor using the appropriate CPT® E&M codes 99211-99215 (for labor attended in the office) or 99347-99350 (for labor attended at the client's home). In addition, HCA will reimburse providers for up to three hours of labor management using prolonged services CPT® codes 99354-99355 with modifier TH.

Reimbursement for prolonged services is limited to three hours per client, per pregnancy, regardless of the number of calendar days a client is in labor, or the number of providers who provide labor management. Labor management may not be billed by the delivering provider, or by any provider within the delivering provider's group practice.

Note: The E&M code and the prolonged services code must be billed on the same claim.

CPT® Code	Modifier	Short Description	Comments
99211-99215	TH	Office visits – labor at birth center	
99347-99350	TH	Home visits – labor at home	
+99354	TH	Prolonged services, First hour	Limited to one unit
+99355	TH	Prolonged services, each add'l 30 minutes	Limited to four units

Does HCA pay for newborn screening tests?

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

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

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

How is the administration of immunizations billed?

Immunization administration CPT® codes 90471 and 90472 may be billed only when the materials are not received free of charge from DOH. For information on Immunizations, see HCA's [Physician-Related Services/Healthcare Professional Services Billing Guide](#) or [Early Periodic Screening, Diagnosis & Treatment \(EPSDT\) Billing Guide](#).

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How are home-birth supplies billed?

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

HCPC Code	Description	Limits
S8415	Supplies for home delivery of infant	Limited to one per client, per pregnancy.

Are medications billed separately?

Certain medications can be billed separately and are listed on the fee schedule. Some of the medications listed in HCA's fee schedule are not billable by licensed midwives. By law, a licensed midwife may obtain and administer only certain medications. Drugs listed as **not billable by a licensed midwife** must be obtained at a pharmacy with a physician's order. (See [EPA criteria for drugs not billable by licensed midwives](#)).

Long-Acting Reversible Contraception (LARC)

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

Note: Drugs must be billed using the procedure codes listed in the fee schedule and they are reimbursed at HCA's established maximum allowable fees. Name, strength, and dosage of the drug must be documented and retained in the client's file for review at HCA's request.

How are newborn assessments billed?

Home birth setting

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

Birth center births

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

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How do I bill for neonates/newborns?

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

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

Note: Bill services for birthing parents on separate claims.

How is the facility fee billed in birth centers?

Note: The midwife may bill HCA for the facility fee or facility transfer fee payment. HCA pays the midwife, who then reimburses the approved birth center. See [Resources Available](#) for a list of approved birth centers.

Facility Fee – When billing for the facility fee, use CPT code 59409 with modifiers SU and 59. Only a facility licensed as a childbirth center by DOH and approved by HCA is eligible for a facility fee. Bill this fee only when the baby is born in the facility. The facility fee includes all room charges for client and baby, equipment, supplies, anesthesia administration, and pain medication. The facility fee does not include other drugs, professional services, newborn hearing screens, lab charges, ultrasounds, other x-rays, blood draws, or injections.

Facility Transfer Fee – The facility transfer fee may be billed when the pregnant client is transferred in active labor to a hospital for delivery there. Use CPT code S4005 when billing for the facility transfer fee.

CPT® Code	Modifier	Description	Limits
59409	59 SU	Delivery only code with use of provider's facility or equipment modifier	Limited to one per client, per pregnancy.

CPT® Code	Modifier	Description	Limits
S4005		Interim labor facility global (labor occurring but not resulting in delivery)	Limited to one per client, per pregnancy. May only be billed when client labors in the birth center and then transfers to a hospital for delivery.

Note: Payments to midwives for facility use are limited to only those birth centers that have been approved by HCA. When modifier SU is attached to the delivery code, it is used to report the use of the provider's facility or equipment only. The name of the birth center must be entered in the *Service Facility* section under the Other Claim Info tab.

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

Prenatal care records

- Initial general (Gen) history, physical examination, and prenatal lab tests
- Gynecological (Gyn) history, including obstetrical history, physical examination, and standard lab tests. Ultrasound, if indicated
- Subsequent Gen/Gyn history, physical and lab tests
- Client's weight, blood pressure, fetal heart tones, fundal height, and fetal position at appropriate gestational age
- Consultation, referrals, and reason for transferring care, if necessary
- Health education and counseling
- Consultation or actual evaluation by the consulting physician for any high-risk condition
- Risk screening evaluation

Intrapartum/postpartum care records

- Labor, delivery, and postpartum periods
- Pregnant client, fetal, and newborn well-being, including monitoring of vital signs, procedures, and lab tests
- Any consultation referrals and reason for transferring care, if necessary
- Initial pediatric care for newborn, including the name of the pediatric care provider, if known
- Postpartum follow-up, including family planning

Informed consent materials

Copy of informed consent, including all the following:

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

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

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

Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information about this policy change, see [Paperless billing at HCA](#). For providers approved to bill paper claims, see HCA's [Paper claim billing resource](#).

What are the general billing requirements?

Providers must follow HCA's [ProviderOne Billing and Resource Guide](#). These billing requirements include:

- What time limits exist for submitting and resubmitting claims and adjustments
- When providers may bill a client
- How to bill for services provided to primary care case management (PCCM) clients
- How to bill for clients eligible for both Medicare and Medicaid
- How to handle third-party liability claims
- What standards to use for record keeping

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

Yes. Expedited prior authorization (EPA) numbers for drugs billed by a licensed midwife and the EPA number for a natural delivery may be billed on the same claim.

How do I bill claims electronically?

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

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

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

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