Clinical Policy Title: Planned home births

Clinical Policy Number: 12.04.01

Effective Date: October 1, 2016
Initial Review Date: June 15, 2016
Most Recent Review Date: June 15, 2016
Next Review Date: June 2017

Related policies:

None.

ABOUT THIS POLICY: Select Health of South Carolina has developed clinical policies to assist with making coverage determinations. Select Health of South Carolina’s clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of “medically necessary,” and the specific facts of the particular situation are considered by Select Health of South Carolina when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. Select Health of South Carolina’s clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. Select Health of South Carolina’s clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, Select Health of South Carolina will update its clinical policies as necessary. Select Health of South Carolina’s clinical policies are not guarantees of payment.

Coverage policy

Select Health of South Carolina considers planned home births to be an elective alternative to delivery in a birthing center or hospital setting therefore, is considered not medically necessary.

Limitations:

All other uses of planned home birth are not medically necessary.

Other limitations include:

- Home delivery emergency.
- LOBs with rural areas where access to hospitals or birthing centers are minimal, home births with participating providers are covered.
  - AmeriHealth Caritas Pennsylvania, AmeriHealth Caritas Northeast and AmeriHealth Caritas Iowa (LOB’s), will cover planned home births. (Contact these specific LOB’s for further benefit information).

Alternative covered services:

- Participating hospital for in-patient births.
- Participating birthing centers with licensed certified nurse-midwife.
**Background**

A planned home birth is an elective alternative to delivery in a birthing center or hospital setting.

Labor and delivery may present hazards to both mother and fetus before and after birth. Planned home birth is associated with a twofold to threefold increased risk of neonatal death when compared with planned hospital birth (AAP, 2013). Standards for safe delivery are required and are provided when delivery takes place in a hospital or birthing center. Consistent with the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP), Cigna considers a hospital or birthing center the safest setting for labor, delivery and postpartum care.

As an alternative to a hospital setting or birthing center, a medically informed decision to deliver in the home setting (i.e., home birth) may be chosen by some women. Planned home birth should only be considered for women who are at low risk for pregnancy complications and when a qualified health care professional is present.

Both the AAP and ACOG recommend the use of certified midwives, a certified nurse-midwife, or a practicing physician for home birth. ACOG and the AAP do not support the provision of care by lay midwives or other midwives who are not certified by the American Midwifery Certification Board due to quality and safety concerns (ACOG, 2011). In addition, the availability of timely transfer and an existing arrangement with a hospital for potential transfer is required for consideration of home birth services.

The ACOG committee does not support planned home births given the published medical data, however, per a committee opinion on Planned Home Births (Feb 2011, updated 2015) the college concludes, “Although the Committee on Obstetric Practice believes that hospitals and birthing centers are the safest setting for birth, it respects the right of a woman to make a medically informed decision about delivery. Women inquiring about planned home birth should be informed of its risks and benefits based on recent evidence. Specifically, they should be informed that although the absolute risk may be low, planned home birth is associated with a twofold to threefold increased risk of neonatal death when compared with planned hospital birth.”

**Searches**

Select Health of South Carolina searched PubMed and the following databases:

- UK National Health Services Centre for Reviews and Dissemination.
- Agency for Healthcare Research and Quality’s National Guideline Clearinghouse and other evidence-based practice centers.
- The Centers for Medicare & Medicaid Services (CMS).

We conducted searches on April 28, 2016. Search terms were: “home birth,” and “certified nurse-midwives”

We included:

- **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.
- **Guidelines based on systematic reviews.**
• **Economic analyses**, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

**Findings**

Investigating the debate of home birth safety: A critical review of cohort studies focusing on selected infant outcomes

There is a debate within the medical community regarding the safety of planned home births. The presumption of increased risk of maternal and infant morbidity and mortality at home due to limited access to life-saving interventions is not clearly supported by research. The aim of the present study was to assess strengths and limitations of the methodological approaches of cohort studies that compare home births with hospital births by focusing on selected infant outcomes.

Studies were identified that assess the risk for at least one of three infant outcomes (mortality, Apgar score, and admission to the neonatal intensive care unit [NICU]) of home births compared with hospital births. Results: Fifteen cohort studies were included. Two studies of low-risk births and two including higher risk births found home births to be at an increased risk of neonatal mortality. However, mortality is rare in developed nations and may not be the best measure of safety. When studies focused on low-risk pregnancies, planned birth location, and well-trained birth attendants, there was no difference in neonatal morbidity (Apgar score and NICU admission).

Many methodological challenges were identified among these studies. This review contributes to the home birth published work by identifying key strengths and limitations that need to be accounted for in the interpretation of study findings and the development of future studies. Based on this review, the key variables that would strengthen future studies are birth attendant identification, documented planned birth location, and specification of the birth risk level. Uniformity of data collection and minimizing missing data are also critical. Elder HR et al. (2016)

**Summary of clinical evidence:**

<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
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<tbody>
<tr>
<td>MacDorman MF et al. (2012)</td>
<td>Key points:</td>
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<tr>
<td>Home Births in the United States, 1990–2009.</td>
<td>• Home births have significantly increased in the United States in the last decade. Home births that are unplanned and that are not attended by a midwife or physician are associated with higher neonatal and infant morbidity and mortality.</td>
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<td>• To assess trends in unattended home births in the United States, we analyzed the Centers for Disease Control and Prevention birth certificate database assessing unattended home births in the United States from 2007 to 2012. Unattended births were defined as those not attended by a midwife, physician, or other doctor.</td>
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<td>• From 2007 to 2012 there were a total of 24,600,409 births in the United States of which 140,912 (0.57%) were home births. Unattended home births (n=42,061) comprised 29.8% of all home births. Unattended home births in the United States increased by 79% from 4,926 in 2007 to 8,822 in 2012 and gradually rose from 1.14 per 1,000 births in 2007 to 2.23 per 1,000 births in 2012 (P&lt;.001).</td>
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<tr>
<td></td>
<td>• The increase of unattended home births among multiparous patients</td>
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<tr>
<td>Citation</td>
<td>Content, Methods, Recommendations</td>
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<td>Chu S· et al. (2014)</td>
<td>- The ratio of unattended home births in nulliparous patients nearly quadrupled between 2007 and 2012 from 0.6 to 2.1 per 1,000 nulliparous births, whereas the ratio of unattended home births in multiparous women doubled from 1.5 to 3.0 per 1,000 multiparous births ($P&lt;.001$). There is concern that unattended home births have significantly increased over recent years. Because unattended home births are associated with increased neonatal and infant mortality, further studies are needed to understand the causes of the increase and to assess interventions aimed to reduce unattended home births in the United States.</td>
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<td>Key points:</td>
<td>- Conducted a comparison of risk profiles for planned home births compared with hospital births. - Analyzed births from 2009 to 2010 U.S. birth certificate data in the Centers for Disease Control and Prevention National Vital Statistics database. - Hospital births and home births by midwife were analyzed on 12 high-risk aspects: advanced maternal age, multiple gestation, preterm, postterm, low birth weight, macrosomia, nulliparity, precipitous labor, breech presentation, premature rupture of membranes, prolonged labor, and prior cesarean delivery. - Population consisted of 8,076,257 deliveries (8,038,365 in a hospital and 37,892 by midwives at home). Midwife home births compared with hospital births had a significantly higher prevalence of five risk factors: advanced maternal age (21.7% compared with 14.3%; odds ratio [OR] 1.66, 95% confidence interval [CI] 1.6-1.7), postterm (27.8% compared with 13.6%; OR 2.43, 95% CI 2.4-2.5), macrosomia (20.5% compared with 7.5%; OR 3.4, 95% CI 3.3-3.5), precipitous labor (7.8 compared with 2.3%; OR 3.8, 95% CI 3.7-3.9), and prolonged labor (3.1% compared with 1.2%; OR 2.9, 95% CI 2.7-3.1) and a high prevalence of three additional risk factors: prior cesarean delivery (4.3%), nulliparity (19.7%), and preterm births (2.3%). - A significant number of high-risk pregnancies were delivered at home across all analyzed risk factors. Six high-risk pregnancy conditions associated with increased adverse outcomes had a higher prevalence in planned home births than in hospital births (advanced maternal age, postdates, macrosomia, premature rupture of membranes, and precipitous and prolonged labor), whereas three others (prior cesarean delivery, nullipara, preterm births) had a high prevalence.</td>
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| MacDorman MF, et al. (2016) | - Out-of-hospital births are increasing in the United States. Our purpose was to examine trends in out-of-hospital births from 2004 to 2014, and to analyze newly available data on risk status and access to care. - Newly available data from the revised birth certificate for 47 states and Washington, DC, were used to examine out-of-hospital births by characteristics and to compare them with hospital births. Trends from 2004 to 2014 were also examined. - Out-of-hospital births increased by 72%, from 0.87% of United States births in 2004 to 1.50% in 2014. Compared with mothers who had hospital births, those with out-of-hospital births had lower pre-
pregnancy obesity (12.5% vs 25.0%) and smoking (2.8% vs 8.5%) rates, and higher college graduation (39.3% vs 30.0%) and breastfeeding initiation (94.3% vs 80.8%) rates. Among planned home births, 67.1% were self-paid, compared with 31.9% of birth center and 3.4% of hospital births. Vaginal births after cesarean (VBACs) comprised 4.6% of planned home births and 1.6% of hospital and birth center births.

- High rates of self-pay for the costs of out-of-hospital birth suggest serious gaps in insurance coverage, whereas higher-than-average rates of VBAC could reflect lack of access to hospital VBACs.
- Mandating private insurance and Medicaid coverage could substantially improve access to out-of-hospital births. Improving access to hospital VBACs might reduce the number of out-of-hospital VBACs.

Glossary

**Low risk**—A term used by clinicians to describe women whose history and condition suggests that there is little likelihood of complications during pregnancy, labor and/or birth.

**Licensed certified nurse-midwife**—A licensed certified nurse-midwife is a registered nurse with advanced training who is registered and licensed to practice midwifery. Nurse-midwives provide care and advice to women during pregnancy, labor, birth, the early postpartum period, and care for the newborn baby in a variety of settings, under direct supervision of a licensed physician or independently if authorized by State law.

**Participating provider**—Coverage level applied when care is provided to a Select Health of South Carolina member by a doctor, certified nurse-midwife, hospital, clinic, or laboratory that is contracted with Select Health of South Carolina to provide health care services.

**Non-participating provider**—Coverage level applied when care is provided to an Select Health of South Carolina member by a doctor, certified nurse-midwife, hospital, clinic, or laboratory that is not contracted with Select Health of South Carolina to provide health care services, who does not participate in the network associated with the member’s Select Health of South Carolina plan, and only when a customer’s health benefit plan allows out-of-network services.

References

Professional society guidelines/other:


Peer-reviewed references:

Heather R Elder · Amina P Alio · Susan G Fisher. Investigating the debate of home birth safety: A critical review of cohort studies focusing on selected infant outcomes.


Chu S, Chervenak FA, Grunebaum A. Are Planned Home Births Really Low Risk May 2014. No preview · Article · May 2014 · Obstetrics and Gynecology.


Clinical trials:

Searched clinicaltrials.gov on May 6, 2016 using terms planned home birth, low risk delivery, high risk delivery | Open Studies. 14 studies found, one relevant.


CMS National Coverage Determinations (NCDs):

No NCDs identified as of the writing of this policy.

Local Coverage Determinations (LCDs):

No LCDs identified as of the writing of this policy.

Commonly submitted codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

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