

Maternity and Newborn Care

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[Instructions for Use](#)

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Related Medicare Advantage Policy Guideline
<ul style="list-style-type: none"> Sterilization (NCD 230.3)

Coverage Guidelines

Maternity care is covered when Medicare criteria are met. Newborn care is not covered.

The following services are covered when criteria are met:

- Skilled medical management throughout the events of pregnancy, beginning with the diagnosis, continuing through delivery and ending after the necessary postnatal care
Note: Surgeons and obstetricians should bill Medicare for an all inclusive package charge intended to cover all services associated with the surgical procedure or delivery of the child. All expenses for surgical and obstetrical care, including preoperative/prenatal examinations and tests and postoperative/postnatal services are considered incurred on the date of surgery or delivery, as appropriate.
Refer to the [Medicare Benefit Policy Manual, Chapter 15, §20.1-Physician Expense for Surgery, Childbirth, and Treatment for Infertility](#). (Accessed March 3, 2021)

- Nurse-midwife services are covered when:
 - Services and supplies furnished incident to a nurse midwife's service if they would have been covered when furnished incident to the services of a doctor of medicine or osteopathy.
 - Services are furnished by a nurse-midwife that he or she is legally authorized to perform in the State in which the services are furnished and that would otherwise be covered if furnished by a physician, including obstetrical and gynecological services. (See definition of Certified Nurse-Midwife in Section II)

Notes:

- Network lock-in may apply per the member's EOC
- Nurse-midwife services are covered if provided in the nurse-midwife's office, in the patient's home, or in a hospital or other facility, such as a clinic or birthing center owned or operated by a nurse-midwife.
- Relationship with physician: Most states have licensure and other requirements applicable to nurse-midwives. For example, some require that the nurse-midwife have an arrangement with a physician for the referral of the patient in the event a problem develops that requires medical attention. Others may require that the nurse-midwife function under the general supervision of a physician. Although these and similar State requirements must be met in order for the nurse-midwife to provide Medicare covered care, they have no effect on the nurse-midwife's right to personally bill for and receive direct Medicare payment. That is, billing does not have to flow through a physician or facility.

Refer to the [Medicare Benefit Policy Manual, Chapter 15, §180-Nurse-Midwife \(CNM\) Services for coverage of services performed by nurse-midwives incident to the service of physicians, educational requirements and other information](#). (Accessed March 3, 2021)

- Laboratory testing when medically reasonable and necessary for the management of pregnancy; refer to the [Medicare Benefit Policy Manual, Chapter 15, §20.1-Physician Expense for Surgery, Childbirth, and Treatment for Infertility](#). (Accessed March 3, 2021)

- Related genetic testing and counseling for prenatal diagnosis of congenital disorders of the unborn child; refer to the Coverage Summary titled [Genetic Testing](#).
- Treatment of a spontaneous abortion (miscarriage) and complications of pregnancy or childbirth.
Refer to the:
 - [Medicare Benefit Policy Manual, Chapter 15, §20.1-Physician Expense for Surgery, Childbirth, and Treatment for Infertility](#). (Accessed March 3, 2021)
 - Coverage Summary titled [Abortion](#).
- In utero fetal surgery:
 - Medicare does not have a National Coverage Determination (NCD) for in utero fetal surgery. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.
 - For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy for [Intrauterine Fetal Surgery](#).
Note: After searching the [Medicare Coverage Database](#), if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

The following services are not covered:

- Services of nurse-midwives are not covered if they are otherwise excluded from Medicare coverage even though a nurse-midwife is authorized by state law to perform them. For example, the Medicare program excludes from coverage routine physical checkups and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.
Refer to the [Medicare Benefit Policy Manual, Chapter 15, §180-Nurse-Midwife \(CNM\) Services](#). (Accessed March 3, 2021)
- Items and services furnished to the infant after delivery are not covered.
Note: After infant is delivered, and is a separate individual, items and services furnished to the infant are not covered on the basis of the mother's eligibility. UnitedHealthCare Medicare Advantage members must arrange for newborn insurance coverage.
Refer to the [Medicare Benefit Policy Manual, Chapter 15, §20.1-Physician Expense for Surgery, Childbirth, and Treatment for Infertility](#). (Accessed March 3, 2021)
- Any procedure intended solely for sex determination (e.g., amniocentesis, ultrasound and chorionic villi sampling [CVS]); refer to the [Medicare Benefit Policy Manual, Chapter 16, §20-Services not Reasonable and Necessary](#). (Accessed March 3, 2021)
- Blood testing to determine paternity; refer to the [Medicare Benefit Policy Manual, Chapter 16, §20-Services not Reasonable and Necessary](#). (Accessed March 3, 2021)
- Routine elective sterilization following delivery (e.g., tubal ligation); refer to the [National Coverage Determination \(NCD\) for Sterilization \(230.3\)](#). (Accessed March 3, 2021)
- Childbirth classes (e.g., Lamaze); refer to the [Medicare Benefit Policy Manual, Chapter 16, §20-Services not Reasonable and Necessary](#). (Accessed March 3, 2021)
- Services of a lactation specialist; refer to the [Medicare Benefit Policy Manual, Chapter 16, §20-Services not Reasonable and Necessary](#). (Accessed March 3, 2021)
- Take home medications and/or supplies, unless the member has a supplemental pharmacy benefit; refer to the [Medicare Benefit Policy Manual, Chapter 1, § 30.5-Drugs for Use Outside Hospital](#). (Accessed March 3, 2021)

Definitions

Certified Nurse-Midwife: A registered nurse who has successfully completed a program of study and clinical experience in nurse-midwifery, meeting guidelines prescribed by the Secretary, or who has been certified by an organization recognized by the Secretary. The Secretary has recognized certification by the American College of Nurse-Midwives and State qualifying requirements in those States that specify a program of education and clinical experience for nurse-midwives for these purposes. A nurse-midwife must:

- Be currently licensed to practice in the State as a registered professional nurse; and
- Meet one of the following requirements:
 - Be legally authorized under State law or regulations to practice as a nurse-midwife and have completed a program of study and clinical experience for nurse-midwives, as specified by the State; or
 - If the State does not specify a program of study and clinical experience that nurse-midwives must complete to practice in that State, the nurse-midwife must:
 - Be currently certified as a nurse-midwife by the American College of Nurse-Midwives;

- Have satisfactorily completed a formal education program (of at least one academic year) that, upon completion, qualifies the nurse to take the certification examination offered by the American College of Nurse-Midwives; or
- Have successfully completed a formal education program for preparing registered nurses to furnish gynecological and obstetrical care to women during pregnancy, delivery, and the postpartum period, and care to normal newborns, and have practiced as a nurse-midwife for a total of 12 months during any 18-month period from August 8, 1976, to July 16, 1982.

[Medicare Benefit Policy Manual, Chapter 15, §180-Nurse-Midwife \(CNM\) Services.](#) (Accessed March 3, 2021)

Policy History/Revision Information

Date	Summary of Changes
05/01/2021	Template Update <ul style="list-style-type: none"> • Reformatted policy; transferred content to new template
03/16/2021	<ul style="list-style-type: none"> • Routine review; no change to coverage guidelines

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The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

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