



# Handbook for Birth Centers

## Chapter BC-200 Policy and Procedures For Birth Centers

**Illinois Department of Healthcare and Family Services**

**Issued December 2013**

# Chapter BC-200

## Birth Center Services

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# Foreword

## Purpose

This handbook has been prepared for the information and guidance of providers who provide birth center services to participants in the department's Medical Programs. It also provides information on the department's requirements for provider participation and enrollment.

The [Birth Center Handbook](#) can be viewed on the department's website. This handbook provides information regarding specific policies and procedures relating to birth center services.

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the department's Medical Programs policy and billing procedures. Revisions in and supplements to the handbook will be released from time to time as operating experience and state or federal regulations require policy and procedure changes in the department's Medical Programs. The updates will be posted to the department's website on the [Provider Releases and Bulletins page](#).

Providers will be held responsible for compliance with all policy and procedures contained herein. Providers wishing to receive [e-mail notification](#), when new provider information has been posted by the department, may register on the website.

**Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Hospital and Provider Services at 1-877-782-5565.**

## Definitions

**Birth Center** - A birth center is defined in the Alternative Healthcare Delivery Act (Public Act 095-0445) as an alternative healthcare delivery model that is exclusively dedicated to serving the childbirth-related needs of women and their newborns and has no more than 10 beds. A birth center is a designated site in which births are planned to occur following a normal, uncomplicated, and low-risk pregnancy that is away from the mother's usual place of residence.

**Department of Healthcare and Family Services (HFS) or (department)** - The Department of Healthcare and Family Services (HFS) or (department) is the agency that administers Illinois' Medical Assistance (Medicaid) Program, as well as other public healthcare programs.

**Document Control Number (DCN)** – As identified on the HFS 194-M-2 paper Remittance advice, a twelve-digit number assigned by the department to identify each claim that is submitted by a provider. The format is YDDDLLSSSSSS.

Y Last digit of year claim was received

DDD Julian date claim was received

LL Document Control Line Number

SSSSSS Sequential Number

**HCPCS** – Healthcare Common Procedure Coding System

**Institutional Claim format** – Claims prepared in the 837I or Direct Data Entry (DDE) electronic formats or UB-04 paper claim format.

**National Provider Identifier (NPI)**: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for healthcare providers and health plans. For healthcare providers, this identifier is referred to as the National Provider Identifier (NPI).

**Procedure Code** – The appropriate codes from the American Medical Association Current Procedural Terminology (CPT) or appropriate HCPCS Codes.

**Provider Participation Unit (PPU)** – The section of the Department of Healthcare and Family Services that is responsible for maintaining provider enrollment records.

**Recipient Identification Number (RIN)** – The nine-digit identification number unique to the individual receiving coverage under one of the department's Medical Programs. It is vital that this number be correctly entered on billings for services rendered.

**Remittance Advice** – A document issued by the department which reports the status of claims (invoices) and adjustments processed. May also be referred to as a voucher.

# Chapter BC-200

## Birth Center Services

### BC-200 Basic Provisions

For consideration for payment by the department for birth center services, a provider enrolled for participation in the department's Medical Programs must provide such services. Services provided must be in full compliance with both the general provisions contained in the [Chapter 100](#), Handbook for Providers of Medical Services, General Policy and Procedures that can be found on the department's website and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

The billing instructions contained within this handbook are specific to the department's paper forms. Providers billing the outpatient services described in this handbook use the UB-04 claim form for billing paper claims. Providers wishing to submit X12 electronic transactions must refer to the [Chapter 300](#), Handbook for Electronic Processing found on the department's website.

Chapter 300 identifies information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other healthcare programs funded or administered by the Illinois Department of Healthcare and Family Services.

## BC-201 Provider Participation

### BC-201.1 Participation Requirements

To participate in the department's Medical Programs, a birth center must meet the definition of a birth center as defined in 89 Ill. Adm. Code sections 146.800-840 and meet the Illinois Department of Public Health licensure requirements under 77 Illinois Administrative Code Part 265.

The following requirements must be met by a birth center to qualify for enrollment:

- The birth center must comply with the participation requirements stated in Chapter 100, Topic 101.1.
- The birth center must hold a valid appropriate license issued by the Illinois Department of Public Health. Depending upon the licensure requirements of the particular facility, the birth center may hold a separate birth center license or may be licensed under a hospital with which it is affiliated.
- The birth center must agree to provide equal access to available services to low income persons, and must agree to provide data and reports on the provision of such care as required by the department;

**Procedure:** The provider must complete and submit:

- Form HFS 2243 (Provider Enrollment/Application)
- Form HFS 1413 (Agreement for Participation)
- Form HFS 1513 (Enrollment Disclosure Statement)
- W9 (Request for Taxpayer Identification Number)

The following documentation must also be provided with the application:

- A copy of the facility medical license
- A copy of the valid Clinical Laboratory Improvement Amendments (CLIA) certificate

These [enrollment forms](#) may be obtained from the department's website. Providers may also request the enrollment forms by [e-mail](#).

Providers may call the unit at 217-782-0538 or mail a request to:

Illinois Department of Healthcare and Family Services  
Provider Participation Unit  
Post Office Box 19114  
Springfield, Illinois 62794-9114

The forms must be completed (printed in ink or typewritten), signed and dated in ink by the Chief Executive Officer of the facility, and returned to the above address to the attention of the Provider Participation Unit Supervisor. The facility should retain a copy of the forms. The date on the application will be the effective date of enrollment unless the facility requests a specific enrollment date and it is approved by the department. No birth center may have an enrollment date prior to May 1, 2013.

Participation approval is not transferable. Refer to Topic H-201.3

### **BC-201.2 Category of Service**

A birth center may only enroll for category of service 024 – Outpatient Services (General).

### **BC-201.3 Participation Approval**

When participation is approved, the birth center will receive a computer-generated notification, the Provider Information Sheet, listing all data on the department's computer files. The birth center is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, see Appendix H-1.

If all information is correct, the birth center is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the department files. If any of the information is incorrect, refer to Topic H-201.5.

When there is a change in ownership, location, name, or a change in the Federal Employer's Identification Number, a new application for participation must be completed.

### **BC-201.4 Participation Denial**

When participation is denied, the provider will receive written notification of the reason for denial.

Within ten calendar days after the date of this notice, the birth center may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the department's action is being challenged. If such a request is not received within ten calendar days, or is received, but later withdrawn, the department's decision shall be a final and binding administrative determination.

Department rules concerning the basis for denial of participation are set out in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C.



## **BC-201.5 Provider File Maintenance**

The information carried in the department's files for participating providers must be maintained on a current basis. The provider and the department share responsibility for keeping the file updated.

### **Provider Responsibility**

The information contained on the Provider Information Sheet is the same as in the department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found are to be corrected and the department notified immediately.

Any time the provider effects a change that causes information on the Provider Information Sheet to become invalid the department is to be notified. When possible, notification should be made in advance of a change.

**Procedure:** The provider is to line out the incorrect or changed data, enter the correct data, sign and date the Provider Information Sheet with an original signature on the line provided. Forward the corrected Provider Information Sheet to:

Illinois Department of Healthcare and Family Services  
Provider Participation Unit  
Post Office Box 19114  
Springfield, Illinois 62794-9114

**Failure of a provider to properly notify the department of corrections or changes may cause an interruption in participation and payments.**

### **Department Responsibility**

When there is a change in a provider's enrollment status or the provider submits a change, the department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to all payees listed if the payee address is different from the provider address.

## **BC-202 Record Requirements and Audits**

The department regards the maintenance of adequate medical records as essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post payment audits. Refer to Chapter 100, Topic 110 for record requirements applicable to all providers.

**In the absence of proper and complete medical records, no payment will be made and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.**

## **BC-230 Covered Services**

A covered service is a service for which payment can be made by the department. Refer to Chapter 100, Topic 103, for a general list of covered services under the department's medical programs.

**Services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook.**

The department reimburses birth centers for medically necessary services that are provided to eligible participants covered under the department's medical programs. These services must be provided in compliance with birth center licensing standards. Payment may be made for the following types of care as described in 89 Illinois Administrative Code Section 146.830:

1. Delivery Services
2. Observation Services
3. Transfer Fee

## **BC-260 Payment Process**

### **BC-260.1 Charges**

Charges for outpatient services must be submitted to the department on a UB-04 claim form or in the X12 837 Institutional claim format. Refer to Appendix H-2 for order information regarding the UB-04 Data Specifications Manual and a list of field requirements for the UB-04 claim format.

To be paid for services, all claims, including claims that are re-billed, must be received within 180 days from the “Through” date of service.

Charges billed to the department must be the provider’s usual and customary charge billed to the general public for the same service. Providers may only bill the department after the service has been provided.

Charges for services and items provided to participants enrolled in a Managed Care Organization (MCO) must be billed to the MCO according to the contractual agreement with the MCO.

### **BC-260.2 Claim Preparation and Submittal**

General policy and procedures for claim submittal are provided in Chapter 100, Topic 112. Appendix H-2 contains specific billing instructions for providers.

Claims are to be submitted as soon as possible after discharge, but only after third party resources have been billed. As the department is the payer of last resort, providers are to bill any known third party first. If at the end of 30 days from the date of the TPL billing, no response has been received, or if a response has been received advising of the amount of the TPL payment, the provider may bill the department in accordance with instructions in Appendix H-2. The department’s TPL status codes are identified in the billing requirements in Appendix H-2.

In instances where the insurance company pays the patient directly and the facility has not received payment from the patient, the facility must indicate the insurance information on the claim and show TPL Status Code 07 (Payment Pending) when submitting the claim for payment to the department.

### **BC-260.3 Split Bills (MANG - Spenddown)**

See Chapter 100, Topic 113 for a full explanation of the spenddown policy. Outpatient charges for a spenddown participant should be submitted to the patient’s Department of Human Services Family Community Resource Center (FCRC) for use in meeting the patient’s spenddown obligation. The day on which the patient has incurred enough medical charges to meet the spenddown obligation is referred to as

the Split Bill Day. FCRC staff will then provide the birth center with an HFS 2432, Split Billing Transmittal, which must be submitted with any claim encompassing the Split Bill Day.

The Split Billing Transmittal will identify any patient liability amount the birth center may collect from the patient. Providers must use the appropriate value code in the UB-04 Data Specifications Manual to identify the patient's spenddown liability. The value code must be utilized even if the patient's spenddown liability is zero.

HFS 2432s will not be issued for bills that are the total responsibility of the patient. When any service is billed for a date that is determined to be a split-bill day, the HFS 2432 must be attached to the claim (see Chapter 100, Topic 113). This form must be attached even if the patient liability amount is zero.

Any questions regarding calculation of spenddown should be directed to the FCRC serving the patient. For information on the FCRCs, please refer to the [DHS website](#). The DHS Office Locator can be found by scrolling to the bottom of the DHS Web page.

#### **BC-260.4 Reimbursement**

Facility delivery services provided by a birth center will be reimbursed at the lower of covered charges or 75 percent of the statewide average facility payment rate made to a hospital for an uncomplicated vaginal birth.

Observation services will be reimbursed at the lower of covered charges or at 75 percent of the rate established by the department for the number of hours of observation billed pursuant to 89 Ill. Adm. Code 148.140(b)(1)(d).

Transfer fees will be reimbursed at the lower of covered charges or 15 percent of the statewide average facility payment rate made to a hospital for an uncomplicated vaginal birth.

Claims containing more than one type of birth center service will be priced according to the following hierarchy:

- Claims containing a delivery procedure and an observation service will be paid based on the highest-payable service, which is the delivery.
- Claims containing observation and a transfer to a hospital will be paid based on the highest-payable service, which is the transfer.

All claims adjudicated by the department will be identified on the HFS 194-M-2, Remittance Advice. The Remittance Advice is sent to the birth center's payee address on file with the department. Refer to Chapter 100, Topics 130 and 132, for payment procedures utilized by the department and General Appendix 7 for explanations of Remittance Advice detail.

Federal and state laws provide that payment by the department or its authorized agent constitutes payment in full. Providers are prohibited from seeking to collect amounts in excess of the department's payment from any other source, including the participant. This prohibition applies to payment made directly by the department and payments made on behalf of an eligible participant by a Managed Care Organization (MCO) under contract with the department. This does not affect the patient cost sharing as identified in Chapter 100, Topic 114.

### **BC-260.5 Fee Schedule**

A [birth center fee schedule](#) of payable services is available on the department's website.

### **BC-260.6 Post Billing of Ancillary and Room and Board Charges**

If a facility determines that an error was made in reporting the usual and customary charge for an ancillary service(s) and/or room and board accommodation(s) on a claim due to late charges, corrective action may be taken, but only after the particular claim has been adjudicated in a payable status and reported on a Remittance Advice (see Chapter 100, General Appendix 7 for an explanation of the information reported on the paper Remittance Advice form). Charges should only be submitted for those omitted from the original bill. Form Locator 4 Type of Bill Frequency Digit Code must be "5."

### **BC-260.7 Payment Adjustments**

General policy and procedures regarding payment adjustments are provided in Chapter 100, Topic 132. Chapter 100, General Appendix 6 provides specific information concerning the use of the adjustment form as it pertains to institutional and fee-for-service claims. Providers are to use the HFS 2249 adjustment form for services previously paid on the institutional claim format.

Adjustments may be initiated only for a service for which payment has been made by the department and reported on the Remittance Advice. It cannot be used to correct a rejected service, to correct a suspended claim or to correct erroneous ancillary services or room and board charges. Completed adjustment forms should be mailed to the following address at the department for processing:

Illinois Department of Healthcare and Family Services  
P.O. Box 19101  
Springfield, Illinois 62794-9101

At this time, the department has not implemented the void/rebill process for institutional claims. The void/rebill mechanism utilizes Type of Bill Frequency Digit 7 (Replacement of Prior Claim) or 8 (Void/Cancel of Prior Claim) to adjust a previously paid claim. Providers will be notified when the department is ready to accept these transactions.

**BC-260.71 Overpayments**

Under federal regulations, the Medicaid agency (HFS) must take all reasonable measures to ensure that it is the payer of last resort. As part of the “Agreement for Participation in the Illinois Medical Assistance Program” upon enrollment in the Illinois Medical Assistance Program, the provider agrees to promptly notify the department of any overpayments of which the provider becomes aware. **The provider is responsible for identifying and repaying monies owed to the department.** The department may suspend a provider’s payments, if the provider does not maintain accurate accounting for these payments.

**BC-260.8 Electronic Claim Submittal**

A service requiring an attachment cannot be billed electronically at this time. The specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, the provider should contact the department in the same manner as would be applicable to a paper claim. It may be necessary for the provider to contact their software vendor if the department determines that the service rejections are being caused by the submission of incorrect or invalid data. Further information can be found in Chapter 100, Topic 112.3

Providers billing electronically should take special note of the requirement that Form HFS 194-M-C, Billing Certification Form, must be signed and retained for a period of three years from the date of the voucher. Failure to do so may result in revocation of the provider’s right to bill electronically, recovery of monies, or other adverse actions. Form HFS 194-M-C can be found on the last page of each Remittance Advice that reports the disposition of any electronic claims. Refer to Chapter 100, Topic 130.5 for further details.