Handbook for Birth Centers

Policy and Procedures For Birth Centers

Illinois Department of Healthcare and Family Services

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Revision History

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Birth Center Services
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Foreword

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. This handbook, along with recent provider notices and Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures, will act as an effective guide to participation in the Department's Medical Programs.

It is important that both the provider of services 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 and supplements to the handbook are released as necessary based on operational need and State or federal laws requiring policy and procedural changes. Updated handbooks are posted on the Provider Handbooks page of the website.

Providers are held responsible for compliance with all policy and procedures contained herein. Providers should register to receive e-mail notification, when new provider information has been posted by the Department.

Charges for services provided to customers enrolled in a HealthChoice Illinois managed care organization (MCO) must be billed to the MCO. Providers should always verify a customer's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the customer's coverage. It is imperative that providers check HFS electronic eligibility systems regularly to determine eligibility. The Recipient Eligibility Verification (REV) System, the Automated Voice Response System (AVRS) at 1-800-842-1461, and the Medical Electronic Data Interchange (MEDI) systems are available.

Inquiries regarding coverage of a service or billing issues may be directed to the Bureau of Professional and Ancillary Services at 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.

Customer - A term used to identify an individual receiving coverage under one of the Department's medical programs. It is interchangeable with the term "recipient."

Department of Healthcare and Family Services (HFS or Department) - The state 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.

National Provider Identifier (NPI) - The standard, unique identifier for healthcare providers mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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

Provider Enrollment Services (PES) - The section of the HFS 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 paper document issued by HFS which reports the status of claims (invoices) and adjustments processed. It may also be referred to as a voucher.

201 Provider Enrollment

201.1 Enrollment 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. Admin. Code sections 146.800-840 and meet the Illinois Department of Public Health (DPH) licensure requirements under 77 Ill. Admin. Code Part 264.

Illinois has a web-based provider enrollment system known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT). Under the IMPACT system, category of service(s) (COS) is replaced with Specialties and Subspecialties. The table of IMPACT Provider Types, Specialties and Subspecialties is a reference guide that provides important information for providers enrolling via IMPACT. A birth center must enroll as identified below, specifying one of the Subspecialties.

IMPACT Provider Type Name	IMPACT Specialty Name	IMPACT Sub-Specialty Name	IMPACT Enrollment Type
Birthing Centers	Birthing Centers	Hospital Associated and Hospital Based	Facility, Agency, Organization (FAO)
Birthing Centers	Birthing Centers	Hospital Associated but Non-Hospital Based	Facility, Agency, Organization (FAO)
Birthing Centers	Birthing Centers	FQHC Based	Facility, Agency, Organization (FAO)
Birthing Centers	Birthing Centers	Not Associated to a Hospital or FQHC	Facility, Agency, Organization (FAO)

Participation approval is not transferable. Refer to Topic 201.2.

201.2 Enrollment Approval

When enrollment is approved, the birth center will receive a systematic email notification. A Provider Information Sheet, listing all data on the Department's computer files, will be received separately. The birth center is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, see the Handbook Supplement.

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.

Enrollment of a provider is subject to a provisional period and shall be conditional for one-year unless otherwise specified by the Department. During the period of conditional enrollment, the Department may terminate or dis-enroll the provider from the Medical Assistance Program without cause.

201.3 Enrollment Denial

If an enrollment is denied by the Office of the Inspector General (OIG), 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.

201.4 Provider File Maintenance

The information carried in the Department’s files for participating providers must be maintained by the provider on a current basis. The provider and the Department share responsibility for keeping the file updated. Provider Enrollment Services (PES) is the section within the Department that is responsible for reviewing provider enrollment records.

Provider Responsibility

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 must be communicated to the Department immediately and corrected via a modification in the IMPACT system.

Provider change information must be updated via the on-line application available on the IMPACT Provider Enrollment web page. The on-line change function is available to notify the Department of updates or changes to enrollment information for the following categories:

- National Provider Identifier (NPI)
- Provider name
- Provider demographic (address, phone, email)
- Payee demographic (address, phone, email)

- Add a Pay To (payee)
- Close a Pay To (payee)
- Close enrollment
- License
- Clinical Laboratory Improvements Amendments (CLIA)

Failure of a provider to properly update the IMPACT system with 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's office address and to all billing providers associated to the provider in the IMPACT system.

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 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.

230 Covered Services

A covered service is a service for which payment can be made by the Department in accordance with 89 Ill. Admin. Code 140.3.

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 customers 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 Ill. Admin. Code Section 146.830:

1. Delivery Services
2. Observation Services

3. Transfer Fee

260 Payment Process

260.1 Charges

Charges for birth center services must be submitted to the Department in the X12 837 Institutional claim format or via the Department's Medical Electronic Data Interchange (MEDI) system.

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 customers enrolled in a Medicaid MCO must be billed to the MCO according to the contractual agreement with the MCO.

260.2 Claim Preparation and Submittal

General policy and procedures for claim submittal are provided in Chapter 100.

Providers submitting X12 electronic transactions must refer to Chapter 300, Handbook for Electronic Processing. Chapter 300 Handbook identifies information specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Department.

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. The Department's TPL Code Directory and Status Code listing is on the Provider Handbooks webpage.

In instances where the insurance company pays the customer directly and the facility has not received payment from the customer, 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.

The Department has prepared a standardized form for institutional providers to use when requesting claim review and override of specific Department claim processing edits. The HFS 1624A, UB-04 Override Request Form, has been designated for use

by institutional providers and must be submitted with the provider's electronic claim form for review by HFS staff. The HFS 1624A is available on the Department's Medical Programs Forms Page.

260.3 Split Bills (MANG - Spenddown)

See Chapter 100 for a full explanation of the spenddown policy. Outpatient charges for a spenddown customer should be submitted to the customer's Department of Human Services (DHS) Family Community Resource Center (FCRC) for use in meeting the customer's spenddown obligation. The day on which the customer 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 customer liability amount the birth center may collect from the customer. Providers must use the appropriate value code in the UB-04 Data Specifications Manual to identify the customer's spenddown liability. The value code must be utilized even if the customer's spenddown liability is zero.

HFS 2432s will not be issued for bills that are the total responsibility of the customer. When any service is billed for a date that is determined to be a split-bill day, the HFS 2432 must be sent as an attachment to the claim. This form must be attached even if the customer liability amount is zero.

Any questions regarding calculation of spenddown should be directed to the FCRC serving the customer. For information on the FCRCs, please refer to the DHS website.

260.4 Reimbursement

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

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

Observation services will be reimbursed at the lower of billed charges or at the rate identified in 89 Ill. Adm. Code 146.840.

Transfer fees for a birth center located in Cook County will be reimbursed at the lower of billed charges or 15 percent of the average facility payment rate made to a hospital located in Cook County for an uncomplicated vaginal birth.

Transfer fees for a birth center located outside of Cook County will be reimbursed at the lower of billed charges or 15 percent of the statewide average facility payment rate made to a hospital located outside of Cook County 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 for payment procedures utilized by the Department and for explanations of Remittance Advice detail.

Providers 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 Remittance Advice. 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 for further details.

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 customer. This prohibition applies to payment made directly by the Department and payments made on behalf of an eligible customer by a Medicaid MCO under contract with the Department.

260.5 Fee Schedule

A birth center fee schedule of payable services is available on the Department's website.

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 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."

260.7 Payment Adjustments

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.

- Adjustments via MEDI or the 837I electronic void/rebill mechanism - 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. Detailed instructions are contained in Chapter 100.

- Adjustments using the HFS 2249 Adjustment Form – Form HFS 2249 can be completed online and printed for mailing to the Department. Detailed information regarding completion of the HFS 2249 is contained in the Handbook Supplement. 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

260.8 Overpayments

Under federal regulations, HFS must take all reasonable measures to ensure that it is the payer of last resort. As part of the IMPACT provider Terms and Conditions 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.