



POSITION STATEMENT

Appropriate Billing & Coding for Birth Centers

Introduction

Appropriate billing and coding is an area that impacts all birth centers, their patients, their providers and payors. An apparent need for clarification of billing practices was identified by AABC from questions and observations by multiple stakeholders. The manner in which birth centers bill for facility charges can vary due to the lack of defined revenue and/or CPT codes specific for the birth center, lack of information on correct billing practices, and different requirements by payors. However, birth center owners, providers and administrators are ultimately responsible for correct billing. The AABC Standards for Birth Centers (revised 2016) now explicitly require ethical billing, so it is important that all birth centers thoroughly understand the meaning of appropriate and ethical billing and coding.

Purpose

Because of the lack of uniformity in birth center billing and variations in requirements of various payors, birth centers and payors may be confused at times about appropriate billing. AABC has identified several contributing factors that may lead to this confusion. Some of these factors include: lack of definitive sources and references for coding and billing, Medicare does not certify birth centers as a facility, and no uniformity in Medicaid billing for birth centers outside of federal Medicaid statute. The federal Centers for Medicare and Medicaid Services (CMS) requires that every Medicaid Managed Care Organization (MCO) in every state provide access to at least one birth center in their network. As a result, an increasing number of insurers are looking for guidance on billing.

The purpose of this document is to define, clarify, and describe appropriate billing for services provided in freestanding birth centers. In addition, educating industry stakeholders and birth centers on the appropriate and acceptable standards for coding and billing for reimbursement of freestanding birth center care is a priority. Ethical billing is a priority for birth center providers and owners and required by the Standards for Birth Centers (2016). Following consistent, acceptable principles, statutory regulations, uniformity and best practices will enable birth centers to bill

appropriately and ethically. This statement will focus on defining, describing and clarifying some of these principles.

Transparency, Consumer Protection and Accountability

Birth centers are required to provide a financial policy to every client before, at, or near the time of service with full disclosure, whether the birth center is in-network or out-of-network, and its billing practices including expected amount of payment from the client for their patient responsibility. Birth centers are accountable to complete accurate medical records reflecting all services, apply appropriate coding for that care, bill for services only medically necessary and charge uniformly. Adherence to federal and state laws and full transparent disclosure to patients enhance consumer protection and patient satisfaction.

3-Legged Stool

Appropriate and ethical billing has four major components. Each of these must be present to operate appropriately. Think of them as a three-legged stool with a seat, it stops functioning if any part is missing.

The Seat of the Stool: A non-discriminatory fee schedule. All medical bills are charges to the patient. Patients pay through different payment methods, whether by credit cards, cash, and health insurers or third party payors (either on their own or as part of their employee salary/benefits) to cover a portion of their medical bills. Generally the fee schedule is the same fee for all payment methods and payors and all providers must adhere to their published fee schedule for reimbursement.

State laws and individual contracts vary widely in regard to offering payment arrangements for lesser reimbursement than charged to an insurer, so what works for some birth centers may not be a legal option at another birth center. There are insurance contracts that require a provider to give the lowest price it has offered automatically to the private insurance company, regardless of what the insurer would otherwise pay. Another example is if a patient wants to pay as a self pay but is covered by an insurer that requires direct billing by the provider which will affect what the provider can charge or get paid. A birth center that submits a claim to an insurer for an insured patient, or issues a bill to an insurance company, should disclose it charges non-insurance patients paying cash at a lower fee.

Prompt pay and cash pay which provides a discount depending on time of payment, or method of payment, is widely used, however regulations in different states may restrict this practice, such as New Jersey and at risk in New York, or states provide regulations approving the practice, such as California. It is recommended that birth centers seek legal advice to verify what is permitted in their individual states because it can vary.

Financial policies of birth centers that accept cash pay services and remain in network with any insurance company need to have an attorney review for any laws in the state affecting the pricing of self pay patients vs the third party insurers contracted and the insurance contracts.

***Note: The above relates to a birth center's published fee schedule, self-pay and out-of-network insurance billing. Insurer contracts which are in-network provide specific rate schedules agreed upon between the birth center and the payor for reimbursement.*

***Note: Prepayment discounts may be a possible way to incentivize people to pay by a certain date early in pregnancy rather than at the time of or after delivery. While prepayment discounts are widely used, one should consult with legal counsel before implementation.*

Leg One: Accurate charting. All billing starts with accurate charting. What actually happens during care is documented in specific information of location, patient demographics, identification of the provider performing the specific care, the procedure performed, and the diagnoses made by the provider, all of which are translated into the appropriate codes for billing. Charts are periodically audited by a payor or government entity and the documentation must support the coding submitted on claims.

Leg Two: Appropriate coding. Coding has a reputation for being both absolute and magical. Both are inaccurate. There are several ways to code care that could be considered accurate, but there are nuances by payor, specialty, region and generally accepted guidelines. Even accurate coding can be considered fraud as defined by the Office of the Inspector General, which governs compliance for federal payors and benefits; whose guidelines are nearly universally adopted by commercial plans. For example: unbundling one's global fee may include all the correct procedure, place of service, bill type, diagnosis, and provider coding, so it is technically accurate, but it is still not allowed. Some methods of coding lead to higher payment than others, but there are almost always guidelines in place to prevent their use for routine care. Since most care that occurs in birth centers involves healthy mothers and infants, most care will be routine. Do not fall into the trap of thinking that "if the code pays, it's okay" as upcoding, unbundling, template coding and charting, non-specific coding, and inaccuracies will result in audits and may be reviewed for an indefinite period of time if found fraudulent. Such audits result in overpayment demands by the payor of refunds, "take backs," cancelled contracts, and in some cases civil or criminal charges.

It may help to think of coding as simply a foreign language with different dialects. The care the patient receives is documented in the medical chart, that chart gets translated into the coding language that the payor can process from the claim. There are no magical or trade secret codes that increase your bottom line. The fees you charge have a code attached to them, and your codes are a translation of the care you gave to the patient as noted in the chart.

Leg Three: Patient responsibility. Patients covered by insurance payors, both in-network and out-of-network, have cost sharing responsibility in the form of deductibles, co-payments and co-insurance and often are contractually required to pay for that portion of their care; a provider is not

allowed to interfere with the contract between the insurance company and the member. If a provider routinely waives, rebates, gives, or pays all or part of the patient's financial responsibility, then the provider may be subject to federal and/or state laws regarding whether such pattern is an inducement to the patient to seek health care services from the provider or allegations of overcharging the party paying and/or the patient.

Patient balance billing is when the patient is responsible for the difference between the billed amount and the allowed amount by the payor. This practice of waiving patient responsibility is not allowed if one is in-network with the payor. If one is out-of-network, there are some states that have passed laws limiting this practice as to what you can balance bill. Please seek out legal resources specific to one's own state regarding allowable patient balance billing.

***Note: There are waivers, rebates, gifts, payment or offers for discounting patient payment that fall within a safe harbor under federal laws, such as financial need and hardship as long as it is in accordance with a written policy that includes documents of proof and the ability to demonstrate a policy commensurate with providing financial consideration on an as needed basis.*

Statutory Regulations, Uniformity and Accepted Best Practices

The following include definitions of different regulations and authorities that control or direct the birth center model of care, including federal and state statutes, AABC, ACOG, national organizations of architecture, planning, and safety guidelines, and industry standards for uniformity and best practices of billing charges for a birth center.

AABC Definition

The birth center is a health care facility for childbirth where care is provided in the midwifery and wellness model. The birth center is freestanding and not a hospital.

Birth centers are an integrated part of the health care system and are guided by principles of prevention, sensitivity, safety, appropriate medical intervention and cost-effectiveness. While the practice of midwifery and the support of physiologic birth and newborn transition may occur in other settings, this is the exclusive model of care in a birth center.

The birth center respects and facilitates a woman's right to make informed choices about her health care and her baby's health care based on her values and beliefs. The woman's family, as she defines it, is welcome to participate in the pregnancy, birth, and the postpartum period.

Approved by AABC Board of Directors: 10.1.1995; Revised 4.23.17

CMS - Centers for Medicare and Medicaid Services federal definition)

A birth center is a facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.

Centers for Medicare & Medicaid Services

Place of Service Codes for Professional Claims Database

Birth Centers Defined in Federal Statute

The Patient Protection and Affordable Care Act added a statutory definition of “freestanding birth center” to section 1905(l)(3) of the Social Security Act:

42 U.S.C. § 1396(l)(3)

(B) The term “freestanding birth center” means a health facility –

(i) that is not a hospital;

(ii) where childbirth is planned to occur away from the pregnant woman’s residence;

(iii) that is licensed or otherwise approved by the State to provide prenatal, labor and delivery or postpartum care and other ambulatory services that are included in the plan; and

(iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the State shall establish.

United States Government. Social Security Act. 42 USC § 1396a(a)(10)(A)

Birth Centers in Industry Classifications

North American Industry Classification System (NAICS) is a system for classifying establishments (individual business locations) by type of economic activity. Sector 62 Health Care and Social Assistance — Freestanding Birth Centers

621498 = All Other Outpatient Care Centers (including birth centers) under group class of ambulatory care facilities

NAICS United States, 2017 Manual– January 2017

Birth Centers in Levels of Maternal Care

The ACOG/SMFM Obstetric Care Consensus document “Levels of Maternal Care” defines birth centers:

Peripartum care of low-risk women with uncomplicated singleton term pregnancies with a vertex presentation who are expected to have an uncomplicated birth.

Levels of Maternal Care. 2015

Birth Centers in the Facility Guidelines Institute (FGI)

The Facilities Guidelines Institute defines birth centers in the FGI Guidelines:

A freestanding birth center is exclusively dedicated to serving childbirth-related needs of women and their newborns. A birth center is any health facility, place, or institution that is not a hospital or in a hospital where birth is planned to occur away from the mother’s residence following a normal, uncomplicated pregnancy. Birth centers are classified as ambulatory care facilities.

FGI Guidelines for Design and Construction of Outpatient Facilities 2018

Birth Centers in Billing Standards

1. Facility Taxonomy – Taxonomy Codes are designed to categorize the type, classification and/or specialization of health care providers. The classification of Birthing Center is 261QB0400X – Based on Type: Level III Area of Specialization, “a freestanding birth center is a health facility other than a hospital where childbirth is planned to occur away from the pregnant woman’s residence, and that provides prenatal, labor and delivery, and postpartum care, as well as other ambulatory services for women and newborns.”

(Source: Washington Publishing Co. & Social Security Act [42 U.S.C. §1396d(1)(3)(B)])

2. Facility Billing Codes – The “Type of Bill” is 084x for Freestanding Birthing Center; and the “Revenue Code” is 0724 for labor room or delivery at a Birthing Center.

(Source: National Uniform Billing Committee, NUBC - publishes the UB-04/CMS 1450)

3. Ambulatory Surgical Centers, Ambulatory Care Facility and Birthing Centers – Ambulatory care refers to medical services performed on an outpatient basis, without admission to a hospital or other facility. Ambulatory care is provided in settings such as dialysis clinics, ambulatory surgical centers, hospital outpatient departments, and the offices of physicians and other health professionals. An ambulatory surgical center (ASC) is a distinct entity that primarily provides outpatient surgical procedures to patients who do not require an overnight stay after the procedure. In addition to ASCs, hospital outpatient departments (HOPDs) and, in some cases, physicians’ offices perform outpatient surgical procedures.

4. Revenue Code for Labor Room/Delivery – Charges for labor and delivery room services provided by specifically trained nursing personnel to patients including prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if they are performed in the delivery suite.

5. UB-04 Billing Platform – The birth center should bill its facility fee on a UB-04 form. The Centers for Medicare & Medicaid Services (CMS) and the National Uniform Billing Committee have approved the UB-04 claim form, also known as the CMS-1450 form, for facility and ancillary paper billing. The UB-04 claim form accommodates the National Provider Identifier (NPI), Revenue Codes and ICD-10 coding. (Insurance companies should not require that a birth center bill on a HCFA 1500 form, which is the official standard form used by physicians and other providers for professional services. The HCFA 1500 form should be reserved for the professional fees of the practitioners practicing at the birth center, while the UB-04 form is more appropriate for the birth center facility fee.)

6. Place of Service – The “Place of Service Code” is 25 for Birthing Center defined as a facility, other than a hospital’s maternity facilities or a physician’s office which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants; 21 for Inpatient Hospital and 11 for Office.

(Source: National Uniform Claim Committee, NUCC – publishes the CMS 1500)

7. Medical Necessity – Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r178cp.pdf>

Birth Centers Defined in State Regulations

Thirty-eight states have birth center specific regulations for birth centers. Three additional states license birth centers under other regulations. In each of these state regulations birth centers have been defined for regulatory purposes. Many of these definitions are based on the APHA Guidelines for Licensing and Regulating Birth Centers. Nine states do not have regulations for licensing birth centers. Two of these states without regulations have defined birth centers in their rules for Medicaid reimbursement.

This document is not intended to be comprehensive. Billing and coding are not universal.

For further information on billing or coding, please refer to these additional resources:

1. AAPC - www.aapc.com
2. AHIMA - www.ahima.org (American Health Information Management Association)
3. Office of Inspector General, U.S. Dept of Health & Human Services - OIG Guidelines for Physician Practices <https://oig.hhs.gov/authorities/docs/physician.pdf> M

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