Chapter 10 Section 1

Freestanding And Hospital-Based Birthing Center Reimbursement

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1.0 APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the Defense Health Agency (DHA) and specifically included in the network provider agreement.

2.0 DESCRIPTION

A birthing center is a freestanding or institution affiliated outpatient maternity care program which principally provides a planned course of outpatient prenatal care and outpatient childbirth service limited to low-risk pregnancies; excludes care for high-risk pregnancies; limits childbirth to the use of natural childbirth procedures; and provides immediate newborn care.

3.0 POLICY

3.1 A freestanding or institution affiliated birthing center may be considered for status as an authorized institutional provider.

3.2 Reimbursement for all-inclusive maternity care and childbirth services furnished by an authorized birthing center shall be limited to the lower of the TRICARE established all-inclusive rate or the billed charge.

3.3 The all-inclusive rate shall include the following to the extent that they are usually associated with a normal pregnancy and childbirth: laboratory studies, prenatal management, labor management, delivery, postpartum management, newborn care, birth assistant, certified nurse-midwife professional services, physician professional services, and the use of the facility. The rate includes physician services for routine consultation when certified nurse-midwife is the attending professional.

Note: The initial complete newborn examination by a pediatrician is not included in the birthing center all-inclusive fee and is to be cost-shared as a part of the maternity episode when performed within 72 hours of the delivery.

3.4 TRICARE maximum allowable birthing center all-inclusive rates for services provided prior to April 1, 2018.

3.4.1 The TRICARE maximum allowable all-inclusive rate is equal to the sum of the CHAMPUS Maximum Allowable Charge (CMAC) for total obstetrical care for a normal pregnancy and delivery (Current Procedural Terminology (CPT) procedure code 59400) based on the appropriate class of the professional provider submitting the claim plus the DHA supplied non-professional price component amount. DHA will supply each contractor with non professional price components for each state annually to be effective for the forthcoming rate year (see Addendum A).

3.4.2 Claims for professional services and tests where the beneficiary has been screened but rejected for admission into the program, or where the woman has been admitted but is discharged from the birthing center program prior to delivery, should be priced as individual services and items, subject to current policies for obstetrical care professional services and reported as appropriate CPT procedure code with either Place of Service code "**22**" or "**25**".

3.4.3 Claims from birthing centers will be processed as outpatient hospital claims using revenue code 724 and the following CPT procedure code with either Place of Service code "**22**" or "**25**".

59400 - *Obstetrical care*

3.4.4 The cost-share amount for birthing center claims is calculated using the ambulatory surgery cost-share formula.

3.4.5 The maximum allowable all-inclusive rate shall be updated on April 1st each year to coincide with the Outpatient Prospective Payment System (OPPS) quarterly update.

3.5 TRICARE maximum allowable birthing center all-inclusive rates for services provided on or after April 1, 2018.

3.5.1 The all-inclusive rate requirement shall not preclude reimbursement of the individual components of covered services (both professional and non-professional) furnished by the birthing center that would otherwise be included within the all-inclusive rate. Therefore, birthing centers may be paid an all-inclusive rate for services (professional and non-professional) that they actually provide. If the birthing center only provides part of the professional services because the beneficiary moves and gets the remaining services elsewhere, TRICARE may pay only for that part of the services (namely, the professional services) they provided as part of the all-inclusive rate for the birthing center. Likewise, if the birthing center does not provide facility services for the actual delivery, the all-inclusive rate would not include the facility component payment.

3.5.2 The facility component of the birthing center all-inclusive rate will be the one-day Diagnosis Related Group (DRG) short-stay outlier for DRG 775 (uncomplicated vaginal birth) adjusted for geographic cost variations. This facility rate more accurately reflects the costs associated with a normal vaginal delivery and will be consistent with TRICARE reimbursement rates currently in use for inpatient institutional services. The DRG zip-to-wage index files will be used for adjusting the facility component rate for geographical labor cost variations.

3.5.3 The total all-inclusive rate [i.e., the global maternity (CPT procedure code 59400) professional rate plus the facility DRG 775 amount] shall only be reimbursed if all of the maternity services (antepartum, delivery, and postpartum services) are provided by the same birthing center.

3.5.4 The all-inclusive rate for partial episodes of care, due in part to the high degree of mobility inherent in military life resulting in changing providers during pregnancy, shall be comprised of the sum of the applicable professional (CMAC) and facility component (DRG 775) rates as reflected in the following coding chart:

CODING USED FOR PAYMENT OF BIRTHING CENTERS			
PROFESSIONAL PAYMENT	**DESCRIPTION**	**FACILITY PAYMENT**	**DESCRIPTION**
59400	(Global Professional Services) *Obstetrical care*	DRG 775 Short Stay Outlier (SSO)	Vaginal Delivery w/o Complicating Diagnosis
Appropriate Evaluation & Management (E/M) Codes	*Antepartum care only, 1-3 visits*	No Payment	
59409	*Obstetrical care*	DRG 775 (SSO)	Vaginal Delivery w/o Complicating Diagnosis
59410	*Obstetrical care*	DRG 775 (SSO)	Vaginal Delivery w/o Complicating Diagnosis
59425	*Antepartum care only*	No Payment	
59426	*Antepartum care only*	No Payment	
59430	*Care after delivery*	No Payment	

3.5.5 The following are examples of payment of itemized services provided by different health care providers using the above coding chart:

3.5.5.1 Antepartum Care Only: CPT codes 59425 (*Antepartum care only; 4-6 visits*) and 59426 (*Antepartum care only; 7 or more visits*) were created for situations such as relocation or change to another health care provider. In these situations, all the routine antepartum care (usually 13 visits) or global care may not be provided by the same health care provider.

Example: A beneficiary receives her antepartum visits (12 visits) from an obstetrics and gynecology (OBGYN) group in San Diego, CA, and is subsequently relocated to Norfolk, VA, where she receives the remainder of her maternity care (i.e., delivery and postpartum care) from a birthing center. The OBGYN group would receive payment for the antepartum visits only (CPT procedure code 59425) while the birthing center would receive payment for the remaining professional services related to the delivery and postpartum care (CPT procedure code 59410), along with DRG 775 for the facility delivery services.

3.5.5.2 Postpartum Care Only: CPT procedure code 59430 (*Care after delivery Postpartum care only (separate procedure)*] was created for situations where postpartum care is not provided by the same health care provider that performed the actual delivery. The American Congress of Obstetricians and Gynecologists (ACOG) considers the postpartum period to be 60 days following the date of the vaginal delivery.

Example: A beneficiary receives her antepartum visits (13 visits) and delivery from a birthing center in Denver, CO, and is subsequently relocated to San Antonio, TX, shortly after delivery where she receives her postpartum care from an OBGYN group. The birthing center would be reimbursed for the antepartum visits (CPT procedure code 59426), the professional delivery services (CPT procedure code 59409), and the delivery facility services (DRG 775) while the OBGYN group would receive separate payment for the postpartum care (CPT procedure code 59430).

3.5.5.3 Vaginal Delivery Only, No Postpartum Care: Delivery services include admission to the birthing center facility, the admission history and physical examination, and management of uncomplicated labor and vaginal delivery. CPT procedure code 59409 (*Obstetrical care Vaginal delivery only, with or without episiotomy and/or forceps*) was created for delivery services only; i.e., where only the delivery component of the maternity care is provided and antepartum and postpartum care are performed by other health care providers.

Example: A beneficiary receives her antepartum visits/care from a birthing center in Colorado Springs, CO, and is subsequently relocated to Augusta, GA, where she delivers at a birthing center, and after which she moves back temporarily to Colorado Springs to be with family and friends. She receives her postpartum care from the birthing center in Colorado Springs. The birthing center in Colorado Springs would receive separate payment for the antepartum (CPT procedure code 59426) and postpartum (CPT procedure code 59430) care, while the birthing center in Augusta, GA, would receive payment for both the facility (DRG 775) and professional (CPT procedure code 59409) delivery services.

3.5.6 The maximum allowable all-inclusive component (professional and facility) rates will be updated to coincide with the annual DRG and CMAC updates.

3.5.7 The cost-share amount for birthing center claims for which there is a facility component (DRG 775) will be calculated using the ambulatory surgery cost-share formula. That is, claims from birthing centers processed as outpatient institutional claims using Revenue Code 724 and the following CPT procedure codes with Place of Service "**25**" for birthing center will be cost-shared the same as an Ambulatory Surgery Center (ASC). Separate cost-sharing will not be deducted for professional services as long as there is a facility component billing (DRG 775) on the claim.

59400 - *Obstetrical care*
59409 - *Obstetrical care*
59410 - *Obstetrical care*

3.5.8 Freestanding birthing center claims for which only the following professional services are billed will be subject to the standard outpatient cost-share provisions; i.e., a separate cost-share will be deducted for professional services for which there is no corresponding non-professional (facility) component billed on the claim.

59425 - *Antepartum care only*
59426 - *Antepartum care only*
59430 - *Care after delivery*

3.6 Extraordinary maternity care services (services in excess of the quantity or type usually associated with all-inclusive maternity care and childbirth service for a normal pregnancy) may be cost-shared as part of the birthing center maternity episode and paid as the lesser of the billed charge or the allowable charge when the service is determined to be otherwise authorized and medically necessary and appropriate.

3.7 Claims for birthing centers must be submitted on a Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 claim form. Claims not submitted on the appropriate claim form will be denied.

3.8 Both the technical and professional components of usual tests are included in the all-inclusive rate.

3.9 Excluded services when billed separately.

99071 - *Patient education materials*
99078 - *Group health education*

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