5101:3-18-01 **Freestanding birth center: eligible providers, covered services and reimbursement.**

(A) A "freestanding birth center" (FBC) is a facility, operated in compliance with rules 3701-83-33 to 3701-83-42 of the Administrative Code, which provides care during pregnancy, birth and the immediate postpartum period to low-risk expectant mothers. A FBC does not include a hospital registered under section 3701.07 of the Revised Code, or an entity that is reviewed as part of a hospital accreditation or certification program.

(B) To receive medicaid reimbursement a FBC must:

(1) Be currently licensed as a FBC by the Ohio department of health or by the state licensing agency where the FBC is located if the FBC is located outside the state of Ohio;

(2) Have a valid, current provider agreement in accordance with rule 5101:3-1-17.2 of the Administrative Code; and,

(3) Meet the standards provided in 42 U.S.C. § 1396d(l)(3)(B) (effective March 23, 2010).

(C) Covered freestanding birth center (FBC) services:

(1) The following FBC services are covered:

(a) Medically necessary services provided during pregnancy, birth and the immediate postpartum period to an eligible medicaid consumer who is a low-risk expectant mother, as defined in rule 3701-83-33 of the Administrative Code, and furnished directly or indirectly by a licensed health care professional within the scope of practice of his or her profession under state law. The services must also be within the scope of FBC licensed services as described in rules 3701-83-33 to 3701-83-37 of the Administrative Code.

(b) "FBC facility services" that are items and services furnished by a FBC and designated as FBC procedures in the appendix to this rule. Facility services include but are not limited to:

(i) Nursing, technician and related services;

(ii) Use of FBC facilities;

(iii) Drugs and equipment directly related to the provision of a FBC procedure; and,

(iv) Diagnostic or therapeutic services or items directly related to the provision of a FBC procedure.

(2) The following facility services are not covered:

(a) Maternity care and delivery services provided to women who are not "low-risk expectant mothers" and

(b) Maternity care and delivery services not provided in accordance with rules 3701-83-34 to 3701-83-37 of the Administrative Code.

(D) Freestanding birth center (FBC) reimbursement:

(1) "Billable services" for a FBC are those identified and provided in accordance with this rule.

(2) "Procedure code" refers to the current procedural terminology (CPT) codes and healthcare common procedure coding system (HCPCS) as defined in rule 5101:3-1-19 of the Administrative Code. Guidelines and definitions for level of care determinations and for new and established patient definitions are as published in the CPT and HCPCS volumes. HCPCS modifier "TH" should be used when obstetrical services, prenatal or postpartum, were provided.

(3) Payment for facility services.

(a) All services must be billed in accordance with Chapter 5101:3-1 of the Administrative Code.

(b) Payment for FBC services is based on a reimbursement rate for each HCPCS code as determined by the department and set forth in the appendix to this rule.

(c) Maximum reimbursement for facility services will be the lesser of the provider's billed charges or one hundred per cent of the rate as specified in the appendix to this rule.

(d) For facility reimbursement, the department recognizes the CPT codes for global obstetrical care for antepartum, delivery and postpartum services, or single procedure codes. If a provider bills using global codes, then the provider cannot bill separately for single procedure codes.

(4) Reimbursement limitations.

Payment for services associated with global codes is considered payment in full for the services described in paragraph (D)(3) of this rule for the service date spans related to the delivery. If single service procedure codes as described in paragraph (D)(3) of this rule have been billed and the provider then seeks reimbursement for a global code, the provider must reverse all

claims with single procedure codes to obtain reimbursement for the global code.

(5) Payment for laboratory services, radiological services, and diagnostic and therapeutic procedures.

In addition to reimbursement for facility services described in this rule, a FBC may also be reimbursed for laboratory procedures, radiological procedures, and diagnostic and therapeutic procedures provided in connection with a covered FBC procedure. To be reimbursed for these procedures, FBC providers must bill using appropriate HCPCS codes.

(a) Payment for laboratory services.

(i) A FBC facility may be reimbursed for covered laboratory services that are provided in accordance with Chapter 5101:3-11 of the Administrative Code

(ii) A FBC will not be reimbursed separately for the professional component of laboratory services.

(b) Payment for radiological services.

(i) A FBC may be reimbursed for radiological procedures that are provided and billed in accordance with rule 5101:3-4-25 of the Administrative Code.

(ii) A FBC will not be reimbursed separately for the professional component of radiological services.

(c) Payment for diagnostic and therapeutic services.

(i) A FBC may be reimbursed for the provision of diagnostic and therapeutic services that are provided in accordance with rules 5101:3-4-11, 5101:3-4-16, 5101:3-4-17 and 5101:3-4-18 of the Administrative Code.

(ii) A FBC will not be reimbursed separately for the professional component of diagnostic and therapeutic services.

(iii) A FBC will not be reimbursed separately for the professional component of any service cited in paragraph (D)(5)(c)(i) of this rule.

Effective:

R.C. 119.032 review dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5111.02
Rule Amplifies:	5111.02, 5111.021