Newborn Care (Inpatient)

Policy

Mass General Brigham Health Plan reimburses participating providers for the provision of medically necessary inpatient newborn care rendered in participating facilities.

For babies born to MassHealth members, MassHealth requires the facility to submit the Notification of Birth form, within 30 days from the newborn's date of birth, to facilitate eligibility determination and health plan enrollment. The form can be accessed by the following link:
MassHealth Notication of Birth

Reimbursement

Providers are reimbursed according to the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan Payment Policy and by the provider's agreement with Mass General Brigham Health Plan. Member liability amounts may include but are not limited to: copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirements can be located here.

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

Mass General Brigham Health Plan reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Please refer to Coding Provider Payment Guidelines for more information.

All claims are subject to audit services and medical records may be requested from the provider.

Mass General Brigham Health Plan reimbursement is based on line of business. Unless otherwise specified within the medical policies, please follow the guidelines based on membership type.

Mass General Brigham Health Plan Reimburses

- Circumcision requested by the parent and performed by a participating provider while the newborn is in the hospital following delivery
- Inpatient physician services
- State mandated diagnostic testing and screening

Mass General Brigham Health Plan Does *Not* Reimburse

- Ritual circumcision performed by non-clinicians

Procedure Codes

Note: This list of codes may not be all-inclusive

Code	Descriptor	Comments
0169	Room & Board – other	For administratively necessary days; use per contractual agreement
0170	Newborn nursery	For routine newborn care
0171	Newborn level I	For routine newborn care
0172	Newborn level II	
0173	Newborn level III	
0174	Newborn level IV	
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block	
54160	Circumcision, surgical excision other than clamp, device, or dorsal slit; neonate (28 days or less)	

Code	Descriptor	Comments
96040	Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family	Not reimbursable
99221-99223	Inpatient hospital care, per day	
99231-99233	Subsequent hospital care, per day	
99460	Initial hospital or birthing center care, per day, for E&M of normal newborn infant	For routine newborn care; do not report in conjunction with 99463
99461	Initial care, per day, for E&M of normal newborn infant seen in other than hospital or birthing center	
99462	Subsequent hospital care, per day, for E&M of normal newborn	Do not report in conjunction with 99460
99463	Initial hospital or birthing center care, per day, for E&M of normal newborn infant admitted and discharged on the same date	For newborns assessed and discharged from the hospital or birthing center on the same day
99464	Attendance at delivery (when requested by the delivering physician) and initial stabilization	Do not report in conjunction with 99465
99465	Delivery/birthing room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output	Do not report in conjunction with 99460, 99468, and 99477
99468	Initial inpatient neonatal critical care, per day	
99469	Subsequent inpatient neonatal critical care, per day	
99477	Initial hospital care, per day, for the neonate, aged 28 days or less, requiring intensive observation, frequent interventions, and other ICU services	For newborns *not* critically ill, only reported by *one* provider, *once* per member

Code	Descriptor	Comments
99478	Subsequent intensive care, very low birth weight infant, (present body weight 1500-2500 grams) day	For newborns *not* critically ill, requiring frequent monitoring, heat maintenance, nutritional adjustments, labs and oxygen monitoring, etc. by a team under direct physician supervision, reported by *one* provider, *once* per day, per member
99479	Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant, (present body weight 1500-2500 grams) day	For newborns *not* critically ill, requiring frequent monitoring, heat maintenance, nutritional adjustments, labs and oxygen monitoring, etc. by a team under direct physician supervision, reported by *one* provider, *once* per day, per member
99480	Subsequent intensive care, per day, for the evaluation and management of the recovering infant, (present body weight 2501-5000 grams)	For newborns *not* critically ill, requiring frequent monitoring, heat maintenance, nutritional adjustments, labs and oxygen monitoring, etc. by a team under direct physician supervision, reported by *one* provider, *once* per day, per member

Provider Payment Guidelines and Documentation

- Routine circumcision requested and performed by a participating provider during the newborn's hospital stay is reimbursed under the inpatient stay
- Sick newborns transferred to the NICU or another facility are reimbursed using the baby's Mass General Brigham Health Plan identification number and corresponding authorization number
- Well newborn care *during and after* the inpatient stay and the mother's discharge is reimbursed using the baby's Mass General Brigham Health Plan identification and corresponding authorization numbers

Diagnosis Related Group (DRG) Provider Billing Guidelines

For DRG contracted hospitals, Mass General Brigham Health Plan uses All Patient Refined Diagnosis-Related Groups (APR-DRG) to administer the policy, incorporating the POA indicator into the DRG assignment.

DRG facilities contracted to use DRG payment methodology must submit claims with DRG coding. Claims submitted for payment by DRG must contain the minimum requirements to ensure accurate claim payment. Mass General Brigham Health Plan processes DRG claims through DRG software. If the submitted DRG and system-aligned DRG differ, the Mass General Brigham Health Plan assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the claim cannot be grouped due to insufficient data, it will be rejected and returned.

Please note: Mass General Brigham Health Plan continues to require authorization for all inpatient services except routine newborn delivery.

Coding Elements

The following discharge data elements are used for APR-DRG subclass assignment:

- ICD-CM diagnosis codes
- ICD-CM procedure codes
- Date of Birth
- Gender
- Birthweight (when applicable)
- Admit Date
- Discharge Date
- Status of Discharge
- Days on Mechanical Ventilator (value or ICD-10-CM code)

Maternity and Nursery Claims

Submit claims for the delivery under the mother's Mass General Brigham Health Plan member ID and the nursery under the newborn's Mass General Brigham Health Plan member ID.

Please note: Routine nursery charges are covered but not reimbursed separately for Mass General Brigham Health Plan commercial line of business. All incurred inpatient services are included in the payment for the other's obstetrical stay, provided that the mother is a MGBHP member.

Related Mass General Brigham Health Plan Payment Guidelines

Inpatient Hospital Admissions

References

MassHealth Acute Inpatient Hospital Bulletin 161

Publication History

Topic: Newborn Care (Inpatient)	Owner: Network Management

June 26, 2009	*Original documentation*
May 25, 2010	*Authorization grid, definitions, updated*
March 20, 2012	*Authorization grid, member cost-sharing, coding grid, NOB-1 link and submission address, disclaimer updated*
April 1, 2017	*Document restructure, removed definitions, added DRG language, NOB-1 for MassHealth link change, added related guidelines, and submission under member's Mass General Brigham Health Plan ID*
March 5, 2018	*Document review; NOB-1 for MassHealth link change; addition of reference to MassHealth Acute Inpatient Hospital Bulletin 161*
January 1, 2019	*Document restructure; codes, code descriptor and references updated*
February 13,2020	*Clarified Commercial DRG language*
January 1, 2023	*Document rebrand*
January 1, 2024	*Annual review, no policy change*
January 1, 2025	*Annual review, no policy change*

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc., and Mass General Brigham Health Plan Insurance Company.