BOSTON MEDICAL CENTER HEALTHNet PLAN

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WELL SENSE HEALTH PLAN

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Reimbursement Policy

Newborn and Neonatal Intensive Care Unit (NICU) Services

Policy Number: 4.106
Version Number: 2
Version Effective Date: 05/15/2021

Product Applicability	☐ **All Plan[+] Products**
Well Sense Health Plan ☐ Well Sense Health Plan	**Boston Medical Center HealthNet Plan** ☒ MassHealth MCO ☒ MassHealth ACO ☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan reimburses covered newborn services and Neonatal Intensive Care Unit (NICU) Services based on the provider's contractual rates with the Plan and the terms of reimbursement identified within this policy.

Prior-Authorization

Please refer to the Plan's Prior Authorization Requirements Matrix at ww.bmchp.org

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Definitions

Newborn Care Services - services performed from birth through 28 days.

Well Newborn – A newborn who does not need special care or intensive care newborn services.

Sick Newborn – A newborn who requires special care or intensive care newborn services.

Minimum Length of Stay - The minimum length of inpatient stay for mothers and infants shall be 48 hours following a vaginal delivery and 96 hours following a cesarean section. These time periods begin at the time of the infant's birth. Inpatient stays of less than these time frames shall constitute early discharge.

MassHealth Member Enrollment Guidelines

Notification of Birth (NOB) Process for MassHealth Eligibility

Effective January 1, 2021, acute inpatient hospitals will be required to complete and submit the Notification of Birth (NOB-1) form to MassHealth Enrollment Center Notification of Birth Unit within 10 days of the newborn's date of birth. In the revised form, the newborn's parent/guardian can voluntarily enter selections for a managed care plan and primary care provider (PCP) enrollment for the newborn. The paper NOB form, as well as the electronic version of this form, referred to as the eNOB, will have two new fields for the parent/guardian to voluntarily select a managed care plan and PCP for their child. Completion of those fields will allow the family to convey their selection of a managed care plan or PCP to MassHealth as soon as possible after birth of the child.

Providers should note that NOB and eNOB forms with "Baby Boy" or "Baby Girl" will not be processed after January 1, 2021.

Once a completed NOB form is received by MassHealth, either by fax or electronically, the eligibility information is loaded into the MassHealth eligibility system and eligibility is established.

Newborn MassHealth Eligibility

When MassHealth eligibility is established for a newborn by MassHealth, the baby is enrolled in MassHealth's fee-for-service program, retroactive to the newborn's date of birth. Starting January 1, 2021, parents/guardians will have an opportunity to voluntarily select BMC HealthNet Plan for their child at the time eligibility is established, using the new managed care plan and PCP selection fields in the NOB form. If the parent/guardian does not select a plan on the form, the baby will remain in MassHealth's fee-for-service program for up to 14 days after the NOB is processed. At any time during this period, the parent/guardian may select a managed care plan for the child voluntarily. While in MassHealth's fee-for-service program, the newborn will have access to the entire MassHealth FFS network.

Newborn Enrollment with the Plan

Enrollment for newborns with the Plan will not take effect until after the plan enrollment has been processed. MassHealth will not retroactively date a newborn's managed care enrollment to the date of birth.

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Only claims with a dates of service that are on or after the newborns managed care enrollment date should be submitted to the Plan for reimbursement. Claims from the newborns date of birth up until the day prior to the newborns managed care enrollment date should be submitted directly to MassHealth for reimbursement.

Provider Reimbursement

MassHealth Members

Claims for the newborn and mother must be billed separately under their individual member IDs. Per MassHealth All-Provider Bulletin 305, inpatient hospital providers should use the MassHealth Eligibility Verification System (EVS) to determine newborn enrollment and follow these billing guidelines:

- If EVS indicates the newborn has MassHealth eligibility but does not yet have a managed care plan enrollment the provider should submit the claim for the newborn to MassHealth.
- Inpatient hospital providers should split any claims for which the newborn member changed enrollment to the Plan during the inpatient stay.
    - For dates of service prior to enrollment in the Plan, inpatient hospitals should bill MassHealth.
    - For dates of service on or after enrollment in the Plan, inpatient hospitals should bill the Plan.

MassHealth All Provider Bulletin 305 does not change any existing guidance around the billing of delivery services. Delivery services should continue to be billed to the Plan.

BMC HealthNet Plan Qualified Health Plans, including ConnectorCare/Employer Choice Direct Members

Well newborn services are included in the payment for the mother's obstetrical delivery when the mother is a Plan member and shall continue for the earlier of the mother's discharge or the minimum length of stay. The following billing guidelines apply for newborns in Wellborn and Non-Routine/Sick categories:

Well Newborn

- If the newborn's own ID is available, routine well newborn charges must be submitted under the newborn's own member ID number.
- If the newborn is not enrolled in BMC HealthNet Plan, charges for the mother and routine well newborn services must be submitted on separate claims under the mother's member ID number.
- When a delivery involves multiple births, separate claims must be submitted for each newborn under the mother's member ID number.

Non-Routine/Sick Newborn

- The charges for the mother and non-routine/sick newborn services must be submitted on separate claims.
- The newborn claim must be submitted under the newborn's own member ID number.

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- When a delivery involves multiple births, separate claims must be submitted for each newborn under the newborn's own member ID.

Birth Weight

Birth weight in grams must be present on claims for newborns and other patients when age at admission is less than 29 days. To report birth weight:

- UB-04 paper claim – In Field Locator 39, 40 or 41, enter Value Code 54 (Newborn birth weight in grams) and the newborn's birth weight in grams in the Value Codes Amount field.
- 837I electronic claim – In Loop 2300, Segment HI, enter Qualifier BE in HI01-01, Value Code 54 in HI01-2 and the newborn's birth weight in grams in HI01-5.

Claims submitted without the birth weight will be denied.

Circumcision

For QHP members only, circumcision for male newborns is covered under the mother's inpatient facility charges as a newborn charge when performed in the hospital by a licensed physician (or licensed practitioner, when this service is within the legal scope of his/her practice). Claims for male newborn circumcision is also reimbursed when billed under the newborn's individual ID and performed by a licensed physician when rendered during the mother's inpatient stay.

If a newborn is circumcised after discharge from a hospital, other Plan reimbursement policies would apply.

Newborn Levels of Care/Revenue Codes for Facility Claims

The Plan will reimburse hospitals for inpatient services utilizing the Executive Office of Health and Human Services (EOHHS) APAD reimbursement methodology. Please refer to the Plan's Inpatient Hospital reimbursement policy, 4.110.

QHP member claims for Wellborn Nursery and Non-Routine/Sick Nursery and MassHealth member Non-Routine/Sick Nursery are based upon the appropriate revenue code, as shown below.

- The newborn level of care and corresponding revenue code directly relates to the intensity of care that is provided to the newborn and should be clinically evaluated on a daily basis.
- Levels of care and the resulting revenue codes can change during the newborn's inpatient stay.
- NICU services are only reimbursed when provided in a Level III or Level IV newborn service.

Hospitals should submit claims using the appropriate revenue codes as described in the table below:

Revenue Code	Level Of Care	Description
0170		General Nursery
0171	Level I Well Newborn	Level of Care I should have the following capabilities:

Revenue Code	Level Of Care	Description
	Nursery	• Provide neonatal resuscitation at every delivery • Evaluate and provide postnatal care to stable term newborn infants • Stabilize and provide care for infants born 35–37 weeks gestational age who remain physiologically stable • Stabilize newborn infants who are ill and those born at <35 weeks gestational age until transfer to a higher level of care
0172	Level II Special Care Nursery	• Level I capabilities plus: • Provide care for infants born ≥32 weeks gestational age and weighing ≥1500g who have physiologic immaturity or who are moderately ill with problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis • Provide care for infants convalescing after intensive care • Provide mechanical ventilation for brief duration (<24 h) or continuous positive airway pressure or both • Stabilize infants born before 32 weeks of gestation and weighing less than 1500g until transfer to a neonatal intensive care facility
0173	Level III Neonatal Intensive-Care Unit (NICU	Level II capabilities plus: • Provide comprehensive care for infants born <32 weeks gestational age and weighing <1500g and infants born at all gestational ages and birth weights with critical illness • Provide prompt and readily available access to a full range of pediatric medical subspecialists and pediatric ophthalmologists • Provide a full range of respiratory support that may include conventional and/or high-frequency ventilation and inhaled nitric oxide • Perform advanced imaging, with interpretation on an urgent basis, including computed tomography, MRI, and echocardiography
0174	Level IV Regional Neonatal Intensive-Care Unit (Regional NICU)	Level III capabilities plus: • Located within an institution with the capability to provide surgical repair of complex congenital or acquired conditions • Maintain a full range of pediatric medical subspecialists, and pediatric, anesthesiologists at the site • Facilitate transport and provide outreach education
0179		Nursery- Other

- In the situation where a newborn no longer meets inpatient level of care criteria but cannot be discharged home due to the absence of an appropriate caregiver (i.e. the mother is hospitalized), see the Plan's policy, Administratively Necessary Days, policy number OCA 3.102.

Applicable Coding and Billing Guidelines

Applicable coding is listed below, subject to codes being active on the date of service. Because the American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), and the U.S. Department of Health and Human Services may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes may not be all inclusive. These codes are not intended to be used for coverage determinations.

Coding For Professional Claims

Code	Description
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)
99221	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity
99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity.
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity.
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity.
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity.
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity.
99460	Initial hospital or birthing center care, per day, for the evaluation and management of normal newborn infant
99462	Subsequent hospital care, per day, for the evaluation and management of normal newborn

Code	Description
99463	Initial hospital or birthing center care, per day, for the evaluation and management of normal newborn infant admitted and discharged on the same date
99464	Attendance at delivery (when requested by the delivering physician or other qualified health care professional) and initial stabilization of newborn
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
99468	Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger
99469	Subsequent inpatient neonatal critical care, per day , for the evaluation and management of a critically ill neonate, 28 days of age or younger
99471	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
99472	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
99477	Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or younger, who requires intensive observation, frequent interventions, and other intensive care services
99478	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)
99479	Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams)
99480	Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
06/15/2015	09/01/2015	Payment Policy	Payment Policy Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
04/20/2021	Updated per MassHealth APB 305, revised levels of care to current AAP guidelines – adding Level IV and	05/15/2021	Payment Policy Committee

Policy Revisions History			
	definitions of levels, added circumcision section for QHP members, further clarified reporting of birth weight		

Other Applicable Policies

Reimbursement Policies

- General Billing and Coding Guidelines, 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines, 4.108
- Inpatient Hospital, 4.110
- Obstetrical, 4.105
- Physician and Non Physician Practitioner Services, 4.608
- Modifiers, 4.23

Medical Policies

- Administratively Necessary Days, OCA 3.102

References

- CMS Claims Processing Manual, Chapter 25
- MassHealth Billing Guide for the UB-04
- MassHealth Regulation, 105 CMR 130.601-130.669
- Uniform Billing Editor, Chapter IV
- MassHealth All Provider Bulletin 305
- McKesson's InterQual Acute Pediatric Level of Care Criteria, Nursery subset

Disclaimer Information

This Policy provides information about the Plan's reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member's benefit plan. Unless otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan's discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan's audit policies, refer to the Provider Manual.