

Payment Policy: Newborn Inpatient Stays

Reference Number: CC.PP.075

Product Types: Marketplace

Effective Date: 05/2024

Last Review Date: 05/2024

[Coding Implications](#)
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Policy Overview

The purpose of this policy is to define payment criteria for newborn inpatient stays to be used in making payment decisions and administering benefits. Newborn inpatient stays are reimbursed by the Health Plan based on Medicare Severity Diagnosis Related Groups (MS-DRGs).

Application

Inpatient Facility Claims

Policy Description

Section 1886(d) of the Social Security Act specifies that the Secretary shall establish a patient classification system for inpatient discharges and adjust payments under the Inpatient Prospective Payment System (IPPS). This system is referred to as Diagnosis Related Groups (DRGs).

DRGs is a patient classification scheme developed by the Centers for Medicaid and Medicare Services (CMS) that is defined by a set of patient classifications that relate a hospital's case mix to resource demands and associated costs experienced by a hospital. Accordingly, inpatient hospital reimbursement is paid on a rate per discharge basis that varies according to the DRG to which a beneficiary's stay is assigned. Each DRG weight represents the average resources required to care for patients in that specific DRG.

The Plan classifies hospitalizations into MS-DRGs for payment under the IPPS. This classification is based on the hospital reporting: principal diagnosis, up to 24 additional diagnoses, and up to 25 procedures performed during the hospitalization. Some DRGs also are based on age, sex and discharge status of the patient.

Reimbursement

The health plan allows reimbursement for newborn inpatient hospitalizations. When provider reimbursement is based on MS-DRG classification, inpatient hospital billing should accurately describe the services or procedures represented by the revenue code(s) billed.

The Health Plan will assign DRG for inpatient newborn stays when NICU revenue codes are billed in the primary/first position:

- DRG [795](#) for revenue codes 170 or 171
- DRG [794](#) for revenue codes 172, 173, or 174

When a non-NICU revenue code is billed, payment will be adjusted to group MS-DRG 795.

Documentation Requirements

Claims should be billed and coded according to industry standard coding guidelines for the services/procedures rendered. Diagnostic and procedural information and the patient’s discharge status should match both the attending physician description and the information contained in the patient’s medical record.

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Revenue Code	Descriptor
0170	Nursery – General
0171	Nursery – Newborn Level I
0172	Nursery – Newborn Level II
0173	Nurse – Newborn Level III
0174	Nurse – Newborn Level IV

DRG	Descriptor
795	Normal Newborn
794	Neonate with Other Significant Problems

Modifier	Descriptor
Not Applicable	Not Applicable

ICD-10 Codes	Descriptor
Not Applicable	Not Applicable

References

1. United States Code: Social Security Act - SEC. 1886. [42 U.S.C. 1395ww] (1940). https://www.ssa.gov/OP_Home/ssact/title18/1886.htm. Accessed April 29, 2024.
2. Centers for Medicare and Medicaid Services (CMS) <https://www.cms.gov/>.
3. Current Procedural Terminology (CPT®), 2024

Revision History	
05/01/2024	Policy finalized with references, definitions, and policy number added
04/11/2024	Initial Policy Draft

Important Reminder

For the purposes of this payment policy, “Health Plan” means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan’s affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

PAYMENT POLICY
NEWBORN INPATIENT STAYS

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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