PI Payment Policy 32
Newborn and NICU

All States & Lines of Business

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In the event of a conflict, federal and state guidelines, as applicable, as well as the member's benefit plan document supersede the information in this policy. Additionally, to the extent there are any conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval.

Overview

The Neonatal Intensive Care Unit (NICU) is a critical care area in a facility for newborn infants who need specialized care. The NICU is a combination of advanced technology and a NICU team of licensed professional providers.

Newborn levels of care are based on the complexity of care provided for an infant with specified diagnoses and symptoms. All levels of care are represented by a unique revenue code: Level I/0170, 0171, Level II (Special Care Nursery)/0172, Level III/0173 and Level IV/0174. Any inpatient newborn revenue codes not billed as levels II-IV will be recognized as a level I.

Process

Molina Healthcare or designee conducts clinical validation reviews both pre-payment and post-payment. This helps to ensure that claims represent the services provided to our members, and that billing and reimbursement is accurate and compliant with federal and state regulations as well as applicable standards, rules, laws, policy, and contract provisions.

Inpatient admissions may be reviewed in order to ensure that all services are of an appropriate duration and level of care in order to promote optimal health outcomes. Clinical documentation of an ongoing neonatal hospitalization may be reviewed concurrently to substantiate the level of care and length of stay, with continued authorization based on the documentation submitted and aligning with MCG Neonatal Facility Levels of Care and Neonatal Intensity of Care Criteria, as adapted by plan policy where applicable.

Reimbursement is independent of the location of care and corresponds to medical treatment and services the neonate requires. To ensure accurate reimbursement, submitted claims may be reviewed to align preauthorized levels of care and/or clinically validate diagnoses, procedures and other claim information that impact payment. Based on review, the following may occur:
- Down-code revenue codes to authorized levels of care
- Issue a base DRG payment
- Adjust claim diagnoses/procedures that are not substantiated in the medical information provided and apply DRG regrouping,
- Request complete medical records and/or itemized statements to support the services on the claim

Newborn members are covered at an inpatient facility for a 2 day stay associated with vaginal deliveries and a 4 day stay associated with cesarean sections without clinical review (notification may be required) if submitted with revenue codes 0170/0171 and a "normal newborn" DRG.

For any newborn diagnoses/revenue codes/procedures that may be associated with care/treatment outside of the routine newborn, which may result in an increased payment, preauthorization is required regardless of the length of stay and may be subject to clinical validation review. The provider must be able to provide documentation establishing that the criteria for the level of care, revenue code, and/or DRG are satisfied, as submitted on the claim.

Coding

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding

practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

Approval History

TYPE	DATE	ACTION
Effective Date	1/7/2022	New Policy
Review Date	5/26/23	State Review - CA

References

1. MCG Care Guidelines 26th Edition Copyright © 2022 MCG Health, LLC

2. CMS. "ICD-10-CM Official Guidelines for Coding and Reporting. FY 2021." Centers for Medicare and Medicaid Services (CMS). https://www.cms.gov/files/document/2021-coding-guidelines-updated-12162020.pdf

3. The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

4. Title 22, California Code of Regulations, Sections 41515.1 et seq, 51013

Supplemental Information

State Addendum
1. MI and CA: May utilize InterQual criteria based on contractual obligations
2. CA: In California, referral to California Children's Services (CCS) for all eligible neonates will be made according to state mandate, and Title 22, CCR, Sections 41515.1, 51013
3. CA: Any claims for hospital stays that are CCS-eligible, but were not submitted to CCS appropriately or did not follow CCS hospital stay rules, and have thus been denied by CCS, will not be authorized by Molina. The only exception is where the neonate's medical condition does not meet medical eligibility under CCS guidelines. All other Molina reimbursement requirements, as outlined above, need to be met.

Appendix