Newborn and NICU

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 a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of 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. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

The Neonatal Intensive Care Unit (NICU) is a specialized area within a medical facility designed to provide critical care for newborn infants requiring advanced medical attention. The NICU integrates cutting-edge technology with the expertise of a team of licensed professional healthcare providers.

Levels of neonatal care are categorized based on the complexity of medical services required by infants with specific diagnoses and conditions. Each level is identified by distinct revenue codes: Level I/0170, 0171; Level II (Special Care Nursery)/0172; Level III/0173; and Level IV/0174. Inpatient newborn revenue codes that do not correspond to levels II II IV will be classified as Level I.

Reimbursement Process

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

Inpatient admissions may be reviewed to verify that all services are provided for an appropriate duration and level of care to promote optimal health outcomes. Clinical documentation of an ongoing neonatal hospitalization may be reviewed concurrently to confirm the level of care and length of stay. Continued authorization is based on the documentation provided, aligning with MCG Neonatal Facility Levels of Care and Neonatal Intensity of Care Criteria.

Reimbursement is determined independently of the location of care and corresponds to the medical treatment and services required by the neonate. To ensure accurate reimbursement, submitted claims may be reviewed to align with preauthorized levels of care and/or to clinically validate diagnoses, procedures, and other claim information that impact payment. Based on the review, the following actions may occur:

- Adjust revenue codes billed 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 adjustment.
- Request complete medical records and/or itemized statements to support the services on the claim.

Molina Healthcare will use medical records received during the concurrent review process and/or any medical records received with the claim form to support the claim billed. If medical records are not received, a presumptive payment adjustment may be made as described above.

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 and SOI (Severity of Illness) 1.

Diagnoses/revenue codes/procedures that may be associated with care/treatment outside of routine newborn care 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/SOI are satisfied, as submitted on the claim.

Supplemental Information

State Exceptions

State	Exception
CA	May utilize InterQual criteria based on contractual obligations.

References

1. MCG Care Guidelines 28th Edition Copyright © 2024 MCG Health, LLC
2. CMS. “ICD-10-CM Official Guidelines for Coding and Reporting. FY 2024.” https://www.cms.gov/files/document/fy-2024-icd-10-cm-coding-guidelines-updated-02/01/2024.pdf
3. The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

Documentation History

Type	Date	Action
Effective Date	01/07/2022	New Policy
Revised Date	08/07/2024	Updated template, verified links
Revised Date	12/12/2024	Updated template and verified links

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 use 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.