

# Newborn Services Payment Policy

## Policy

The Plan covers well and sick newborn services.

## Reimbursement

Well newborn services are included in the payment for the mother's obstetrical delivery when the mother is a Plan member. If the newborn is not being added as a dependent, coverage for the well newborn care will cease upon the mother's discharge from the hospital. Payment for services requiring sick newborn care is contingent upon the newborn being enrolled as a plan member.

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). If a newborn is circumcised after discharge from a hospital, a surgical day copayment may apply when performed in an outpatient surgical setting. If performed in a doctor's office or community health center, the member would be responsible for an office visit copayment.

The Plan will not reimburse:

Circumcisions that are not performed by a licensed physician (or licensed practitioner, when this service is within the legal scope of his/her practice).

Circumcisions performed in any setting other than a hospital, day surgery, or physician's office are not covered.

Mother and newborn charges must be submitted together when both parties are discharged on the same day. A separate claim for the newborn must be submitted with dates of service occurring after the mother's discharge date.

## Referral/notification/prior authorization requirements

Authorization is required for inpatient admissions and the transfer of a newborn to a Neonatal Intensive Care Unit (NICU).

The ordering physician is required to obtain prior authorization for:

- Unlisted CPT codes
- The applicable codes found on the *List of Procedures Requiring Prior Authorization* located in the *Managing Patient Care* section of the *Provider Manual* under *PCP Referral and Plan Prior Authorization Process*.

Prior authorization is required for services with non-participating providers.

## Billing/coding guidelines

Accurate and timely claims processing is contingent upon the newborn's enrollment in the plan.

Submit claim(s) for well newborn services to the mother's primary insurance carrier under the mother's ID # when the newborn has not been added to the plan.

Submit claims under the newborn's ID # when the newborn has been added to the plan.

Submit a separate claim for each newborn if there are multiple births.

### MassHealth members:

For MassHealth members, hospitals must submit a completed NOB-1 form (appended to this policy) to the MassHealth Enrollment Center Notification of Birth Unit in a timely manner; this should be done no later than 30 calendar days after the delivery. Instructions for completion are indicated on the NOB-1 form and include the appropriate address and fax number for submission.

To bill for multiple birth deliveries when two different methods are used to deliver:

- CPT code 59510 (routine obstetric care including antepartum care, cesarean delivery, and postpartum care), or 59618 (routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery). Reimbursement will be 100% of the global fee schedule.
- CPT code 59409 (vaginal delivery only - with or without episiotomy and/or forceps) with modifier 51, or 59612 (vaginal delivery only, after previous cesarean delivery - with or without episiotomy and/or forceps) with modifier 51. Reimbursement will be 50% of delivery only fee schedule.

## Place of service

This policy applies to services rendered in all settings.

## Policy history

Origination date:	1/1/2015
Previous revision date(s):	11/01/2015 - Annual review and moved to new Plan template. 09/01/2016 - Added instructions for billing multiple births when two different delivery methods are used.
Connection date & details:	May 2017 – Added information regarding submitting the notification of birth form to MassHealth and added licensed practitioner language. July 2018 – Updated MassHealth NOB-1 Form. July 2019 – Updated the reimbursement section.

*The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.*