Newborn Services
Payment Policy

Applicability

This Policy applies to the following Fallon Health products:

☒ Fallon Medicare Plus, Fallon Medicare Plus Central (Medicare Advantage)
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ NaviCare SCO (Medicaid-only)
☒ Summit Eldercare PACE
☒ Fallon Health Weinberg PACE
☒ Community Care (Commercial/Exchange)

Policy

The Plan covers medically necessary well and sick newborn services.

Reimbursement

Newborn care for Community Care and Medicare members

For Community Care and Medicare members, well newborn care is included in the payment for the mother's obstetrical delivery. 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 member.

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.

Newborn enrollment for MassHealth ACO members

For MassHealth ACO members, effectve January 1, 2021 there is a default time-limited MassHealth fee-for-service enrollment for all newborns until the newborn's parent/guardian selects a managed care plan or MassHealth assigns the newborn to a managed care plan. If the newborn is enrolled in a Fallon MassHealth ACO plan, all claims must be billed to Fallon Health under the newborn's own member ID number.

Circumcision

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.

Newborn hearing screening

When rendered in an inpatient setting, newborn hearing screening is not separately reimbursed.

CPT 92650 (Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis) is covered for MassHealth, NaviCare and Summit ElderCare plan members when billed by a physician or audiologist in an office setting. CPT 92650 is a screening service

and is not covered by Medicare, accordingly, CPT 92650 is not covered for Medicare Advantage members. Effective March 1, 2021, CPT 92650 is not separately reimbursed for Community Caremembers.

Donor human milk and donor human milk-derived products for Community Care members

In accordance with Massachusetts General Laws Chapter 176G, Section 4QQ, the Plan will cover donor human milk and donor human milk-derived products for Community Care members when all of the following coverage criteria are met:

- The covered infant is under the age of 6 months; and
- The covered infant is undergoing treatment in an inpatient setting for a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis or a congenital or acquired condition that may benefit from the use of such human breast milk as determined by the department of public health; and
- The covered infant is medically or physically unable to receive maternal breast milk or participate in breast feeding or whose mother is medically or physically unable, despite receiving lactation support, to produce maternal breast milk in sufficient quantities or caloric density; and
- The milk is obtained from a human milk bank that meets quality guidelines establishedby the department of public health; and
- A licensed medical practitioner has issued a written order for the provision of such human breast milk or donor human breast milk-derived products for the covered infant.

Donor human breast-milk derived products includes, for example, pasteurized donor human milk that is specially formulated to meet the specific needs of newborns in neonatal intensive care units (NICUs).

Hospitals should report donor human milk and donor human milk-derived products on the UB-04 claim form, with revenue code 0220.

When the inpatient stay is reimbursed through a diagnosis related group or other bundled payment arrangement, reimbursement for donor human milk and donor human milk-derived products is included in the reimbursement for such diagnosis related group or bundled payment.

Referral/notification/prior authorization requirements

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

Hospitals are required to notify Fallon Health of any inpatient admission for MassHealth newborns transferring from MassHealth fee-for-service to a Fallon Health ACO plan. Hospitals can check the MassHealth Electronic Verification System (EVS) to find out if a newborn has been assigned to a managed care plan.

The ordering physician is required to obtain prior authorization for unlisted CPT codes.

To find out if a procedure code requires prior authorization, please use Procedure code look-up on the Fallon Health website http://fchp.org/providertools/ProcedureCodeLookup/.

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.

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.

MassHealth ACO members

For MassHealth members, hospitals must submit a completed Notification of Birth (NOB-1) form to the MassHealth Enrollment Center Notification of Birth Unit within 10 days of the newborn's date of birth. Starting January 1, 2021, MassHealth will require hospitals to use an updated NOB-1 form. This form will be available January 1, 2021 at: https://www.mass.gov/lists/masshealth-provider-forms-by-provider-type-h-m. The updated NOB-1 form includes additional fields for information that will ensure proper payment for services. These changes are also reflected in the electronic NOB, referred to as the eNOB, available via the MassHealth Virtual Gateway. Hospitals are encouraged to use the eNOB in place of the paper NOB-1 form whenever possible. Providers should note that NOB 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, and eligibility information is loaded into the MassHealth eligibility system and eligibility has been established, the baby will be enrolled in MassHealth's fee-for-service program retroactive to the newborn's date of birth. Parents/guardians will have an opportunity to voluntarily select a managed care plan and PCP at the time the NOB form is completed by the hospital. If a parent/guardian does not select a managed care plan on the NOB form, the newborn will remain in MassHealth's fee-for-service program for up to 14 days after the NOB is processed. Managed care enrollment for newborns will take effect after the plan enrollment has been processed by MassHealth. MassHealth will no longer retroactively date a newborn's managed care enrollment to the date of birth. If a parent/guardian does not make a voluntary managed care plan choice for the newborn within 14 days after MassHealth eligibility was established, MassHealth will assign the child to a managed care plan. For additional information refer to MassHealth All-Provider Bulletin 305, issued Decemter 2020, available at: https://www.mass.gov/lists/2020-masshealth-provider-bulletins.

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.

- 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 a managed care plan during the inpatient stay.

MassHealth Bulletin 305 does not change any existing guidance around the billing of delivery services. Delivery services should continue to be billed to the mother's plan, i.e., Fallon Health ACO.

Birth weight requirement for hospitals reimbursed based on APR-DRG methodology

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:

- On a 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.
- On an 837 Institutional 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 that do not have a valid birth weight will be denied.

Revenue Codes

Claims for newborn nursery, including well newborn nursery, must be submitted under the newborn's own member ID using the appropriate revenue code, as shown below. Levels of care and the resulting revenue codes can change during the newborn's inpatient stay.

Revenue Code	Descriptor
0170	General nursery
0171	Newborn level I
0172	Newborn level II
0173	Newborn level III
0174	Newborn level IV
0179	Nursery other

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. July 2020 – Clarified reimbursement and billing for MassHealth ACO. January 2021 – Updated Referral/notification/prior authorization requirements for MassHealth newborns, updated Billing/coding guidelines for MassHealth newborns, added requirement for birth weight on claims. October 2021 – Added information about reimbursment for newborn hearing screening rendered in an inpatient setting. July 2025 – Under Reimbursement, added new section for Donor Human Milk and Donor Human Milk-Derived Products for Community Care Members.

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.