Diagnosis-Related Group Newborn Inpatient Stays facility reimbursement policy update

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Effective for dates of service on and after September 1, 2018, we will implement the new facility reimbursement policy, Diagnosis-Related Group (DRG) Newborn Inpatient Stays.

The following details provide important information about this policy:

- All newborn inpatient stays must include sufficient documentation or prior authorization to support an admission to a level of care area beyond the newborn nursery, such as the neonatal intensive care unit (NICU), or for the higher level of care associated with more complex newborn DRG.
- Newborn claims submitted for a higher level of care DRG that do not include the appropriate documentation, or those submitted with only newborn care revenue codes (170 and 171) and no prior authorization will be automatically processed based on the normal newborn rate.
- Current prior authorization guidelines for normal newborn and higher level of care newborn inpatient stays apply.

We have created a new remark code to help provide additional detail in the above mentioned claim scenarios. The explanation, “Claim did not meet criteria for higher DRG payment. Level of care adjustment has been made. Claim paid at Normal Newborn DRG.” will appear on the provider remit when a claim is submitted with a higher level of care newborn DRG code and the required documentation or prior authorization is not on file. Providers may appeal decisions related to the DRG Newborn Inpatient Stays policy by following their normal appeal process and submitting the appropriate supporting clinical documentation.

For more information about DRG Newborn Inpatient Stays reimbursement policy, visit the CT facility reimbursement policy webpage ME facility reimbursement policy webpage NH facility reimbursement policy webpage at anthem.com.


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