Payment Policy: Newborn Inpatient Stays

Reference Number: CC.PP.075
Product Types: Marketplace & Medicaid
Effective Date: 05/2024
Last Review Date: 04/2025

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
The purpose of this policy is to define payment criteria for newborn inpatient stays to be used in making payment decisions and administering benefits. Newborn inpatient stays are reimbursed by the Health Plan based on Medicare Severity Diagnosis Related Groups (MS-DRGs).

Application
Inpatient Facility Claims

Policy Description
Section 1886(d) of the Social Security Act specifies that the Secretary shall establish a patient classification system for inpatient discharges and adjust payments under the Inpatient Prospective Payment System (IPPS). This system is referred to as Diagnosis Related Groups (DRGs).

DRGs is a patient classification scheme developed by the Centers for Medicaid and Medicare Services (CMS) that is defined by a set of patient classifications that relate a hospital's case mix to resource demands and associated costs experienced by a hospital. Accordingly, inpatient hospital reimbursement is paid on a rate per discharge basis that varies according to the DRG to which a beneficiary's stay is assigned. Each DRG weight represents the average resources required to care for patients in that specific DRG.

The Plan classifies hospitalizations into MS-DRGs for payment under the IPPS. This classification is based on the hospital reporting: principal diagnosis, up to 24 additional diagnoses, and up to 25 procedures performed during the hospitalization. Some DRGS also are based on age, sex and discharge status of the patient.

Reimbursement
The health plan allows reimbursement for newborn inpatient hospitalizations. When provider reimbursement is based on MS-DRG classification, inpatient hospital billing should accurately describe the services or procedures represented by the revenue code(s) billed.

For inpatient newborn stays, assignment of a NICU-level DRG is dependent upon the exclusive billing of NICU revenue codes. When a claim reflects only non-NICU revenue codes (170/171 normal newborn stay), it will be reclassified and reimbursement will be adjusted to MS-DRG 795 in accordance with health plan policy requirements.

When a claim includes both NICU and non-NICU revenue codes billed on the same claim, the claim will be excluded from the application of this reimbursement policy.

Documentation Requirements
Claims should be billed and coded according to industry standard coding guidelines for the services/procedures rendered. Diagnostic and procedural information and the patient's discharge status should match both the attending physician description and the information contained in the patient's medical record.

Coding and Modifier Information
This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Revenue Code	Descriptor
0170	Nursery – General
0171	Nursery – Newborn Level I
0172	Nursery – Newborn Level II
0173	Nursey – Newborn Level III
0174	Nursey – Newborn Level IV

DRG	Descriptor
795	Normal Newborn
794	Neonate with Other Significant Problems
793	Full term neonate with major problems
792	Prematurity without major problems
791	Prematurity with major problems

Modifier	Descriptor
Not Applicable	Not Applicable

ICD-10 Codes	Descriptor
Not Applicable	Not Applicable

References
1. United States Code: Social Security Act - SEC. 1886. [42 U.S.C. 1395ww] (1940). https://www.ssa.gov/OP_Home/ssact/title18/1886.htm. Accessed April 29, 2024.
2. Centers for Medicare and Medicaid Services (CMS) https://www.cms.gov/.
3. Current Procedural Terminology (CPT®), 2025

Revision History	
04/11/2024	Initial Policy Draft
05/01/2024	Policy finalized with references, definitions, and policy number added
01/24/2025	Added Medicaid as a Product Type
04/09/2025	Added DRGs 791, 792, 793, revised reimbursement language, updated policy dates

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

 Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.