

## FAX

To: All Aetna Better Health of Louisiana Providers

Date: November 28, 2016

### Reminder: Newborn Billing Guidelines

Providers, this fax blast is to remind you it is inappropriate to bill procedures using an ICD-10 code that is specific to newborns when the patient is not of newborn age.

Aetna Better Health is seeing quite a few denials of procedure code 99479 when billed by neonatologist/pediatric groups whose patients are no longer of newborn age but are stilling billing with newborn diagnosis codes.

“Per CMS Policy a newborn is defined as the first 28 days of life.”

Proper billing guidelines can be reviewed at the following hyper-links below. Please refer to [www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10ClinicalConceptsPediatrics1.pdf](http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10ClinicalConceptsPediatrics1.pdf).

In ICD-10-CM, newborn remains defined as the first 28 days of life. Please refer to: [www.eicd.com/guidelines/Newborn.htm](http://www.eicd.com/guidelines/Newborn.htm).

#### NEWBORN GUIDELINES

##### Definition

The newborn period is defined as beginning at birth and lasting through the 28<sup>th</sup> day following birth.

The following guidelines are provided for reporting purposes. Hospitals may record other diagnoses as needed for internal data use.

##### General Rule

All clinically significant conditions noted on routine newborn examination should be coded. A condition is clinically significant if it requires:

- clinical evaluation; or
- therapeutic treatment; or

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- diagnostic procedures; or
- extended length of hospital stay; or
- increased nursing care and/or monitoring; or
- has implications for future health care needs.

**Note:** The newborn guidelines listed above are the same as the general coding guidelines for "other diagnoses," except for the final bullet regarding implications for future health care needs. Whether or not a condition is clinically significant can only be determined by the physician.

**A. Use of Codes V30-V 39**

When coding the birth of an infant, assign a code from categories V30-V39, according to the type of birth. A code from this series is assigned as a principal diagnosis, and assigned only once to a newborn at the time of birth.

**B. Newborn Transfers**

If the newborn is transferred to another institution, the V30 series is not used.

**C. Use of Category V29**

1. Assign a code from category V29, Observation and evaluation of newborns and infants for suspected conditions not found, to identify those instances when a healthy newborn is evaluated for a suspected condition that is determined after study not to be present. Do not use a code from category V29 when the patient has identified signs or symptoms of a suspected problem; in such cases, code the sign or symptom.
2. A V29 code is to be used as a secondary code after the V30, Outcome of delivery, code. It may also be assigned as a principal code for readmissions or encounters when the V30 code no longer applies. It is for use only for healthy newborns and infants for which no condition after study is found to be present.

**D. Maternal Causes of Perinatal Morbidity**

Codes from categories 760-763, Maternal causes of perinatal morbidity and mortality, are assigned only when the maternal condition has actually affected the fetus or newborn. The fact that the mother has an associated medical condition or experiences some complication of pregnancy, labor or delivery does not justify the routine assignment of codes from these categories to the newborn record.

**E. Congenital Anomalies**

Assign an appropriate code from categories 740-759, Congenital anomalies, when a specific abnormality is diagnosed for an infant. Such abnormalities may occur as a set of symptoms or multiple malformations. A code should be assigned for each presenting manifestation of the syndrome if the syndrome is not specifically indexed in ICD-9-CM.

**F. Coding of Other (Additional) Diagnoses**

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1. Assign codes for conditions that require treatment or further investigation, prolong the length of stay, or require resource utilization.
2. Assign codes for conditions that have been specified by the physician as having implications for future health care needs.

**Note:** This guideline should not be used for adult patients.

3. Assign a code for Newborn conditions originating in the perinatal period (categories 760-779), as well as complications arising during the current episode of care classified in other chapters, only if the diagnoses have been documented by the responsible physician at the time of transfer or discharge as having affected the fetus or newborn.
4. Insignificant conditions or signs or symptoms that resolve without treatment are not coded.

**G. Prematurity and Fetal Growth Retardation**

Codes from categories 764 and 765 should not be assigned based solely on recorded birth weight or estimated gestational age, but upon the attending physician's clinical assessment of maturity of the infant.

**Note:** Since physicians may utilize different criteria in determining prematurity, do not code the diagnosis of prematurity unless the physician documents this condition.

For questions or concerns, please contact Aetna Better Health of Louisiana Provider Relations by calling **1-855-242-0802**, and **selecting option 2** then **option 6**.

Thank you,

Aetna Better Health of Louisiana

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