In the event of a conflict between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. Plan documents include but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents.

In the event of a conflict between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern.

Providers are responsible for accurately, completely, and legibly documenting the services performed including any preoperative workup. The billing office is expected to submit claims for services rendered using valid codes from the Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), National Drug Codes (NDC) ,Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines. Claims are subject to the code auditing protocols for services/procedures billed.

# Neonatal Intensive Care Unit (NICU) Level of Care Authorization and Reimbursement Policy

**Policy Number: CPCP004**

**Version 3.0**

**Enterprise Clinical Payment and Coding Policy Committee Approval Date: 03/25/2019**

**Plan Effective Date: 05/15/2019**

## Description

The Neonatal Intensive Care Unit (NICU) is a critical care area in a facility for newborn babies who need specialized care. The NICU is a combination of advanced technology and a NICU team of licensed professionals. While most infants admitted to the NICU are premature, others are born at term but suffer from medical conditions such as infections or birth defects. A newborn also could be admitted to the NICU for associated maternal risk factors or complicated deliveries.

The NICU levels of care are based on the complexity of care that a newborn with specified diagnoses and symptoms requires. All four levels of care are represented by a unique revenue code: Level 1/0171, Level 2/0172, Level 3/0173 and Level 4/0174. *Any inpatient revenue codes not billed as levels 2-4 will be recognized as a level 1.*

## Reimbursement Information

Inpatient admissions may be reviewed in order to ensure that all services are of an appropriate duration and level of care to promote optimal health outcomes. Clinical documentation of an ongoing NICU hospitalization may be reviewed concurrently to substantiate level of care with continued authorization based on the documentation submitted and aligning with the MCG level of care guidelines.

A case may be referred to a Physician Reviewer if the information received does not meet established criteria for a NICU level of care and corresponding revenue code. The attending physician or professional provider who ordered the services shall be afforded a reasonable opportunity to discuss the plan of treatment with the Physician Reviewer. In situations where preauthorization request for level of care differs from what would be authorized based on clinical documentation and or MCG care guidelines, the Physician Reviewer can deny preauthorization for that level of care. A new preauthorization request will need to be submitted for the appropriate level of care.

Inpatient claims may be reviewed to ensure that billing is in accordance with what is preauthorized. If the claim submitted does not align with approved authorizations, then complete medical records and itemized bills may be requested to support the services billed.

Authorization requests are reviewed using criteria outlined within the MCG care guidelines. MCG care guidelines were developed in strict accordance with the principles of evidence-based medicine. Usage promotes consistent decisions leading to appropriate use of medical resources. Internally developed criteria for extension requests are based on established industry standards, scientific medical literature and other broadly accepted criteria, such as Medicare guidelines. The review criteria may be customized to reflect HCSC Medical Policy and internally developed guidelines. Diagnosis, procedure, comorbid conditions and age are considered when assigning the length of stay/service. A provider submitting a request for preauthorization of a NICU level of care or a charge with a NICU revenue code must be able to provide documentation establishing that the criteria for that level of care/revenue code are satisfied.

| NICU Level | Revenue Code Description | Criteria for NICU level of Care |
|---|---|---|
| **Level 1** | **0171**: Newborn Level I | For NICU Level 1 criteria see MCG Care Guidelines LOC: LOC-010 (ISC GRG) |
| **Level 2** | **0172:** Newborn Level II | For NICU Level 2 criteria see MCG Care Guidelines LOC: LOC-011 (ISC GRG) |

| NICU Level | Revenue Code Description | Criteria NICU level of care |
|---|---|---|
| **Level 3** | **0173:** Newborn Level III | For NICU level 3 criteria see MCG Care Guidelines LOC: LOC-012 (ISC GRG) |
| **Level 4** | **0174:** Newborn Level IV | For NICU Level 4 criteria see MCG Care Guidelines LOC: LOC-013 (ISC GRG) |

## References

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## Policy Update History

| HCSC Approval Date | Description | BCBSNM Approval Date | BCBSNM Effective Date | BCBSNM End Date |
|---|---|---|---|---|
| 06/08/2017 | New policy | | | |
| 04/20/2018 | Annual Review | 06/12/2018 | 09/07/2018 | 05/14/2019 |
| 03/25/2019 | Annual Review | 05/01/2019 | 05/15/2019 | |

| Date | Summary of Changes |
|---|---|
| 5/1/2019 | Minimum Criteria for Acceptance removed and replaced with Criteria for NICU level of care and corresponding MCG care guideline by name. Reference section updated with MCG care guidelines 21st edition. |