Name of Policy:
Pediatric and Neonatal Critical Care Services and Intensive (Non-Critical) Care Services

Policy #: 089  Latest Review Date: October 2010
Category: Administrative  Policy Grade: Not applicable

Background/Definitions:
As a general rule, benefits are payable under Blue Cross and Blue Shield of Alabama health plans only in cases of medical necessity and only if services or supplies are not investigational, provided the customer group contracts have such coverage.

The following Association Technology Evaluation Criteria must be met for a service/supply to be considered for coverage:
1. The technology must have final approval from the appropriate government regulatory bodies;
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
3. The technology must improve the net health outcome;
4. The technology must be as beneficial as any established alternatives;
5. The improvement must be attainable outside the investigational setting.

Medical Necessity means that health care services (e.g., procedures, treatments, supplies, devices, equipment, facilities or drugs) that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice; and
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease; and
3. Not primarily for the convenience of the patient, physician or other health care provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.
**Description of Procedure or Service:**

Initial and subsequent neonatal critical care per day for the evaluation and management for the critically ill neonate, can only be used for neonates who are 28 days of age or less. Critically ill neonates require cardiac and/or respiratory support (including ventilatory or CPAP when indicated), continuous or frequent vital signs monitoring, laboratory and blood gas interpretations, follow-up physician re-evaluations, and constant observations by the health care team under direct physician supervision. This would also include immediate pre-operative evaluation and stabilization of neonates with life threatening surgical, or cardiac conditions.

Initial neonatal critical care code is for the initial evaluation on the first day of critical care of the patient.

Subsequent neonatal critical care (99469) would be reported for the subsequent days the child is critically ill up to 28 days of age.

Initial pediatric critical care, 29 days up through 24 months of age, per day, for the evaluation and management of a critically ill infant or young child (99471) is reported for the initial day of care.

Subsequent pediatric critical care, 29 days up through 24 months of age, per day, for the evaluation and management of a critically ill infant or young child (99472) would be reported for the subsequent days of critical care.

Initial pediatric critical care, per day for the evaluation and management of a critically ill infant or young, 2 through 5 years of age, (99475) would be used to report these initial days of care.

Subsequent pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age, (99476) would be reported for the subsequent days of critical care.

These critically ill infants or young children would also require cardiac and/or respiratory support (including ventilatory or nasal CPAP as indicated), continuous or frequent vital sign monitoring, laboratory and blood gas interpretations, follow-up physician re-evaluations, and constant observation by the health care team under direct physician supervision. Immediate pre-operative evaluation and stabilization of infants or young children with life threatening surgical or cardiac conditions are included.

**Subsequent Intensive Care**

99478—Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams).

99479—Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams)

99480—Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight of 2501-5000 grams)
These codes are used to report care subsequent to the day of admission provided by a physician directing the continuing intensive care of the very low birth weight infant who no longer meets the definition of being critically ill. Low birth weight services are reported for neonates less than 2500 grams who do not meet the definition of critical care but continue to require intensive observation and frequent services and intervention only available in an intensive care setting. Services provided to these infants exceed those available in less intensive hospital areas or medical floors. These infants require intensive cardiac and respiratory monitoring, continuous and/or frequent vital signs monitoring, heat maintenance, enteral and/or parental nutritional adjustments, laboratory and oxygen monitoring and constant observation by the health care team under direct supervision.

The pediatric and neonatal critical care codes and the intensive (noncritical) low birth weight services codes would only be reported once per day per patient. Per previous policy, initial hospital care can be reimbursed in addition to initial inpatient neonatal critical care. (Deleted for dates of service on or after 12/6/2010.)

For dates of service on or after December 6, 2010:
The pediatric and neonatal critical care codes include management, monitoring and treatment of the patient including respiratory, pharmacological control of the circulatory system, enteral and parental nutrition, metabolic and hematologic maintenance, parent/family counseling, case management services and personal direct supervision of the health care team in the performance of their daily activities.

Routinely these codes may include any of the following services; therefore, these services would not be billed separately from the critical care codes: umbilical venous or umbilical arterial catheters, central or peripheral vessel catheterization, other arterial catheters, oral or nasal gastric tube placement, endotracheal intubation, lumbar puncture, suprapubic bladder aspiration, bladder catheterization, initiation and management of mechanical ventilation or CPAP, surfactant administration, intravascular fluid administration, transfusion of blood components (excluding exchange transfusions), vascular puncture, invasive or non-invasive electronic monitoring of vital signs, bedside pulmonary function testing, and/or monitoring or interpretation of blood gases or oxygen saturation.

When a physician is present for delivery and newborn resuscitation is required, procedure codes 99356, 99357, or 99440 99465 may be reported in addition to the initial care, 99477 and 99295 99468. When services are provided between 7 p.m. and 7 a.m. the critical care codes, 99291 and 99292, may be reported. This excludes admission work ups that occur during this time period. These services should be clearly documented in the medical record.

The following criteria should be used as guidelines for the correct reporting of neonatal and pediatric critical care codes for the subsequent care of critically ill neonate/infant. (Only one criteria is required to be classified as critically ill)

- Respiratory support by ventilator or CPAP
- Nitric oxide therapy (INOmax) or ECMO
Optimum patient management requires frequent visits and ongoing supervision of the health care team by the physician in order to perform complex integrated decisions and applications for these children.

The following examples are outlined in the 2003 CPT Changes book to clarify the correct reporting of these critical care codes.

The following examples **WOULD** qualify as critical care:

- A neonate with a hypoplastic left heart syndrome not receiving mechanical ventilation, but requiring nitrogen, dopamine and prostaglandins to prevent death or immediate morbidity from hypertension or ductal closure

- A pre-catheter or pre-operative neonate who demonstrates cardiovascular and neurological stability who is admitted for the evaluation of a possible cardiac lesion. This child is currently on prostaglandin, pressors, and oxygen/nitrogen therapy

- A post-operative neonate who has not yet established normal urine output, who is at risk for post-anesthesia arrest, who has not regained normal bowel function, and whose blood pressure is unstable

**Billing for the non-critical neonate/infant or premature infant:**

- Initial day of care for a non-critical neonate/infant or premature infant who is not admitted to the neonatal critical care unit should be billed using codes 99221-99223.

- Subsequent days of hospitalization for the non-critical neonate/infant or premature infant would be billed using 99231-99233.

- Subsequent days of a non-critical premature infant requiring intensive care setting with a present body weight less than 1500 grams would be billed using procedure 99298 99478.

- Subsequent days for a non-critical premature infant requiring intensive care setting with a present body weight of 1500-2500 grams would be reported with code 99299 99479.

- Subsequent days for a non-critical infant requiring intensive care setting with a present body greater than weight of 2501 grams would be reported with code 99300 99480.
Policy: For dates of service prior to December 6, 2010:
The pediatric and neonatal critical care codes include management, monitoring and treatment of the patient including respiratory, pharmacological control of the circulatory system, enteral and parental nutrition, metabolic and hematologic maintenance, parent/family counseling, case management services and personal direct supervision of the health care team in the performance of their daily activities.

Routinely these codes may include any of the following services; therefore, these services would not be billed separately from the critical care codes: umbilical venous or umbilical arterial catheters, central or peripheral vessel catheterization, other arterial catheters, oral or nasal gastric tube placement, endotracheal intubation, lumbar puncture, suprapubic bladder aspiration, bladder catheterization, initiation and management of mechanical ventilation or CPAP, surfactant administration, intravascular fluid administration, transfusion of blood components (excluding exchange transfusions), vascular puncture, invasive or non-invasive electronic monitoring of vital signs, bedside pulmonary function testing, and/or monitoring or interpretation of blood gases or oxygen saturation.

When a physician is present for delivery and newborn resuscitation is required, procedure codes 99356, 99357, or 99440 99465 may be reported in addition to the initial care, 99477 and 99295 99468. When services are provided between 7 p.m. and 7 a.m. the critical care codes, 99291 and 99292, may be reported. This excludes admission work-ups that occur during this time period. These services should be clearly documented in the medical record.

The following criteria should be used as guidelines for the correct reporting of neonatal and pediatric critical care codes for the subsequent care of critically ill neonate/infant. (Only one criteria is required to be classified as critically ill)

- Respiratory support by ventilator or CPAP
- Nitric oxide therapy (INOmax) or ECMO
- Prostaglandin, Inotropin, or Chronotropic or Insulin infusions
- NPO with IV fluids
- Acute Dialysis (renal or peritoneal)
- Weight less than 1,250 grams
- Acute respiratory deterioration with FIO₂ of 35% or greater by oxyhood

Optimum patient management requires frequent visits and ongoing supervision of the health care team by the physician in order to perform complex integrated decisions and applications for these children.

The following examples are outlined in the 2003 CPT Changes book to clarify the correct reporting of these critical care codes.

The following examples WOULD qualify as critical care:
• A neonate with a hypoplastic left heart syndrome not receiving mechanical ventilation, but requiring nitrogen, dopamine and prostaglandins to prevent death or immediate morbidity from hypertension or ductal closure

• A pre-catheter or pre-operative neonate who demonstrates cardiovascular and neurological stability who is admitted for the evaluation of a possible cardiac lesion. This child is currently on prostaglandin, pressors, and oxygen/nitrogen therapy

• A post-operative neonate who has not yet established normal urine output, who is at risk for post-anesthesia arrest, who has not regained normal bowel function, and whose blood pressure is unstable

Billing for the non-critical neonate/infant or premature infant:

• Initial day of care for a non-critical neonate/infant or premature infant who is not admitted to the neonatal critical care unit should be billed using codes 99221-99223.

• Subsequent days of hospitalization for the non-critical neonate/infant or premature infant would be billed using 99231-99233.

• Subsequent days of a non-critical premature infant requiring intensive care setting with a present body weight less than 1500 grams would be billed using procedure 99298 99478.

• Subsequent days for a non-critical premature infant requiring intensive care setting with a present body weight of 1500-2500 grams would be reported with code 99299 99479.

• Subsequent days for a non-critical infant requiring intensive care setting with a present body greater than weight of 2501 grams would be reported with code 99300 99480.

Blue Cross and Blue Shield of Alabama does not approve or deny procedures, services, testing, or equipment for our members. Our decisions concern coverage only. The decision of whether or not to have a certain test, treatment or procedure is one made between the physician and his/her patient. Blue Cross and Blue Shield of Alabama administers benefits based on the members' contract and corporate medical policies. Physicians should always exercise their best medical judgment in providing the care they feel is most appropriate for their patients. Needed care should not be delayed or refused because of a coverage determination.

Key Words:
Neonatal, critical care, intensive care, low-birth weight, premature

Approved by Governing Bodies:
Not applicable
**Benefit Application:**
Coverage is subject to member’s specific benefits. Group specific policy will supersede this policy when applicable.

ITS: Home Policy provisions apply
BellSouth/AT&T contracts: No special consideration
FEP contracts: FEP does not consider investigational. Will be reviewed for medical necessity
Wal-Mart: Special benefit consideration may apply. Refer to member’s benefit plan.
Pre-certification/Pre-determination requirements: Not applicable

**Coding:**
CPT codes:
**Effective for dates of service on or after January 1, 2009:**

- **99468** Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less
- **99469** Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less
- **99471** Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
- **99472** Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
- **99475** Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age
- **99476** Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age
- **99478** Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)
- **99479** Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight of 1500-2500 grams)
- **99480** Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight of 2501-5000 grams)

**Effective for dates of service on or after January 1, 2008:**

- **99477** Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or less, who requires intensive observation, frequent interventions, and other intensive care services
Effective for dates of service on or after January 1, 2005:

- **99293** — Initial inpatient pediatric critical care, 29 days up through 24 months of age, per day, for the evaluation and management of a critically ill infant or young child (Code deleted effective January 1, 2009)
- **99294** — Subsequent inpatient pediatric critical care, 29 days up through 24 months of age, per day, for the evaluation and management of a critically ill infant or young child (Code deleted effective January 1, 2009)
- **99295** — Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less (Code deleted effective January 1, 2009)
- **99296** — Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less (Code deleted effective January 1, 2009)
- **99298** — Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams) (Code deleted effective January 1, 2009)
- **99299** — Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams) (Code deleted effective January 1, 2009)

Effective for dates of service on or after January 1, 2006:

- **99300** — Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams) (Code deleted effective January 1, 2009)

References:

Policy History:
Neonatal Review, 1993
Neonatal Review, February 2003
Available for comment February 10-March 28, 2003
Medical Policy Group, January 2006 (3)
Available for comment January 5-February 20, 2006
Medical Policy Group, December 2008 (3)
Medical Policy Group, August 2009 (3)
Medical Policy Administration Committee, August 2009
Available for comment August 21-October 5, 2009
Available for comment October 20 – December 6, 2010

This medical policy is not an authorization, certification, explanation of benefits, or a contract. Eligibility and benefits are determined on a case-by-case basis according to the terms of the member’s plan in effect as of the date services are rendered. All medical policies are based on (i) research of current medical literature and (ii) review of common medical practices in the treatment and diagnosis of disease as of the date of the policy.
hereof. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment.

This policy is intended to be used for adjudication of claims (including pre-admission certification, pre-determinations, and pre-procedure review) in Blue Cross and Blue Shield’s administration of plans contracts.