If a conflict arises between a Clinical Payment and Coding Policy (CPCP) and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP 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. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSTX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from 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), ICD-10 CM and PCS, National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

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

Policy Number: CPCP004

Version 2.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: December 15, 2020

Plan Effective Date: April 5, 2021 (Blue Cross and Blue Shield of Texas Only)

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 describe the type of unit and care available in the NICU that are based on the complexity of care that a newborn with specified diagnoses and symptoms requires. Reimbursement is independent of the location of care and corresponds to medical treatment and services the neonate requires which may include MCG guidelines on the Intensity of Care (IOC) and/or the Facility Level of Care (LOC). The following codes should correspond to the level of care provided. 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 in order to promote optimal health outcomes. Clinical documentation of an ongoing NICU hospitalization may be reviewed concurrently to substantiate the level of care with continued authorization based on the documentation submitted and aligning with MCG Neonatal Facility Levels of Care and Neonatal Intensity of Care Criteria.

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 may deny preauthorization for that level of care. A new preauthorization request may need to be submitted for the appropriate level of care unless otherwise agreed upon.

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. Providers who do not have access to the MCG website may request guidelines by contacting the Plan. 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 a 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 (0171-0174) must be able to provide documentation establishing that the criteria for that level of care/revenue code are satisfied.

Neonatal Level of Care	Revenue Code Description	MCG Guideline Criteria
Level 1	0171: Newborn Level I	• For Neonatal Facility Level I, see MCG Care Guidelines LOC: LOC-004 (ISC, GRG) • For IOC Criteria 1, see MCG Care Guidelines LOC: LOC-010 (ISC, GRG)
Level 2	0172: Newborn Level II	• For Neonatal Facility Level II, see MCG Care Guidelines LOC: LOC-005 (ISC, GRG) • For IOC Criteria 2, see MCG Care Guidelines LOC: LOC-011 (ISC, GRG)
Level 3	0173: Newborn Level III	• For Neonatal Facility Level III, see MCG Care Guidelines LOC: LOC-006 (ISC, GRG) • For IOC Criteria 3, see MCG Care Guidelines LOC: LOC-012 (ISC, GRG)
Level 4	0174: Newborn Level IV	• For Neonatal Facility Level IV, see MCG Care Guidelines LOC: LOC-007 (ISC, GRG) • For IOC Criteria 4, see MCG Care Guidelines LOC: LOC-013 (ISC, GRG)

Please refer to the Plan's website or contact your Network Management Office for any additional information related to this policy.

References:

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Policy Update History:

Approval Date	Description
06/08/2017	New policy
04/20/2018	Annual Review
03/25/2019	Annual Review
05/27/2020	Annual Review, Disclaimer Update
12/15/2020	Revised verbiage