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1.0 Description of the Procedure, Product, or Service

Neonatal and pediatric critical and intensive care services are evaluation and management services provided to other than normal newborns, infants and children from birth through 5 years of age. The level of care is based on the intensity of service and status of the beneficiary.

1.1 Definitions

1.1.1 Neonatal and Pediatric Critical Care

Neonatal and pediatric critical care is the direct delivery by a physician of medical care for critically ill or critically injured newborns, infants and children from birth through 5 years of age. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the beneficiary's condition. Critical care involves high complexity decision making to access, manipulate, and support vital system function to treat single or multiple vital organ system failure and to prevent further life threatening deterioration of the beneficiary's condition.

1.1.2 Neonatal and Infant Intensive Care

Neonatal and infant intensive care is when the neonate or infant is not critically ill but requires intensive observation, frequent interventions, and other intensive care services. These services are for the neonate or infant who although no longer critically ill, continues to require intensive cardiac and respiratory monitoring, continuous or frequent vital sign monitoring, heat maintenance, enteral or parenteral nutritional adjustments, laboratory and oxygen monitoring, and constant observation by the health care team under direct physician supervision.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term "General" found throughout this policy applies to all Medicaid and NCHC policies)

- a. An eligible beneficiary shall be enrolled in either:
 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(The term “Specific” found throughout this policy only applies to this policy)

- a. **Medicaid**
None Apply.
- b. **NCHC**
NCHC beneficiaries are not eligible for neonatal and pediatric critical and intensive care services.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

- a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary’s physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary’s right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

- 1. that is unsafe, ineffective, or experimental or investigational.
- 2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider’s documentation shows that the requested service is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition” [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the

beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://dma.ncdhhs.gov/>

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

None Apply.

3.2.2 Medicaid Additional Criteria Covered

a. Neonatal and Pediatric Critical Care Services

Neonatal and Pediatric critical care services are covered when a newborn, infant or child from birth through 5 years of age is critically ill or injured as defined in **Subsection 1.1.1** and direct personal management by a physician is required.

b. Neonatal and Infant Intensive Care Services

Neonatal and infant intensive care services are covered when a newborn does not meet the definition of critically ill or injured, but requires intensive observation, frequent interventions and other intensive care services as defined in **Subsection 1.1.2**.

3.2.3 NCHC Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

Neonatal and pediatric critical and intensive care services are not covered when the criteria in **Section 3.2** are not met and for the following:

- a. admission to the critical or intensive care unit because no other hospital beds are available; or
- b. admission to the critical or intensive care unit because hospital rules require certain treatments to be administered in the unit.

4.2.3 NCHC Additional Criteria Not Covered

- a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent

to coverage provided for dependents under North Carolina Medicaid Program except for the following:

1. No services for long-term care.
2. No nonemergency medical transportation.
3. No EPSDT.
4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Medicaid shall not require prior approval for neonatal and pediatric critical and intensive care services.

5.2 Limitations

- a. Neonatal and pediatric critical and intensive care services are limited to once per day.
- b. The following procedures and services are included as part of neonatal and pediatric critical and intensive care services and must not be billed separately:
 1. interpretation of cardiac output measurements;
 2. chest x-rays;
 3. pulse oximetry;
 4. blood gases and information data stored in computers (eg, EKGs, blood pressures, hematologic data);
 5. monitoring or interpretation of blood gases or oxygen saturation;
 6. oral or nasogastric tube placement;
 7. gastric intubation;
 8. temporary transcutaneous pacing;
 9. airway and ventilation management;
 10. vascular access procedures;
 11. invasive or non-invasive electronic monitoring of vital signs;
 12. transfusion of blood components;
 13. suprapubic bladder aspiration;
 14. bladder catheterization; or
 15. lumbar puncture.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation/Revision Information

Original Effective Date: June 1, 2002

Revision Information:

Date	Section Updated	Change
09/01/04	Section 5.1	2003 CPT codes added to services included in global NICU service
09/01/04	Title	The title of the policy was changed to "Neonatal and Pediatric Critical and Intensive Care Services"
09/01/04	Section 1.0	"Pediatric" and "inpatient" were added to the description of critical care services. Description of inpatient intensive care services added.
09/01/04	Section 2.0	The age limitation two years of age or less was added to the eligibility information.
09/01/04	Section 3.0	"Infant or a very young child" was added to the criteria. Intensive care information added.
09/01/04	Section 4.0	"Infant or a very young child" was added to the criteria. Intensive care information added.
09/01/04	Section 5.0	"Infant or a very young child" was added to the criteria.
09/01/04	Section 5.1	Codes updated to reflect changes in national CPT codes. Guidelines references updated.
09/01/04	Section 5.2	Policy guidelines for billing CPT codes 99298 and 99299 were added. Reference to global codes and codes listed in 5.1 added.

Date	Section Updated	Change
09/01/04	Section 5.3	Policy guidelines for billing CPT codes 99231 – 99233 were added. Title “Continued Hospitalization care” added.
09/01/04	Section 6.0	Text stating that reimbursement requires compliance with all Medicaid guidelines including obtaining appropriate referrals for beneficiaries enrolled in Medicaid Managed Care programs was added.
09/01/04	Section 8.3	Word “intensive” added. CPT codes 99293, 99294, 99298, and 99299 were added to the list of covered procedure codes. Code 99297 deleted since it was deleted by CPT.
9/1/05	Section 2.0	A special provision related to EPSDT was added.
9/1/05	Section 8.0	The sentence stating that providers must comply with Medicaid guidelines and obtain referral where appropriate for Managed Care enrollees was moved from Section 6.0 to Section 8.0.
12/1/05	Section 2.3	The web address for DMA’s EDPST policy instructions was added to this section.
12/1/06	Sections 2 through 5	A special provision related to EPSDT was added.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for beneficiaries under 21 years of age
3/12/12	Sections 1,3,4,6,7, Attachment A	Updated to standard DMA policy language
3/12/12	Section 8	Billing Guidelines moved to Attachment A
3/12/12	Section 9	Becomes section 8 due to moving Billing Guidelines to Attachment A
3/12/12	Section 1.0	Added definitions of neonatal and pediatric critical and intensive care
3/12/12	Subsection 3.2	Added specific criteria
3/12/12	Subsection 4.2	Added specific noncoverage criteria
3/12/12	Subsection 5.1	Added statement regarding no requirement for prior approval
3/12/12	Subsection 5.2	Added limitations for neonatal and pediatric critical and intensive care services
3/12/12	Attachment A, C	Procedure codes updated and descriptions added.
3/12/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
09/15/2016	Attachment A, C	Added the words “or pediatric” to the phrase, “bills the appropriate neonatal or pediatric critical care code and the transferring bills ...” This revision was a technical correction, so no change was made to the Amended Date.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

In the case of a transfer, the receiving physician bills the appropriate neonatal or pediatric critical care code and the transferring bills for services using hospital management or critical care codes.

CPT Code(s)		
99468	99472	99477
99469	99475	99478
99471	99476	99479
		99480

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Neonatal and pediatric critical and intensive care services are billed with one unit per day by only one physician.

F. Place of Service

Inpatient.

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at

<http://dma.ncdhhs.gov/>.

For NCHC refer to G.S. 108A-70.21(d), located at

http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html.

H. Reimbursement

Providers shall bill their usual and customary charges.

For a schedule of rates, see: <http://dma.ncdhhs.gov/>