Billing and Reimbursement Guideline: Inpatient Neonatal and Pediatric Critical Care Services

Guideline Publication Date:	**September 1, 2010**

Key coding, documentation and reimbursement points include:

- Constant attendance or constant attention is a prerequisite for care to be considered critical care. The duration of critical care time is the time the physician spent working on the critically ill patient. The following are activities that can be included in the critical care time:

  - Review of medical data – lab, x-ray, or other diagnostic tests.
  - Discussion of the patient's care with other medical staff in the unit or at the nurse's station.
  - Obtaining medical history and discussion of treatment options with the family members or guardian if the patient is unable to contribute. The conversation must have a direct contribution to medical decision-making. Other family discussions that include the routine updating of the family of the patient's condition or emotional support are not considered critical care.

- The Inpatient Neonatal and Pediatric Critical Care Services are divided into two age groupings:

  - Under 28 days
  - 29 days to 24 months

- Services that are bundled into the critical care services according to CPT include the following:

  - Umbilical venous and umbilical arterial catheters
  - Other arterial catheters, including central or peripheral catheterization
  - Vascular access procedures
  - Vascular punctures

Version History	
Original Publish Date:	September 1, 2010
Revision Date (s):	
9/1/2013	Format change, minor edits

- Oral or nasogastric tube placement
- Endotracheal intubation
- Lumbar puncture
- Suprapubic bladder aspiration
- Bladder catheterization
- Ventilatory management
- Continuous positive airway pressure (CPAP)
- Surfactant administration
- Intravascular fluid administration
- Transfusion of blood components
- Invasive or noninvasive electronic monitoring of vital signs, bedside pulmonary function testing
- Monitoring or interpretation of blood gases or oxygen concentration

- Documentation may be required to support the personal management by the patient's physician including notation of time in the patient's medical record.

- Payment may be made for critical care services in any location as long as the care meets the definition of critical care.

- Modifiers 24, 25 or 59 should be used to indicate a separately identifiable service. Notes may be required to support separate payment.

- This guideline applies to CMS-1500 claim submissions.

- This guideline applies to place of service 21.

Please refer to Neighborhood's provider website at http://www.nhpri.org for specific provisions by product line.

This guideline is not a guarantee of reimbursement. Plan coverage, eligibility and claim payment edit rules may apply.

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