# Reducing Neonatal ICU Level of Care Denials

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*When your child needs a hospital, everything matters.*

# Disclaimer

- I have no real or perceived conflicts of interest that relate to this presentation.

# Objectives

- Understand neonatal facility accreditation status versus neonatal intensity / level of care (LOC) billing
- Review the medical necessity for levels of care
- Evaluate processes & key stakeholders in NICU charge capture
- Identify opportunities to improve accurate LOC NICU charge capture

# NICU: We have a Problem

- Our facility was experiencing greater than anticipated high-dollar NICU denials

- Upon review, 2023 NICU charts were billed 49% LOC 3 & 51% LOC4
- Denials averaging >$50k/month

# Challenges Unique to NICU

- Neonatal ICUs (NICU) are located in adult AND pediatric facilities
- Patient population is based strictly on age
- Multiple levels of care (LOC) are provided in a singular location
- Per diem payment rates may change daily based on LOC

# Neonatal Acuity Level Accreditation

- State (ODH) licensure & accreditation
  - Ohio Administrative Code
- AAP NICU Verification Program

# Neonatal Acuity Level Accreditation

- Level I: Newborn nursery
- Level II-IV: NICU
  - Neonatal medical director
  - Onsite neonatologist OR access to NICU consultant
  - Providers have pediatric/neonatal specific training
  - Nursing training in perinatal nursing & neonatal conditions
  - NRP trained & oriented clinical staff
  - Local neonatal transport program access
  - Appropriate ancillary staff/service support

# Neonatal Acuity Level Accreditation

| | |
|---|---|
| Level II Special Care Nursery (SCN) | • Comprehensive care for infants born ≥ 32 wk or with birth wt ≥ 1500 g<br>• Provide CPAP or short-tern (<24h) conventional mechanical ventilation |
| Level III NICU (IIIA & IIIB) | • Comprehensive care for infants born at all gestational ages and weights<br>• Ability to provide high frequency ventilation, iNO, and therapeutic hypothermia<br>• Have polices and procedures to facilitate transfer to higher level of care |
| Level IV NICU | All components of Level III NICU, PLUS:<br>• Capability to provide surgical repair of complex congenital or acquired conditions<br>• Ability to provide ECMO or policies to transfer to a facility with ECMO |

# NICU Levels of Care

Based on the **intensity** of medical care

| Stable neonate requiring normal newborn care | Mild to moderately ill with a condition that is expected to resolve rapidly and dose not require urgent subspecialty services | Mild to complex critical condition requiring comprehensive, subspecialty intensive care | Mild to complex critical condition requiring highest level of service intensity |
|---|---|---|---|
| **Newborn Level 1** | **Special Care Level 2** | **Neonatal Intensive Care Level 3** | **Neonatal Intensive Care Level 4** |
| *Routine Care* | *Continuing Care* | *Intermediate Care* | *Intensive Care* |

# Accreditation ≠ NICU Billing

- **Billing level** correlate to intensity of medical care and not the state designated NICU facility certification
- Billing levels:
  - Determined retrospectively
  - Reflect quantity & intensity of nursing, needed medical services
  - May change day to day, up or down
  - Independent of location of care
  - May be based on gestational age or patient weight
  - Lower-level NICU may submit higher LOC billing for short time periods

# How are NICU billing charges decided??

Know your internal processes, payors and guidelines!!

# NICU Level of Care Determination

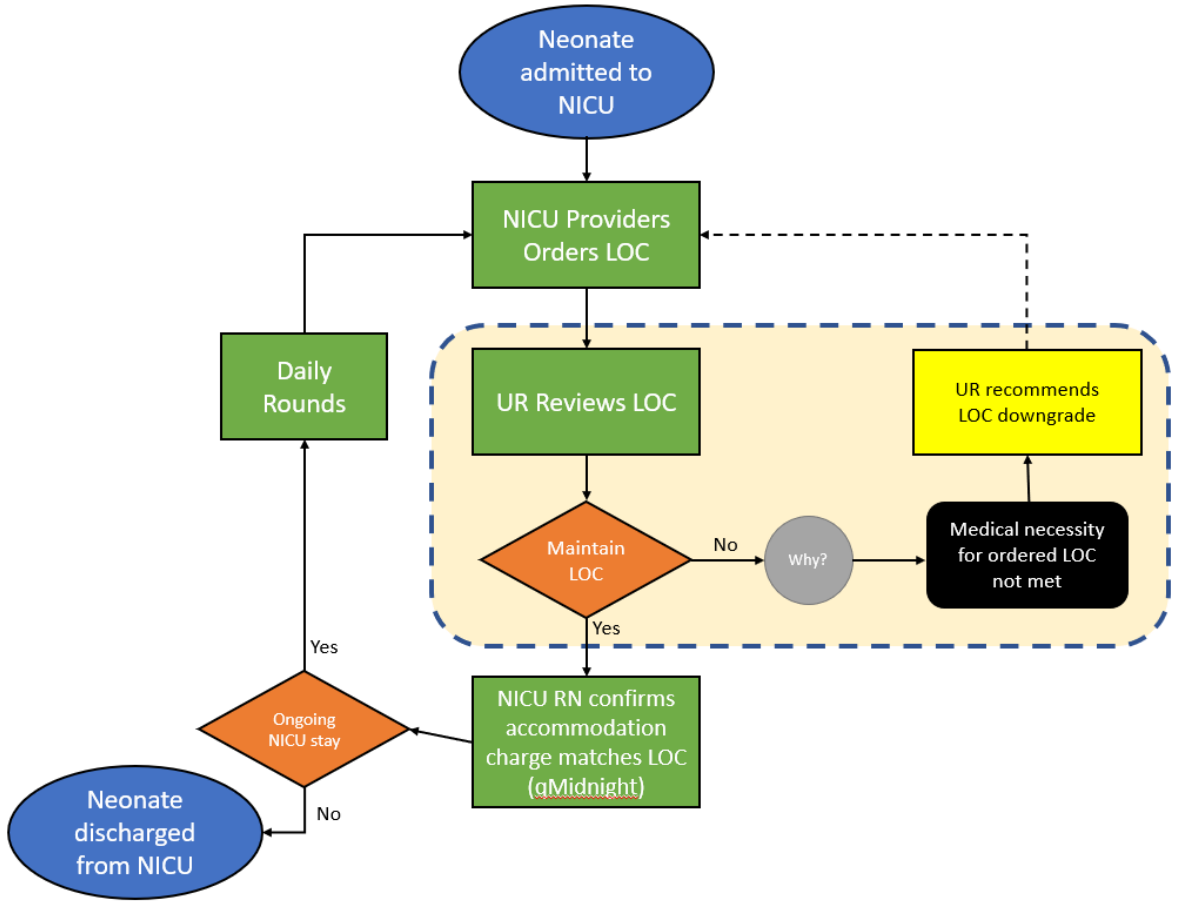
- InterQual vs MCG
- Level of respiratory support: O2 NC, HFNC, CPAP, mechanical ventilation
- Degree of invasive monitoring: UAC, UVC, ICP
- Urgent or emergent need for surgical procedure or subspecialist involvement
- Gestational age or birth weight
- Many specifics based on **resource utilization**
- Utilize the highest level met
  - Only ONE criteria necessary to meet highest supported level

# The Physician Advisor's Role

- Familiarize yourself with YOUR institutional process
  - Processes vary greatly
- Identify key stakeholders
- Determine guidelines used for your patient population
- Provide education & resources for your NICU clinical team
  - Create an easy-to-read provider resource based on medical necessity & guidelines
  - Embedded smart phrasing within electronic medical record documentation
- Collaborate with Utilization Management

# Evaluate Your Facility Workflow

- Who determines LOC?
  - Physician
  - UR
- Is accommodation code tied to LOC order?
- Does the bed order matter?



# NICU LOC Workflow Challenges

- Components linked to bedded order
- Accommodation code
- Revenue cycle team unable to adjust LOC
- Bedside physician involvement for a billing issue
- Payor contractual language
- If LOC denied, may only pay DRG rate
- Others?

# Identify Key Stakeholders

- Neonatology physicians
- Advanced Practice Providers (APPs)
- Charge Nurse/Nursing Leadership
- Hospital Executives/Leadership
- Utilization Management Team
- Revenue Cycle
- Charge Capture Team
- Denials/Appeals Team
- Others: Bed Board?

# NICU Clinical Team Education

- Help NICU Leadership, Physicians, & APPs understand WHY change is necessary
  - Background
  - Process
  - Data
- Clarify Facility vs Professional Billing
- Include Clinical Documentation Integrity (CDI)
  - Diagnoses with clinical validation
  - Stress clinical care is NOT changed
  - Focus on high quality documentation

# NICU Team LOC Tool

**NICU Facility Level of Care Guidelines**

| | NICU Level 4 (Critical Intensive) | NICU Level 3 (Intensive) | NICU Level 2 (Special Care) | NICU Level 1 (Newborn) |
|---|---|---|---|---|
| | *Neonates requiring* ***extreme support services for critical illness*** .<br><br>**Requires 1 or more of the following:** | Neonates who are ***critically*** ill and require intensive support.<br><br>**Requires 1 or more of the following:** | Neonates who are ***stable or moderately ill*** with potentially serious problems, but are expected to resolved rapidly.<br>**Requires 1 or more of the following:** | Physiologically stable neonates who require ***normal newborn care*** with low risk for complications. |
| **Gestational Age** | | < 32 weeks | ≥ 32 weeks | ≥ 35 weeks with routine newborn care |
| **Birth weight** | | < 1500 grams | ≥ 1500 grams | |
| **Respiratory** | High-frequency ventilation<br>iNO administration | Conventional ventilation, CPAP, HFNC > 1 L/min | Apnea, on therapy<br>Tachypnea (RR > 60)<br>Supplemental O2 via nasal cannula<br>Stable, chronic long-term ventilation plan in place | Room air |
| **Cardiovascular** | ECMO<br>Hypotension necessitating IV pressor support | IV fluid resuscitation (repeated boluses -or- high rate IVFs)<br>TPN >50% total daily fluids | | |
| **Neurology** | Total body cooling for hypoxic injury<br>Status epilepticus | Hypoxic-ischemic encephalopathy<br>Stroke<br>Seizures requiring IV med or AED change/escalation<br>CNS pressure monitoring | Opiod replacement therapy | |
| **Fluids, Electrolytes, Nutrition, and Gastrointestinal** | | Electrolyte or acid-base disorder requiring continuous monitoring and ongoing IV correction | Unable to take oral feeds<br>Gavage feeds >25% daily fluids | Advancing oral intake<br>Improving nipple or other feeding<br>Monitoring weight gain |
| **Renal** | Dialysis | Anuria | | |
| **Hematology** | Jaundice or other etiology requiring exchange transfusion<br>Severe acute need for transfusion (hemolysis, DIC, hemorrhage) | Blood product transfusion wihtout severe, acute etiology (i.e. anemia of prematurity)<br>Jaundice requiring IVIG | Hyperbilirubinemia requiring phototherapy & IVFs | Routine CBC, bilirubin, Coombs testing, etc. |
| **Infectious Disease** | | Septic shock | Suspected sepsis expected to resolve rapidly & not require urgent pediatric subspecialty care | |
| **Endocrinology** | | Persistent hypoglycemia requiring IV glucose<br>Dextrose rate >5 mg/kg/min; more than one IV dextrose bolus in 24h | Transitional hypoglycemia expected to resolve rapidly<br>Hypoglycemia treatment <=5 mg/kg/min; 1 dextrose bolus/24h | Routine glucose testing |
| **Surgery and Procedures** | Surgical repair of complex condition<br>Perioperative care for surgery for severe defects or conditions, i.e. cardiac defects, bowel obstruction or perforation, and gastroschisis | Urgent or emergent major surgery required | | |
| **IV Support and Monitoring** | Severely ill neonate requiring near-constant nursing and continuous cardiopulmonary or other support<br>Invasive monitoring (arterial line, EVD, etc) | Umbilical vessel catheter, peripheral artery catheter, central vein catheter | Temperature instability (interventions needed to maintain >36.5C), i.e. warmer/isolette<br>IV medications in clinically stable neonate | Monitoring of asymptomatic abnormalities (e.g. hypoglycemia) |
| **Other** | CPR needed<br>**Urgent** pediatric medical or surgical subspecialist care | Advanced imaging with interpretation on urgent basis (e.g. CT, MRI, ECHO)<br>Other condition requiring ongoing evaluation, active management, and therapy adjustment by continuously available neonatologist and readily accessible subspecialty care | Abnormal VS or function indicating physiologic immaturity or instability requiring care<br>Urgent pediatric medical or surgical subspecialty care NOT expected<br>Convalescent infant care after Level 3 or 4 NICU stay who has continued Moderate needs (e.g. advancing feeds, medication titration) | Convalescent care for infants after special care unit or NICU stay who have routine care needs (e.g. advancing oral intake, monitoring weight gain) |

**"Choose the HIGHEST status that the infant qualifies for in choosing the daily charge capture."**
**Use your medical judgement with supportive documentation (data, examination, clinical expertise) for any situation not explicitly specified.**

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# LOC 4
# -HIGH-

| | NICU Level IV- HIGH |
|---|---|
| | *Critically ill* neonates requiring the *highest level* of service intensity. **Requires 1 or more of the following:** |
| **Corrected Age** | |
| **Current Weight** | |
| **Respiratory** | High frequency ventilation<br>iNO administration<br>Mechanical ventilation in severely ill neonate requiring near-constant nursing and continuous cardiopulmonary or other support (consider if FiO2 >50%, OI >15, or PEEP >8) |
| **Cardiovascular** | ECMO<br>Prostaglandins for PDA patency |
| **Neurology** | cEEG<br>ICP monitor<br>Total body cooling for hypoxic injury |
| **Fluids, Electrolytes, Nutrition, and Gastrointestinal** | |
| **Renal** | Hemodialysis |
| **Hematology** | Exchange transfusion for hyperbili<br>Transfusion of blood products for severe acute etiology |
| **Infectious Disease** | |
| **Endocrinology** | |
| **Surgery and Procedures** | Surgical repair of complex condition<br>Periop care for **severe** defects or conditions (e.g. cardiac defects, bowel obstruction or perforation, gastroschisis) |
| **IV Support and Monitoring** | **BOTH** IV med administration (excludes anti-infectives and glucose) **AND** invasive BP monitoring |
| **Other** | **Urgent** need for pediatric medical or surgical subspecialist care<br>Clinical situation or combination of treatment, intervention, post-op state, illness, acuity, or diagnosis such that a ratio of 1 or 2 neonates per RN is clinically necessary and appropriate |

# LOC 3
# -MEDIUM-

| | NICU Level III- MEDIUM |
|---|---|
| | Neonates who are *critically ill* and require *comprehensive, subspecialty* intensive care.<br>**Requires 1 or more of the following:** |
| Corrected Age | **< 32 weeks** |
| Current Weight | **< 1500 grams** |
| Respiratory | Conventional vent, CPAP, HFNC > 1 L/min for > 24 hrs<br>FiO2 ≥ 0.4<br>Apnea requiring resuscitation<br>Chest tube |
| Cardiovascular | Bradycardia requiring resuscitation<br>Need for pressors<br>IV fluid resuscitation |
| Neurology | Acute, moderate to severe, encephalopathy<br>Seizures requiring IV med or AED change/escalation |
| Fluids, Electrolytes, Nutrition, and Gastrointestinal | TPN<br>IVF ≥ 50 ml/kg/24h<br>Electrolyte or acid-base disorder requiring continuous monitoring and ongoing IV correction |
| Renal | Anuria, Peritoneal dialysis |
| Hematology | Blood product transfusion<br>Hyperbili requiring IVIG OR approaching exchange transfusion and requiring phototherapy and IV hydration<br>Polycythemia with partial exchange |
| Infectious Disease | Septic shock |
| Endocrinology | Persistent hypoglycemia requiring IV glucose |
| Surgery and Procedures | Urgent or emergent major surgery required |
| IV Support and Monitoring | |
| Other | Delivery-related emergency (e.g. pulmonary or cardiac arrest)<br>Advanced imaging with interpretation on **urgent** basis (e.g. CT, MRI, ECHO)<br>Other condition requiring ongoing evaluation, active management, and therapy adjustment by continuously available neonatologist and readily accessible subspecialty care |

# LOC 2
# Special
# Care Nursery

| | Special Care Level II- LOW |
|---|---|
| | *Stable or moderately ill* neonates who have problems that, while potentially serious, are expected to resolve rapidly.<br>**Requires 1 or more of the following:** |
| **Corrected Age** | ≥ 32 weeks |
| **Current Weight** | ≥ 1500 grams |
| **Respiratory** | **Short-term** (< 24 hrs) mech vent, CPAP, HFNC > 1 L/min<br>**Brief** apnea requiring blow by or caffeine<br>HFNC ≤ 1 L/min<br>FiO2 < 0.40<br>Tachypnea (RR >60)<br>Chronic ventilation (e.g. trach, long term need) |
| **Cardiovascular** | **Brief** bradycardia without need for ongoing intervention |
| **Neurology** | Acute, mild encephalopathy<br>Neonatal abstinence syndrome requiring drug withdrawal therapy |
| **Fluids, Electrolytes, Nutrition, and Gastrointestinal** | Unable to take po feeds (gavage > 25%)<br>Requiring IVF < 50 ml/kg/24h<br>Inborn error of metabolism requiring initiation of special formula |
| **Renal** | |
| **Hematology** | Hyperbili requiring intensive phototherapy |
| **Infectious Disease** | High risk early onset sepsis on IV antibiotics |
| **Endocrinology** | Transitional hypoglycemia requiring glucose bolus x1 |
| **Surgery and Procedures** | |
| **IV Support and Monitoring** | Temperature instability (interventions needed to maintain >36.5 ℃)<br>IV meds but clinically stable |
| **Other** | Convalescent care for infant after Level III or IV NICU stay who has continued moderate needs (e.g. advancing enteral feeds, titration of medications) |

# Embed Smart Phrases

Patients current care meets medical necessity for:

- NICU Level 4 (Newborn Critical Intensive Care) due to requiring:

- High-frequency ventilation
- iNO administration
- Intravenous pressor support
- Total body cooling
- Treatment for status epilepticus
- Exchange transfusions
- Acute blood transfusions for *** (i.e. hemolysis)
- Complex surgical care
- Near constant nursing support and continuous cardiopulmonary & invasive monitoring
- CPR
- Urgent subspecialist care
- Other: ***

This dotphrase (.niculoc) is embedded in our EMR, and includes a multi-select drop-down option for each LOC.

NICU physicians & APPs include it at the end of their progress note.

# Utilization Management Collaboration

- Facility dependent
  - UM review using payor-specific guideline criteria
    - Recommend LOC changes to NICU clinical team
  - UM auth request mobility
    - Submit LOC request consistent with guidelines
    - Accept reasonable LOC counter offers
      - *Evaluate accommodation code reimbursement

# Implement Consistent Monitoring

- NICU daily huddle
- NICU designee(s) for LOC reviews
- UR/NICU liaison (Physician Advisor)

# Monitor NICU Progress

- Chart audits
- Longitudinal data capture
  - LOC charge volumes
  - Denial rates
  - Write-offs
  - Revenue impact

# Evaluate & Re-evaluate

- PDSA cycling
- Implementation barriers
- Overlooked process components
- Maintain stakeholder communication
- Reinforce and share change impact

# NICU: We (no longer) have a Problem

- Our facility was experiencing high-dollar NICU denials far greater than anticipated
  - 2023 NICU charts were billed 49% LOC 3 & 51% LOC4
  - Denials averaging >$50k/month

- Following revised processes, NICU LOC denials reduced to nearly $0

# Questions?

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