

# You Asked for It! High Dollar NICU Denials

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The Association for Healthcare Denial & Appeal Management



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Association for Healthcare Denial & Appeal Management

You Asked for It! High Dollar NICU Denials

November 13, 2024

Online

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1. Identify an example of an effective strategy for appealing NICU level of care denials.
2. Pick out a clinical validation strategy for appealing NICU clinical validation denials.
3. Choose one way to find payer policies.

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Karla Hiravi	NA
Alice Pomplon	NA
Raymond Smith	NA
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At the conclusion of the webinar, the learner will be able to self-report they can:

- Identify an example of an effective strategy for appealing NICU level of care denials.
- Pick out a clinical validation strategy for appealing NICU clinical validation denials.
- Choose one way to find payer policies.



**Kendall Smith, MD, SFHM**  
**Chief Physician Advisor | PayerWatch - AppealMasters**

Dr. Kendall Smith is a Senior Fellow in Hospital Medicine (SFHM) and currently acts as Chief Physician Advisor for PayerWatch - AppealMasters, a leading appeal educator and appeal services firm for hospitals and health systems. He's been deeply involved in denial and appeals management throughout his hospitalist career. He has served as a physician leader on hospital revenue cycle management teams while also serving as the Physician Advisor for Clinical Resource Management. Dr. Smith is also an AHIMA ICD-CM/PCS approved trainer/ambassador.

## Reggie Allen, MBA, RN, ACM



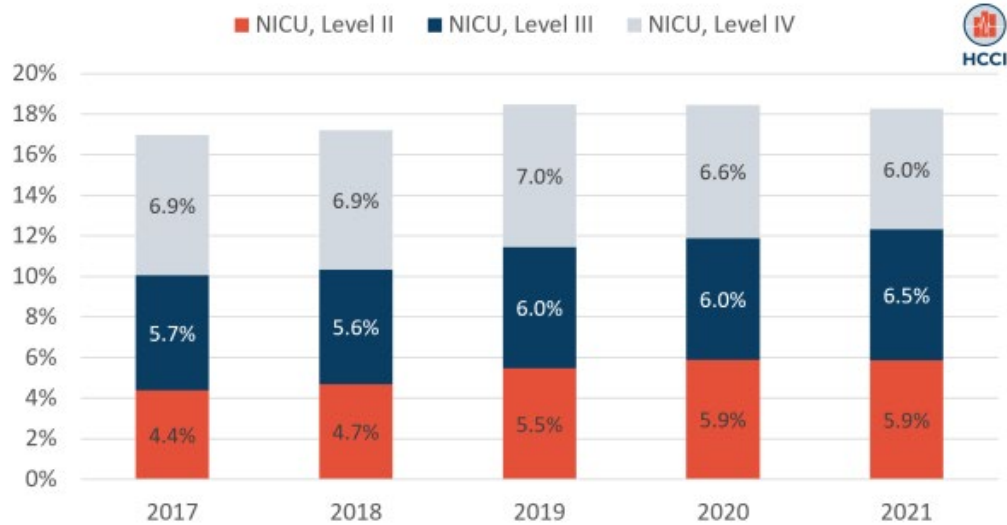
**Reggie Allen, MBA RN ACM**, is the Chief of Clinical/Business Operations for PayerWatch. Reggie has more than 35 years of experience in a variety of healthcare positions, including staff nurse, nurse manager, Chief Nursing Officer, Chief Operating Officer, and Vice President, Clinical/Business Operations Transformation. He has been recognized nationally as an expert in care management and clinical operations. He is a results-driven leader who emphasizes operational transformation by integrating clinical and financial care aspects. He obtained a bachelor's degree in nursing from Vanderbilt University and an MBA from the University of Phoenix. He is a member of the American Case Management Association (ACMA) and the American College of Healthcare Executives.

Reggie possesses comprehensive knowledge and experience in all facets of care management, including case management, utilization management, disease management, quality management, and resource management. He has designed and implemented an enterprise-wide Clinical Appeals Unit and a clinical documentation program with success. Using six sigma and Lean principles, he is an expert in clinical and operational efficiencies that enhance clinical outcomes and financial performance through a variety of methodologies.

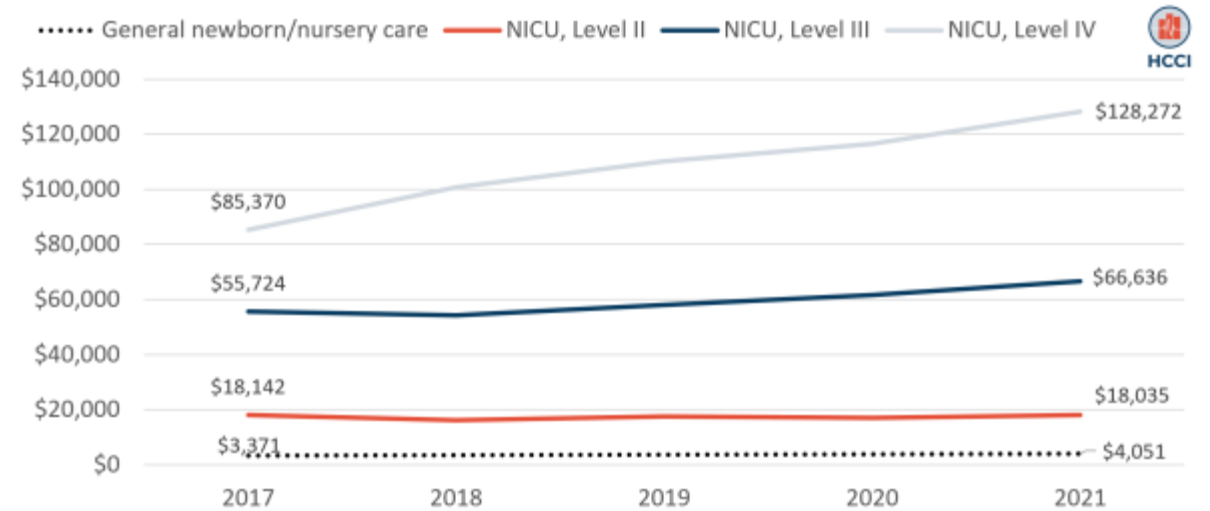
**NICU**

**Levels of  
Care Denials**

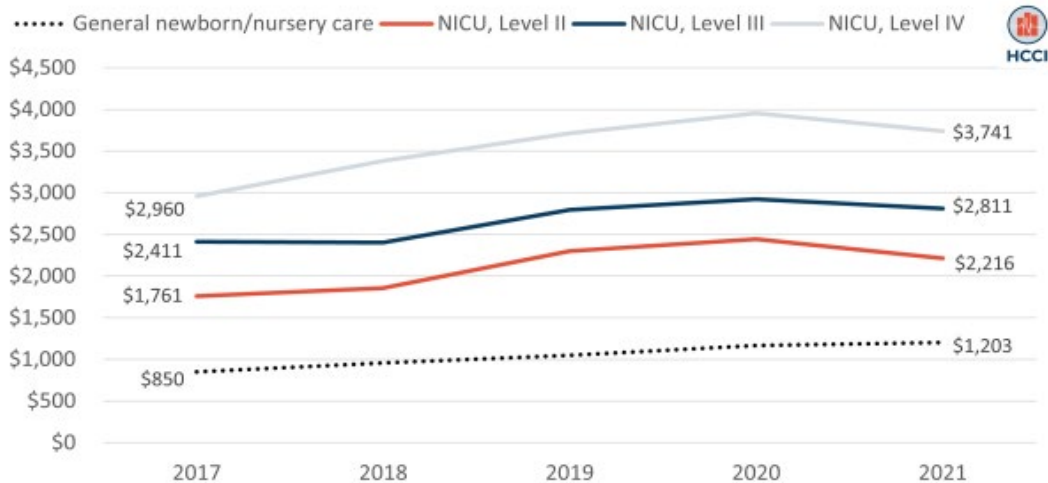
## Share of Newborns Receiving NICU Care



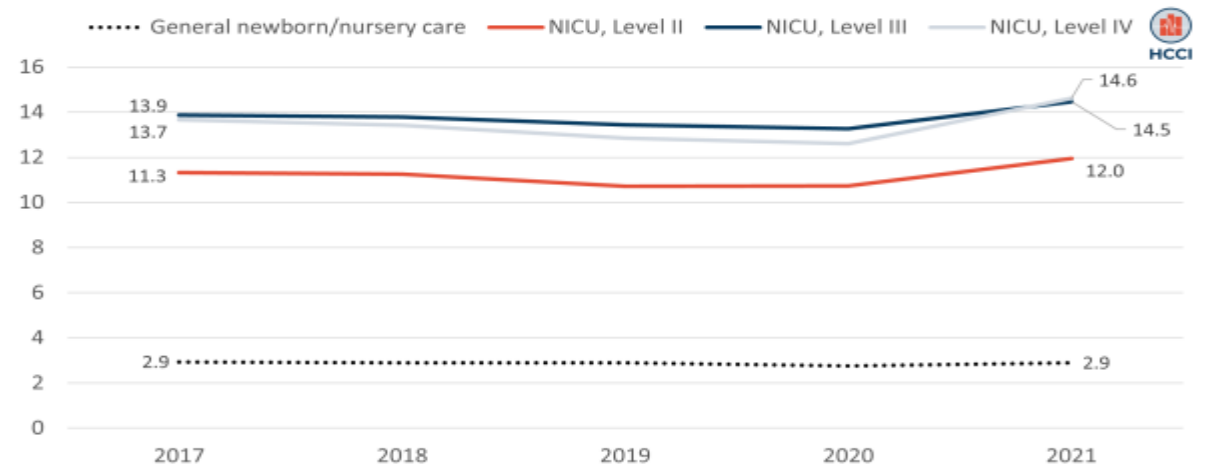
## Avg. Spending per Newborn Admission



## Avg. Daily Inpatient Spending for Newborn Care Admissions



## Length of Inpatient Stay per Newborn Admission



A photograph of a newborn baby in a neonatal intensive care unit (NICU) incubator. The baby is lying in the incubator, which is illuminated with a soft blue light. The incubator has a clear plastic front panel and various medical equipment attached to it. The background is dark, making the blue light from the incubator stand out.

# NICU Denial Challenges / Impacts

- Financial / Emotional Strain on Families
- Administrative Burden on Providers
  - ❖ Payment Structure
    - Percentage of charges
    - Per Diem Rates
    - Medicaid
    - Stop Loss
  - ❖ Audits

# NICU Denials Influence

- Authorization
- Level of Care
- Length of Stay
- Documentation Issues
- Coding Errors
- Policy Exclusions
- Stop Loss





# AUTHORIZATION

- Pre-Admission Work-up
- Coordination of Benefits
  - ❖ Birthday Rule
  - ❖ 30-day expectation
- Notification
  - ❖ Know the payer policies
  - ❖ Know where to find them
  - ❖ Timely submission

# UTILIZATION MANAGEMENT

- NICU Levels of Care vs Nursing Acuity
  - ❖ Level Daily; many babies will have interventions between levels; Level at the highest level
- Have access to the criteria used by the payer and expectation of when clinicals are needed
- Continued Stay Justification:
  - ❖ Clinical Status – changes in condition
  - ❖ Medical Interventions Planned and Required
  - ❖ Expected Length of Stay
  - ❖ Discharge Planning Initiation
- If peer to peer, submit documentation that allowed for the overturn; follow-up to make sure it got overturned and updated in the payer system
- Inhalation Nitrous Oxide – need prior authorization by some payers; expensive and outside the norm

# American Academy of Pediatrics (AAP) is the GOLD STANDARD

## NEONATAL LEVELS OF CARE COMPARISON: LEVEL (II, III, AND IV) REQUIREMENTS

Level II	Level III	Level IV
<p><b>Level of Neonatal Care Requirements</b></p> <p>(a) The Level II SCN will provide comprehensive care of infants born <math>\geq 32</math> wk or with birth wt <math>\geq 1500</math> g who<sup>2</sup>:</p> <ol style="list-style-type: none"> <li>1. are mild to moderately ill with physiologic immaturity or who have conditions that are expected to resolve quickly<sup>2</sup>;</li> <li>2. are not anticipated to require subspecialty services on an urgent basis<sup>2</sup>;</li> <li>3. require CPAP or short term (less than 24 h) conventional mechanical ventilation for a condition expected to resolve rapidly or until transfer to a higher-level facility is achieved<sup>2</sup>; or</li> <li>4. are back transferred from a higher-level facility for convalescent care.<sup>2</sup></li> </ol>	<p>(a) The Level III neonatal facility will:</p> <ol style="list-style-type: none"> <li>1. provide comprehensive care for infants born at all gestational ages and birth weights, with mild to complex critical conditions or medical problems requiring sustained life support, hemodynamic support, and/or conventional mechanical ventilation<sup>2</sup>;</li> <li>2. have the ability to provide high-frequency ventilation, iNO delivery, and/or therapeutic hypothermia or have policies and procedures in place to facilitate neonatal transfer to another unit or facility that provides these services<sup>2</sup>;</li> <li>3. provide care for infants who are back transferred for convalescent care<sup>2</sup>; and</li> <li>4. have sufficient experience based on patient volume and a systematic process to assess the quality of care provided to each very low birth weight infant, including a method to track specific quality indicators including obstetrical and neonatal transfers, review aggregate data using accepted methodology, and develop</li> </ol>	<p>(a) The Level IV neonatal facility will:</p> <ol style="list-style-type: none"> <li>1. provide comprehensive care for infants born at all gestational ages and birth weights, with mild to complex critical conditions or medical problems requiring sustained life support, hemodynamic support, conventional and high frequency mechanical ventilation, iNO delivery, and/or therapeutic hypothermia<sup>2</sup>;</li> <li>2. have the capability to provide surgical repair of complex congenital or acquired conditions<sup>2</sup>;</li> <li>3. have the ability to provide ECMO or have policies and procedures in place to facilitate neonatal transfer to another unit or facility that provides ECMO<sup>2</sup>;</li> <li>4. maintain a broad range of pediatric medical subspecialists, pediatric surgical specialists, and pediatric anesthesiologists<sup>2</sup>;</li> <li>5. facilitate transport and provide outreach education to lower-level facilities<sup>2</sup>; and</li> <li>6. have sufficient experience based on patient volume and a systematic process to assess the quality of care provided, including a method</li> </ol>

# Strategies / Arguments

- Develop a process for regular review and reconciliation of the neonate's level of care with the payer's criteria during hospitalization, especially for long-stay patients.
- Engage in real-time negotiation with the payer while the neonate is hospitalized to avoid surprise denials later. Example, insurance wants to pay for Level 2, however, you have leveled the neonate as a Level 4, you can negotiate a Level 3.
- Understand the payer's criteria and reasons for denial and make sure the clinical team is familiar with these guidelines to provide documentation that matches the payer's expectation.
- Gather complete clinical documentation:
  - ❖ Physician notes detail the complexity of the neonate's condition.
  - ❖ Progress notes reflect the need for interventions (e.g., mechanical ventilation, specialized surgeries).
  - ❖ Nursing notes clearly indicate the need for NICU interventions that justify the appropriate level of care.
- Write a clear, concise appeal letter highlighting medical necessity
  - ❖ Begin with a summary of the neonate's clinical presentation.
  - ❖ Reference the payer's criteria and explain why the care provided meets or exceeds these standards.
  - ❖ Cite clinical guidelines from authoritative sources such as the **American Academy of Pediatrics (AAP)**, **InterQual**, or **MCG** to substantiate your arguments.
  - ❖ Use clinical data such as lab results, imaging studies, and clinical assessments to back your claim.
  - ❖ Attach copies of supporting documentation, including physician notes, diagnostic reports, and daily progress notes.

# CASE STUDY

## NICU LOC



## Denial Letter Rationale

### Denial Summary:

According to denial letter dated 5/4/202x:

- Dates of service 2/3-3/23/202x were down coded from 174 to 173.
- Dates of service 3/25-4/28/202x were down coded from 173 to 172.
- Dates of service 4/29/202x to 5/2/202x were down coded from 173 to 171.

## Justification for Appeal

Baby A was a male infant born on 1/14/202x at 1538 at **26 weeks gestation via c-section for pre-term labor, advanced cervical dilation, and multiple gestation (twin B) weighing 900 grams to a 33-year-old mother gravida 2 para 1103** who pregnancy was complicated by **Group B strep positive, polyhydramnios, intrauterine growth retardation (IUGR) and mono-di twins.**

His mother was given cephalosporins four hours prior to delivery and one dose of betamethasone and one dose of magnesium sulfate one hour prior to delivery.

Baby A **emerged limp with minimal respiratory effort.** He was started on **CPAP 6 21% immediately**, had few spontaneous breaths with initial heart rate >100. Baby A had **secondary apnea at two minutes of life with no respiratory effort.** He was started on **positive pressure ventilation (PPV) at that time with heart rate >100 and SpO2 <40.** Baby A was **intubated at five minutes of life for no respiratory effort and persistent hypoxemia.** His SpO2 remained less than 20. **Manual ventilation was continued via ETT at 35/7 at 100% FiO2 with no recovery of SpO2 and heart rate remained >100.** Pneumothorax was ruled out by negative transillumination test. ETT was confirmed to be in by misting in the ETT, colour change, chest rise and breath sounds. **Bagged at pressures 35/7 with longer iTime** via manual bag ventilation, with recovery to SpO2>70 by 16 minutes of life.

Chest x-ray confirmed ETT placement, and **Surfactant was administered at 40 minutes of life.** He was **switched to ventilator by 20 minutes of life.** UAC/UVC was placed by 70 minutes of life, and starter total parenteral nutrition (TPN) was started at 95 minutes of life. His lowest **pH of 7.06 was at 1746.** Baby A was transported to the NICU for further management. (H&P, pgs. 507-508)

## Justification for Appeal, continued

Baby A was **admitted as an inpatient on the Neonatal Intensive Care unit on 1/14/202x at 1540.**(Orders, pg. 24)

Baby A was **admitted as an inpatient for further evaluation and management of extreme prematurity and respiratory failure.** He remained on ventilator with plan to wean him to less invasive form of ventilation with higher levels of PEEP. **Caffeine was loaded** for apnea risk. He received **one bolus of normal saline for blood pressure support** and pressors were planned for decreasing blood pressure. **Blood cultures were drawn, and he was started on IV ampicillin and gentamycin.** He continued parenteral nutrition. (H&P, pg. 505-506)

Baby A was successfully **extubated on 1/18 and switched to neurally-adjusted ventilatory assist (NAVA).** He was **trialed on CPAP on 1/27/202x which he did not tolerate due to apnea, bradycardia desaturation (ABD) events including the need for PPV and was restarted on NAVA by 1/28/2x.** He was then trialed on **bCPAP8 on 2/3** to see if this would provide more optimal support given his prior NAVA (PEEP 7, NAVA level 2.0) may not have been synchronizing well with his breathing. He **tolerated his bCPAP8 well with decreased ABD events.**

He was **weaned to CPAP +7 on 2/10. CPAP was increased back to 8 on 2/12 for increasing FiO2 needs.** Baby A was **weaned from CPAP 5 to HFNC 3L on 3/14.** He was weaned to room air by discharge. He had ongoing apnea and bradycardia events.

**Trophic feeds started with expressed breast milk (EBM) on 1/16** (delayed initiation after birth for 24 hours due to indomethacin). He was using tube feedings. NaCl supplementation was increased to 4 meq/kg/day on 2/4/22 due to down-trending Na levels, likely from renal losses. The low sodium resolved, and NaCl was discontinued. Echocardiogram on 1/19, following third dose of indomethacin, showed a **large patent ductus arteriosus (PDA)** and follow up echocardiogram on 1/25 showed a moderate PDA. He was hemodynamically appropriate but had been intermittently requiring FiO2 >35% for 2-3 days so he was started on a **treatment course of Tylenol for PDA closure on 2/3-2/8.** Follow up echocardiogram on 2/9 showed a moderate PDA, small fenestrated ASD, and greater than 50% systemic RVP. **Repeat echocardiogram on 3/21 demonstrated no PDA.**

He was **transfused with PRBCs on 1/16.** He received phototherapy for hyperbilirubinemia on 1/15-1/23 and 1/25-1/26. He also had some coagulopathy problems requiring fresh frozen plasma on 1/15-1/17. Baby A **saw the ophthalmologist on 2/24, 3/8 and 4/20.** Most recent exam showed **retinopathy of prematurity Zone III, stage 0, no plus.** (Discharge Summary, pgs. 624-625; Progress Notes, pgs. 27, 31,199)



## Justification for Appeal, continued

**Dates of service 2/3-3/23/202x were down coded from 174 to 173 by Blue Shield of California. As documented above during these dates of service, he was on CPAP ranging from 8 to 5. Baby A was not weaned to high flow nasal cannula until 3/14 and was not weaned off oxygen completely until discharge. For an infant weighing less than 1,000 grams any nasal cannula greater than one liter per minute qualifies for claim charges of 174. During these dates of service Baby A was also having oxygen issues related to a large PDA that was being followed and treated by pediatric cardiology. Apnea and bradycardia events were occurring daily.**

- This level of care was NICU Level 4.

**Dates of service 3/25-4/28/202x were down coded from 173 to 172 by Blue Shield of California. During these dates of service, he was receiving tube feedings with some oral breast and bottle feeding. Baby A also continued having apnea and bradycardia events.**

- The enteral feeding alone qualified him for NICU Level 3 care.

## Justification for Appeal, continued

**Dates of service 4/29-5/2/202x** were down coded from 173 to 171 by Blue Shield of California. Occupational therapy evaluation on 4/29 (OT Eval, pg. 525) showed **oral volumes continued to be highly variable (30-77mls per feeding in past 24 hrs)**. The OT believed Logan would **require additional time to reach full oral feeding given slow progression of oral feeding and history of extreme prematurity**. Tube feedings continued throughout this time with oral feeding slowly improving leading to mostly oral feedings. **Even on 5/2/202x he took 10 cc per his tube feeding.** (Progress Notes, pg. 28)

- Having any enteral feeding would be NICU Level 3 care.

# References

Source/Reference	The American Academy of Pediatrics (2012). Levels of Neonatal Care. <i>PEDIATRICS</i> , 130(3), 587-597. Retrieved from: <a href="https://pediatrics.aappublications.org/content/pediatrics/130/3/587.full.pdf">https://pediatrics.aappublications.org/content/pediatrics/130/3/587.full.pdf</a>
Evidence Based Guideline/Practice Guideline Recommendation	<p>The updated classification consists of basic care (level I), specialty care (level II), and subspecialty intensive care (level III, level IV). [p. 591]</p> <ul style="list-style-type: none"> <li>• Level I-Well newborn nursery:             <ul style="list-style-type: none"> <li>○ Provide neonatal resuscitation at every delivery</li> <li>○ Evaluate and provide postnatal care to stable term newborn infants</li> <li>○ Stabilize and provide care for infants born 35–37 wk gestation who remain physiologically stable</li> <li>○ Stabilize newborn infants who are ill and those born at &lt;35 wk gestation until transfer to a higher level of care</li> </ul> </li> <li>• Level II-Special care nursery: Level I capabilities plus:             <ul style="list-style-type: none"> <li>○ Provide care for infants born ≥32 wk gestation and weighing ≥1500 g who have physiologic immaturity or who are moderately ill with problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis</li> <li>○ Provide care for infants convalescing after intensive care</li> <li>○ Provide mechanical ventilation for brief duration (&lt;24 h) or continuous positive airway pressure or both</li> <li>○ Stabilize infants born before 32 wk gestation and weighing less than 1500 g until transfer to a neonatal intensive care facility.</li> </ul> </li> <li>• Level III-NICU:             <ul style="list-style-type: none"> <li>○ <b>Provide comprehensive care for infants born &lt;32 wks gestation and weighing &lt;1500 g and infants born at all gestational ages and birth weights with critical illness</b></li> <li>○ Provide prompt and readily available access to a full range of pediatric medical subspecialists, pediatric surgical specialists, pediatric anesthesiologists, and <b>pediatric ophthalmologists</b></li> <li>○ Provide a full range of respiratory support that may include conventional and/or high-frequency ventilation and inhaled nitric oxide</li> <li>○ Perform advanced imaging, with interpretation on an urgent basis, including computed tomography, MRI, and echocardiography</li> </ul> </li> <li>• Level IV Regional NICU- Level III capabilities plus:             <ul style="list-style-type: none"> <li>○ Located within an institution with the capability to provide surgical repair of complex congenital or acquired conditions</li> <li>○ Maintain a full range of <b>pediatric medical subspecialists</b>, pediatric surgical subspecialists, and pediatric anesthesiologists at the site</li> <li>○ Facilitate transport and provide outreach education. [p. 592]</li> </ul> </li> </ul>

# References, continued

<b>Evidence Based Guideline/Practice Guideline Recommendation</b>	<ul style="list-style-type: none"><li>• Provider types for level 1- Pediatricians, family physicians, nurse practitioners, and other advanced practice registered nurses. [p. 592]</li><li>• Provider types for level 2- Level I health care providers plus: Pediatric hospitalists, neonatologist, and neonatal nurse practitioners. [p. 592]</li><li>• Provider types for level 3- Level II health care providers plus: Pediatric medical subspecialists, pediatric anesthesiologists, pediatric surgeons, and pediatric ophthalmologists. [p. 592]</li><li>• Provider types for level 4- Level III health care providers plus: Pediatric surgical subspecialists. [p. 592]</li><li>• Regionalized systems of perinatal care are recommended to ensure that each newborn infant is delivered and cared for in a facility most appropriate for his or her health care needs, when possible, and to facilitate the achievement of optimal health outcomes. [p. 594]</li></ul>
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# References, continued

<p><b>Source/Reference</b></p>	<p><b>Board Certified Neonatologists (2011). NICU Level of Care Criteria. Blueshieldca, 2011, 1-5. Retrieved from: <a href="https://www.blueshieldca.com/provider/content_assets/documents/MiscPDFs/guidelinesresources/NICU.pdf">https://www.blueshieldca.com/provider/content_assets/documents/MiscPDFs/guidelinesresources/NICU.pdf</a></b></p>
<p><b>Evidence Based Guideline/Practice Guideline Recommendation</b></p>	<p>The following criteria are appropriate for: <b>Level 4-NICU – Revenue Code 174</b></p> <ol style="list-style-type: none"> <li>1. <b>Ventilator/Intubated</b></li> <li>2. Extracorporeal Membrane Oxygenation (ECMO) / Nitric Oxide (NO)</li> <li>3. Any nasal flow delivered at &gt; 2 LPM. <b>For infants &lt;1 kg, any nasal flow delivered at &gt;1 LPM</b></li> <li>4. Chest Tube</li> <li>5. Exchange transfusion, dialysis</li> <li>6. IV bolus or continuous drip therapy for severe physiologic/metabolic instability</li> <li>7. <b>Apnea/bradycardia</b> &gt; 10 episodes/day all requiring tactile stimulation or any episodes requiring Positive Pressure Ventilation (PPV)</li> <li>8. <b>Unstable vital signs</b> requiring therapy or conditions requiring frequent Vital Signs (Medical Director consult required prior to assignment). [p. 2]</li> </ol> <p>The following criteria are appropriate for: <b>Level 3- TRANSITIONAL – Revenue Code 173</b></p> <ol style="list-style-type: none"> <li>1. Isolette/Warmer for thermoregulation in unstable infants (excludes warmers solely for phototherapy)</li> <li>2. Static ↓ oxygen requirement via nasal cannula (less than or equal to 2 LPM) or hood</li> <li>3. <b>Enteral nutrition delivered by methods other than p.o.</b></li> <li>4. <b>Intravenous fluids/blood transfusion</b></li> <li>5. Initial sepsis evaluation (CBC, blood culture and treatment in an asymptomatic patient on the first day of evaluation)</li> <li>6. <b>Apnea/bradycardia not meeting criteria in NICU IV Level of care</b></li> </ol>

# References, continued

<p><b>Evidence Based Guideline/Practice Guideline Recommendation</b></p>	<p>7. Neonatal abstinence syndrome when (NAS) scores are: greater than or equal to 8 on three consecutive scores or greater than or equal to 12 on two consecutive scores. (Medical Director consult required prior to assignment)</p> <p>8. Invasive diagnostic test/procedures e.g. diagnostic laryngoscopy, ventricular tap, intravitreal injections, thoracentesis. [p. 3]</p> <p>The following criteria are appropriate for: <b><u>Level 2- CONVALESCENT – Revenue Code 172</u></b></p> <ol style="list-style-type: none"><li>1. <b>Phototherapy – intensive</b> (double phototherapy or greater)</li><li>2. IV heplock meds</li><li>3. Neonatal Abstinence Syndrome when (NAS) scores do not meet LOC 173 criteria</li><li>4. No Apnea/Bradycardia (greater than 48 hours since last episode, and otherwise meeting detained Rev Code 171 criteria)</li><li>5. Diagnostic work-up/surveillance, otherwise stable using &gt;1 consultant and/or diagnostic test.</li><li>6. Temperature instability</li><li>7. Advancing to full volume feeds</li><li>8. Stable with sub-optimal PO</li><li>9. Apnea countdown</li><li>10. Post hemorrhagic hydrocephalus</li><li>11. Growing preemie</li><li>12. Growing preemie who is stable except O2 with feeds. [p. 4]</li></ol> <p>The following criteria are appropriate for: <b><u>Level 1- DETAINED/NORMAL – Revenue Code 171</u></b></p> <ol style="list-style-type: none"><li>1. Diagnostic work-up/surveillance otherwise stable using 1 consultant and/or diagnostic test</li><li>2. Routine well baby care</li><li>3. Phototherapy (single source phototherapy). [p. 5]</li></ol>
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**Respiratory Distress Syndrome (RDS)**  
**vs.**  
**Transient Tachypnea of the Newborn (TTN)**

## **Intensity of Medical Intervention:**

- Transient Tachypnea of the Newborn (TTN) typically resolves with minimal support, such as supplemental oxygen.
- Respiratory Distress Syndrome (RDS) often necessitates advanced interventions like mechanical ventilation, continuous positive airway pressure (CPAP), or surfactant therapy.

## **Evidence in Patient Care:**

- If the infant required intensive respiratory support beyond basic oxygen supplementation, this indicates a severity consistent with RDS rather than TTN.



## Chest X-Ray Differentiation:

- TTN usually shows hyperinflation and prominent vascular markings on radiographs due to delayed fluid clearance.
- RDS, however, presents a characteristic "ground-glass" appearance with air bronchograms, indicating widespread alveolar collapse.

## Diagnostic Confirmation:

- Presenting radiographic evidence that displays the hallmarks of RDS can substantiate the diagnosis and refute claims that the condition was merely TTN.

## **Prematurity as a Key Indicator:**

- RDS predominantly affects preterm infants due to insufficient surfactant production in underdeveloped lungs.
- TTN is more common in term or near-term infants, especially following cesarean deliveries without labor.

## **Correlation with Patient's Profile:**

- If the affected infant was born preterm and exhibited risk factors like maternal diabetes or perinatal asphyxia, it strengthens the case for RDS over TTN.

## **Transient Nature of TTN:**

- TTN symptoms typically resolve within 24 to 72 hours as the excess lung fluid is absorbed.
- RDS symptoms persist longer and may progressively worsen without appropriate intervention.

## **Clinical Course Analysis:**

- Documenting that the infant's respiratory distress extended beyond 72 hours or that the condition escalated despite initial treatment supports the diagnosis of RDS

# Clinical Validation Case Study

## Respiratory Distress Syndrome



## Denial Letter Rationale

### Denial Summary:

- TTN documented repeatedly for the first 2 days
- TTN documented as the diagnosis on (date)
- Xray showed hyperinflation, not hypoinflation
- Breathing problems resolved by day 3

# Interdisciplinary Documentation

Document Source & Date	Pertinent Information	Page(s)
H & P (date, day of life 1)	<p>Newborn Information- Baby A: Complication -Respiratory distress.</p> <p>Labor and Delivery: Infant born on vertex presentation..., After several minutes infant started <b>grunting and retracting</b>.</p> <p>Lungs- <b>Grunting</b> intermittent, <b>intercostal muscles</b> mild <b>retractions</b>.</p> <p><b>Preterm infant</b>, 2,000-2,499 grams.</p> <p><b>RDS vs TTN.</b> Requires <b>CPAP</b> Plan: <b>admit to NICU</b> for further care and management.</p>	453
Attending Progress Note (date, day of life 2)	<b>RDS vs TTN</b>	477

# Interdisciplinary Documentation

Pulmonary Consult (date, day 2)	<p>Respiratory: <b>Continues to desat and have tachypnea. Nasal flaring.</b></p> <p><b>Placed on NIMV (BiPAP) 30 18/6 40% continues to grunt and have substernal retractions.</b></p> <p><b>If unable to wean will intubate and give surfactant.</b></p> <p><b>Problem 3: RDS (respiratory distress syndrome in the newborn)</b></p>	511
Progress Note (date, day 3)	Weaned to CPAP	537
Progress Note (date, day 4)	Weaned to room air <b>S/P RDS</b>	624
Discharge Note (date, day 9)	Reason for admission: Preterm newborn infant of 34 completed weeks of gestation 2,000-2,499 grams, <b>RDS (respiratory distress syndrome in the newborn)</b> , immature thermoregulation, <b>IDM</b> , and observation and evaluation of newborn for suspected infectious condition.	761

# Diagnostic Test Results and Pertinent VS

Test	Date(s)	Results	Reference Range	Page(s)
Blood Gases	(date)	<b>PO2 – 45</b>	83 – 108 mmHg	10
Chest X-ray	(date)	There is mild <b>interstitial and airspace disease.</b>  Lungs appear mildly hyperinflated which <u>may be secondary to CPAP administration</u>	Negative findings	6

Vital Sign	Date(s)	Value	Page(s)
Respiration Rate	DOL 1	32-120	482
	DOL 2	50-78	490
	DOL 3	44-88	499



## Justification for Appeal

1. Documentation in the medical record revealed an **infant of a diabetic mother (IDM), grunting, tachypnea, hypoxia, retractions, nasal flaring, prematurity, placed on CPAP, symptoms continued, placed on BiPAP, and surfactant was considered.**

➤ Surfactant would never be considered for TTN.

2. The auditor claimed that the chest Xray showed hyperinflation, rather than hypoinflation.

➤ What the auditor did not relay was that **the baby was on a CPAP at the time the chest Xray was taken.**

➤ The radiologist stated in the CXR report, "**Lungs appear mildly hyperinflated which may be secondary to CPAP administration.**" (*emphasis added*)

## Justification for Appeal

3. The auditor claimed that TTN was documented repeatedly for the first 2 days as a potential diagnosis.
  - **Of concern is that the above statement does not state that RDS was also repeatedly documented as a potential diagnosis.**
  - For the first 2 days, attending documentation was “TTN vs RDS.”
4. The reviewer claimed the infant’s “breathing problems were resolved by day 3.”
  - This statement is erroneous.
  - **On day 3 of life, the newborn required a BiPAP, and was later weaned to a CPAP**
  - **The baby was weaned to room air on day 4 of life.**
  - **This scenario is fitting for RDS as evidenced in the references provided.**

## Justification for Appeal

5. After study, the treating and examining physicians responsible for the care of this premature infant made a diagnosis of RDS, not TTN.
- Please note the discharge summary made it eminently clear this baby had overcome RDS.
  - There is not mention of TTN whatsoever in the discharge summary.

## Diagnostic and Evidence Based Clinical References

<b>Source/Reference</b>	Ismail, R., Murthy, P., Abou Mehrem, A. <i>et al.</i> Fluid handling and blood flow patterns in neonatal respiratory distress syndrome versus transient tachypnea: a pilot study. <i>BMC Pediatr</i> 21, 541 (2021). (Accessed on 29 Jun 2023). <a href="https://doi.org/10.1186/s12887-021-03025-z">https://doi.org/10.1186/s12887-021-03025-z</a>
<b>Evidence Based Guideline/Practice Guideline Recommendation</b>	<b>RDS is characterized by surfactant deficiency with worsening pulmonary insufficiency over 2–3 days.</b>  <b>TTN, in contrast, is believed to result from incomplete resorption of fluid from the newborn lung with immediate-onset tachypnea and mild work of breathing confined generally to the first 24 h of life.</b>

## Clinical Reference

## Coding Reference

### General Perinatal Rules

### ICD-10-CM Official Guidelines for Coding and Reporting

#### a. General Perinatal Rules

##### 6) Code all clinically significant conditions

All clinically significant conditions noted on routine newborn examination should be coded. A condition is clinically significant if it requires:

- **Clinical Evaluation; MET as evidenced by provider documentation of grunting, retractions, prematurity, consideration of surfactant use, and the final diagnosis of respiratory distress syndrome.**
- **Or Therapeutic Treatment; MET as evidenced by initiation of supplemental oxygen, CPAP, and BiPAP.**
- **Or Diagnostic Procedures; MET as evidenced by serial ABGs**
- Or Extended Length of Hospital Stay;
- **Or Increased Nursing Care and/or Monitoring; MET as evidenced by NICU monitoring.**
- Or has implications for future health care needs

## Takeaways

- Overturned at external review after reviewed by a neonatologist.
  - Billed DRG 790 ~ \$30,000
  - Payer DRG: 792 ~ \$13,000  
~\$17,000 difference  
(DRG RW x base rate = payment)
- Pursue as far as you can if you are right.
- Never, ever believe the reviewer is correct.
- Scrutinize every reason for denial and try to prove them wrong.



# Clinical Validation Case Study

## Infant of a Diabetic Mother

# Denial Letter Rationale

## Summary:

- A syndrome is a group of symptoms that consistently occur together or a condition characterized by a set of associated symptoms.
    - Both criteria are needed, therefore, to constitute a “syndrome.”
  - The syndrome of infant of diabetic mother includes an infant who is large for gestational age and who has hypoglycemia after birth.
  - Healthy newborns maintain a blood glucose level of 40 mg/dl or higher after the first 12 hours of life.
  - Neonatal hypoglycemia is defined as a blood glucose level of 40 mg/dl or less in the first 24 hours of life.
  - After the first 24 hours, hypoglycemia is defined as a blood glucose level of less than 45 mg/dl.
- 
- The newborn was appropriately sized for gestational age (65th percentile).
  - No documented episodes of hypoglycemia.
  - The baby did not exhibit other symptoms like lethargy, tachypnea, reddish facial appearance, cardiac anomalies, or respiratory distress.



## Interdisciplinary Documentation

<b>Document Source &amp; Date</b>	<b>Pertinent Information</b>	<b>Page(s)</b>
H&P, DOL 0	<p>Baby is a 37.2 week gestational age male born to a 35 year old G2P1 mother via NSVD.</p> <p><b>Maternal history of gestational diabetes requiring insulin (GDMA2), PCOS (metformin).</b></p> <p>Apgars 9/9. Weight 3075 Gm.</p> <p>Assessments and Plans: Normal newborn vaginal delivery</p> <p><b>Infant of a diabetic mother: Hypoglycemia guideline, monitor</b></p>	124-126

# Interdisciplinary Documentation

Document Source & Date	Pertinent Information	Page(s)
Orders DOL 0	Blood glucose point of care testing: Hypoglycemia screen for IDM. <b>If glucose less than or equal to 45 mg/dl, notify provider, treat with breastfeed/formula feed and dextrose gel then recheck 30 minutes after each treatment.</b>	88
Orders DOL 0	Dextrose 40% Oral Gel, 0.62 Grams, buccal <b>Indication: hypoglycemia</b>	29
Nurses Note DOL 0	Baby with <b>episode of low glucose</b> and low temperature. <b>Glucose gel and formula given.</b>	49
Progress Note DOL 1	This is a 1day male with <b>active issues of IDM. Hypoglycemia Protocol for IDM</b>	154
Discharge Note Newborn DOL 2	Secondary discharge diagnosis: Infant of diabetic mother <b>IDM with noted neonatal hypoglycemia that resolved with glucose gel and feeding.</b>  Because your baby was born to a diabetic mother, we monitored your baby's blood glucose during his hospital stay. Please follow up with your pediatrician if you see any signs of low blood sugar including if your baby is jittery or irritable.	132

# Diagnostic Test Results and Pertinent VS

Test	Date(s)	Results	Reference Range	Page(s)
Accu-Checks	1/18/xx 13:27	44 (C)	70-99 mg/dl	24
	1/18/xx 16:37	41 (C)		23

## Justification for Appeal

The arguments presented below justify the inclusion of Syndrome of Infant of a Diabetic Mother as a valid diagnosis for the following reasons:

1. The clinical information contained in the medical record is consistent with evidence based guidelines for establishing the diagnosis.
  - Physicians are not bound by one group's opinions as to what constitutes a certain diagnosis.
  - Shortly after birth, the neonatal assessment and plan of care included clinical evaluation, monitoring, and management of the infant's hypoglycemia. This was an infant born to a diabetic mother.
  - Orders were written by physician stating if the infant's glucose fell less than or equal to 45 mg/dl, notify provider, treat with breastfeed/formula feed and dextrose gel then recheck 30 minutes after each treatment.
2. Per the reviewer, "The baby also never had any documented episode of hypoglycemia."  
Response: There was clear documentation in the medical record of an episode of hypoglycemia.
  - On 1/18/xx at 16:37, the patient had a **blood glucose level of 41.**
  - An order was written for **buccal administration of Dextrose glucose gel as indicated for hypoglycemia.**
  - The final discharge summary stated that the baby had noted **neonatal hypoglycemia that resolved with glucose gel and feeding.**

## Justification for Appeal

Inclusion of Neonatal Hypoglycemia on the billed claim is in accordance with the Uniform Hospital Discharge Data Set (UHDDS) and ICD-10-CM Official Coding Guidelines, and AHA Coding Clinic Guidelines (see citations below).

- There is no disclosure indicating the payer's contract provisions vary from Uniform Hospital Discharge Data Set (UHDDS) and ICD-10-CM Official Coding Guidelines.
- **Neonatal hypoglycemia impacted patient care as it was documented by the physician, supported by a blood glucose level of 41, clinically evaluated by the physician, therapeutically treated with glucose gel and feedings, and required increased nursing care with frequent blood glucose monitoring and administration of glucose gel. Therefore, syndrome of infant of a diabetic mother met criteria for a reportable secondary diagnosis.**

## Diagnostic and Evidence Based Clinical References

<b>Source/Reference</b>	Edwards, T., & Harding, J. E. (2021). Clinical Aspects of Neonatal Hypoglycemia: A Mini Review. <i>Frontiers in pediatrics</i> , 8, 562251. <a href="https://doi.org/10.3389/fped.2020.562251">https://doi.org/10.3389/fped.2020.562251</a>
<b>Evidence Based Guideline/Practice Guideline Recommendation</b>	<p>The most widely used definition for neonatal hypoglycemia is a glucose concentration of &lt;47 mg/dl (2.6 mmol/l).</p> <p>The American Academy of Pediatrics recommends that monitoring continues until 12 h after birth for infants of diabetic mothers or large for gestational age, but for 24 h for babies who are born late preterm or small for gestational age.</p>

## Clinical Reference

## Coding Reference

### General Perinatal Rules

### ICD-10-CM Official Guidelines for Coding and Reporting

#### a. General Perinatal Rules

##### 6) Code all clinically significant conditions

All clinically significant conditions noted on routine newborn examination should be coded. A condition is clinically significant if it requires:

- **Clinical Evaluation; MET as evidenced by provider evaluation of glucose levels, plan formed**
- **Or Therapeutic Treatment; MET as evidenced by glucose gel and additional feeding.**
- **Or Diagnostic Procedures; MET as evidenced by serial glucose levels**
- **Or Extended Length of Hospital Stay;**
- **Or Increased Nursing Care and/or Monitoring; MET as evidenced by NICU monitoring.**
- **Or has implications for future health care needs**

## Takeaways

Demonstrate how the medical record supported:

- current clinical criteria as supported by peer reviewed medical literature current at the time of the hospitalization
- Just a bit of coding information: how criteria for a reportable diagnosis were met

Look for and rebut all inaccurate statements by the payer.



# Common Documentation Issues in NICU Denials

1. Insufficient detail on intervention
2. Lack of correlation with clinical severity
3. Missing progress notes
4. Copy and paste

# Role of Utilization Management in NICU Care

1. Assess criteria for level of care justification
2. Authorization protocols
3. Impact of payer-specific guidelines on authorization and continued stay requirements

# Real-Time Appeal Strategies During NICU Stay

1. Proactive approaches to engage with payers during hospitalization
2. Real-time negotiation for level of care
3. Clinical updates to preempt denials
4. Early intervention tactics that prevent denial escalation

# Questions and Answers



# AHDAM

The Association for Healthcare Denial & Appeal Management

**Thank you for attending today's event!**

For more information, please contact:

[info@ahdam.org](mailto:info@ahdam.org)

**PayerWatch**

