AMERICAN COLLEGE OF PHYSICIAN ADVISORS

The Million Dollar Baby

ACPA Pediatrics Committee

October 28, 2025

ACPA Town Hall Disclaimer

All opinions and interpretations expressed in this educational event are those of the presenters themselves and do not represent an official opinion or position of the American College of Physician Advisors (ACPA). ACPA does not certify the accuracy or authority of these materials. They are presented an educational content only to be used by the participants in conjunctions with any other research as deemed necessary. Any and all references provided are for informational purposes only and should not be interpreted as official ACPA endorsements.

ACPA Pediatrics Committee and this Town Hall

- Largest committee for the tiniest patients
- Membership is open to any member of ACPA with interest in pediatrics
- We meet periodically to determine areas of focus
- Neonatal reimbursement has always been complex. Our goal is to ensure all days of newborn care are reimbursed
- This Town Hall: joint effort by 15 members, led by Dr. Alyssa Riley

Town Hall “The Million Dollar Baby” Team

- Roshani Agarwal MD
- Tina Chu, MD
- Samantha Dallefield, MD
- Elizabeth Dunbar, MD, MBA, FACEP, ACPA-C, CHCQM-PHYADV
- Jennifer Goodrich, MD, FAAP, ACPA-C
- Beatriz Ladd, MD, FAAP
- Rhiana Lau, MD, FAAP
- Michelle Lyn, MD, CHCQM-PHYADV
- Erik Madsen, MD, PhD
- Sumana Narasimhan, MD, FAAP, CHCQM
- Ade Ojo MD, MHA
- Deepak Pahuja, MD, MBA
- Vipul Parikh, MD, MBA
- Anita Raghavan, MD
- Alyssa Riley, MD, MEd, FAAP, ACPA-C

Introduction

Sumana Narasimhan, MD, FAAP, CHCQM
Samantha Dallefield (Moderator)

Agenda

- Introduction
- Levels of Care
- Reimbursement & Payor/Policy Considerations
- Denials

Why is the NICU important?

- Potential for HUGE financial impact
  - Prolonged length of stay
  - High intensity of care - intensive care setting
  - High utilization of resources
- Unique billing model very different from adult (and other pediatric) patients

Unique challenges of NICUs

- Located in both adult and pediatric facilities
- Host a patient population strictly based on age
- Provide multiple levels of care (LOC) in a single location
- Operate with high-dollar daily LOC payment models needing daily assessment

Levels of Care

Jennifer Goodrich, MD, FAAP, ACPA-C (Panelist)
Rhiana Lau, MD, FAAP
Alyssa Riley, MD, MEd, FAAP, ACPA-C

Neonatal Acuity Level Accreditation

- Governed by State Department of Health Services
- AAP NICU verification program
- Level I: newborn nursery
- Level II-IV: neonatal intensive care unit
  - Neonatal Medical Director
  - Onsite Neonatologist OR access to NICU consultant (depending on level)
  - Providers with pediatric or neonatal specific training
  - Nursing leadership with training in perinatal nursing and neonatal conditions
  - Clinical nurse staffing plan with NRP trained nurses and appropriate orientation/education plans
  - Access to local neonatal transport program
  - Appropriate lab services, pharmacy, diagnostic imaging, resp therapy, dietitian, and discharge f/u

NICU Acuity Level Accreditation

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

NICU Levels of Care

Based on the INTENSITY of medical care

Newborn Level 1 Routine Care	Special Care Level 2 Continuing Care	Neonatal Intensive Care Level 3 Intermediate Care	Neonatal Intensive Care Level 4 Intensive Care
Stable neonate requiring normal newborn care	Mild to moderately ill with a condition that is expected to resolve rapidly and does 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

Accreditation ≠ NICU billing

- **Billing levels** 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 the location of care
  - May be based on gestational age or patient weight

NICU Level of Care Determination

- InterQual vs MCG vs CG-Med-26
- Level of respiratory support: O_2 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
- Lots of other specifics based on resource utilization
- Utilize the highest level met
  - Only need ONE criteria at that level

Ascension NICU Tool Billing Guidelines			
	NICU Level IV- HIGH	**NICU Level III- MEDIUM**	**Special Care Level II- LOW**
	Critically ill neonates requiring the *highest level* of service intensity. **Requires 1 or more of the following:**	Neonates who are *critically ill* and require *comprehensive, subspecialty* intensive care. **Requires 1 or more of the following:**	*Stable or moderately ill* neonates who have problems that, while potentially serious, are expected to resolve rapidly. **Requires 1 or more of the following:**
Corrected Age		**< 32 weeks**	≥ 32 weeks
Current Weight		**< 1500 grams**	≥ 1500 grams
Respiratory	High frequency jet or oscillatory ventilation iNO administration 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)	Conventional ventilation +/- trach (including need for vent adjustments and intensive airway clearance) CPAP, or HFNC (> 1 L/min) Apnea requiring resuscitation Chest tube	**Brief** apnea requiring blow by O2 or caffeine Supplemental O2 with LFNC ≤ 1 L/min Tachypnea (RR >60) Chronic ventilation with stable ventilatory support **after first trach change**
Cardiovascular	ECMO Prostaglandins for PDA patency	Bradycardia requiring resuscitation Need for pressors IV fluid resuscitation	**Brief** bradycardia without need for ongoing intervention
Neurology	cEEG ICP monitor Total body cooling for hypoxic injury	Acute, moderate to severe, encephalopathy Seizures requiring IV med or AED change/escalation Neonatal abstinence syndrome requiring drug withdrawal therapy at least q6h	Acute, mild encephalopathy Neonatal abstinence syndrome requiring drug withdrawal therapy less frequently than q6h
Fluids, Electrolytes, Nutrition, and Gastrointestinal		TPN IVF ≥ 50 ml/kg/24h Electrolyte or acid-base disorder requiring continuous monitoring and ongoing IV correction	Initiation of tube feeds Transition from parenteral or tube feeding to PO feeds ≤ 3 days Tube feeding ≥ 50% of daily calories Requiring IVF < 50 ml/kg/24h Inborn error of metabolism requiring initiation of special formula
Renal	Hemodialysis	Anuria, Peritoneal dialysis	
Hematology	Exchange transfusion for hyperbili Transfusion of blood products for severe acute etiology	Blood product transfusion Hyperbili requiring IVIG OR approaching exchange transfusion and requiring phototherapy and IV hydration Polycythemia with partial exchange	Hyperbili requiring intensive phototherapy
Infectious Disease		Septic shock	High risk early onset sepsis on IV antibiotics (asymptomatic)
Endocrinology		Persistent hypoglycemia requiring IV glucose	Transitional hypoglycemia requiring glucose bolus x1
Surgery and Procedures	Surgical repair of complex condition Peri-op care for severe defects or conditions (e.g. CDH repair, gastroschisis, NEC/SIP, bowel obstruction, Piccolo post-op care 23h post-procedure, CSF diversion with EVD placement)	Urgent or emergent major surgery required (including new tracheostomy placement until first trach change and new gastrostomy tube placement)	
IV Support and Monitoring	**BOTH** IV med administration (excludes anti-infectives and glucose) **AND** invasive BP monitoring		Hypothermia with need for interventions to maintain >36.5 ℃
Other	**Urgent** need for pediatric medical or surgical subspecialist care 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	Delivery-related emergency (e.g. pulmonary or cardiac arrest) Advanced imaging with interpretation on **urgent** basis (e.g. CT, MRI, ECHO) Other condition requiring ongoing evaluation, active management, and therapy adjustment by continuously available neonatologist and readily accessible subspecialty care	Need for subspecialist evaluation Convalescent care for infant after Level III or IV NICU stay who has continued moderate needs (e.g. advancing enteral feeds, titration of medications)

****Choose the HIGHEST status that the infant qualifies for in choosing the daily charge capture**

NICU LOC 4

	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 jet or oscillatory ventilation iNO administration 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 Prostaglandins for PDA patency
Neurology	cEEG ICP monitor Total body cooling for hypoxic injury
Fluids, Electrolytes, Nutrition, and Gastrointestinal	
Renal	Hemodialysis
Hematology	Exchange transfusion for hyperbili Transfusion of blood products for severe acute etiology
Infectious Disease	
Endocrinology	
Surgery and Procedures	Surgical repair of complex condition Peri-op care for severe defects or conditions (e.g. CDH repair, gastroschisis, NEC/SIP, bowel obstruction, Piccolo post-op care 23h post-procedure, CSF diversion with EVD placement)
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 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

NICU LOC 3

	NICU Level III- MEDIUM
	Neonates who are *critically ill* and require *comprehensive, subspecialty* intensive care. **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 FiO2 ≥ 0.4 Apnea requiring resuscitation Chest tube
Cardiovascular	Bradycardia requiring resuscitation Need for pressors IV fluid resuscitation
Neurology	Acute, moderate to severe, encephalopathy Seizures requiring IV med or AED change/escalation
Fluids, Electrolytes, Nutrition, and Gastrointestinal	**TPN** IVF ≥ 50 ml/kg/24h Electrolyte or acid-base disorder requiring continuous monitoring and ongoing IV correction
Renal	Anuria, Peritoneal dialysis
Hematology	Blood product transfusion Hyperbili requiring IVIG OR approaching exchange transfusion and requiring phototherapy and IV hydration 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) Advanced imaging with interpretation on **urgent** basis (e.g. CT, MRI, ECHO) Other condition requiring ongoing evaluation, active management, and therapy adjustment by continuously available neonatologist and readily accessible subspecialty care

Special Care Nursery Level 2

	Special Care Level II- LOW
	Stable or moderately ill neonates who have problems that, while potentially serious, are expected to resolve rapidly. **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 **Brief** apnea requiring blow by or caffeine HFNC ≤ 1 L/min FiO2 < 0.40 Tachypnea (RR >60) Chronic ventilation (e.g. trach, long term need)
Cardiovascular	**Brief** bradycardia without need for ongoing intervention
Neurology	Acute, mild encephalopathy Neonatal abstinence syndrome requiring drug withdrawal therapy
Fluids, Electrolytes, Nutrition, and Gastrointestinal	Unable to take po feeds (gavage > 25%) Requiring IVF < 50 ml/kg/24h 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 ℃) 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)

Role of the Physician Advisor in LOC

- Evaluate LOC determination processes in your institution
- Determine which guidelines are used by your institution and/or payors
- Provide education & resources for impacted clinicians
- Engage with payor Medical Directors

NICU Reimbursement and Payor/Policy Considerations

Erik Madsen, MD, PhD (Panelist)
Beatriz Ladd, MD, FAAP
Elizabeth Dunbar, MD, MBA, FACEP, ACPA-C, CHCQM-PHYADV

How is NICU Care Reimbursed – Per Diem

- Per Diem
  - Daily rate directly linked to Level of Care
    - Highest reimbursement for Level IV, lowest Newborn Nursery
  - Contractually negotiated for each payor
    - Level of Care definitions can be different between payors
    - Important to know your contracted rates when deciding about P2P
      - The payment difference between two adjacent levels may not be significant
      - Having a resource in the billing/reimbursement department is critical
  - Fewer payors (Especially Medicaid) are using Per Diem
    - Missouri just moved from Per Diem to APR-DRG July 2025

How is NICU Care Reimbursed – DRG

- DRG-Based Payment
  - Lump sum based on DRG assigned
    - Significantly impacted by type of DRG used
    - Hospital and Payor Specific
    - Example: APR DRG 591 Neonate 500-749 Grams without major procedure
      - SOI 1: Base Payment $5,636, Outlier Threshold $30,000
      - SOI 2: Base Payment $216,087, Outlier Threshold $420,755
      - SOI 3: Base Payment $233,972, Outlier Threshold $484,708
      - SOI 4: Base Payment $343,241, Outlier Threshold: $715,433
  - Outlier payments for long/costly stays
    - Not necessarily NICU specific
    - Can be based on LOS or direct cost calculation
    - Each APR-DRG has a cost outlier threshold

How is NICU Care Reimbursed – DRG Example

TRANSFER PAYMENT		
Transfer Indicator	No	If Discharge Status in ('02', '05', '66') and DRG is NOT 580 or 581 Then Yes Else No
Transfer Adjusted Payment	$0.00	If Transfer Indicator = Yes then (DRG Payment / Average LOS) * (LOS + 1)
Transfer Payment or DRG Payment	$0.00	If Transfer Indicator = Yes then Minimum of DRG Payment and Transfer Adjusted Payment
POLICY ADJUSTER PAYMENT		
Policy Adjuster Payment	$240,268.84	
DRG Payment with Policy Adjuster	$583,510.04	DRG Payment * Policy Adjuster
OUTLIER PAYMENT		
Cost or Day Outlier?	Cost Outlier	If APR-DRG Code is a MH&SA DRG then it will be eligible to receive a day outlier.
DAY OUTLIER CALCULATIONS		
Day Outlier Indicator	No	If APR-DRG Code is a MH&SA DRG AND Covered Days > Day Outlier Threshold then Yes else No
Day Outlier - Per Diem Amount	N/A	State Policy - $500.00 per day
Day Outlier Payment	$0.00	Day Outlier Payment
COST OUTLIER CALCULATIONS		
Estimated Cost of the Stay	$358,552.15	Charges * CCR Did not cross threshold
Marginal Cost Percentage	80%	State Policy - Marginal Cost set to 80%
Cost Outlier Indicator	No	If Estimated Cost > Cost Outlier Threshold then Yes else No
Cost Above Threshold	$0.00	Estimated Cost - Cost Outlier Threshold
Cost Outlier Payment	$0.00	Cost Above Threshold * Marginal Cost Percentage
Outlier Payment	$0.00	Day Outlier Payment OR Cost Outlier Payment
APR-DRG Service Line Description	Pediatrics	Look up from DRG table
DRG Relative Weight	30.1628	Look up from DRG table
Cost Outlier Threshold	$715,433.03	Look up from DRG table
Average LOS	55.79	Look up from DRG table
Day Outlier Threshold	0.00	Look up from DRG table
Policy Adjuster	1.70	Look up from DRG table
DRG BASE PAYMENT		
DRG Base Payment	$343,241.20	Hospital Rate * APR-DRG Weight

MO pays 80% of extra cost above the threshold

How is NICU Care Reimbursed – Transfers

- Transfers get a modified DRG Code
- “Transfer Out” hospital gets paid a partial payment based on LOS
- “Transfer In” hospital re-bills with same DRG

01: D/c home or self care
02: Transferred to a short-term general hospital for inpatient care
05: Transferred to a designated cancer center or children’s hospital
66: Transferred to a critical access hospital

INFORMATION FROM THE HOSPITAL		
Provider NPI	1518065523	Used for look ups to the provider reference table
Covered Charges	$60,000.00	UB-04 Field Locator 47 minus FL 48
Length of Stay	2	Total Length of Stay (Discharge minus Admit Date)
Covered Days	2	Covered Days from Claim (If 0 covered days are entered, no payment is calculated)
Discharge Status	5	
APR-DRG Code	591-4	rom separate APR-DRG grouping software
HOSPITAL INFORMATION		
Provider Name	SSM HEALTH ST MARYS HOSPITAL	Look up from Provider Parameters table
Hospital Specific Facility Rate	$7,400.92	Look up from Provider Parameters table
Hospital Specific cost-to-charge ratio	0.5510	Look up from Provider Parameters table

DRG BASE PAYMENT		
DRG Base Payment	$223,232.47	Hospital Rate * APR-DRG Weight
TRANSFER PAYMENT		
Transfer Indicator	Yes	If Discharge Status in ('02', '05', '66') and DRG is NOT 580 or 581 Then Yes Else No
Transfer Adjusted Payment	$12,003.90	If Transfer Indicator = Yes then (DRG Payment / Average LOS) * (LOS + 1)
Transfer Payment or DRG Payment	$12,003.90	If Transfer Indicator = Yes the Minimum of DRG Payment and Transfer Adjusted Payment

(DRG Payment/Average LOS)*(LOS + 1)
Calculates base payment per average day
Multiplies by actual LOS + one extra day

MO HealthNet Inpatient APR-DRG Calculator | mydss.mo.gov

Nitric Oxide

- Inhaled Nitric Oxide (iNO) is expensive
  - $90,000 per month (n = 1)
- Many (but not all) contracts have a “carve out” for iNO
  - Payor specific policies: CG-MED-69 Inhaled Nitric Oxide (Anthem)
  - Various levels (and quality) of evidence
- Denials for iNO can be costly
  - One patient on iNO for 17 days
    - Denial would cost $127,000 in reimbursement
  - Another patient, iNO for 2.7 days: $20,000 in reimbursement
- Often require a specific response to a specific payor policy
  - Involve a neonatologist or pediatric intensivist if you need help

Implications

- Per Diem
  - What “Leveling” criteria is the payor using?
- DRG
  - Which DRG system is used directly impacts reimbursement
    - And Benchmarking: LOS is directly calculated from DRG
  - DRG disputes “should” be minimal as largely based on birthweight
  - End of Stay Denials Still Matter (though not as much??)
    - Total cost of stay includes daily bed charge for every NICU day
- Don’t ignore iNO denials; Get help if you need it
- Know what your State Medicaid plan is doing
- Work with billing/contracting to understand payor specific reimbursement as needed

NICU Denials

Tina Chu, MD (Panelist)
Ade Ojo MD, MHA (Panelist)
Roshani Agarwal MD
Michelle Lyn, MD, CHCQM-PHYADV
Vipul Parikh, MD, MBA
Deepak Pahuja, MD, MBA
Anita Raghavan, MD

NICU DENIALS

Case 1

- Female infant born at 39 4/7 wk, now 35 days old, transferred for further evaluation and management of Pulmonary Hypertension
- Patient born at OSH & required resuscitation for hypoxic respiratory failure. TAPVR was ruled out. Patient had recurrent pneumothoraces requiring chest tubes. Subsequently transferred to higher level care hospital for Pulmonary Hypertension (PH) management.
- Upon transfer, patient was treated with NIPPV, then intubated 12 hours after arrival for respiratory failure. Patient was sedated and iNO was initiated for acute management of PH. Patient remained intubated, sedated, treated for PH (iNO/Sildenafil), and provided nutrition with TPN. She showed improvement on hospital day 3 and began iNO wean on hospital day 4.
- On the 5th day, a denial notification was received for *NICU 4 LOC* and for *iNO use*
  - **iNO denial was for duration of use despite lack of response**

NICU DENIALS

- COSTS
  - Estimated care costs for 1st hospital (35 days) for NICU Bed charges: $88,000
  - Estimated care costs for second hospitalization with iNO
    - NICU LOC 4 for 5 days: $3,000-5,000/day
    - iNO cost: iNO therapy at over $2000/day

  - A denial for iNO may call into question medical necessity of an entire NICU stay, which costs thousands of dollars per day
  - Total amount at risk in complex cases may far exceed $100,000-$250,000

*** Clinical and Economic Effects of iNO in Premature Newborns With Respiratory Failure at 1 Year** *R. Scott Watson, MD, MPH; Gilles Clermont, MD, MSc; John P. Kinsella, MD; Lan Kong, PhD; Robert E. Arendt, PhD; Gary Cutter, PhD; Walter T. Linde-Zwirble; Steven H. Abman, MD; Derek C. Angus, MD, MPH; on behalf of the Prolonged Outcomes After Nitric Oxide Investigators.* ***Pediatrics (2009) 124 (5): 1333–1343*** *https://doi.org/10.1542/peds.2009-0114*

NICU DENIALS

Case 2

- Infant prematurely born at 27 wk EGA, was twin & VLBW, developed short-bowel syndrome due to NEC with jejunoileal re-anastomosis and TPN dependence
- Comorbid conditions:
  - Chronic lung disease, on chronic oxygen therapy and diuretics
  - Retinopathy of prematurity
  - Metabolic bone disease of prematurity
- Last 4 weeks of stay denied for lack of medical necessity (Total LOS 190 days)
- Therapies provided during the denied period:
  - Oxygen weaning protocol
  - Continued TPN weaning
  - Slow feeding advancement (malabsorption and dumping)
  - Monitoring for adequate weight gain

Total cost of care: $450,000, denial period (4 wk) ~ $55K

NICU DENIALS

Medical Necessity Denials

- Payers use different criteria to determine LOC (MCG, IQ, CG-MED)
- Denials for the following reasons are due to these guidelines
  - Lack of demonstrated medical necessity
  - Failure to meet specific clinical criteria for certain NICU levels of care (III vs IV)
- Incomplete/poor documentation (cut & paste, note similarity)
- Delayed procedures
- Delayed discharges (social reasons)

NICU DENIALS

Administrative Barriers

- Prior authorization requirements or notification of admission or transfers
- Issues with insurance eligibility or enrollment
- Lack of clinical information
- Stop loss insurance

DOCUMENTATION TIPS

NICU Documentation Errors Result From:

- **Omission or inaccurate recording** of medications, vascular lines, and patient weights.
- **Discrepancies** are common in daily progress notes, with errors including both missing information and incorrect entries.
- Patients with **more medications, more vascular lines, or longer lengths of stay** are at higher risk for such errors.

DOCUMENTATION TIPS

Continued Stay Justification: Focus Areas

- ❑ Clinical status – changes in condition
- ❑ Medical interventions – planned & required
- ❑ Expected length of stay
- ❑ Discharge planning initiation

Documentation Principles

- ❑ Clear, detailed, simultaneous records
- ❑ Explicitly justify **medical necessity** for NICU care
- ❑ Be specific, timely, and focused on:
  - *Infant's clinical status
  - *Required interventions
  - *Medical intensity

DOCUMENTATION TIPS

Team & Guidelines

- ❑ Reference **consultant notes** and MDT recommendations
- ❑ Align with **evidence-based / consensus guidelines**
- ❑ Document inability to provide care in lower-level setting (AAP guidance)

Best Practices

- ❑ Use structured electronic templates & computer-assisted coding
- ❑ Avoid vague phrases/local abbreviations (e.g., **“NAEON**”- No Acute events overnight)
- ❑ Do not copy-paste notes
- ❑ Exclude irrelevant details not supporting the clinical narrative

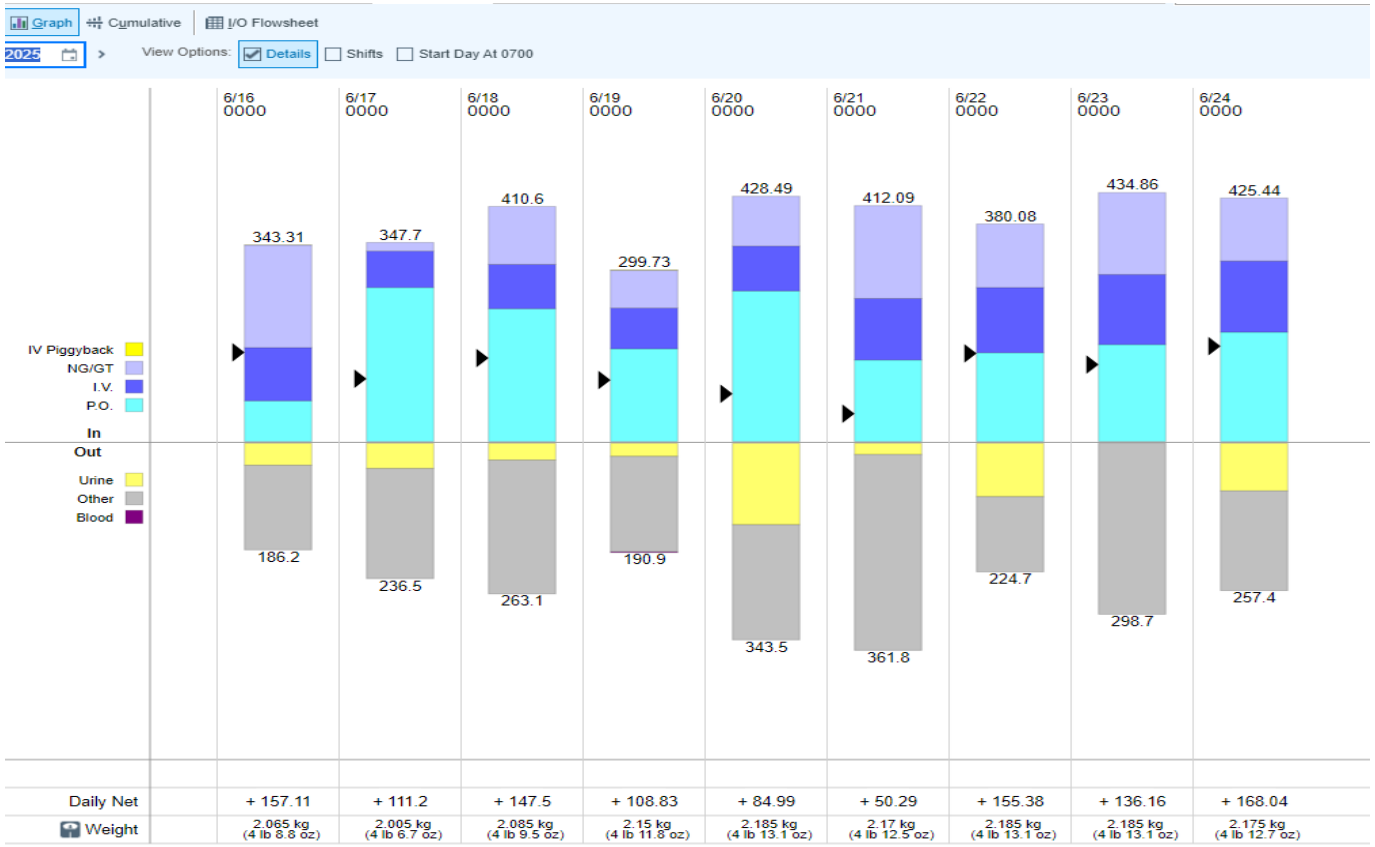
DOCUMENTATION TIPS – FLOW SHEETS

Make Your EMR Work for You

- ❑ Use **flow sheets** for structured documentation
- ❑ Track **intake & output**
- ❑ Monitor **weight changes**
- ❑ Record **lines** (arterial lines, invasive BP)
- ❑ Document **apnea episodes**
- ❑ Capture **respiratory flow sheets** & frequency of interventions (not just weaning)
- ❑ Include results of **car seat tests**

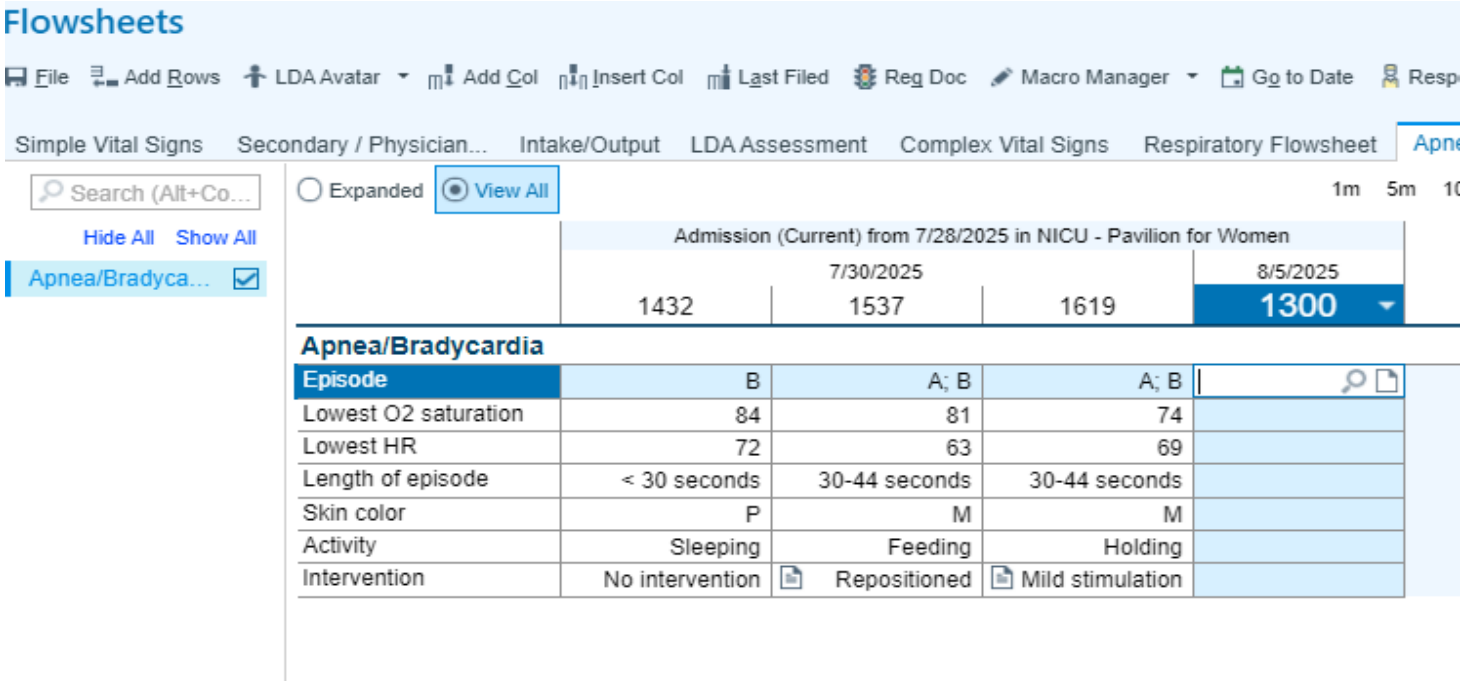
Make your EMR work for you- Tips from EMR

- Look at the Is & Os flow sheet, or in graphic format, to view documented intake, how it's taken (oral vs gavage), quantity of total feeds, and weight gains



Make your EMR work for you - Tips from EPIC

- Review the Apnea documentation flow sheet
- Based on some protocols - 4-5 days apnea watch –
  - **Best practices recommend 5 days apnea watch from time of last significant event**



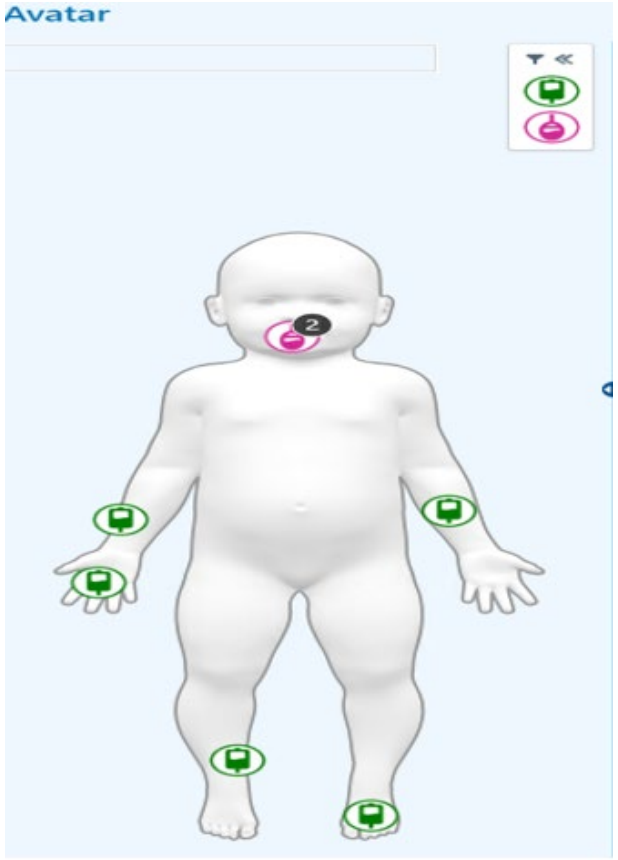
*Coughlin K, Posencheg M, Orfe L, et al. Reducing Variation in the Management of Apnea of Prematurity in the Intensive Care Nursery. Pediatrics. 2020;145(2):e20190861. doi:10.1542/peds.2019-0861.

2025 Best Practices for Managing Infants with Apnea & Bradycardia of Prematurity Clinical guidelines for management and discharge planning https://www.progenyhealth.com/shared-files/6492/?ProgenyHealth_Best_Practice_Apnea.pdf

Tips from EMR- Lines and Drains

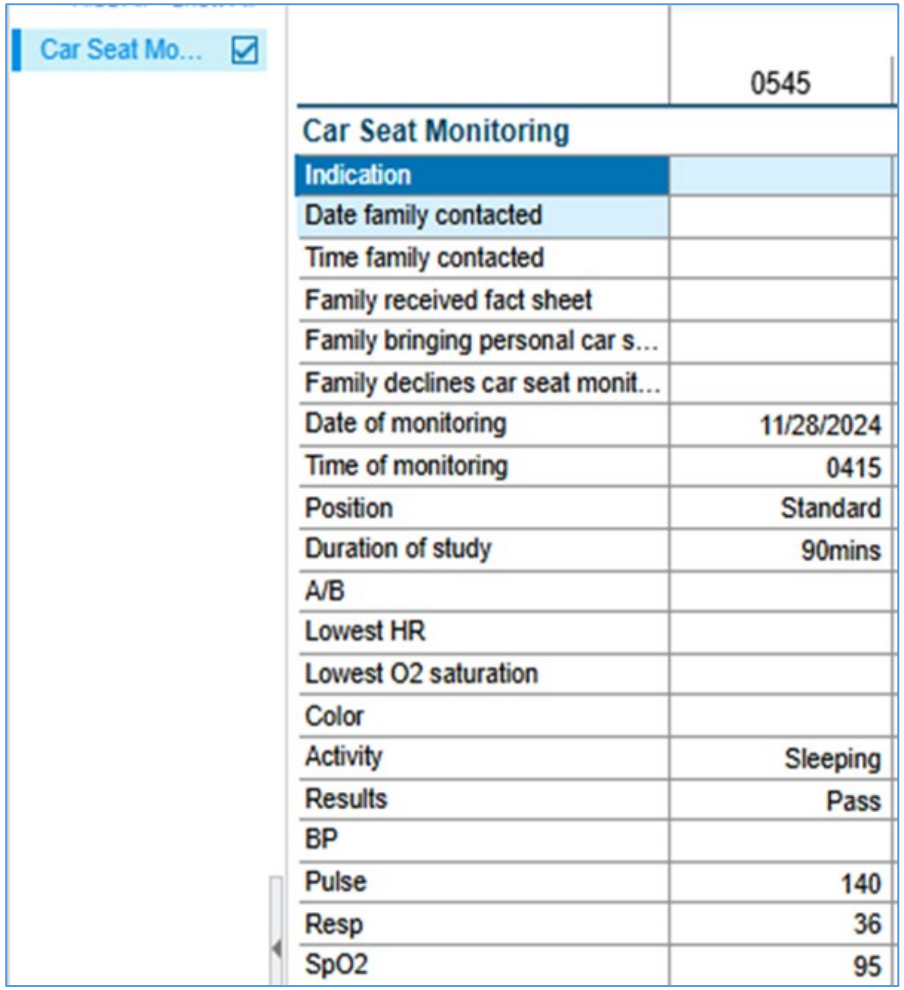
- A quick place to search for ‘lines, drains, and tubes’ will be the avatar on the flow sheet

  - Review the Lines, Drains and Airways (LDA).
  - **The presence of an arterial line for invasive monitoring can make a difference between NICU LOC III and IV**



Tips from EMR- Car Seat Test

- A discharge Milestone for all patients discharged < 37 weeks
- **The AAP recommends pre-discharge Car Seat Tolerance Screening (CSTS) or car seat challenge for infants born <37 weeks EGA or those otherwise at risk for cardiorespiratory compromise**



Car Seat Monitoring	0545
Indication	
Date family contacted	
Time family contacted	
Family received fact sheet	
Family bringing personal car s...	
Family declines car seat monit...	
Date of monitoring	11/28/2024
Time of monitoring	0415
Position	Standard
Duration of study	90mins
A/B	
Lowest HR	
Lowest O2 saturation	
Color	
Activity	Sleeping
Results	Pass
BP	
Pulse	140
Resp	36
SpO2	95

Davis NL, Zenchenko Y, Lever A, Rhein L. Car Seat Safety for Preterm Neonates: Implementation and Testing Parameters of the Infant Car Seat Challenge. Academic Pediatrics. 2013 May-Jun;13(3):272-7. doi:10.1016/j.acap.2013.01.009.

PEER TO PEER TIPS

- PREPARE
- Understand the reason for the letter/notification
- Review medical records (notes & flow sheets)
  - Gather all relevant information
  - Speak to your Neonatologist/specialists
  - Review industry guidelines. Payers conveniently follow guidelines when it is beneficial - they are usually not all inclusive
  - Reference evidence-based guidelines/literature is helpful especially when guidelines don't add up
  - Physician advisors are not hired to discuss these guidelines

- Summarize –organize the conversation to be concise and focused
  - P2P are typically time limited
  - Make sure you have all information you need at hand

- With complex cases, you may invite a subspecialist to join you on the call
- This is an opportunity to know & develop relationships with payer Medical Directors
- Be cordial, you can agree to disagree
- Document the results of your P2P
- Appeal

FEATURES IN NICU APPEALS

- **Clinical indicators**
  - Prematurity
  - Feeding
  - Respiratory status - NIPPV/highflow
  - Birth/pregnancy history
- **Hospitalization complications**
  - Hemodynamic instability
  - Infections
  - Barriers to discharge (GTUBE, SDOH)
- **Medical management & monitoring**
  - Invasive and non-invasive
  - Is & Os, meds, pressors, sedation
  - Higher level of care-Transfers
- **Maternal and High risk factors**
  - Comorbidities
  - Serologies
- **Diagnostic supports**
  - Laboratory data, imaging
  - Consults

Essential Features in a NICU P2P-Appeal

Clinical Indicators

- Prematurity (<32 weeks) or **birth weight <1500g**
- Nutrition Notes, Feeding trends
- Respiratory distress (CPAP/ventilation), seizures
- Congenital anomalies, metabolic disorders, cardiac disease
- Severe hypoxic-ischemic injury, hyperbilirubinemia, IUGR
- Infants of diabetic mothers / high-risk pregnancies

Hospitalization Complications

- Hemodynamic instability, respiratory failure, renal/cardiac failure
- Embolic events (DVT/PE/arterial/fat)
- Infections, uncontrolled pain, mobility issues
- Barriers to discharge (SDOH, skilled needs)

Medical Management & Monitoring

- Oxygen therapy, cardiopulmonary monitoring, frequent vitals
- IV medications, antibiotics, fluids, transfusions
- Specialized procedures not available at referring hospital

High-Risk Maternal & Delivery Factors

- Maternal: hypertension, anemia, obesity, advanced age, stillbirth history
- Social: age <16 or >35, alcohol, smoking, low SES
- Labor/Delivery: PROM, prolonged labor, C-section, breech, cord issues
- Fetal: distress, growth restriction, meconium, malformations

Diagnostics & Support

- Key labs: ABG, bilirubin, blood glucose, cultures, inflammatory markers
- Imaging: chest X-ray, CT/MRI brain, echocardiogram
- Consults: neonatology, cardiology, neurology, pulmonology, ID, nutrition, lactation
- Discuss with Care Team esp. Neonatology

Levels of NICU Care

- **Level I**: Routine newborn care (stable infants, feeding, monitoring)
- **Level II**: IV glucose <24h, TPN peripheral, phototherapy, tube feeds
- **Level III**: <32wks/<1500g, IV therapy >24h, ventilation, invasive procedures
- **Level IV**: ECMO, HFV, dialysis, hypothermia therapy, complex surgery, palliative care

AMERICAN COLLEGE OF PHYSICIAN ADVISORS

THANK YOU!

Questions?