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Ethics and Wellness Column: Why Neonatologists Need to Have Leadership Roles in Hospital Utilization Review Committees

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Abstract:

We highlight the compelling reasons for Neonatologists' active participation and integration into the Utilization Review process. By meticulously analyzing the intricacies of Utilization Review Committees' decision-making, as stipulated in federal regulations, we underscore the pivotal role played by medical necessity evaluations and the assessment of extended stays. A particular focal point revolves around the guidelines for length of stay and underlying causes of variation from national benchmarks. Many insurers reference entities like MCG and InterQual, which serve as benchmarks for some third-party payers'. We have meticulously examined the nuanced landscape wherein certain private organizations have capitalized on the commercialization of lengths of stay based on specific diagnoses and provide "case management," consequently exerting substantial influence on payers regarding the readiness for patient discharge and attempt to limit payment based on their guidelines that may not be evidence-based. A striking comparison emerges between the avenues available to Neonatologists for disputing lengths of stay and other denials, as afforded by the Code of Federal Regulations (CFR), and the more abrupt denial of care often observed when insurers make decisions regarding discharge dates or decisions regarding ongoing care.

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Introduction

While comprehensive datasets from organizations like Vermont Oxford Network (VON) and California Perinatal Quality Care Collaborative (CPQCC) provide valuable insights regarding the appropriateness of NICU hospital stay, we critically assess how limitations in accounting for combined diagnoses, the intricate interplay of family-related factors, the local availability of home health resources, outpatient therapies and distances to sub-specialists for follow-up care required by infants may lead to deviations from average length of stays. This paves the way for a compelling conclusion, wherein the authors advocate for proactive engagement of Neonatologists within the framework of Utilization Review (UR) committees, particularly those mandated by the Centers for Medicare and Medicaid Services (CMS). We underscore the committee's multifaceted roles, functions in the intricate healthcare ecosystem, and susceptibility to potential errors, thus urging the Neonatologists to take an assertive stance in shaping this vital aspect of medical practice.

Infants admitted to the Neonatal Intensive Care Units (NICU) have some of the longest hospital stays of all hospitalized patients, and among infants born at 24-25 weeks gestation, hospital stays can equal or exceed 15-16 weeks at enormous expense. Parents of many of these infants have comprehensive insurance coverage that pays in part for their hospital care, and many infants covered by Medicaid are covered by the State Children's Health Insurance Program, assuming that the State has expanded their Medicaid coverage. Insurers frequently question the "medical necessity" of these protracted hospital stays and have contracted with commercial groups that monitor an infant's progress in the NICU. They perform "case management" on behalf of insurers and advertise that their case management saves thousands of dollars. However, when coverage is denied during the stay, how do Neonatologists, NICU leadership, and Hospital fiscal officers respond to these denials for payments after specific dates? **What is the recourse to appeal such denials for payments, and who performs them on behalf of the treating Neonatologist and the institution of care? What is the Utilization Review Committee's responsibility? Who forms part of this committee, and how can they advocate for patients, physicians, and parents who are often sent a bill for hundreds of thousands of dollars for incurred costs after the insurer stops coverage? Do third-party case managers, often without licensure in the State where the infant is being cared for, influence care decisions that belong to the bedside Neonatologist?**

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Understanding the Code of Federal Regulations regarding Utilization Review

The overall regulatory mandate governing the Utilization Review Committee in the hospital setting and the role of case managers, among others, who are striving to provide medically necessary care and prepare for discharge at the earliest possible time when medical stability has occurred is governed by the Code of Federal Regulations Title 42, Chapter IV, Subchapter G, Part 482 Subpart C, subsection 482.30. (https://www.ecfr.Gov/current/title-42-IV/subchapter-G/part-482/subpart-C/section-482.30) (CFR). Hospital case management is related to compliance with the Centers for Medicare and Medicaid Services, Conditions of Participation, and regulatory mandates that can affect patient care and financial well-being. Hospital case manager leaders must stay current with these governmental requirements for hospitals and all levels of care and keep case managers informed, proficient, and fluent when coordinating the care of patients and assisting in discharge planning. The COVID-19 pandemic led to a dramatic change in the healthcare landscape. As a result, the hospital case management leader must proactively address evolving therapies, medication,

and durable medical equipment shortages, a multigenerational workforce, lack of title protection, and issues of appropriate and timely placement and follow-up care for the infant with parents who are often overwhelmed when facing complicated discharges.

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42 CFR Utilization Review (UR) guidelines mandate hospitals to have in effect a utilization review (UR) plan that reviews services furnished by the institution and by members of the medical staff to patients entitled to benefits under Medicare and Medicaid programs. The Centers for Medicare and Medicaid Services has determined that the UR procedures established by the State under XIX of the Act are superior to the procedures required by this section and have required hospitals in a State to meet the UR plans under subsections 456.50 through 456.245. The composition of the UR committee must include two or more practitioners who must carry out the UR function, and at least two members of the UR committee must be doctors of medicine or osteopathy. The others may be any of the types of practitioners specified in subsection 482. c(1). The UR committee must be one of the following: a staff committee of the institution; a group outside the institution, established by the local medical society and some or all the hospitals in the locality; or established in a manner approved by the Centers for Medicare and Medicaid. The UR committee may not be conducted by someone with a direct financial interest (for example, an ownership interest) in that hospital or who was professionally involved in the care of the patient whose case is being reviewed. Precisely, what is determined to be a direct financial interest in a hospital is not defined, as many physicians sit on executive committees within hospitals that make financial decisions that benefit their institution.

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The UR committee must provide for review for Medicare and Medicaid patients concerning the medical necessity of (i) admissions to the institution, (ii) the duration of stays, and (iii) professional services furnished, including drugs and biologicals. Admission reviews may be performed before, at, or after hospital admission. In some circumstances, reviews may be conducted on a sample basis. Hospitals that are paid for inpatient hospital services under the prospective payment system must conduct as follows: (i) for duration of stays, these hospitals need review only cases that they reasonably assume to be outlier cases based on extended length of stay and (ii) for professional services, these hospitals need review only cases that they reasonably assume to be outlier cases based on extraordinarily high costs, as described in the CFR chapter. Certainly, many extremely low birth weight infants meet these categories, as well as term infants requiring ECMO or prolonged ventilatory support, infants requiring one or multiple surgeries (especially cardiovascular surgery), and infants with genetic conditions requiring an extended work-up and initiation of treatment.

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The determination that an admission or continued stay is not medically necessary may be made by (i) one member of the UR committee if the practitioner or practitioners responsible for the care of the patient concur with determination or fail to present their views when afforded the opportunity, and (ii) must be made by a least two members of the UR committee in all other cases. Before deciding that an admission or continued stay is not medically necessary, the UR committee must consult with the practitioner or practitioners responsible for the patient's care and allow the practitioner or practitioners to present their views. Suppose the UR committee decides that Admission to or continuing stay in the hospital is not medically necessary. In that case, written notification must be given to the hospital, the patient (or parents), and the practitioner or practitioners responsible for the patient's care no later than two days after the determination.

In hospitals paid under the prospective payment system, the UR committee must review all cases reasonably assumed by the hospital to be outlier cases because the extended length of stay exceeds the threshold criteria for the diagnosis, as described in subsection 412.80(a)1(1)(i). The hospital is not required to review an extended stay that does not exceed the outlier threshold for the diagnosis. The UR committee must make the periodic review no later than seven days after the day required by the UR plan. The UR committee is responsible for reviewing professional services, determining medical necessity, and promoting the most efficient use of available health facilities and services.

Funding from Medicare and Medicaid Services, especially within States with expanded Medicaid services, provides significant revenue for NICUs and their ancillary services, imaging, laboratory, and administrative functions after an infant is admitted. Professional services in Neonatology are paid by using specific codes with modifiers whose criteria for use have been determined by

Neonatologists, among others, to bill for both medical care and specific procedures using a formula that includes not only the complexity of medical decisions and procedural skills but also includes regional adjustments or modifiers. While UR committees do not influence professional reimbursements directly, they determine medical necessity that distinguishes between inpatient, observation, or outpatient appropriate levels of care and, thus, professional reimbursement levels.

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Length of Stay

The length of care that is appropriate for specific diagnoses, gestational age at birth, and birth weight by consortia of NICUs, NICU networks such as VON, national databases, but also by MCG Health (https://www.mc.com/) and their companion Indicia provides evidence-based clinical decision support for mitigating commercial payer and CMS denial for payments, as does another database called InterQual (https://www.cargehealthcare.com/clinical-decision-support/interqual/level-of-care-critria). Insurers use these data as "norms" for care. However, these estimates of "norms" for the duration of care needed by an individual infant's diagnoses fail to consider predicted complications associated with an infant born extremely premature or a complicated cardiovascular condition that requires unique surgical approaches. These "norms" fail to include unique family situations, especially families living in rural areas, accessibility to recommended therapists, availability of necessary sub-specialists (pediatric ophthalmologists, pulmonary, and developmental specialists), and parents with their health limitations.

Several insurers, such as Humana, have a Case Management division that audits NICU care and length of stay. American Health Holdings advertise "Neonatal and Pediatric Case Management" that "maximizes cost savings for high-risk neonatal and pediatric cases" (https://www.americanhealthholding.com/OurProducts/NeonatalAndPediatricCaseManagement), and Progeny Health indicates that they return 2:1 or better return on investment by insurers delivering 12-16% savings, a 10-15% reduction in Length of Stay, and up to a 50% reduction in readmission and emergency room visits.. They claim to have managed "60,000+ NICU cases" in over 1400 facilities with cost savings for health plans. (https://progenyhealth.com) They report that the average length of stay is a stepping stone to savings for all payment methodologies, and they work to lower the average level of stay in NICUs using their case management strategies. Dr. Ellen Stang founded this case management company with Dr. Linda Genen, a pediatrician, as their Chief Medical Officer with a Medical Advisory Committee comprised of Neonatologists. (https://info.progencyhealth.com/nicu-economics-soilved.).

Recommended Length of Stay (LOS) for Extremely Low Birthweight Infants

Many independent insurers utilize guidelines from MCG Health Informed Care Strategies. For "Prematurity, Extreme (Less than 1000 Grams or Less than 28 weeks' gestation ORG: P-P359) updated 6/28/23 their guidelines explicitly state that "the assignment of a goal length of stay for a neonate requiring higher-level care is not possible to determine with precision." They discuss the "stages of recovery" that allows clinicians and case managers to anticipate known predictable milestones in the recovery of the neonate, and note that the infant's progression through the identified Recovery Milestones may not be smooth or strictly linear. However, they stress that the "overarching purpose" of their Recovery Milestones is to assist in identifying and tracking clinical progress toward discharge readiness. Attainment of all relevant recovery milestones indicates that an infant may be discharge-ready. However, they explicitly state, "Not all clinical and social (e.g., home or caregiver situation) factors can be included in a table. Thus, deciding when a neonate is ready for discharge must be individualized." They quote data from a national all-payer hospital discharge database of 7467 neonates that they analyzed to determine hospital length of stay (birth to discharge), by gestation at birth, for premature infants (born less than 37 weeks gestation age), discharged alive.

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Gestational Age at Birth (weeks)	% of cohort	Average Length of Stay (days)
28 0/7 to 28 6/7	27.1%	64.2
27 0/7 to 27 6/7	19.8%	74.9
26 0/7 to 26 6/7	16.5%	84.0
25 0/7 to 25 6/7	11.0%	91.5
24 0/7 to 24 6/7	8.6%	94.9

(referenced to Premier PINC AI (trademark) Healthcare Database (PHD) -12/31/2021. Premier, Inc.)

They cite the American Hospital Association categories of care provided to neonates by delineating four codes corresponding to varying degrees of intensity of clinical care provided to neonates. These four codes are widely accepted as billing designations and focus on the quantity and intensity of nursing, medical care, and services the newborn needs on a given day. The billing level of care is determined retrospectively and should reflect the resources and intensity needed (over 24 hours, midnight to midnight). The appropriate billing code fluctuates (up or down) during the neonate's stay. Billing codes are independent of the care location and do not directly correspond to the facility level. (Revenue code table 017x Nursery In: UB-84 Official Data Specifications Manual 2023 Ver 17:00 July 2022 ed. American Hospital Association. 2022: 128-129.

"Edwards and coworkers reported in 2021 that between 2005 and 2018, postmenstrual age discharge increased an estimated 8 to 9 days for all infants among 314,811 infants from 814 US Vermont-Oxford Network member hospitals born at 24-29 weeks gestational age without major congenital abnormalities who survived to discharge from the hospital."

Their report lacks the variation in LOS among various NICUs, usually expressed as a Z score. Edwards and coworkers reported in 2021 that **between 2005 and 2018, postmenstrual age discharge increased an estimated 8 to 9 days for all infants among 314,811 infants from 814 US Vermont-Oxford Network member hospitals born at 24-29 weeks** gestational age without major congenital abnormalities who survived to discharge from the hospital. They used quantile regression, adjusting for infant characteristics and complexity for the hospital course, and estimated differences in median age weight and discharge z-score at discharge stratified by gestational age at birth and NICU type. An increase in postmenstrual age at discharge increased in all gestation age categories, with the greatest increases among infants born at 24 weeks (discharge at 42 weeks), at 25 weeks (discharge at 40.7 weeks), and at 26 weeks (discharge at 39.8 weeks) from 2005 to 2018. During this interval, the number of infants discharged from the hospital on any human milk, which included exclusive human milk and human milk plus fortifier, increased from 2005 to 2018. Previously, they had described that infants discharged on human milk alone or in combination with formula showed improvements in weight z-score charge and weight velocity from 2012 to 2016, similar to formula-fed infants. They noted that non-Hispanic Black and Native American infants less likely than non-Hispanic white infants to be discharged on any human milk (2) Further, variation in the diagnosis of apnea of prematurity and its treatment in moderately premature infants 33-34 weeks' gestation at birth was noted by Eichenwald and coworkers (3) found that the mean postmenstrual age at discharge was higher infant diagnosed with apnea compared with those without apnea (36.4 +/- 1.3 vs 35.7 +/- 0.0, P<0.001, analysis of variance). They also report among 10 NICUs in California and Massachusetts comprising the study population that there was significant inter-NICU variation in the proportion of infants diagnosed with apnea (range 24-76%), p<0.001) and an increase in the age at discharge among infants with a diagnosis that included apnea of 1.2 weeks, p<0.001. They suggest that as much as 28% of the variability in postmenstrual age at discharge between NICUs could be explained by the variability in the proportion of infants diagnosed with apnea.

Thus, any determination of the "appropriate" length of stay must take into consideration the choice of nutrition for very low birth weight infants and the occurrence of apnea, and no single predicted "normal length of stay" can be predicted by MCG Health Informed Care Strategies or another firm without consideration of these factors among many.

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Recommended LOS for Hypoxic-Ischemic Encephalopathy

MCG Informed Care Strategies also states the goal of the length of stay for an infant with hypoxic-ischemic encephalopathy is three days, but that extended stays beyond this goal can be of moderate (four to seven days) or prolonged (seven or more days) when there is insufficient feeding, developmental or neurologic abnormalities (e.g., Seizures, lethargy, abnormal imaging finding or EEG), respiratory insufficiency and the need for ventilatory assistance or infection (e.g., sepsis, pneumonia) diagnosed or suspected (e.g., fever, hypotension). (MCG Health Informed Care Strategies. Update 6/28/2023). Nothing is stated regarding neonatal cooling and rewarming intervals, time until imaging, and requirement for subspecialty services, physical and/or occupational therapy assessments, or home readiness.

Recommended LOS for Sepsis

Their 27th edition guideline for confirmed neonatal sepsis (ORG: P-425) lists an anticipated stay of 10 days, with an extended stay for delayed diagnosis, gram-negative bacteremia, Herpes simplex, and a positive cerebrospinal fluid culture. Fungal infections are expected to have a moderate stay extension.

Recommended LOS for Neonatal Hyperbilirubinemia

Neonatal hyperbilirubinemia has a goal of two days hospitalization according to MCG Informed Care Strategies, and Admission indicated by one or more of the following indications: Total serum bilirubin (TSB) exceeding risk threshold for phototherapy in an infant without neurotoxicity risk factors (other than gestational age) as indicted by: TSB meets or exceed phototherapy threshold, the rapid rise of TSB within the first 24 hours after birth at a rate of 0.30 mg/dl per hour or more, and rapid rise of TSB at 24 hours after birth or later at a rate of 0.20 mg/dL per hour or more Risk factors include serum albumin < 3.0 g/dL, iso-immune hemolytic disease with a positive direct antiglobulin test, glucose-6-phosphae dehydrogenase deficiency, and other hemolytic conditions such

as sepsis, significant clinical instability in the previous 24 hours, such as asphyxia, significant lethargy temperature instability, or acidosis that could extend the hospital stay. Need for exchange transfusion or intravenous immune globulin are designated as reasons for an extended stay. They cite American Academy of Pediatrics guidelines for indications for phototherapy with the caveat that "clinicians and families may choose to employ phototherapy at lower levels of TSB based on individual circumstances and preferences such beginning phototherapy at a subthreshold level during a birth hospitalization to reduce the risk of readmission if the absolute level or rate of rise of the TSB suggests a high likelihood of exceeding the treatment threshold after discharge citing the American Academy of Pediatrics Clinical Practice Guideline revision by Kemper, AR, et al. (4). Alternatives to hospital admission are listed to include home phototherapy and frequent feeding with lactation consultant if needed. However, no consideration is made for parents living far from hospital laboratories for sequential bilirubin measurements or the safety of home phototherapy in many households.

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Recommended LOS for Neonatal Opioid Withdrawal

A commercial group encourages the use of non-evidence-based guidelines. For example, Amerigroup Guideline CG-MED-26 (https://medpol.providers.amerigroup.com/dam/medpolicies/amerigroup/activie/guidelines/gl_\pw_a053765.html.) cite int their 4/12/2023 Utilization Management Guidelines for Neonatal levels of care. They list conditions and services for many neonatal levels of care (levels 1-4 NICU care) with specific diagnoses. They particularly focus on neonatal opioid withdrawal syndrome and mention the modified Neonatal Abstinence Scoring System but also endorse an alternate tool called Eat, Sleep, Console (ESC) suggested by Grishman and coworkers (5) to guide treatment by the infant's clinical signs of withdrawal though their ability to eat, sleep undisturbed, and be consoled. They acknowledge that this approach has only been studied through quality improvement programs, and it is unclear if improvements result from this approach itself or better adherence to nonpharmacologic management, resulting in cost savings by earlier discharge. However, they state, "Admission to and continued stay in appropriate neonatal levels of care are considered NOT MEDICALLY NECESSARY when their criteria are not met. Often, funding is halted using guidelines that have not been rigorously tested in contrast to other scoring systems for neonatal opioid withdrawal.

It is disappointing that most NICU case management groups fail to cite the 2023 Standards for Levels of Neonatal Care: II, III, and IV published in Pediatrics, which provides the most current description of care practices by the American Academy of Pediatrics NICU Verification Program (6). Furthermore, the multiple variables associated with an infant's diagnosis and multidisciplinary approaches for discharge readiness using a parental and nurse survey for all families prior to discharge from a large NICU as discussed by Gupta and coworkers (7), demonstrated substantial variability but improved readiness when caregiver-parent dyads dedicate resources to improve parental readiness for taking their infant is not mentioned or used by commercial case management firms. Parental psychosocial support using individualized, flexible, but realistic pre-and post-discharge plans with parents requires insurance funding in the transition from hospital to home and community (8).

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In conclusion, we have meticulously examined the nuanced landscape wherein certain private organizations have capitalized on the commercialization of lengths of stay or very low birth weight infants based on gestational age at birth, disregarding associated diagnoses and consequently attempting to exert a substantial influence on when payers perceive that an infant has readiness for NICU discharge. These are based on stay averages and do not generally account for unique aspects of required care for many neonates and their families and their readiness to get their infants home.

A striking comparison emerges between the avenues available to primary physicians for disputing lengths of stay, as afforded by the CFR, and the more abrupt denial of care often observed when insurers make decisions regarding discharge dates and those advising them through contractual arrangements focused on reducing the cost of care as they promise in their promotional materials.

"Neonatologists are advised to be informed and willingly collaborate with their institutional Utilization Review committee to represent infants and families under their care better and advocate for more patient and family-centered decisions regarding length of stay, utilization of resources, and quality of care in the NICU. "

Neonatologists are advised to be informed and willingly collaborate with their institutional Utilization Review committee to represent infants and families under their care better and advocate for more patient and family-centered decisions regarding length of stay, utilization of resources, and quality of care in the NICU. Knowledge of their right to appeal decisions through their Utilization Review committee and arbitrary decisions by insurers is essential. Neonatologists should exercise their rights to dispute denials for funding of care granted through the cited CFR regarding Utilization Review and peer-to-peer discussions to refute arbitrary

decisions made by insurers. UR committees afford opportunities to defend care practices and needed lengths of stays for individual patients and not be tied to a formula proposed by case management firms. Neonatologists should embrace this opportunity for the well-being of their patients, families, and professionals dedicated to caring for critically ill newborns.

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