

Implications of Managed Care Denials for Pediatric Inpatient Care

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Abstract

With the growing penetration of managed care into the healthcare market, providers continue to experience increasing cost constraints. In this environment, it is important to track reimbursement denials and understand the managed care organization's rationale for refusal of payment. This is especially critical for providers of pediatric care, as children justifiably have unique healthcare needs and utilization patterns. We developed a system for tracking and documenting denials in our institution and found that health maintenance organizations denied claims primarily for one of three reasons: medically unnecessary care, care provided as a response to social (rather than medical) need, and provider inefficiencies. Health maintenance organization denials are also growing annually at our institution. This knowledge can not only help providers of pediatric care more effectively negotiate future contracts, but provides an opportunity to differentiate the health needs of the pediatric patient from those of the adult. This information can be used as a basis for education, pediatric outcome studies, and guideline development—all tools that can help providers receive reasonable reimbursement for pediatric services and enable them to meet the complex health needs of children. Recommendations for action are discussed.

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Our Milwaukee-based tertiary care pediatric hospital is in a region of the country with almost 50% market penetration by managed care organizations (MCOs). The most common MCO model in our area is the health maintenance organization (HMO). According to the Wisconsin Hospital Association, in 1994 HMO penetration was estimated to be 36%, and preferred provider organization (PPO)

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penetration was approximately 15% to 20%.

Our institution, in particular, has more than 50 managed care contracts with a variety of HMOs, PPOs, independent practitioner associations, medical groups, businesses coalitions, and physician hospital organizations. Under nearly all of these contracts, we discount our charges, and three of our contracts provide a capitated payment structure. Under these capitated contracts, we receive a regular, fixed payment per member in return for a specified level of care, almost regardless of how often each patient uses our services. However, outlier clauses in these contracts do protect our institution from excessive expenses.

Recently, we designed an inpatient tracking system that categorizes all third-party payor denials. This system allows us to identify and document recurrent reimbursement problems. Intimate knowledge of trends is essential if we are to successfully negotiate future MCO contracts and maintain our current level of care.

... METHODS ...

We developed a computerized system based on Medical Information Data Systems (MIDS) software that tracks and categorizes all HMO denials.

We classified each denial into one of the following eight categories: clinical management (denied surgical and medical care days), no neonatal intensive care unit (NICU) status (patient received NICU care unnecessarily), no intermediate intensive care unit (IICU) status, family/social (social problems that impede discharge), child protection services (eg, neglect or abuse but no immediate medical danger), no home care available or permitted, hospital-based problems/delay in services, and other. Essentially, regardless of the specific category, HMO denials were based on one of the three primary rationales: unnecessary care, social reasons, or provider inefficiencies.

We subsequently collated total days denied based on diagnosis-related group (DRG) data and recorded

the related financial loss associated with each category. We have also developed a relational data base of all patient related-diagnosis related groups (APR-DRGs), and this will enable us to compare our data with that of other pediatric hospitals nationwide.

We then assessed the trends and created a narrative description of our analysis in the context of the managed-care environment at our pediatric institution. Our intention was to gain a deeper understanding of the HMO's denial policies, strengthen our negotiating position, and use this information as a platform for future reform.

... RESULTS ...

In 1994, 111 claims were denied by the HMOs, amounting to 223 days and \$193,000 worth of care.

Table 1 summarizes all of our HMO denials for 1994. Since 1994, the number of days denied has risen by approximately 80 to 100 each year.

Table 2 shows the number of cases and days denied for each of the eight categories. Although there were only four cases denied due to unnecessary surgical or medical care days, "clinical management" is the denial category with the most financial impact on our institution. Fifty-six percent of the total days denied in 1994 (124/223) resulted from these four cases.

Unnecessary Care Denials

Payors argue that they are responsible only for medically necessary care. This policy, strictly interpreted and enforced, is particularly challenging for the physician who cares for chronically ill children.

Clinical Management Category.

Denials in this category tend to stem from the fact that, while advances in the management of chronically ill children have increased dependence on high technology equipment in the inpatient setting, this level of care is not matched by a supporting system of trained providers and step-down units. This supporting system is needed to provide continued care on an outpatient basis.⁸

Managed care payors also closely scrutinize rehabilitative services for inpatients and increasingly require documented time and treatment outcome parameters as a prerequisite for reimbursement approval. Given the multidisciplinary nature of rehabilitative care and the lack of scientifically validated outcomes guidelines, it is not always possible to provide these data.

Case 1 is an example of a denied claim in this category. In this category, our institution has experienced both denied medical days, as well as denied surgical days.

Providers and payors commonly disagree on the number of medical days required to treat respiratory disorders, especially asthma. This is primarily due to conflicting judgments about the child's stability and

Table 1. 1994 HMO Denials in Number of Denials, Days, and Dollar Amount

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
# of Denials Received	56	26	12	17	111
# of Days Denied	93	59	30	41	223
Amount Denied*	\$70,800	\$51,700	\$36,900	\$33,600	\$193,000

*Does not reflect amount under appeal or lost under capitation.

Table 2. 1994 HMO Denials by Category*

Rationale/Category	Number of Cases	Number of Days Denied
Unnecessary Care:		
Clinical Management	4	124
No NICU Status	3	5
No IICU Status	2	8
Social Reasons:		
Family/Social	3	23
Child Protection Services	5	43
No Home Care	1	6
Provider Inefficiencies:		
Hospital Services	9	9
Other	2	5
Total	29	223

*Does not include cases under appeal.

thus, readiness for discharge. Generally, HMOs expect discharge shortly after the intensity and severity criteria for hospitalization are no longer met. Physicians commonly disagree, arguing that the child, although no longer in the throes of an acute episode, requires some observation in order to prevent a quick readmission.

As far as surgical days, HMOs increasingly require documentation of expected outcomes, and when clinical situations lack scientifically validated outcomes data, the circumstances of one case can set a precedent for future reimbursement claims. For example, HMOs may frequently question the physician about the time a child with a femoral fracture spends in traction, prior to casting and discharge. In doing so, the HMO is essentially documenting the amount of time needed to allow new bone formation and the degree of ambulation required to permit discharge. The HMO may then use these criteria to judge future pediatric femoral fracture claims.

In addition, HMOs rarely approve preoperative days, as they require evidence that the child is medically unstable and needs consultation and/or therapy before surgery. HMOs also tend to monitor postoperative days very closely, and documentation of stability is interpreted by the HMO as readiness for discharge.¹ Retaining the patient beyond this point is often considered unnecessary.

No NICU/ICU Status Categories. Although there is a relatively small number of claims in these categories, ICU criteria present potentially difficult issues. There are no standard criteria to justify the need for intensive care, so these claims are open to subjective interpretation by third-party payors. In our experience, many HMOs perceive that, unless a patient requires respiratory support and multiple intensive monitoring, care should be provided in intermediate units. Further, the practice of using an intermediate unit as a step-down facility (before discharge to a general floor) is not recognized as higher-level care and is reimbursed at a regular floor rate. A similar argument is being used by payors for the NICU.

Denials for Social Reasons

Payors also hold that they are not responsible for care that is necessary due to social reasons. In the care of the chronically ill pediatric patient, however, social and medical issues are not always separable.

Family/Social Category. We have noted several social circumstances that tend to recur in this category. They are: delayed discharge due to inadequate or lack of facilities, or lack of a trained caregiver. Although a lack

of physical necessities at home such as heat, a working phone, wheelchair ramps, or appropriate bathroom facilities may impede discharge, HMOs define these circumstances as purely social problems. When a newly disabled or chronically ill child has an acute-care need, there can be a significant delay in locating an appropriate care facility, despite the fact that certain state and county agencies are charged with ensuring their availability. Although it may be unsafe to discharge these children, the hospital bears full financial responsibility for any care provided during the delay.

When there is difficulty training a caregiver at home, which is most common in single, young adult households, expenses incurred by the hospital due to delayed discharge are not reimbursable if the child is medically stable. As illustrated in case 2, payors increasingly refuse reimbursement for care of technology-dependent children who do not have caregivers. Unfortunately, this position has also been taken by the state authorities, based on appeal of an HMO denial to the State Commissioner of Insurance.

Child Protection Services Category. In our experience, HMOs almost universally deny reimbursement when a county protection agency is involved. The only exception is a clearly unstable medical condition. Two types of denials, in particular, are most common in this category. The first is the patient who has been or is suspected of being abused physically or sexually but is

Case 1. Clinical Management Denial

A patient dependent on total parenteral nutrition was brought to the hospital with a clotted central line. Multiple interventions in the emergency room failed. The patient was admitted. The hospital stay was denied, because the payor claimed that surgery for a replacement line should have been performed immediately.

Case 2. Family and Social Problems Denial

The sole caregiver brought a ventilator-dependent child to the hospital, because the caregiver had significant mental stress and could no longer care for the patient. In the absence of any alternative, the patient was admitted for ventilation and monitoring while an alternative family was identified and trained. The payor denied the entire claim, citing this case as a social issue.

in no immediate medical danger. The initial emergency room evaluation is reimbursable, but any further intervention such as psychosocial, psychiatric, or imaging studies designed to determine the extent of abuse are authorized as outpatient services only if they are proven to be medically necessary. Any examination or further evaluation performed while a policy hold order exists (ie, detention in hospital) is defined as a legal/social issue, and in many cases, is not reimbursable.

The second type of denial that we commonly see in this category is one of neglect; ie, when a child presents with failure to thrive or has a recurrent medical condition due to inadequate parental care. If these children do not have an immediate, medically unstable condition, care is not reimbursable. This policy has placed an enormous burden on local agencies, which previously used hospitals as temporary homes for these children while finding foster families.

No Home Care Category. Claims resulting from care of patients who are unable to obtain home care are routinely denied by third-party payors. Agencies most commonly refuse this care due to lack of state reimbursement, physical barriers, or lack of family cooperation.

Denials Based on Provider Inefficiencies

The hospital services category denials is based on the payor's assessment of hospital operations and determination that care could have been provided more efficiently. For example, HMOs are increasingly requesting hospitals to facilitate late evening discharges. For infants with suspected sepsis, payors have requested our clinicians to read culture results at 48 hours and discharge the patient, provided all results are negative. To accomplish this, we altered staff schedules and purchased continuous blood culture sampling equipment.

We cannot always increase efficiency, however. For example, we do not have control over timing of tests performed at independent laboratories. In some circumstances, we cannot reduce the amount of time needed to perform tests, such as sleep studies. We have also found that it is not cost effective to provide fully staffed magnetic resonance imaging or operating rooms 24 hours a day, 7 days a week.

Other Denials

Other denials are rare but typically involve costs for observation only, last-day care, procedures deemed medically unnecessary, and cosmetic procedures.

Managed care in general has significantly affected the operating budget of our hospital. In 1994, the hospital's total operating budget was an estimated \$200 million. Approximately 25% of our operating expenses were due to a discrepancy between charges for services rendered and reimbursement received for the services. Managed care 'discounts and adjustments' totaled \$20 million and the state title 19 (Medicaid) program accounted for approximately \$30 million in similar adjustments.

Studies show that this financial burden may be greatest on healthcare institutions that provide care to children. According to resource-based studies, the cost of care provided to children is often substantially greater than that provided to the 'average' patient.² In particular, resource-based costs per unit of service are highest for patients under 3 years of age. Children's hospitals also serve a disproportionate share of patients with chronic conditions. In 1990, 54.7% of children's hospital patients had at least one chronic condition.³

Because pediatric patients have unique care needs, children's hospitals also have unique resource utilization patterns. Yet, this distinction is not recognized by MCOs. For example, we provide ancillary services such as respiratory therapy, physical therapy, and recreational therapy using specialized equipment designed for children. We also provide hospital-based schooling and specialized testing, such as pediatric pulmonary function. As a result, reimbursement for pediatric healthcare that is based on average DRG costs can be inadequate.

Our pattern of denials further demonstrates that MCOs continue to apply adult principles to the pediatric market. Yet, unlike the adult patient, the health of the pediatric patient is often dependent on social and/or economic circumstances that are beyond the patient's sphere of influence. A child's medical stability depends to a significant extent on the adequacy of the home and ability of the caregiver, and as a result, his medical and social needs cannot be separated.

If this pattern of reimbursement continues, the situation for both pediatric patients and children's healthcare institutions may worsen. Our institution has experienced increasing financial constraints in an era where reimbursement is still based on a discount-from-charges model. In the future, the anticipated increase in the number of fully capitated contracts may further restrict reimbursement. In addition, it appears that any movement toward a national healthcare system is likely to be based on Medicare's prospective payment sys-

tem, since a consistent classification system will allow maximum comparison among hospitals.⁴ Yet, this system is based on adult utilization patterns.

This problem, however, also presents opportunity for providers of pediatric healthcare. Through education, pediatric outcome studies, and guideline development, we can help ensure that the health needs of the pediatric patient are met in the future.⁵⁻⁹ Our recommendations for action, which are both inside and outside of the institutional purview, follow.

Federal and State Levels

1. Hospital managers should encourage the use of payment systems based on the APR-DRG grouper, rather than institutional level adjustments.

2. Chronically ill, technology-dependent, and disabled children incur significant healthcare costs. High-risk pools that provide reasonable reimbursement to providers should be offered to payors. A similar program, Targeted Managed Care, has been instituted in Wisconsin.

3. Create and license long-term care facilities for chronically ill and disabled children with special needs. Without these facilities, MCOs may restrict access to care, and there is less incentive for providers to develop programs that will ensure quality care for these patients.

4. Promote legislation that increases patient responsibility. Currently, providers are unable to hold members responsible for seeking unnecessary care. Examples include unnecessary ambulance transports, unauthorized and unnecessary emergency room visits, and noncompliance. Specific measures may include institution of a copayment or payment of an administrative fee, elementary and high-school education about appropriate health care use, and a reward system for appropriate behavior.

5. Generate outcomes-based clinical practice guidelines. Until these data are available, encourage regulation of the MCOs' ability to make subjective reimbursement decisions.

6. Create a new DRG class for the medically neglected patient. This would enable reimbursement for care given to children who lack an adequate caregiver or have other social reasons for medical instability.

Local and Institutional Levels

1. Encourage involvement of local MCOs in the design of case management plans for patient diagnoses. This will eliminate conflicting management decisions and allow for reasonable reimbursement until national data are available.

2. When designing or modifying hospital programs, involve major third-party payors at the onset. An ongoing dialogue may help minimize contracting issues that will arise when the new program is implemented.

3. Providers should create regular managed care forums that allow a joint approach to complex issues such as care of abused and neglected children and creation of long-term care facilities to reduce costs.

4. Focus on developing effective prevention and monitoring programs for patients with recurrent health-care demands. For example, asthma is associated with enormous morbidity and costs, and measures such as home inspection for allergens and proper ventilation, as well as smoking cessation programs, could help reduce these costs.

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